REPORTABLE **Case No 4026/2003**

IN THE HIGH COURT OF KWAZULU-NATAL,
PIETERMARITZBURG
REPUBLIC OF SOUTH AFRICA

In the matter between :

KISHORE SONNY	First Plaintiff
JAYANTHIE DEVI SONNY	Second Plaintiff

and

PREMIER OF THE PROVINCE OF KWAZULU-NATAL	First Defendant
eTHEKWINI MUNICIPALITY	Second Defendant

Delivered : 7 August 2009

J U D G M E N T

LEVINSOHN DJP

INTRODUCTION

[1] During December 2003 first and second plaintiffs, husband and wife, instituted an action against the first defendant, the premier of the province of KwaZulu-Natal, and the second defendant

the eThekwini Municipality. In the first instance the two plaintiffs claimed payment of an amount of R6 600 000-00 from the defendants jointly and severally, alternatively, the first defendant, and further alternatively, the second defendant. The second plaintiff claimed an amount of R150 000-00 from the defendants.

[2] In support of the relief claimed the plaintiffs made the following allegations in their particulars of claim which I briefly summarise.

[3] During February 2002 the second plaintiff conceived a child whose natural father was the first plaintiff. At that time second plaintiff's age was approximately 36.5 years.

[4] During or about the 26th June 2002 the second plaintiff attended at the Clare Estate clinic which was under the control of the second defendant. She became a patient at that clinic. Thereafter she was referred to the antenatal clinic at Addington Hospital under the control of the first defendant.

[5] The plaintiffs aver that a contract was concluded between the second defendant and the second plaintiff. The material terms of such contract were that the second plaintiff would receive advice and treatment at the clinic in connection with her pregnancy, that advice and treatment would be carried out with due and proper care and skill. In addition the second defendant's servants would take reasonable steps to establish whether there existed a substantial risk that the foetus would suffer from any severe physical or mental abnormality. If such a risk existed the second defendant's servants would timeously advise the second plaintiff and afford her an opportunity of electing whether to terminate her pregnancy in terms of the Choice on Termination of Pregnancy Act, 1996 (Act No 92 of 1996).

[6] The plaintiffs further allege that the servants of the second defendant owed a duty of care to the plaintiffs to take all reasonable steps to ensure that the second plaintiff would be

advised timeously of any substantial risk that the foetus would suffer from a severe physical or mental abnormality.

[7] During the periods 25th June 2002 to 22nd October 2002 the second plaintiff was treated and advised at the Clare Estate clinic on the following dates 25th June, 26th June 2002, 30th July 2002, 27th August 2002, 1st October 2002 and 22nd October 2002. On two dates, namely 26th June 2002 and 22nd October 2002 it is alleged that the second plaintiff was referred by the personnel at the Clare Estate clinic to the antenatal clinic at Addington Hospital. On the first mentioned date the second plaintiff became a patient at Addington Hospital. She was diagnosed as being pregnant with a foetus of seventeen weeks gestational age. An ultrasound scan indicated that the head of the foetus was low and difficult to assess but that the lateral ventricles of the brain appeared prominent.

[8] The plaintiffs allege that the second plaintiff concluded an agreement with the first defendant in terms whereof she would receive

treatment and advice and that such treatment and advice would be carried out with due diligence and skill. In particular the first defendant's servants would take all reasonable steps to establish whether there existed any substantial risk that the foetus would suffer from any severe physical or mental abnormality. If so they would advise the second plaintiff accordingly and afford her the choice of terminating the pregnancy in terms of the said Act. An allegation is also made that the first defendant owed the second plaintiff a duty of care.

[9] It is alleged that both on 26th June 2002 and 23rd October 2002 the second plaintiff underwent an ultrasound scan. On 28th October 2002 a cordocentesis was performed on the second plaintiff. This was a procedure to determine the chromosomal composition of the foetus.

[10] On 16th November 2002 the second plaintiff gave birth to a girl. The child suffered from Down Syndrome. At the same time the first defendant's servants performed a bilateral tubal

ligation upon her which rendered her permanently incapable of natural procreation. It is averred that this procedure was performed without the second plaintiff's informed consent.

[11] It is further averred that the first defendant's servants breached their obligations in terms of the alleged agreement and also they acted unlawfully and negligently in breach of the duty of care. The particulars of claim go on to allege various grounds of negligence which at this stage it is unnecessary to traverse but I shall presently focus on the pleadings in more detail.

[12] It is alleged that had the second plaintiff been properly advised she would have caused the pregnancy to be terminated. Instead she gave birth to a child who is severely physically and mentally disabled and will be unable to support herself. The plaintiffs are in consequence obliged to support the child for the rest of her natural life. Thus the first head of damage mentioned above.

[13] The claim for R150 000-00 is alleged to be the damage suffered by the second plaintiff in consequence of the unlawful performance of the tubal ligation mentioned above.

[14] The first and second defendants in due course delivered pleas and joined issue. At this issue it is unnecessary to traverse those documents. Later in this judgment I shall refer thereto if it becomes necessary.

