THE SUPREME COURT OF APPEAL OF SOUTH AFRICA

JUDGMENT

Not Reportable

Case no: 117/2020

In the matter between:

THE MEMBER OF THE EXECUTIVE COUNCIL FOR HEALTH, EASTERN CAPE **APPELLANT**

and

D L obo AL

RESPONDENT

Neutral citation: *The Member of the Executive Council for Health, Eastern Cape v DL obo AL* (Case no 117/2020) [2021] ZASCA 68 (03 June 2021)

Coram: MBHA, MOLEMELA and NICHOLLS JJA, GOOSEN and POYO-DLWATI AJJA

Heard: 16 March 2021

Delivered: This judgment was handed down electronically by circulation to the parties' legal representatives by email, publication on the Supreme Court of Appeal website and released to SAFLII. The date and time for hand-down is deemed to be 09H45 on 03 June 2021.

Summary: Delict – medical negligence – child suffering cerebral palsy as a result of acute profound hypoxic ischaemic event during labour – whether negligence of hospital staff was causally connected to the child's brain damage – causation not established on the facts – appeal upheld

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ORDER

On appeal from: Eastern Cape Division of the High Court, Bhisho (Mfenyane AJ sitting as court of first instance): judgment reported as *sub nom*: *Member of the Executive Council for Health Eastern Cape v Danene Levonia Lottering* [2016] ZAECBHC X; (2019) XX ILJ XXX (ECB); [2021] x All SA XXX (ECB):

1. The appeal is upheld.
2. The order of the high court is set aside and replaced with the following:
   'The plaintiff's claim is dismissed'.

JUDGMENT

Molemela, JA (Mbha and Nicholls JJA and Goosen and Poyo-Dlwati AJJA concurring)

Introduction

[1] This is an appeal against an order granted by the Eastern Cape Division of the High Court, Bhisho (Mfenyana AJ) (the high court) in favour of the respondent who, as the plaintiff, had instituted a medical negligence claim against the appellant, the Member of the Executive Council for Health, Eastern Cape (the MEC). The respondent's claim was on behalf of her minor child, AL, who had suffered cerebral palsy as a consequence of a hypoxic ischemic event during the birth process. Having been called upon to adjudicate the matter on the issue of liability only, the high court found that the respondent had succeeded in proving negligence and causation. It found that the MEC was vicariously liable to compensate the respondent, as the hospital staff had dispensed medical care to the respondent within the course and scope of their employment. Aggrieved by that decision, the MEC sought leave to appeal the high court's judgment. The appeal is with the leave of that court. The basis of the appeal is that the high court erred in fact and in law, misdirected itself and committed several irregularities. A further ground of appeal was that the judgment of the high court was tainted by bias.

Background Facts

[2] The factual matrix is largely common cause. The common cause facts are that on 20 October 2011, the highly expectant respondent was picked up from her home by an ambulance and arrived at Midlands Hospital, Graaf-Reinet at 01h45. Her pregnancy was at full term. Midlands hospital (the hospital) is a public hospital under the administration of the Eastern Cape Provincial Department of Health. Shortly after the respondent's arrival at the hospital, she was seen by a nurse. Her time of admission at the labour ward was recorded as 01h50. Upon arrival at the labour ward, the respondent was medically examined. A vaginal examination revealed that her dilation at that stage was 2cm. It was common cause that at the time of the respondent's admission, she was in the first phase of the first stage of labour.[1]

[3] Following the vaginal examination, the nurse connected the cardiotocography (CTG) equipment to the respondent's abdomen for purposes of monitoring the uterine contractions as well as the foetal[2] heart rate. The CTG tracing was done from 02h01 until 02h18. The printout showed a baseline foetal heart rate of just below 160 beats per minute, but was recorded in the clinical notes as 160 beats per minute, with a variability of 5-10 minutes. There were no accelerations and no decelerations of the foetal heart rate. There were 5-6 contractions in 10 minutes, which were categorised as borderline high. It is common cause that after the CTG monitoring was discontinued at 02h18, no further monitoring of the respondent was done until 06h00.

[4] A CTG tracing done from 06h11 to 06h23 (the 6 o'clock CTG monitoring) showed a baseline foetal heart rate of 175-180 beats per minute, with normal variability. During that period, no accelerations nor decelerations were noted. The clinical notes recorded that at 06h30, the nurse notified Dr Mpependuku about the respondent's condition and he promised to come and see the respondent.

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[1] In terms of the National Maternal Guidelines applicable in South Africa, the first stage of labour consists of two phases – the latent phase (during which the cervical dilation is less or equal to 3cm dilation; whilst, the second phase of the first stage is from 4cm dilation until the cervix is fully dilated. The second stage is from full dilation until delivery. The third stage is from the delivery of the foetus until delivery of the placenta.

