REPORTABLE

IN THE HIGH COURT OF SOUTH AFRICA

KWAZULU-NATAL DIVISION, PIETERMARITZBURG

CASE NO: AR 501/2018

In the matter between:

THE MEMBER OF THE EXECUTIVE COUNCIL

FOR HEALTH FOR THE PROVINCE

OF KWAZULU-NATAL Appellant

and

NOKWANDA CHARLOTTE MQADI

(obo S[….] D[….]) Respondent

ORDER

On appeal from: Pietermaritzburg High Court (Mahabeer AJ sitting as court of first instance):

The appeal is dismissed with costs.

JUDGMENT

Delivered on.

Chili J et (Moodley J et Ntshulana AJ)

Introduction

[1] This appeal relates to a medical negligence claim brought by the respondent (plaintiff before the court *a quo)* in her representative capacity as the mother and legal guardian of her minor child, SD (hereinafter "the child"), who was born with cerebral palsy on 15 July 2013 at the appellant's Mahatma Ghandi Hospital in Phoenix, Durban. The issue for determination by the court *a quo* (as agreed) was whether the appellant was liable to compensate the respondent for a brain injury sustained by the child at birth. The court *a quo* found in favour of the respondent, and ordered the appellant to pay the costs of the action, including costs of two counsel, all reserved costs and qualifying fees of various expert witnesses, plus costs of preparation for the expert reports. The appeal before us is directed at the entire judgment of the court *a quo.* From hereon I refer to the respondent (Ms Mqadi) as the plaintiff.

[2] The three main issues raised before us are:

(a) Whether negligence was established;

(b) Whether causation was proved; and

(c) Which party carried the onus on these issues.

[3] It was argued on behalf of the appellant that the court *a quo* misdirected itself in placing the onus on the appellant. This argument was based on the finding made by the court *a quo* that the appellant bore the onus of showing:

> '(a) The pre-existing conditions which caused the child's cerebral palsy;
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> (b) That regardless of whether monitoring had occurred during the six hours following the administration of cytotec, the cerebral palsy would have still occurred;
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> (c) That the plaintiff was not mismanaged; and
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> (d) That even if the monitoring ought to have occurred but did not and the management was poor, that these did not amount to negligence.'

In my view, the onus on the issues of negligence and causation rested on the plaintiff. In *Goliath v MEC for Health, Eastern Cape*[1] Ponnan JA made the following remarks:

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[1] *Goliath v MEC for Health,* Eastern Cape 2015 (2) SA 97 (SCA) para 8.

> 'The general rule is that she who asserts must prove. Thus in a case such as this a plaintiff must prove that the damage that she has sustained has been caused by the defendant's negligence.'

It is trite that the onus resting upon a plaintiff never shifts.[2] I therefore am satisfied, that the court *a quo* misdirected itself on the issue of onus.

That however is not the end of the matter. With regard to a misdirection committed by the court *a quo*, Harcourt J in *Twigger v Starweave Pty Ltd*[3] commented:

> 'What, then, is the position when there has been a misdirection in regard to the incidence of *onus* by the court *a quo?* In the first place it seems to me that by reasoning analagous to that leading to the conclusion set out in point (11) in *Dhlumayo's* case, *supra*, the appellate Court is at large to disregard the reasons based upon, or clearly affected by, such misdirection and to come to its own conclusion on the matter.'

From that premise I proceed with the judgment.

The plaintiff's evidence

[4] The plaintiff's claim was decided on the contents of hospital records, expert reports and *viva voce* evidence. Four witnesses testified in the plaintiff's case viz. the plaintiff, Professor Lotz, Dr Sevenster and Dr Kara. Doctors Batchelder and Mtambo testified in the appellant's case.

[5] The plaintiff was born on 15 August 1992. She was 20 years old when she gave birth to the baby boy who is the subject of this appeal. She told the court that when she suspected that she was pregnant around September 2012, she proceeded to Clarance Park Clinic at Verulam for a check-up where her pregnancy was confirmed. She was issued with a clinic card and directed to attend monthly antenatal clinics, which she did. After relocating to Dube village, she attended a prenatal clinic at Inanda C section on two occasions, and was thereafter advised to attend at Mahatma Ghandi Clinic for her next appointment. She however took ill prior to the next appointment date and decided

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[2] See also *Arthur v Bezuidenhout and Mieny* 1962 (2) SA 566 [AD] at 573 C.
[3] *Twigger v Starweave (Pty) Ltd* 1969 (4) NDP 369 at 372 H.

to go to Mahatma Ghandi Hospital. She was kept in hospital overnight, given medication and discharged on the next day. Clinical records reflect that she was admitted on 7 July and discharged on 8 July 2013.

[6] On 14 July 2013, at approximately 19h00 she experienced lower back pains and was subsequently conveyed to the Mahatma Gandhi Hospital. She was attended to by nurses who told her to wait until around midnight when she was subsequently examined by a nurse who booked her into the maternity ward. Around 9h00 the next day, she was put on a CTG scan by a doctor and was told that the baby was still far along. An hour later she experienced pains and informed a nurse, who in turn told her to walk around to ease pain. The plaintiff told the court that the pains kept coming back a couple of times and on every occasion she repeated the same exercise. She proceeded to say that at some stage the pains were so severe that she fell when attempting to walk as directed, and had to be helped back to her bed by a fellow patient. At that moment, she realised that her water had broken and was checked by a nurse who subsequently relocated her to the labour ward.

[7] The plaintiff told the court that after the administration of a pill (which clearly was Cytotec) she experienced severe labour pains. At some point she was told by the nurses to try and deliver the baby naturally, but she was unable to due to the fact that she had lost so much strength that she could hardly breath on her own without the aid of an oxygen mask. She was eventually told that the baby was to be delivered by caesarean section.