[15] The trial of this action commenced on 12th March 2007 and proceeded on the following days 13th, 14th and 15th. The parties had agreed that the issue of liability should be determined in terms of Rule 33(4) and it was ordered accordingly. The trial was then adjourned and resumed again on 9th June 2008. Evidence was led on 9th, 10th, 11th June whereafter the trial was again adjourned. When the trial resumed on 1st December 2008 the second defendant had instructed a new counsel, Mr Naidoo. Counsel informed the Court that the second defendant had made a "with prejudice" offer to settle the issue of liability with the

plaintiffs. In essence the second defendant conceded liability for 33⅓% of the plaintiffs' damages. Plaintiffs' counsel announced that the offer was accepted. It followed therefore that a valid agreement of settlement had been concluded between the plaintiffs and the second defendant and that therefore the *lis* between them had fallen away. Consequently counsel for the second defendant was given leave to withdraw.

[16] It became clear after debate between counsel and the Court that inasmuch as the first defendant had not sought to join the second defendant as a third party joint wrongdoer in terms of Rule 13 nor did it allege that the second defendant was liable to make any contribution to it, this essentially boiled down to the fact that there was no *lis* between the first and second defendants. The second defendant thus effectively fell out of the picture.

[17] Notwithstanding that it had resolved the matter with the second defendant the plaintiffs persisted in pursuing their case against the first

defendant. The trial proceeded. Evidence was concluded on 2nd December 2008. The Court heard argument on 26th March 2009. Judgment was reserved on that date.

THE EVIDENCE IN THE CASE

[18] It is convenient at this stage to set forth in summary form the salient evidence which I conceive to be relevant to the issues which fall to be decided in this case.

[19] The second plaintiff was the first witness called by her side. She testified that on 25th June 2002 she went to the Clare Estate clinic which is under the control of the second defendant. That clinic is close to her home and she had attended at that clinic for the birth of her first child. According to the second plaintiff she went to the clinic early in the morning. She underwent a registration process and was given a green card which was handed in as exhibit "A2a". She was then directed to the nurse in charge where her medical history was taken, including the fact that her first pregnancy had been a normal one and a

normal delivery. She indicated that there was a family history of diabetes and high blood pressure. The nurse then took some blood samples and did a urine, blood pressure and diabetes check. The second plaintiff was told that she should come to the clinic the next day in order to receive a referral letter to Addington Hospital. When she returned to the clinic the following day the nurse performed another sugar test and then gave her a referral letter to Addington Hospital. The referral letter was handed in as exhibit "95a". According to the second plaintiff it was sealed in a brown envelope.

[20] The second plaintiff arrived at Addington Hospital and she showed the nurse in charge her referral letter. The second plaintiff had overheard that same nurse at Addington Hospital announcing that no one would be seen unless they were in possession of a referral letter. The second plaintiff then underwent a registration process at Addington Hospital. She handed her green card, exhibit "A2a" to the clerk for that

purpose. All the information which she gave to the clerk was recorded on a computer.

[21] The second plaintiff that her husband, the first plaintiff, accompanied her and was present when she registered.

[22] The second plaintiff was then told to see a nurse who also did a urine, blood tissue, sugar test as well as a weight check.

[23] The second plaintiff said that she then saw a doctor. When asked to give a description of the doctor she said the following : -

> "She was an Indian female. She was not a South African.
>
> Why do you say she is not a South African? --- Because I could make out from her tone of – the way she spoke.
>
> LEVINSOHN DJP Her accent? --- Her accent, the way she spoke.
>
> Who did she speak like? Came from India, or Mauritius? --- More or less India, if not India, Pakistan or something."

[24] When asked what happened when she went to the doctor she said that the doctor examined her and referred her to the ultrasound room. She said

that when she was examined the doctor placed a cone on her stomach and pressed her hands thereon. While this was happening her husband was outside waiting on the bench. The second plaintiff said that she was directed by the doctor to the ultrasound room : -

> "Go down the passage, turn left and you'll find the ultrasound".

[25] She described the ultrasound procedure. She said that a gel was applied to her stomach and an object was rolled around her stomach. The person performing the procedure was watching a screen as she did that. Thereafter she was handed the ultrasound examination report which was apparently computer-generated. She was told by the Indian radiographer that she must take the report to the doctor and also that she needed to be re-scanned in two weeks' time.

[26] The second plaintiff returned to the doctor that she had previously seen. On her way while she walked down the passage she said that she read the ultrasound examination report and remembered

reading the words "the head was low and difficult to assess." She also remembered reading the words "suggest re-scan in two weeks' time". At that stage no one had suggested that there was anything wrong with the foetus. No one had suggested to her at that stage that she was indeed a high-risk patient.

[27] The second plaintiff said that she returned to the same doctor. The second plaintiff testified as follows and I quote *verbatim* : -

> "MR HARTZENBERG Thank you, M'Lord. Ms Sonny, did you then, as you were requested to do, go back to that same doctor? --- Yes, I did, M'Lord.
>
> And what happened there? --- I handed my ultrasound examination report to the doctor. She read it and she asked me to come back in two weeks' time.
>
> LEVINSOHN DJP Did she say why? --- No, she did not.
>
> Did she tell you you were a high risk patient? --- Not at all.
>
> Did she tell you that there might be some dangers in your pregnancy? --- No, M'Lord.