[2] There are different ways of spelling the medical terms for foetus (fetus), foetal (fetus), ischaemic (ischemic) etc. In this judgment, I have used the English spelling in the text but have retained the original spelling when used in quotes.

Dr Mpependuku arrived at the labour ward at 07h00 and saw the respondent. He then indicated that he would ask another doctor, Dr Othman, to assess the respondent. It is undisputed that Dr Mpependuku deferred to Dr Othman. Dr Othman examined the respondent at 07h15 and ordered delivery by caesarean section. The baby, AL, was delivered by caesarean section at 08h40. AL's subsequent assessment revealed that he had developed cerebral palsy. It was common cause that there were no antenatal problems that could have contributed to that outcome.

[5] In her particulars of claim, the respondent averred that the hospital staff failed to recognise that she was experiencing complications during labour and to enlist the service of duly qualified personnel to attend to her. The respondent's case was that AL developed cerebral palsy because of the hospital's failure to monitor her adequately and to take appropriate action when foetal distress arose. Various grounds of negligence were advanced. The respondent's main contention was that the failure of the hospital staff to monitor her in accordance with the National Maternal Guidelines published in 2007 (2007 guidelines) constituted a negligent omission which caused the foetus to suffer a hypoxic ischemic encephalopathy of an acute profound nature. The respondent asserted that if the monitoring of her labour had taken place according to the 2007 guidelines, a change in the foetal condition would have been timeously observed and AL's delivery would then have been expedited, thereby preventing the brain injury that eventuated as a result of hypoxic ischemia. It was alleged that the hospital staff had acted negligently by failing to expedite delivery when the presenting circumstances warranted it. It was also contended that the caesarean section, contrary to the provisions of the 2007 guidelines, was not performed within one hour of the decision to operate being taken.

[6] The appellant's case was that all the hospital staff members who had attended to the respondent had acted with the necessary skill, care and diligence as could reasonably have been expected in similar circumstances, and had not been negligent in dispensing medical care to the respondent. Furthermore, the appellant denied that there was any causal link between the negligent omission alleged by the respondent and the brain injury that was ultimately sustained by AL. The question before the high court related only to liability. Thus, the question for determination was whether the respondent had proven the elements of her medical negligence claim. As the trial

progressed, the issues became distilled, with the result that the remaining issues for determination were whether the respondent had proven the elements of negligence and causation on a balance of probabilities. As regards negligence, the issue in dispute was whether or not the CTG reading taken at 02h01 to 02h18 was suspicious. Allied to that was the question whether the non-monitoring of the respondent between 02h00 and 06h00, coupled with the failure to deliver AL within one hour of the decision to perform the operation, constituted negligence which caused AL's cerebral palsy. Relying on the expert evidence of Dr Murray and Dr Alheit, the high court found that negligence and causation were proven on a balance of probabilities, and consequently found in favour of the respondent.

Issues to be decided

[7] The central issues at the trial in the high court, as in this Court, were whether the hospital staff were negligent in their treatment of the respondent and, if so, whether their negligence caused AL's hypoxic ischemic injury and the resultant cerebral palsy.

Negligence

[8] The proper approach for establishing the existence or otherwise of negligence was laid down in *Kruger v Coetzee*[3] decades ago and remains the same. This test rests on two bases, namely, reasonable foreseeability and the reasonable preventability of damage.[4] It is important to emphasise that what is required is foresight of the reasonable possibility of harm ensuing; foresight of a mere possibility of harm does not suffice.[5] What is or is not reasonably foreseeable in a particular case is a fact bound enquiry that entails the consideration of all the circumstances of the case.[6] Health professionals such as doctors and nurses are required to dispense reasonable care by adhering to the level of skill and diligence exercised by members of their profession, failing which they would be negligent.[7] In the circumstances of this case, the hospital staff who attended to the respondent will be found to have been

[3] *Kruger v Coetzee* 1966 (2) SA 428 (A); [1966] 2 All SA 490 (A); *Lee v Minister of Correctional Services* [2012] ZACC 30; 2013 (2) SA 144 (CC) at para 18; *Oppelt v Head: Health, Department of Health Provincial Administration: Western Cape* [2015] ZACC 33; 2016 (1) SA 325 (CC) para 63.
[4] *Jacobs v Transnet Ltd t/a Metrorail* [2014] ZASCA 113; 2015 (1) SA 139 (SCA) para 6.
[5] *Road Accident Fund v Sauls* [2001] ZASCA 135; 2002 (2) SA 55 (SCA) para 8.
[6] *Pitzer v Eskom* [2012] ZASCA 44 para 24. *Kruger v Coetzee*, note 2 above, at 430G.
[7] *Van Wyk v Lewis* 1924 AD 438 at 444.

negligent if, in dispensing medical care to the respondent, they failed to foresee the possibility of harm occurring in circumstances where similarly qualified health professionals in the same position would have reasonably foreseen this possibility and would have taken steps to prevent it.