[8] She apparently was given anaesthetics, and when she regained consciousness, she was told that her child was in the nursery. She only saw her child three days after his birth, and he clearly was not well. She was informed that the condition the child was in was caused by the fact that he did not breath properly when she was in labour. With regard to the child’s present condition, the plaintiff stated that his right hand cannot open, his arm cannot stretch, he cannot pronounce words properly and he cannot swallow solids. The plaintiff expressed extreme dissatisfaction with the conduct of the

nurses who attended to her in hospital. I will return to this aspect later in the judgment. During cross-examination, she told the court that after the administration of Cytotec, she was examined by the nurses and told that the child was still far along. Only three questions were asked of the plaintiff during cross-examination. The first question related to the administration of Cytotec as aforesaid, the second, to the child's condition and the third, to the date and time during which her water membrane broke.

[9] Dr Kara, a specialist paediatrician, told the court that the child was two years and three months old when he examined him on 1 September 2015. Dr Kara subsequently compiled a report dated 8 September 2015. He began his testimony by confirming what is contained in his report, namely, that the purpose of the examination was to establish the disability suffered by the child and to advise on a causal connection between the delivery and subsequent neurological outcome and a probability of intrapartum asphyxia being the cause of the cerebral palsy. He described 'intrapartum asphyxia' as an interruption in the supply of blood and oxygen to the foetus during labour resulting in 'hypoxic ischemic injury'.[4] Dr Kara opined that the child suffered what is referred to as neonatal encephalopathy, an altered level of brain function in a new born baby which presents itself in many forms. He made a finding in his report that the child had a motor developmental delay, which he described as a delay in movement and ability to ambulate or ability to walk. He arrived at this conclusion (so he testified) after having had regard to both his examination of the child, and the report he received from the plaintiff during consultation, and in particular, that the child sat at 10 months, that he did not crawl, and that he only walked at 21 months. Dr Kara opined that the child suffered what he termed 'quadriparesis'[5] that could possibly be resolved. He confirmed that a weakness he was able to identify was more on the child's right upper limbs.

[10] With regard to a document titled 'hospital discharge summary',[6] Dr Kara testified as follows. He stated that the perinatal problems recorded are that the child was

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[4] Hypoxia is the lack of oxygen and ischemia is the lack of pressure or lack of blood pressure.
[5] One weakness of all four limbs.
[6] Exhibit 'F' at page 370, volume 4.

exposed to meconium 3 with respiratory distress which had since resolved. He was critical of the final diagnosis recorded, namely, that the child suffered hypoxic ischemic encephalopathy grade 2 given the fact that the doctors had attended to the child for two weeks prior to discharge.[7] When referred to clinical records, Dr Kara made an observation that the child was diagnosed with metabolic acidosis at birth. He expressed a view that one of the commonest causes of metabolic acidosis at birth or soon after birth is hypoxic ischemic encephalopathy. When referred to an entry made in the discharge summary that the doctor did a CK blood level of the child after birth, Dr Kara expressed a view that a doctor would only do that if he or she suspected hypoxic ischemic encephalopathy.

[11] Dr Kara referred the court to the ultra sound results reflecting 'patchy changes in the cerebrum on the right side, suggestive of hypoxic damage'. He disputed a proposition put to him during cross-examination that the injury to the child's brain (hypoxic ischemic injury) was caused by a urinary tract infection. In support of his view, he referred the court to results of a dipstick test that was done which showed that the plaintiff did not have a urinary tract infection. It was then put to him that the defence would call a neonatologist who was sitting in court, if necessary, to say that the accuracy of a dipstick test is low. Dr Kara conceded that he is not an expert in neonatology but stuck to his version, and added that the use of a dipstick requires basic medicine. It is worth noting that the neonatologist referred to during cross-examination did not testify.

[12] At the beginning of his testimony, Dr Sevenster, a specialist obstetrician gynaecologist, was called upon to comment on the plaintiff's testimony regarding her earlier visit to the Mahatma Ghandi Hospital. He confirmed the plaintiff's testimony that she was first admitted to hospital on 7 July 2013 at 10h00. According to Dr Sevenster, she was 38 weeks pregnant at the time, and she presented with complaints of lower abdominal pain and burning urine with micturition. A cardiotogram was done and the

[7] Hospital records reflect that the child was discharged on 30 July 2013, two weeks after birth.

plaintiff was given antibiotics and panado. Dr Sevenster confirmed that the hospital records reflected that the child's condition was normal. The plaintiff and the child were again checked on the following day (8 July 2013) at 06h30, and according to Dr Sevenster, both the plaintiff and the child were normal. Nothing turns on the records of the antenatal clinic, and it is not necessary for the purposes of this judgment to deal with that aspect.

[13] Dr Sevenster testified about the three stages of labour. He told the court that the first stage is when the patient has contractions which usually begin with lower abdominal pain. The first stage has two phases, the latent phase and the active phase. At the start of labour, contractions get more frequent and more painful and the cervix begins to dilate. He proceeded to say that it usually takes eight hours for a patient to progress from the latent phase to the active phase of the first stage. If after eight hours of labour there has been no progress, alarm bells should start to ring.

[14] The active phase is when the cervix has reached four centimetres of dilation. His evidence was that in order for one to establish whether the patient has reached the active phase, one must examine the patient vaginally according to the guidelines.[8] The guidelines further stipulate that the foetal heart rate and contractions should be monitored two hourly. At the active phase, the patient's cervix is expected to dilate by one centimetre per hour. A patient who has not had a prior delivery is thus expected to be fully dilated within six hours after the active phase,[9] and this according to Dr Sevenster, happens when the patient has sufficient contractions and where there is no complication.[10] If after six hours of the active phase the patient is not fully dilated, the midwife or nurse should contact a doctor in order to investigate why the patient is not fully dilated. The two reasons for not fully dilating, according to Dr Sevenster, are either

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[8] The Guidelines for Maternity Care in South Africa, revised in 2015, state that the patient should be examined four hourly, vaginally.
[9] Full dilation means that the cervix is 10 centimetres dilated.
[10] A complication occurs where there is disproportion, meaning: the baby is either too big or the pelvis is too small; or in instances where the bladder was full the whole time resulting in the child's head being kept out of the birth canal.

insufficient contractions or cephalopelvic disproportion (CPD).[11] If the CPD cannot be negotiated, then the child should be delivered by caesarean section.