MR HARTZENBERG Was any appointment made for you at Addington Hospital or to return? --- I asked her for an appointment, M'Lord, and I was told I need to go to the Clare Estate Clinic as they were to refer me to Addington Hospital.

LEVINSOHN DJP But surely, you'd already been referred and that would just be – this is just a follow-up on, why would you have to go back to Clare Estate to be referred once again? Did you ask them why? --- I said to her, "I need a referral letter to come here because the nurse would not attend to me in the front, she won't let me to go and register at the desk" and then I said to her I need an appointment. She said, "no, we do not make appointment at Addington".

Yes, so she told you you had to go back to Clare Estate to get a letter? --- Clare Estate, yes, M'Lord."

[28] The second plaintiff said that she and her husband on the same day returned to the Clare Estate clinic. They found the clinic had closed. There were no patients there. She knocked on the door. A nurse came to the door and the second plaintiff explained to her why she was at the clinic. She told this nurse that she had been at

the clinic that morning and had been given the referral letter to Addington to have an ultrasound examination done. She showed the nurse the ultrasound report and told her that she was advised by the doctor to come back in two weeks' time for a re-scan. The nurse in question read the report and told the second plaintiff that there are only two ultrasounds done, one early in the pregnancy and one later. She described this nurse that she had spoken to as a senior person. This nurse wore a green uniform and actually told her that there was nothing wrong with her ultrasound report and everything was in order. Acting on the advice of this particular nurse the second plaintiff did not return to Addington Hospital for a re-scan.

[29] What in fact happened was that she remained at the Clare Estate clinic which monitored her pregnancy from time to time. According to the second plaintiff her next follow-up was on 30th July 2002 and thereafter on 27th August, 1st October and 22nd October 2002 respectively. From time to time the second plaintiff attempted to remind the nurses

at the clinic that she needed a re-scan and drew their attention to the first scan which was stapled to the green patient card, exhibit "A2a".

[30] On 22nd October 2002 the second plaintiff went to the clinic for a routine check. On that day it was found that her blood pressure and her sugar readings were abnormally high. She was given medication and told to lie down. It was then decided that she should be referred to Addington Hospital for an ultrasound scan. She was given a referral letter. This is exhibit "A93a".

[31] At Addington Hospital an ultrasound examination was performed and once again she was referred back to a doctor. The doctor read the new ultrasound report which appeared to indicate that there was "water on the baby's head". She was then given a referral letter to King Edward VIII Hospital on 24th October 2002.

[32] At King Edward VII Hospital she saw a Dr Kirsten. She explained why she had come from Addington. She showed him her ultrasound examination report as well as the first ultrasound

report. Dr Kirsten advised her that they would need to investigate whether the baby had Down Syndrome. He referred her to a Dr Govender who performed a cordocentesis. This test was performed on 28th October 2002. The results became available some time in November 2002. She was informed by Dr Kirsten that the tests showed that the baby was normal.

[33] On 15th November her baby was born by caesarean section. The second plaintiff said that prior to undergoing this operation she signed a consent to sterilisation. Her husband, the first plaintiff, also appended his signature to the form. She said that she agreed to do this because she believed there was nothing wrong with her baby.

[34] After the baby was born it was determined that she had Down Syndrome.

[35] The second plaintiff said that if she had been told that there was a substantial risk that the foetus would suffer from severe physical or mental abnormality she would have terminated the pregnancy immediately.

[36] I turn now to the first plaintiff's evidence. The first plaintiff said he was the husband of the second plaintiff. He confirmed her evidence that he had accompanied the second plaintiff to Addington Hospital. He said that his wife had seen a doctor on that occasion. He was sitting outside on a bench. His wife was attended by an Indian lady doctor. She came out of the consulting room and showed the second plaintiff where the ultrasound room was. He accompanied her to the ultrasound room. When she emerged from the ultrasound room he accompanied her back to the doctor's room where they had been earlier. The first plaintiff also confirmed his wife's evidence to the effect that if they had known about the abnormality he would have agreed to terminate the pregnancy.

[37] Professor van Gelderen was the first of three expert witnesses called by the plaintiffs. He is a specialist obstetrician and gynaecologist. He is at present professor emeritus at the

Witwatersrand University and is employed at Baragwanath Hospital as a senior specialist.

[38] He had the opportunity of perusing the various documents connected with the second plaintiff's case history. He confirmed from these that she had become pregnant in 2002. On 25th June 2002 she was 37 years of age. He said that 37 years of age is regarded as "advanced maternal age" because it renders a patient more susceptible to certain complications, in particular the incidence of congenital abnormalities. In particular genetic chromosomal abnormalities. Patients of this advanced maternal age are also prone to suffer from hypertension and diabetes. However pregnancy is not precluded at this age if it is managed properly.

[39] The professor said that normally pregnant women are managed in primary health care facilities, like the clinic in this case. However if certain alarm bells ring which would include complications that arise during pregnancy or if there are pre-existing features such as age, hypertension or diabetes,

such patients should be referred for care at a higher level.