Causation

[9] The test for factual causation is whether the act or omission of the defendant has been proved to have caused or materially contributed to the harm suffered. Where the defendant has negligently breached a legal duty and the plaintiff has suffered harm, it must still be proved that the breach is what caused the harm suffered.[8] In the present matter, the question is whether the brain damage sustained by AL would have been averted if the hospital staff had properly monitored the mother and foetus and had acted appropriately on the results? If so, factual causation is established. If not, factual causation has not been established and one is left with only wrongful conduct without proof that it caused the harm suffered.[9]

The evidence

[10] The only evidence before the trial court was expert testimony. Both oral and documentary evidence was adduced. The respondent did not testify. Two experts, Dr Murray, an obstetrician and Dr Alheit, a paediatric neurological radiologist, testified on behalf of the respondent. Prof Buchmann, an obstetrician, testified on behalf of the appellant. As the determination of the issues in this case is dependent on the correct evaluation of expert evidence, it is prudent to preface this part of the judgment with the applicable principles. This Court in *Coopers (South Africa) (Pty) Ltd v Deutsche Gesellschaft für Schädlingsbekämpfung MBH*[10] stated as follows:

'An expert's opinion represents his reasoned conclusion based on certain facts or 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

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[8] *AN obo EN v Member of the Executive Council for Health, Eastern Cape* [2019] ZASCA 102; [2019] 4 All SA 1 (SCA) para 4.
[9] Ibid para 8.
[10] *Coopers (South Africa) (Pty) Ltd v Deutsche Gesellschaft für Schädlingsbekämpfung MBH* 1976 (3) SA 352 (A) at 371F-G. Also see *BEE v Road Accident Fund* [2018] ZASCA 52; 2018 (4) SA 366 (SCA) para 73.

process of reasoning which led to the conclusion, including the premises from which the reasoning proceeds, are disclosed by the expert.'

[11] As regards the functions of an expert witness, this Court in *McGregor and another v MEC Health, Western Cape*[11] stated as follows:

'The functions of an expert witness are threefold. First, where they have themselves observed relevant facts that evidence will be evidence of fact and admissible as such. Second, they provide the court with abstract or general knowledge concerning their discipline that is necessary to enable the court to understand the issues arising in the litigation. This includes evidence of the current state of knowledge and generally accepted practice in the field in question. Although such evidence can only be given by an expert qualified in the relevant field, it remains, at the end of the day, essentially evidence of fact on which the court will have to make factual findings. It is necessary to enable the court to assess the validity of opinions that they express. Third, they give evidence concerning their own inferences and opinions on the issues in the case and the grounds for drawing those inferences and expressing those conclusions.'

[12] With those principles in mind, it is now opportune to examine the salient aspects of the evidence that was placed before the high court. It bears mentioning that the respondent placed reliance on the provisions of the 2007 guidelines. There are three stipulations in the 2007 guidelines that are central to this case. The first relevant provision, under the heading of 'routine monitoring of the first stage of labour, provides that the foetal heart rate of a woman in the first stage of labour should be monitored 2-hourly. The second provision relevant to this case is that uterine contractions should be monitored every 2 hours. The third relevant provision, under the heading of 'emergencies during labour', is couched as follows in relation to foetal distress:

'**FETAL DISTRESS**

This is suspected when the following signs are observed:

• Baseline fetal heart rate ≥160 beats per minute

• Baseline fetal heart rate <110 beats per minute

• Variability persistently <5 beats per minute on CTG, in the absence of sedating drugs

• Late decelerations of the fetal heart rate.'

[11] *McGregor and another v MEC Health, Western Cape* [2020] ZASCA 89 para 17.

It is plain from the above, that a foetal heart rate that is equal or greater than 160 beats per minute or less than 110 beats per minute is not, on its own, sufficient to justify a conclusion that a foetus is in distress.

[13] An issue was raised about the frequency of the respondent's monitoring at the hospital. There was also a dispute as to whether the 2015 national guidelines, which had replaced the 2007 national guidelines, were to be considered as the applicable standard of medical care. The issue arose because Prof Buchmann had mentioned that the 2007 guidelines were reviewed and were replaced with the 2015 guidelines so as to align them with the UK-based National Institute for Health and Care Excellence Guidelines published in 2007 (NICE guidelines). He pointed out that the NICE guidelines recommended a 4-hourly monitoring for women in the first phase of labour, which is why the 2015 national guidelines replaced the 2-hourly monitoring with the 4-hourly one. He advanced that as the reason why he considered a 4-hourly monitoring as reasonable even in relation to an incident that happened in 2011. Dr Murray was adamant that the 2-hourly monitoring specified in the 2007 guidelines was the standard that was applied in South African public hospitals in 2011. Notwithstanding Prof Buchmann's explanation, I am satisfied that since the respondent's accouchement occurred in 2011, the 2007 guidelines were, in the absence of a protocol stating otherwise, applicable during her admission and labour at the hospital. For reasons that will become evident later, there is no need for the discrepancy in the monitoring recommended by the 2007 guidelines and the NICE guidelines to detain us any further.