[15] The second stage of labour occurs when the patient's cervix is fully dilated. For a first time labour, delivery should occur within 45 minutes to an hour. If after 45 minutes the baby has not emerged, labour or delivery has to be expedited. A caesarean section should be done if the baby is still in sound condition within an hour. The third stage of labour occurs with the delivery of the placenta.

Augmentation

[16] With regard to the induction or augmentation of labour, Dr Sevenster testified as follows. He told the court that if contractions are insufficient (provided that the baby is in good health), labour can be augmented by giving the patient medication to improve her contractions and added that when one does so, the baby must be monitored closely because the medicine prescribed for uterine contractions could cause severe uterine contractions resulting in serious oxygen deprivation to the foetus. He emphasised the point that it is absolutely essential that the mother, her contractions, and the foetal heart rate be monitored continuously. The guidelines require that the patient be examined vaginally every two hours, and that the foetal heart rate and contractions be monitored half hourly.

Monitoring

[17] Dr Sevenster told the court that there was a duty on the part of the appellant's staff to monitor the plaintiff closely for two reasons, firstly because she was a high risk patient and secondly, because her labour had been augmented. He proceeded to say that the plaintiff ought to have been on a CTG[12] in order to monitor both her contractions and the foetal heart rate. Dr Sevenster testified that it is important to observe what happens to the performance of a foetal heart rate during and after contractions because

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[11] Cephalopelvic disproportion means the head is either too big or the pelvis is too small.
[12] CTG stands for cardiotocograph, which when broken into three parts means: cardio = heart (of infant); toco = contractions; graph = a piece of paper.

the foetal heart rate accelerates or decelerates with contradictions. If a deceleration occurs with contractions it is called a type one deceleration and that is normal. On the other hand, if deceleration occurs after contractions, it is called a type two deceleration and that, according to Dr Sevenster, is an ominous sign. The CTG is used to predict when the problem starts and then act on it. Dr Sevenster further testified that the plaintiff ought to have been examined vaginally as required by the guidelines for three reasons, firstly in order to determine the extent of the dilation of the cervix, secondly, in order to check the effacement of the cervix,[13] and thirdly, in order to determine the descent of the head in the pelvis. He proceeded to say that a vaginal examination also enables a person to tell whether there is caput[14] or moulding.[15] Lastly, one is also able to feel whether the membranes are intact or not. Of relevance to note is that Dr Sevenster testified that without a vaginal examination, one cannot assume that there is no moulding or no caput. One cannot assess the extent of the dilation either or whether or not it is taking place.

[18] With regard to the plaintiff's admission to hospital, Dr Sevenster testified as follows. The plaintiff was admitted on 15 July 2013 at 00h25 according to the first entry made in the hospital records. She was 41 plus weeks pregnant, which made her a higher risk patient because she was post-dated. She complained of abdominal pain since 17h00, and that according to Dr Sevenster meant that labour started at 17h00 on the previous day (14 July). There is an entry made at 09h30 (on 15 July 2015) suggesting that Cytotec was administered at that time. From the above, Dr Sevenster thus concluded that the plaintiff was probably given Cytotec nine and a half hours later because her latent phase of labour was prolonged. He made an observation that there is no indication of any monitoring being done between 11h30 and 17h25. He therefore noted that there is no indication of what was happening between the mother and foetus for that period of time. When asked about an entry made in the clinical notes at 17h25

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[13] Dr Sevenster stated that when the cervix dilates, it effaces, which means, that it gets thinner and thinner until one cannot feel it anymore.
[14] Caput means a swelling of the foetal head (an accumulation of water between the skull and the skin) associated with foetal distress.
[15] Moulding means overlapping of skull bones.

which reads ‘patient had PV Cytotec’ Dr Sevenster testified that the nurse or midwife who made that entry did not mean that another dose of Cytotec was administered at that time, but that Cytotec had been administered earlier.[16] Dr Sevenster again noted that there is no indication in the clinical notes that a vaginal examination was done at 19h15. He further noted that there is no indication of the foetal heart rate, and monitoring of the contractions either. His testimony was that the plaintiff was definitely in labour and contracting at 11h30 according to the CTG.[17] He again observed that there is no evidence of any vaginal examination having been done from 09h30 to 20h00. There is also no evidence of foetal monitoring, except for a CTG performed at 11h30.

[19] With regard to the events that unfolded shortly before the delivery of the baby, Dr Sevenster testified as follows. Having had regard to the hospital records, he confirmed the plaintiff’s evidence that around 20h00 she experienced severe lower back pains. He further confirmed that her membranes raptured and that it was discovered that they contained meconium stained liquor 2 (MSL 2). In his opinion, the presence of meconium stained liquor was associated with foetal distress which took place around 10 to 12 hours prior to the delivery of the baby, the period during which there was no monitoring. Dr Sevenster expressed concern about the CTG that appears to have been done around 20h00 revealing that the foetal heart was decelerating. His main concern was that there is no record of the level of deceleration, whether it decelerated from 140 bpm (beats per minute) to 100 bpm or to 110 bpm, because there is no CTG to prove that.