[40] The professor was asked to comment on the initial ultrasound examination performed on the second plaintiff at seventeen weeks. He said this was performed to assess gestational age and to look for any foetal abnormalities. He noted that the ventricles were enlarged and that was a "soft marker" of Down Syndrome. He said that had he been the consulting physician he would have kept her as a patient of Addington, or if necessary, referred her to King Edward VIII Hospital for further elucidation. He agreed with the suggestion that once one reads the ultrasound report "alarm bells start ringing". He accepted that the suggestion that she be re-scanned in two weeks' time was a reasonable procedure. Arrangements should have been made for that to have happened.

[41] I turn now to review the factual evidence given by the first defendant's witnesses.

[42] Dr Devjee is the head of the antenatal clinic at Addington Hospital. She is a registered obstetrician and gynaecologist. She was asked about the protocol applied to patients who are referred from outside clinics to Addington Hospital. She said they are registered. The referral note is attached to their patient card which they have brought from the clinic. The nursing staff then take blood. She confirmed that patients will not be seen unless they do have a referral note. She said that a patient that has already undergone a scan and who is told that a repeat scan is required will need to make an appointment for that. This appointment is made by the clerk at the hospital. She said that another referral note will not be required.

[43] According to Dr Devjee at about 8.00 am in the morning there are no doctors present at the antenatal department of the hospital. These doctors are doing ward rounds and they come to the clinic much later. The nursing staff in fact order the various tests. In a case where an

ultrasound is done, the results of this together with all the other tests are put together and the patient waits for a doctor to assess her : -

> "LEVINSOHN DJP So the patient, after these tests are done, the patient will see a doctor?
> --- Yes, M'Lord.
> A doctor will for example look at the ultrasound?
> --- That is correct, the doctor will review all the results, M'Lord.
> The doctor will review the results."

[44] Dr Devjee was adamant that a doctor would record all her observations on the patient's card. If she was told to attend for a follow-up that too would be recorded.

[45] In the instant case although the second plaintiff had had an ultrasound done there was no record that she had seen a doctor because nothing was recorded on her card. Because of that Dr Devjee insisted that she had not in fact seen a doctor. Dr Devjee commented on the first scan taken. She said in the light of this scan it was not unreasonable to re-scan in two weeks' time. This more so in the light of the fact that the head

of the baby was difficult to assess and if a re-scan was performed in two weeks' time the position of the baby may have changed and this feature would have been more readily observed.

[46] Dr Devjee also that in her hospital there was no system in place to follow-up whether a patient returns for a re-scan or not. Dr Devjee made the point that if the nursing staff at the Clare Estate clinic had read the scan it would have been manifestly clear to them that they needed to send this patient back for a re-scan. The witness also made the point that the fact that the patient did not return to the hospital meant that the hospital lost out and were not in a position to perform further tests which may well have resulted in the termination of the pregnancy. In Dr Devjee's opinion there rests a responsibility upon the patient to return to the hospital.

[47] I turn now to summarise the evidence of Dr L. Govender.

[48] Dr Govender attended to the second plaintiff at the King Edward VIII hospital. On 24th October

2002 she performed the cordocentesis. She explained that this is also known as foetal blood sampling. To her knowledge she was the only person at that time in KwaZulu-Natal who performed this procedure. She enumerated her qualifications in foetal medicine which included an honorary research fellowship towards a Master's degree. She explained that this procedure is performed under direct ultrasound guidance. The placenta is visualised and they specifically look for the area of the cord insertion, the placenta cord insertion. A centimetre of the cord is visualised and a spot is found wherein a needle is inserted. This needle is visualised on the ultrasound monitor. Thereafter the witness described in detail how the blood is drawn with the assistance of a nurse. She explained that the first millilitre of blood is discarded and another two to four millilitres taken. This first millilitre is discarded because they wish to reduce the risk of maternal contamination. Dr Govender was adamant that she had properly performed this procedure. She

recalled that this was one of the best she had ever done. In her opinion there was no possibility that the blood specimens withdrawn were contaminated by maternal blood.

[49] Dr Govender also said, importantly, that s foeticide could be performed where there is gross malformation present. She said that in her hospital a fair number of these are done. When asked whether such foeticide would be performed on a foetus which has been diagnosed as having Down Syndrome she answered in the negative. She said that the view that was taken in 2002 was that because they were unable to predict the severity of Down Syndrome on a prenatal ultrasound in respect of a foetus that had become viable, the baby would be given the benefit of the doubt. In those circumstances they were would not perform a foeticide. She admitted however that after 2006 the policy had changed and a foeticide would be performed on a Down Syndrome foetus after 24 weeks.

[50] Dr Govender also said that even if the results of the cordocentesis had come back positive for

Down Syndrome they would not have performed a foeticide.

[51] In my opinion the summary of the evidence of the abovementioned witnesses provides a broad overview of the factual issues that arise in this case. There were of course several other witnesses that testified, some of them at length, but in the view I take of this case it is unnecessary to summarise their testimony in any detail.

[52] I proceed now to consider whether the plaintiffs have discharged the onus of proving liability on the part of the second defendant on the various grounds set out in the pleadings. It is of course common cause that second plaintiff gave birth to a baby which was afflicted with Down Syndrome. Stripped to bare essentials her case is that the medical professionals charged with the duty of monitoring her pregnancy breached their obligations in various respects. More particularly they failed at an early stage of her pregnancy to perform the various tests that are

required to determine whether the foetus was normal or whether it suffered from a genetic abnormality. All the expert witnesses that testified were in agreement that the second plaintiff was a high-risk patient. Her age alone proclaimed that her pregnancy ought to have been monitored at a higher level of medical care.

[53] It appears to me that from the outset the staff of the Clare Estate clinic were alive to this. Given her history of diabetes and her age the second plaintiff was indeed referred to the obstetrics unit of Addington Hospital. There is a major dispute of fact between plaintiffs' and the first defendant's servants in regard to the events which transpired on 26th June 2002. Counsel for the first defendant has argued strenuously that the second defendant's evidence is unsatisfactory and falls to be rejected. His principal hypothesis is that she is the sole author of her misfortune inasmuch as she failed to return to the hospital when she was instructed to do so. According to the first defendant's version of events, the second

plaintiff did not see a doctor on that day nor was she instructed to return to the clinic to obtain a second referral to the hospital. The first defendant's case is quite simply that once a patient of Addington and having been registered on its system there was no need for such a further referral. The system and the various protocols applicable at Addington Hospital were articulated by Dr Devjee who maintained throughout her evidence that given the absence of records to that effect, the second plaintiff had not seen a doctor on that day.

[54] I would say at once that both plaintiffs, in particular the second plaintiff, made a very good impression on me. I have no doubt whatsoever that they are honest witnesses. The second plaintiff gave me the impression that she was giving an honest and spontaneous account of what occurred on that day. The alleged inconsistencies and/or discrepancies appear to me to be of no moment whatsoever. The second plaintiff said, and this was corroborated by her husband, that after the

registration process she went to a doctor. She describes the doctor as a female doctor of overseas Indian origin. She said that doctor directed her to the ultrasound. She had the ultrasound and returned to the doctor who read her scan and told her simply that she must return for a re-scan in two weeks' time. This same doctor told her that it is the clinic that will make an appointment for this second scan. She returned to the clinic that very day for that purpose. None of the defendants ever disputed the fact that she did so. In my view this conduct on her part highlights an overwhelming probability in favour of her version. Why else would she go back to the clinic if she had not been told to do so? Somebody had told her and in my view it is overwhelmingly probable that it was a doctor that had done so. One recalls Dr Devjee's evidence that in the normal course of events a patient such as the second plaintiff would inevitably be seen by a doctor who would review her ultrasound scan. Dr Devjee was inclined to concede when questioned that it was strange that on

the first defendant's version she had simply walked out of the hospital after having the scan without seeing anyone.

[55] There is a further matter which casts doubts on first defendant's version. In paragraph 22(d) of the plaintiffs' particulars of claim the following allegations were made : -

> "The Second Plaintiff, when seen on 25 June 2002, alternatively on 26 June 2002, was assessed as being high risk because she was diabetic."

[56] The reply by the first defendant is of significance : -

> "**AD PARAGRAPHS 22(c), (d) AND (e)**
>
> **Save to state that the servants of the Second Defendant failed to make a booking for Second Plaintiff for a follow up scan, First Defendant has no knowledge of the remainder of the averments contained therein.**"

[57] In the plaintiffs' Notice in terms of Rule 37(4) the following enquiry was made : -

> "2. The Plaintiffs will address the following enquiries to the First Defendant, namely :

(a) The First Defendant is requested to describe the procedure of referral of maternity patients from Clare Estate Clinic to Addington Hospital which applied during the period June to October 2002.

(b) How many obstetric ultrasound examinations were routinely performed on each patient at the Addington Hospital Ante-Natal Clinic during such period?

(c) What are the reasons why the Second Plaintiff was not given a fixed appointment for a follow-up ultrasound examination on 26 June 2002 while she was at Addington Hospital?"

[58] The first defendant provided the following answer to question 2(c) above : -

"AD PARAGRAPH 2(c)

She was told to come back in two (2) weeks. Normally the clinic makes the booking for the patient."

[59] The enquiry posed in 2(n) was as follows : -

> "Did the servants of the First Defendant take any steps to up (*sic*) when the Second Plaintiff did not return to Addington Hospital within two weeks after 26 June 2002? If so, the First Defendant will be requested to provide full particulars with regard to such steps taken by the First Defendant's servants."

[60] The answer to this was as follows : -

> "**No, the clinic must have referred her in two (2) weeks' time for a follow up scan.**"

[61] I have quoted extensively from the pre-trial exchange of information to demonstrate that the first defendant's legal advisers were obviously instructed by their client to provide the information that they did and there has been no explanation for this. Dr Devjee's protestations therefore have a hollow ring to them. The same would apply to Dr Praveen's evidence. As indicated above the first defendant's answers serve to substantially corroborate the plaintiff's version.