[20] Dr Sevenster was required to comment on a possibility that the plaintiff’s cervix was eight centimetres dilated at 20h00, given the fact that at 17h15 and 17h25 according to the hospital records, she was not in labour. In response Dr Sevenster stated that it is totally impossible for the cervix to have dilated to eight centimetres in the space of two and half hours, without the plaintiff having been in labour. He proceeded to say that the plaintiff must have had contractions after the administration of Cytotec, and

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[16] See the record at page 1138, volume 12, lines 13-18. See also clinical notes at page 285, volume 3. The abbreviation PV according to Dr Sevenster means ‘per vagina’ which simply means that Cytotec was administered vaginally.
[17] See copy of the CTG scan at pages 286 and 287, volume 3, reflecting the presence of contractions.

reiterated that without contractions, it would have been impossible for the plaintiff's cervix to dilate to eight centimetres. In amplification, he stated that it is unfortunate that there is no record of any examination or monitoring after the administration of Cytotec at 09h30. When referred to the hospital records reflecting that the plaintiff was not in labour at 17h25, he replied:

> 'I do not believe that this patient was not in labour by 17:25 as recorded. The plaintiff should have been, must have been in labour (at 17:25) for her to be 8 centimetres dilated at 20:00.'

He reiterated the point earlier referred to, that Cytotec is known to cause hypertonic uterine contractions, and that during contractions there is virtually no oxygen delivery to the foetus. I will return to this aspect later in the judgment.

[21] Dr Sevenster conceded during cross-examination that he was mistaken, when concluding in his report, that a caesarean section was done almost two hours later after the decision was made. He further conceded having made a mistake when stating in his report that there was no indication of the foetal condition between 09h30 and 19h15 on 15 July 2013, almost 10 hours, given the fact that hospital records reflect that a CTG scan of the foetus was done at 11h30. He nevertheless pointed to the fact that he did mention in the joint minute with Dr Batchelder that there was a foetal condition and that the CTG was available. He was sceptical about the use of a Doppler to assess the foetal heart beat at 19h15 on 15 July 2013 as being 154 bpm, and his reason for this scepticism was that there is no record of whether the Doppler was used before, during or after contractions. In amplification, he stated that a Doppler does not give one the variability of the foetal heart rate which a CTG tracing gives.

[22] Professor Lotz is an academic professor of radiology at Stellenbosch University. He qualified as a radiologist in 1980, and spent the last 12 years of his career in paediatric neuroradiology.[18] In the past six years 90% of his work has been focused on hypoxic ischemic injury. His testimony was focussed squarely on his interpretation of MRI images with no reliance at all on clinical records or expert reports. He neither

[18] The study of the brain and spinal cord.

consulted with the plaintiff, nor examined the child and all this he did, so he testified, with the view of insulating himself from any possible influence of whatsoever nature.

[23] As part of his testimony, Professor Lotz prepared and presented slides to the court. He began his testimony by explaining the different parts of the brain, namely, the reptilian core, the mammal brain, and the neocortex or human brain. The central part of the brain is the reptilian brain in which all vital centres of life are embedded. The other parts of the brain (the neocortex and mammal brain) are in the periphery. Professor Lotz proceeded to say that the reptilian is the only part of the brain that is alive at birth, and it is therefore essential for nature to ensure that it survives at all costs. In order for the reptilian brain to survive, as it should, it sets up what Professor Lotz referred to as an auto regulatory process (also called the salvage team). By this process, blood gets stolen from the periphery which is the human brain and pumped into the centre which is reptilian brain in order to sustain life. As a result, the human brain gets sacrificed and that has the potential of causing either a prolonged partial injury or an acute profound injury to the brain. A prolonged partial injury is an injury to human brain. An acute profound injury on the other hand is an injury to the reptilian brain. It was Professor Lotz's evidence that the baby in question suffered a prolonged partial injury, as opposed to an acute profound injury. Professor Lotz opined, having had regard to the nature of the injury caused to the child's brain, that the baby must have been both hypoxic and ischemic at birth.[19]

[24] To illustrate the point, Professor Lotz referred the court to MRI slide six.[20] From this image Professor Lotz was able to point out that the salvaging process was a success given the fact that damage only occurred on the periphery (human brain) and further, that the reptilian brain was 'pristine' (to use the word he preferred). With regard to the nature of the injury caused to the brain, Professor Lotz testified as follows. He told

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[19] Hypoxia means a lack of oxygen, and ischemia means a loss of pressure. The blood (which contains oxygen) gets pumped to the heart and is pushed into the brain by the vector, and if this does not happen due to a deceleration of the heart, the reptilia steals blood from the periphery.
[20] Page 184, volume 3.

the court that the shape of the gyri[21] is indicative of the fact that they were compromised. The gyri were mushroom shaped, not finger shaped as they should be and that according to Professor Lotz, was a sign that blood was stolen from them (the gyri), 'a classic feature of prolonged partial hypoxic ischemic injury' (to use Professor Lotz's exact words). Professor Lotz confirmed that in the joint minute with Dr Reitz, they convincingly state that they believe that the most likely diagnosis in the present case is a prolonged partial ischemic injury. In paragraph 3 of their joint minute report,[22] they agreed to the following:

> '3.1 The appearance is compatible with a prolonged partial pattern of hypoxic ischemic injury in a term brain, now in a chronic state of evolution;
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> 3.2 A term pattern of injury implies that the causative event, or events, most likely occurred after approximately 36 weeks gestation;
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> 3.3 Review of the clinical and obstetrical records by appropriate specialists in the fields of neonatology and obstetrics is necessary to determine the probable cause and timing of the injury.'

[25] During cross-examination, Professor Lotz also confirmed that he is in agreement with Dr Misser's opinion that 'this pattern of injury would favour partial prolonged ischemia'.[23] He disputed a proposition put to him that the injury suffered by the child is more typical of a stroke than hypoxia, and in amplification stated that if you have two watershed areas, an infarct involves the main vessel, not the watershed territory in between. In fact, he stated that a proposition that a child suffered a stroke is wrong. Counsel placed on record that evidence would be presented on behalf of the appellant that the injury suffered by the child is not typical of hypoxia, and that it is more typical of a stroke. It is worth mentioning that no evidence was led by the defence in that regard.

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[21] Gyri is plural for gyrus meaning part of the brain.
[22] See joint minute of radiologists, Professor Lotz (on behalf of the plaintiff) and Dr D Reitz (on behalf of the defendant), held and signed on 18 May 2017 and filed on 16 November 2017, at page 1019, volume 10 of indexed bundle.
[23] See medico legal report of specialist radiologist Dr S Misser at pages 75–77, volume 1 of indexed bundle.

[26] Dr Mtambo qualified as a doctor in 2001. He was previously stationed at the King Edward Hospital, and was at Mahatma Gandhi Hospital on a rotational basis. He told the court that he saw the plaintiff for the first time at 20h45, following on a request by a junior doctor. He found the plaintiff in the antenatal ward and she was on a CTG. A report had been made that the CTG was showing decelerations, and when he personally assessed the CTG, he formed an impression that the CTG was recording the maternal pulse, not the foetal pulse. When Dr Mtambo was referred to a diagram of the CTG tracing,[24] he made an observation that it is unfortunate that the tracing does not have the name of the patient. In amplification, he stated that when a patient is put on a CTG, the first thing to do is to record her name on the trace itself, then the time the CTG started and the registration number of the patient. He stated that the time reflected on the tracing (20h45) is the time during which a doctor was informed of the abnormality. It could have been a junior doctor or him. He had no idea as to whose hand writing was on the tracing. All he was able to say was that it is possibly the nurse's handwriting.

[27] Dr Mtambo told the court that he instructed the nurses to put the CTG on continuous tracing and not to remove it after 20 minutes because it was not normal. After examining the foetal heart rate, he expressed a concern that the foetus could be compromised and thus decided to perform intrapartum resuscitation that involves oxygen and an intravenous line to the mother. At 21h20 he did the second assessment and established that there was no progress of labour besides strong contractions. The foetal heart rate was 105 bpm, and there were persistent decelerations. A repeat vaginal examination yielded the same results as the previous one. There was then one plus caput from no caput, meaning that the head had not descended. He then decided, based on the above, to perform a caesarean section for CPD. Intrapartum resuscitation continued in the mean time until the plaintiff was in the theatre. Surgery commenced at 22h33, and the child was delivered at 22h35.

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[24] See CTG tracing exhibit 'E' page 291, volume 3 of the indexed bundle.

[28] During cross-examination, Dr Mtambo conceded that he was only a medical officer when the baby was born, and that he only qualified as an obstetrician gynaecologist during September 2013 (after the birth of the child). Dr Mtambo changed his earlier version during cross-examination, and stated that the CTG that was presented to him exhibited traces of both the maternal heart rate and the foetal heart rate. He however conceded that he did not record in his notes that the tracing in question skipped between the maternal pulse and the foetal pulse.[25] He conceded that he does not have an independent recollection in respect of the present case, and added that his evidence was reliant on medical notes. He also conceded that the fact that he was called by a junior doctor was not in his notes.

[29] Dr Mtambo had given evidence that he recommended to the nurses that the plaintiff be given tocolytic medication to try and reduce contractions, because an assessment had been made that the passages were probably inadequate for the plaintiff to deliver the baby naturally. He made an observation that there was no progress in the presence of strong contractions, increase in caput and no head descent. During cross-examination he conceded that there is no record of tocolytic medication having been given to the plaintiff, and conceded that if it was, an entry to that effect would have been made either on the tocogram or prescription card. When asked whether he was able to diagnose the child with foetal distress, he responded in the negative, and stated in amplification, that the only tool available to him to diagnose foetal distress (the CTG) did not allow him to conclusively say that the child was in foetal distress. Dr Mtambo was referred to a consent form he completed when referring the plaintiff to theatre for a caesarean section[26] in which he recorded, in his own hand writing:

> 'To emergency caesarean section for CPD and foetal distress.'

[30] Dr Batchelder is a retired specialist obstetrician gynaecologist living in Durban. He confirmed Dr Sevenster's evidence that when the plaintiff was admitted, she was

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[25] See diagrams of CTG scan at pages 291 to 294, volume 3.
[26] Page 31 of exhibit 'E' at page 297 of indexed papers, volume 3.

diagnosed as being in the latent phase of labour. He further stated that a possibility of her being postdates was recognised by a CTG performed on admission. She was thereafter assessed four hourly and after nine hours, it was decided that her labour should either be enhanced or induced with vaginal Cytotec. The pre-induction CTG was normal and so was the repeat CTG performed two hours later. Dr Batchelder observed that there was no evidence of assessments being done for eight hours after the insertion of a CTG, but added that when the plaintiff was reassessed after eight hours, she was not in labour. Dr Batchelder noted that the fact that there is no record of the foetal condition and evidence that the plaintiff was examined, is substandard care. He however stated that 10 hours after the induction of labour was initiated, she was not in obvious labour. The foetal heart rate was in the normal range of 154 bpm. Dr Batchelder expressed a view that it was therefore reasonable to conclude that the failure to monitor or assess the plaintiff four hourly, although not acceptable, did not result in any obvious adverse outcome.