[62] I accordingly reject the first defendant's version. I find as a fact that the plaintiff was

sent back to the clinic by the doctor that had seen her. This event set in motion a chain of events which ultimately led to the unfortunate consequence that the second plaintiff gave birth to a Down Syndrome child. The second plaintiff returned to the clinic and was given advice which was palpably wrong. Any health professional at the clinic applying her mind would have realised, firstly, that the second plaintiff required to be re-scanned. Furthermore, that the second plaintiff was a high-risk patient because of her age and she needed to be monitored at a higher level of care. More importantly the patient herself conveyed this information not only to the nurse that saw her on 26th June but subsequently when she reported at the clinic for her follow-up monitoring. In my opinion the servants of the second defendant were grossly negligent and it is not at all surprising that the second defendant was advised to conclude a compromise.

[63] The issue of whether the first defendant's servants were negligent or not must be approached

from an entirely different vantage point. I have found as a fact that the second plaintiff was told that it was the clinic that would make an appointment for her second scan. She was also told that this re-scan would take place in two weeks' time. The issue is whether the servants of the first defendant have been shown to have been negligent in not ensuring that an appointment was made there and then by the hospital for the re-scan. The question then is whether by sending her back to the clinic these servants created the risk that she may not return and therefore oculd not be subjected to the early tests to determine whether she carried a Down Syndrome child.

[64] The test for negligence has been laid down in several cases. One of the leading cases seems to me to be ***Kruger v Coetzee*** 1966 (2) SA 428 AD where Holmes JA said at 430 E the following : -

> "For the purposes of liability *culpa* arises if -
>
> (a) a *diligens paterfamilias* in the position of the defendant -
>
> (i) would foresee the reasonable possibility of his conduct injuring

another in his person or property and causing him patrimonial loss; and

(ii) would take reasonable steps to guard against such occurrence; and

(b) the defendant failed to take such steps.

This has been constantly stated by this Court for some 50 years. Requirement (a) (ii) is sometimes overlooked. Whether a *diligens paterfamilias* in the position of the person concerned would take any guarding steps at all and, if so, what steps would be reasonable, must always depend upon the particular circumstances of each case. No hard and fast basis can be laid down. Hence the futility, in general, of seeking guidance from the facts and results of other cases."

[65] In regard to foreseeability the principles laid down in ***Kruger v van der Merwe and Another*** 1966 (2) SA 266 AD are of importance. Williamson JA said the following at page 272 F : -

"The doctrine of foreseeability in relation to the remoteness of damage does not require foresight as to the exact nature and extent of the damage; cf. *American Restatement of the Law*,

> Torts (Negligence), para. 435. It is sufficient if the person sought to be held liable therefor should reasonably have foreseen the general nature of the harm that might, as a result of his conduct, befall some person exposed to a risk of harm by such conduct."

[66] I am called upon to apply these principles to the facts in casu. At the outset the observation is made that the plaintiffs are an unsophisticated middle-class couple and obviously not persons in a high-earning bracket. This is evidenced by the fact that they use the public health facilities. In the ordinary scheme of things one would expect the second plaintiff to respect and adhere to any instructions and directions given to her by the medical personnel charged with her case.

[67] All the experts in the case were agreed that the second plaintiff was a high-risk patient principally because of her age. The risk of her giving birth to a Down Syndrome child was ever present. The first ultrasound scan revealed, at the very least, a "red flag". I accept that she was told by both the doctor and the sonologist that

she had to undergo a re-scan. I have accepted as a fact that the doctor she saw told her that she had to return for a further scan. It would obviously have been desirable, given that in matters of this nature time is of the essence, for the scan to have been done on the very same day while she was in the precincts of the hospital. I shall assume in favour of the first defendant that, having regard to the number of patients that attend and other logistical difficulties that such a system was not practical at the time.

[68] However once the patient is sent out of the hospital's control, as it were, there rests a heavy responsibility on the attending doctor to properly inform and counsel the patient. A reasonable person in the position of a doctor would foresee the reasonable possibility of the patient falling through the cracks and not returning to the hospital and secondly, given the vagaries of the primary health care facilities she might receive the defective and almost bizarre advice from a member of the clinic staff that she did in fact

receive. It was incumbent on the doctor to inform the second plaintiff in detail of the risks she faced and precisely what the effect was of the inconclusive scan and the absolute necessity of having an urgent re-scan.

[69] I would go further. Having regard to the foreseeable consequence of some breakdown of communication or gross misunderstanding that may occur in the clinic environment, I think it was at least necessary for the doctor to have given or caused to be given some written instruction to the clinic to make it absolutely clear that the second plaintiff was required to return.