[31] With regard to the entry made in the clinical records reflecting that at 20h00 the plaintiff's membranes raptured, and it was discovered that her cervix had dilated to eight centimetres, Dr Batchelder told the court that there are two possible explanations for that. It is either that the previous assessment[27] was incorrect or that the plaintiff had a very rapid or precipitated labour which, according to Dr Batchelder, occurs after the administration of Cytotec. Dr Batchelder excluded the former possibility and opined that the cause of the sudden dilation of the plaintiff's cervix to eight centimetres was precipitated labour. He told the court that the administration of Cytotec vaginally is associated with an increased risk of precipitated labour. He however conceded that if the nurse's assessment of the plaintiff was wrong or fictitious, then he would not be able to advance any defence. Dr Batchelder considered the plaintiff to be a high risk patient on admission for two reasons, firstly, because her pregnancy was possibly post days, and secondly, because she had a previous possible urinary tract infection history of antepartum haemorrhage and of hypertension in pregnancy. These factors, he added,

[27] The assessment done at 19h15 on 15 July 2013 reflected that the plaintiff's condition was stable and that the foetal heart rate was 154 bpm.

increased the risk of foetal distress during labour, and all patients with that history require routine observation during labour as described in the Guidelines. Immediately thereafter he remarked:

> 'However, the staff were not aware of this history, under these circumstances the management of Ms Mqadi's labour was acceptable based on the guidelines apart from a lack of examination following the administration of vaginal cytotec for induction of labour.'[28]

[32] Dr Batchelder told the court that the decision to induce or enhance labour was correct. He however expressed the view that there is no reason to suspect that the substandard care of the nursing staff that followed after the administration of Cytotec, led to any foetal complications. With regard to the plaintiff's cervical dilation, he told the court that it is difficult to explain how the plaintiff did not appear to be in labour during an assessment done at 19h15 yet her cervix was eight centimetres dilated 45 minutes later. I will return to the cross-examination of Dr Batchelder in due course. That sums up the evidence on which the plaintiff's claim was decided.

Did the plaintiff succeed in establishing negligence on the part of the appellant?

[33] The plaintiff had an onus to prove that the injury sustained by the child was caused by negligence on the part of the appellant's staff. A negligent omission is unlawful only in circumstances which the law regard as sufficient to give rise to a legal duty to avoid negligently causing harm.[29] It was held in *Van Wyk v Lewis*[30] (per Innes CJ), that 'a medical practitioner is not expected to bring to bear upon the case entrusted to him the highest possible degree of professional skill, but he is bound to employ reasonable skill and care'. On the question of reasonableness, the learned judge proceeded:

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[28] Record page 1368, volume 14.
[29] *Minister of Safety and Security v Van Duivenboden* [2002] 3 All SA 741 (SCA); 2002 (6) SA 431 (SCA) para 12.
[30] *Van Wyk v Lewis* 1924 AD 438 at 444. Quoting from *Mitchell v Dixon* 1914 AD 519 at 525.

> '. . . in deciding what is reasonable the Court will have regard to the general level of skill and diligence possessed and exercised at the time by the members of the branch of the profession to which the practitioner belongs.'

Writing for the minority, Majiedt JA in *Magqeya v MEC for Health, Eastern Cape*[31], made the following observation:

> 'This court has held that the nursing profession is a distinct profession and nurses are expected to perform their duties with the requisite skill and diligence exercised by members of that profession.'

[34] The argument advanced on behalf of the plaintiff that the appellant's staff lacked reasonable care can only be determined on consideration of all the facts. The plaintiff gave damning, unchallenged testimony about the conduct of the nursing staff that attended to her during the latter stages of her labour. She told the court that they paid little or no attention to her. They were lazing at their desks, and whenever she complained about labour pains they merely told her to walk around. She proceeded to say that after the administration of Cytotec the labour pains escalated to the point that she fell when attempting to walk as directed by a nurse, and had to be helped back to her bed by a fellow patient. The plaintiff's evidence of lack of monitoring finds corroboration in the contents of the clinical records which clearly indicated that there was no monitoring of the plaintiff and the baby at all after the administration of Cytotec, for a period of seven hours and 55 minutes (from 09h30 to 17h25). The appellant presented a partogram indicating that the plaintiff was put on a CTG reflecting the foetal heart rate to be normal at 11h20 or 11h25. Hospital records indicated that the next foetal examination occurred when the nursing staff changed shifts at 19h15. The records reflect that a nurse who took over at that time used a Doppler to check the foetal heart rate and recorded it to be normal at 154 bpm.

[35] Dr Sevenster was critical of this exercise. He made a point that there is no indication in the clinical records of whether a Doppler was used before, during or after the contractions. From the clinical notes it is clear that no vaginal examination was done

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[31] *Magqeya v MEC for Health Eastern Cape* [2018] ZASCA 141 para 40.

between 9h30 and the critical time at 20h00. That piece of evidence supports the plaintiff's version that whenever she told the nurses that she was in labour they simply disregarded her and idled on their phones. From the above, it is clear that two facts were sufficiently established, namely firstly, that other than the CTG done at 09h30 and 11h30 or 11h38, there was no monitoring of the plaintiff and the baby between 09h30 and 20h00 and secondly, that there was no vaginal examination done between 09h30 and 20h00 when the plaintiff's cervix was found to have dilated to eight centimetres.

[36] Both expert witnesses, Doctors Sevenster and Batchelder, agreed that the doctor who attended to the plaintiff at 09h30 was correct in augmenting or inducing her labour by the administration of Cytotec vaginally.[32] The issue is whether negligent lack of monitoring and care after the administration of Cytotec, resulted in the risk of *inter alia*, hypoxia developing unnoticed. According to Dr Sevenster, it did. Dr Sevenster's evidence was that it is highly impossible that the plaintiff's cervix would have dilated to eight centimetres without the plaintiff having entered the active phase of labour. He disputed Dr Batchelder's evidence that the plaintiff was not in labour after the administration of Cytotec, and in amplification stated that it is clinically impossible that the plaintiff would not have been in labour at 17h25 as indicated in the clinical notes, and then suddenly be eight centimetres dilated at 20h00. His testimony was that a sudden dilation only occurs in precipitate labour, described as a sudden dilation to capacity (10cm) of a womb's mouth which had either been closed or one centimetre dilated, within two hours. He vehemently disputed a proposition that the plaintiff experienced precipitous labour.[33]

[37] Dr Sevenster told the court that if labour had been augmented, like in the present case, it is absolutely necessary that the mother, her contractions, and the foetal heart beat be monitored continuously because medicine prescribed for augmentation could cause severe uterine contractions or hyperstimulation, resulting in the shortage of supply of oxygen to the child's brain. During cross-examination he stuck to his version

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[32] The clinical records reflect that the plaintiff's cervix was one centimetre dilated at the time.
[33] Precipitate labour is labour that results in rapid expulsion of the foetus.

that Cytotec is known to cause hypertonic uterine contractions and that during contractions there is virtually no delivery of oxygen to the foetus. It was subsequently put to him that the appellant would call a witness to state that a test had been carried out and evidence would be led to the effect that amongst the sample group of tested individuals, only 8% exhibited contractions that were stronger than usual and more importantly, that those excessive contractions had had no effect on the foetus. When addressing that proposition, Mr Pillemar who appeared on behalf of the plaintiff, placed on record that no expert notice or summary of evidence relating to the said witness had been made available to the plaintiff's legal team. I might just add that no such witness testified in the appellant's case.

[38] Dr Sevenster's evidence pertaining to the shortage of blood supply or oxygen to the foetal brain during contraction was corroborated by Professor Lotz, the only specialist radiologist who testified before the court *a quo*. It was common cause or at least not in dispute, that it is normal for the foetal heart rate to decelerate with contractions. It was further not in dispute that a deceleration which occurs after contractions is a sign that the foetus is in distress which is associated with lack of oxygen. Dr Sevenster testified that a shortage of oxygen could result in the foetus becoming both hypoxic and ischemic which leads to brain damage. In support of that version, Professor Lotz told the court that in order for the injury similar to that caused to the child's brain to occur, the child had to be both hypoxic and ischemic at birth. He gave unchallenged evidence that the cause of the injury sustained by the child was a shortage of blood supply to the brain. His diagnosis that the child suffered a prolonged partial hypoxic ischemic injury was confirmed by the appellant's own expert witness, Dr Reitz, in a joint minute,[34] and Dr Misser, the radiologist whose expert report forms part of the record. I might just add that Doctors Sevenster and Batchelder also agreed in their joint minute that the MRI of the child's brain is indicative of a partial prolonged

[34] See para 3.1 of the joint minute of radiologists, Professor Lotz and Dr Reitz held on 18 May 2017, page 1019, volume 10.

ischemic injury to the brain of a term foetus.[35] When describing the term 'prolonged partial injury' Professor Lotz stated that it relates to a partial injury to the brain that happens over time. Professor Lotz confirmed Dr Sevenster's testimony that if the foetal heart rate decelerates after contractions, it means that the foetal heart is unable to supply blood to the brain. He further confirmed Dr Sevenster's evidence that the only method of detecting deceleration of foetal heart rate is the monitoring of both the contractions and the foetal heart rate.

[39] Dr Batchelder conceded that there were areas of substandard care in the management of the plaintiff and the baby, but nevertheless expressed a view that there is no reason to suspect that the substandard care led to any foetal complications. I do not agree. He conceded during cross-examination that after the administration of Cytotec, the plaintiff was only put on a CTG scan once at 11h30 or thereabout,[36] and that from then on there was no monitoring of both the plaintiff and the foetal heart rate until 20h00. It is worth noting that there is no record in the clinical notes that the trace at 11h30 or 11h38 was monitored.[37] Dr Batchelder sought to suggest that no harm could have been caused to the child at the stage where there was no monitoring because during that period the plaintiff was not in labour. That cannot be true. The evidence of Dr Sevenster supported by the plaintiff herself that she was in labour, was convincing. It is highly improbable, as Dr Sevenster convincingly stated, that the plaintiff who had not been in labour at 19h15 would have dilated to eight centimetres in a space of 45 minutes. Even Dr Batchelder himself was unable to explain that mystery. At best all he was only able to say was that it is either that the nurse wrote something down without having spoken to the plaintiff, or the plaintiff had a precipitate labour. Again, a possibility of labour being precipitated was convincingly rejected by Dr Sevenster. His evidence was that precipitate labour only occurs in instances where a patient had a previous delivery or an operation, both of which did not apply in the plaintiff's case.

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[35] See para 1.3.6 of the joint minute of meeting of specialist obstetricians, Doctors Sevenster and Batchelder, signed on 17 November 2017, pages 1030 and 1031, volume 10 of the indexed bundle.
[36] See partogram at pages 286 and 287, volume 3 of the record.
[37] See copy of clinical notes at page 285, volume 3 of the record. In fact, no entry was made at all at 11h30 or 11h38.

[40] It is worthy to be noted that the person who made the entries at 19h15 and 20h00 did not testify. The only evidence presented to court was the evidence of the plaintiff, who stated without contest, that she experienced severe labour pains after the administration of Cytotec, and the scientific evidence of Dr Sevenster that the plaintiff was definitely in labour at 11h30 or 11h38 as reflected in the partogram. Dr Batchelder conceded during cross-examination that if the entry made at 19h15 was wrong or incorrect, 'it is certainly possible' that the foetal distress and injury caused to the child occurred much earlier than the time he referred to in his report.[38] When asked to comment about Dr Mtambo's failure to view a partogram pertaining to the CTG taken at 20h00, Dr Batchelder conceded that if Dr Mtambo had had sight of the said partogram, a decision to deliver the child by caesarean section would have been made much earlier.

[41] I am of the view that the court *a quo* was correct in preferring the evidence of the expert witnesses called in the plaintiff's case to that of Dr Batchelder. I gathered the impression that Dr Batchelder was not as neutral as would be expected of an expert witness. He persisted in his version irrespective of the amount of evidence pointing in the opposite direction. By way of example, when asked whether the plaintiff was in labour prior to the critical moment at 20h00, he persisted in his version that she was not, in the face of the evidence of a partogram clearly indicating that she had contractions around 11h30. It has been held that an expert's opinion must be based on facts. As Wessels JA succinctly put it in *Coopers (South Africa)*:[39]

> 'As I see it, an expert's opinion represents his reasoned conclusion based on certain facts on *data*, which are either common cause, or established by his own evidence or that of some other competent witness. Except possibly where it is not controverted, an expert's bald statement of his opinion is not of any real assistance. Proper evaluation of the opinion can only be undertaken if the process of reasoning which led to the

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[38] In his report Dr Batchelder expressed the view that a decision to transfer the plaintiff to the labour ward around 20h00 was taken at an acceptable time. See lines 5–8 of the medico legal report at page 230, volume 2 of bundle.