[70] My view is fortified by the *dicta* contained in the case of ***Dube v Administrator*** 1963 (4) SA 260 at 268 – 269, a judgment of Trollip J (as he then was). The learned judge quoted passages from a work by Lord Nathan "**Medical Jurisprudence**" and from a Canadian case ***Murrin v* James**. I quote from both these and the highlighted portions have been inserted by me : -

(Page 268)

"'In many cases it is reasonable or even necessary for the medical man to make the patient himself responsible for the performance of some part of the treatment which the medical man has undertaken to give. Where, as often happens, the medical man's course of action depends upon a report by the patient as to his condition or symptoms or as to the progress of the treatment, the medical man has no choice in the matter; he must rely upon the patient for the necessary information by which to determine what action should be taken, and must therefore, in a sense, delegate to the patient part of his own duties. Frequently also it would be quite unreasonable to expect the medical man to be in constant attendance upon the patient or to exercise supervision over every detail of the treatment; he is compelled therefore to delegate to the patient the performance of some part of the treatment or cure. **In all these cases where the medical man justifiably delegates to the patient the performance of some part of the treatment, there is a special duty towards the patient to give clear and unambiguous instructions, to explain to the patient in intelligible terms what is required of h+im and to give him any warning**

which may be necessary in the circumstances; and a failure in any of these respects may amount to a breach of duty and expose the medical man to liability for any injury which occurs.'"

(Page 269)

"'I am prepared to believe that in some kinds of cases, particularly in this domain of medicine and surgery, the failure by a doctor or a surgeon to warn a patient as to the meaning of certain symptoms, the significance of which might not be apparent to a layman, might properly expose a practitioner to a charge of negligence. The physician cannot always be in constant attendance upon his patient, who may have to be left to his own devices; and if the former knows of some specific danger and the possibility of its occurring, it may well be part of his duty to his patient to advise him of the proper action in such emergency.'"

[71] The learned judge also dealt with the issue of whether the plaintiff concerned was guilty of contributory negligence. He said the following:-

(Page 270)

"The remaining enquiry is whether the plaintiff himself was guilty of contributory negligence. It

> was contended that he was negligent in not returning immediately he noticed that the pain was persisting and the swelling on the Thursday or Friday. His reasons for not doing so have already been set out fully. **They show that his inaction at the critical stage was entirely due to the lack of proper instruction and warning about his returning on the part of the Hospital, as canvassed above.** This is a classical situation for the application of the principle which for the present purpose may be summarised thus: A plaintiff is generally not guilty of contributory negligence if his ostensible lack of care for his own health or safety was caused by the conduct of the defendant which induced or misled him to believe or assume reasonably that his action or inaction would not endanger his health or safety."

[72] To sum up then, I conclude that the servant or servants of Addington Hospital were negligent in the respects set out above and that for purposes of any delictual action there is no contributory negligence on the part of the second plaintiff. In any event no such contributory negligence can be

taken into account as far as the plaintiffs' contractual claim is concerned.

[73] This negligence was causatively related to the birth of the child which but for such negligence would not have been born. The finding of causative negligence recorded in the previous paragraph, strictly speaking, makes it unnecessary for me to consider whether the allegations of negligence on the part of the first defendant's servants after 23rd October 2002 have been proved. However in case this case goes further I shall set forth my finding in that regard.

[74] One recalls that that at this stage the second plaintiff's pregnancy had almost reached full term. She was referred back to Addington Hospital during this period because complications arose. The second plaintiff was subjected to tests at both Addington Hospital and King Edward VIII Hospital. The cordocentesis performed by Dr Govender was intended to exclude the possibility of any genetic abnormalities. It is common cause that the result of the foetal blood test was negative. However we

know for a fact that something went wrong either in the manner in which the test was performed or in the analysis of the samples at the laboratory. On this part of the case the plaintiffs' contention is that there was negligence on the part of the first defendant's servants, particularly Dr Govender. Dr Govender has testified that she was satisfied that she performed the test properly and that there was no possibility of the foetal blood being contaminated by maternal blood. She specifically remembered performing the test and recalled that this was one of the best procedures she had performed. There is no reason to doubt Dr Govender's expertise. Nor is there any basis to hold that she was negligent in any respects. At the same time there is no evidence to suggest that the samples taken could have been confused with anybody else's blood samples.

[75] The evidence of Mrs Kavonic who is in charge of the laboratory establishes also in my view that the testing was performed in a highly professional manner and by persons with the necessary experience

and expertise. Considering all the evidence on this issue I am constrained to come to the conclusion that the case is entirely in balance and that there is no preponderance of probability in favour of the plaintiffs' hypothesis in the case.

[76] Reverting to the issue of the cordocentesis and the probability that maternal blood had contaminated the foetal blood, thus distorting the results, there is an aspect in the evidence of Mrs Kavonic which in my view is of importance. Questioned by me at page 455, the following is recorded : -

> "LEVINSOHN DJP Just explain something to me. Let us assume as a hypothesis that you received the sample, which is contaminated by the mother's blood. Now obviously you would not have the problem of male/female thing. You know it is a female, because of the mother. --- Yes.
> But what would the effect of this contamination be on the reading of the chromosomes in general? --- If - should we have received a foetal blood specimen that was contaminated with maternal cells, then I would have expected to see both normal female cells, which would be the maternal,

and the 21:21translocation of the foetus. So we would have seen what we term a mosaic, two different cell lines.

Yes, that is what I was getting at. I other words what I was really getting at is that the fact of this contamination would not have blurred the 21:21 chromosome? - No.