[39] *Coopers (South Africa) (Pty) Ltd v Deutsche Gesellschaft für Schädlingsbekämpfung MBH* 1976 (3) SA 352 (A) at 371F–H.

> conclusion, including the premises from which the reasoning proceeds, are disclosed by the expert.'

[42] When asked to comment about the failure on the part of the nursing staff to make an entry on the partogram,[40] Dr Batchelder became evasive and stated that partograms are only completed when a patient is in confirmed labour, and added that in certain hospitals they only start a partogram when the patient reaches two centimetres of cervical dilation. When required to comment about the conduct of a nurse who simply placed a question mark in a space where he/she was supposed to comment about the plaintiff's pelvis, he embarked on a speculative hypothesis and stated:

> 'I think what was implied here when she was 8cm dilated, that the head was still quite high and so she said 'I am not sure if this pelvis is big enough', so she probably felt the size of the pelvis and the shape of the pelvis and there are various diameters one measures with one finger to try and access the pelvic size.'

He proceeded to say:

> '. . . and in her experience, and I have no idea how experienced she was, she was unsure if it was big enough or not.'

[43] When asked to comment about whether tocolysis was given to the plaintiff, he prefaced his response with words 'I do not want to be accused of bias' and immediately thereafter stated:

> '. . . but I know how it happens in these labour wards, they are busy, they are just running around and they probably just gave some tablets and said 'take these'… **but they didn't record it**.' (My emphasis.)

That response, in my view, is not only speculative but it also borders on biasness. In *Stock v Stock,*[41] Diemont JA made the following remarks:

> 'An expert . . . must be made to understand that he is there to assist the Court. If he is to be helpful he must be neutral. The evidence of such a witness is of little value where he, or she, is partisan and consistently asserts the cause of the party who calls him.'

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[40] See copy of a partogram taken on 15 July 2015 at page 288, volume 3.
[41] *Stock v Stock* 1981 (3) SA 1280 (A) at 1296E–G. See also *Jacobs and another v Transnet Ltd t/a Metrorail and another* 2015 (1) SA 139 (SCA) para 15.

[44] To conclude, I am satisfied that the plaintiff succeeded in establishing the following facts:

(a) That the injury sustained by the child was prolonged in that it happened over a period of time as attested to by both Dr Sevenster and Professor Lotz.

(b) That the injury probably occurred at any stage prior to 20h00 when the plaintiff and the child were not monitored.

(c) That failure to monitor the plaintiff and the child after augmentation of labour through the administration of Cytotec, amounted to negligence on the part of the appellant's nursing staff.

(d) That had the plaintiff and the child been monitored, the appellant's nursing staff would have established sooner than 20h00, that the plaintiff was in labour and that the child was in distress. A decision to deliver the child by caesarean section would therefore have been taken sooner resulting in the child being born either without or with a less severe injury.

[45] Writing for the majority, Molemela AJ in *Oppelt v Department of Health, Western Cape*[42] made the following remarks:

> "A successful delictual claim entails proof of a causal link between a defendant's actions or omissions, on the one hand, and the harm suffered by the plaintiff, on the other hand."

In the words of Nkabinde J, 'there can be no liability if it is not proved, on a balance of probabilities, that the conduct of the defendant caused the harm'.[43] Based on the above proved facts, it can in my view safely be concluded, and I hereby do, that it was sufficiently established before the court *a quo*, that it is more probable than not, that the ischemic hypoxic injury caused to the child's brain is casually connected to the negligent lack of monitoring of the plaintiff and the child after the administration of Cytotec to the plaintiff. For the above reasons, I hold the view that the ultimate finding of the court *a quo* should not be disturbed.

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[42] *Oppelt v Department of Health*, Western Cape 2016 (1) SA 325 at 339 para 35.

[43] See *Lee v Minister for Correctional Services* 2013 (2) SA 144 (cc) (2013 (2) BCLR 129; [2012] ZACC 30 para 39.

Order

[46] In the circumstances, the following order shall issue:

The appeal is dismissed with costs.

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CHILI J

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MOODLEY J

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NTSHULANA AJ

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Date of hearing: 29 July 2019

Date of judgment: 15 December 2020

Case law

1. *Twigger v Starweave Pty (Ltd)* 1969(4) NPD 369 - dictum applied.

2. *Goliath v MEC for Health, Eastern Cape* 2015 (2) SA 97 – applied.

3. *Van Wyk v Lewis* 1924 AD 438 – dictum applied.

4. *Lillicrap, Wassenaar and Partners v Pilkington Brothers* (SA) (Pty) Ltd 1985 (1) SA (1) 475 (A) – referred to.

5. *Mitchell v Dixon* 1914 AD 519 – referred to.

6. *Castel v De Greef* 1993 (3) SA 501 – referred to.

7. *Buthelezi v Ndaba* 2013 (5) SA 437 (SCA) – referred to.

8. *Arthur v Bezuidenhout and Mieny* 1962 (2) SA 566 [AD] – referred to.

9. *Oppelt v Department of Health Western Cape* 2016 (1) SA 325 – dictum applied.

10. *Lee v Minister for Correctional Correctional Services* 2013 (2) SA 144 (cc) (2013 (2) BCLR 129, [2012] ZACC 30 – referred to.

Applicable Guidelines

1. Department of Health's Guidelines for Maternity Care in South Africa by Prof EJ Buchmann, *et al* Third Edition, 2007, revised in 2015 - referred to.