You would still have seen that? --- I believe we would have seen it in a proportion of the cells, yes."

[77] The significance of this is that even if it is assumed that there was contamination the testing of the blood would nonetheless still revealed the presence of Down Syndrome in this sample. The effect of this evidence is that the contamination theory which is said to distort the results completely carries no weight in my view.

[78] I find therefore on this part of the case that the plaintiffs have not proved any negligence on the part of the first defendant.

[79] Even assuming I am wrong in the above conclusion and the first defendant's servants were negligent, I am of the view that the first defendant's servants would not have terminated the

pregnancy, in the sense of performing a foeticide. Dr Govender said that in 2002 the ethical policy of the first defendant was not to regard a viable Down Syndrome foetus as a "malformation". A foeticide would not be performed in those circumstances. The conclusion therefore is that even if the second plaintiff was told that she carried a Down Syndrome child she would not have been given the opportunity to terminate the pregnancy at 34 weeks.

[80] In the result on this part of the case the plaintiffs fall to be non-suited on the issue of whether the negligence of the first defendant is causatively related to the damage suffered.

[81] I turn finally to consider whether in the circumstances the sterilisation of the second plaintiff or the tubal ligation procedure performed on her was wrongful.

[82] The main thrust of second plaintiff's case is that the consent to the procedure was obtained without her informed consent. What this means is if she had been told she was carrying a Down Syndrome child she would not have consented.

[83] The plaintiff gave birth by caesarean section on 16th November 2002. The hospital notes reflect that a note was made on 19th November 2002 that the baby had a dysmorphic appearance which according to Professor van Gelderen is not suggestive of Down Syndrome *per se* but an appearance of abnormality. When the attending medical personnel obtained the second plaintiff's consent to the tubal ligation they would have believed on very reasonable grounds that the second plaintiff was about to give birth to a normal baby.

[84] One must not lose sight of the fact that the caesarean section delivery involves surgery and I have no hesitation in accepting Dr Govender's characterisation of the situation which I quote hereunder in full : -

> "Doctor, let us go on to the sterilisation of the second plaintiff. You have listened to the evidence of Prof Nikolaou. Basically the gist of what he said was that when one at birth sees dysmorphic child, despite the fact that there may be a consent to sterilisation, one would then not proceed with it out of caution. Do you agree

with that evidence? --- Unless it is an obvious abnormality like an encephalon seal and in that situation yes, I would say, because a sterilisation is not a life saving procedure, it could be deferred. But here in the case of Downs, where there might just be subtle dysmorphic features, and I must add it is not the duty of the doctor performing the Caesarean section to examine the baby at birth. His priority is once that baby is out to close up that uterus as soon as possible, otherwise the patient is going to bleed. So his priority is the mother and not the baby. And facial features in Down syndrome can be subtle, especially when covered with blood. So it is not his priority to examine the baby.

Doctor, the notes in the record indicate that. The doctor must have made an observation that the child was dysmorphic, abnormal in appearance. --- Was that the Caesarean section doctor's notes?

Yes. --- He probably made it retrospectively, not at the time when he took the baby out.

And if I understood your evidence earlier when I asked you about the clinical description of the child on 19 November, if I understood you

> correctly that would not have differed from what one saw at the time of birth. --- Yes, the difference being the baby at that time was covered with fresh blood as well and he is not really examining the baby. He may have documented that in the notes after he has finished the Caesar and he was informed about the baby, when the baby had been cleared up."

[85] Dr Nicolaou said that it is possible that a junior surgeon doing the caesarean may miss the dysmorphic appearance while performing the operation. In any event, as Dr Govender points out, the surgeon's main priority is to make sure that the mother does not bleed to death. The baby's face is covered with blood at the moment of delivery and it is hardly likely that the surgeon would at that stage notice subtle signs of abnormality in the baby's appearance.

[86] I am not persuaded on the evidence that the servants of the first defendant in performing the tubal ligation committed any wrongful act either intentionally or negligently *vis a vis* the second plaintiff.

[87] In the result I find that liability on this part of the case has not been proved.

[88] To sum up finally I hold

(a) that the first defendant is liable to the plaintiffs for any damage the plaintiffs may prove arising from the birth of the child on 16 November 2002;

(b) that on the claim relating to the sterilisation of the second plaintiff, the first defendant is absolved from the instance;

(c) that the first defendant is directed to pay the plaintiffs' party and party costs, to date, which costs shall include:-

(i) where applicable, the costs consequent upon the employment by the plaintiffs of two counsel;

(ii) the costs consequent arising from consultations with experts,

including travelling time and expenses;

(iii) the expenses of the following witnesses who are to be declared necessary witnesses, namely, : -

the first plaintiff, the second plaintiff and Mrs S. J. Kavonic;

(iv) the reasonable qualifying and attendance fees and expenses of the following expert witnesses, namely : -

Professor E. Nicolaou;

Dr J. Rosendorff;

Professor C. J. van Gelderen;

Mrs S. J. Kavonic;

(d) The liability to pay costs as set forth in (c) above shall be a joint and several liability with the second

defendant up to and including 1st December 2008.

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