[14] A contentious issue was whether the baseline CTG reading of 160 beats per minute, recorded during the CTG monitoring that was done from 02h01 to 02h18 (the 2 o'clock CTG monitoring), warranted other interventions being resorted to over and above the steps taken by the nurse who attended to the respondent. The respondent asserted that there had been no foetal monitoring from 02h18 until a non-reassuring heart pattern was observed during the CTH monitoring that was done from 06h11 to 06h23. The two obstetricians called as witnesses by the parties (Prof Buchmann and Dr Murray, respectively) gave mutually destructive accounts on whether a CTG reading of 160 beats per minute was non-reassuring or fell within the normal range. The obstetrician called by the respondent, Dr Murray, described a baseline heart rate

of 160 beats per minute as ‘a borderline heart rate’. When pressed on the issue under cross-examination, she stated that a baseline heart rate of 160 beats per minute was ‘enough to be suspicious by definition’ and warranted that the CTG monitoring be continued.

[15] An important consideration on whether a baseline of 160 beats per minute is suspicious or within the normal range is that Prof Buchmann testified that in terms of the NICE guidelines, which were applicable in 2011, a baseline foetal heart rate of 110 to 160 beats per minute was considered normal. Dr Murray conceded that those specific guidelines were also being applied at hospitals in South Africa. The NICE guidelines stipulate that ‘if there is a stable baseline fetal heart rate between 110 and 160 beats/minute and normal variability, continue usual care as the risk of fetal acidosis[12] is low’. Prof Buchman testified that regardless of the guidelines relied upon, the decisive foetal heart rate was a baseline foetal heart rate, which he described as the average foetal heart rate over a period of 10 minutes. He opined that in this matter, despite the fact that the nurse who was responsible for the CTG monitoring recorded the baseline foetal heart rate as 160 beats per minute, the baseline foetal heart rate was actually below 160 beats per minute. Dr Murray conceded this point. It is evident from the CTG printout that the baseline foetal heart rate (in other words the average heart rate) was slightly less than 160 beats per minute and therefore falling within the normal baseline range.

[16] Prof Buchmann expounded that a baseline of 160 beats per minute did not, on its own, suggest that the foetus was in distress. Notably, Dr Murray agreed with him on this point. Prof Buchmann and Dr Murray were agreed that in addition to the baseline foetal heart rate, there were two other equally important facets of heart normality that are monitored via CTG by the nursing staff monitoring a patient, namely the baseline variability of the heartbeat, which normally should be between 5 – 10 beats per minute, on the one hand and accelerations and decelerations in the heartbeat, on the other hand.

[12] Acidosis is caused by an overproduction of acid in the blood that builds up in the blood or by a build-up of carbon dioxide in the blood that results from depressed breathing or lack of oxygen. (Own footnote.)

[17] According to Dr Murray, strong contractions would normally cause a deceleration, which in itself was dangerous as it was associated with a change in the foetal heart rate. Dr Murray and Prof Buchmann were agreed that a series of late decelerations of the heartbeat were generally a cause for concern, as they could suggest that a foetus was in distress. They were eventually in agreement that during the 2 o'clock CTG monitoring, there was good variability and there were no accelerations nor decelerations that were noted. Dr Murray also conceded that even though she had initially expressed the view that further monitoring with CTG would have been advisable because the respondent was experiencing relatively strong contractions, it was unlikely that the foetus was in distress, given the normal variability and the absence of accelerations and decelerations. The following exchange on that aspect speaks for itself:

'Mr de Bruin: But nothing points to HI or anything like that on this 2 o'clock [CTG readings]?

Dr Murray: What do you mean by HI, sorry?

Mr de Bruin: Hypoxia or ischemia.

Dr Murray: Well we cannot really measure it directly on a CTG, but *I would not have thought this foetus was hypoxic or ischemic at this point*.

. . .

'Mr de Bruin: If there was stress doctor I must put to you with all these contractions the heart rate would have differed, it would have dipped with the contractions.

Dr Murray: Well that is why the contractions are unusual, firstly because they are there, they are frequent, they are there in early labour. And although yesterday it might have been misleading, I did speak about tachysystole,[13] *I have not anywhere made a link to say that this baby was distressed, because of too many contractions*. They are simply there, I cannot explain them and I do believe they were potentially significant, but they are unusual contractions and so I pointed them out as an abnormality that may have played a role.

Mr de Bruin: But on the baseline, on the fetal heart rate you do not see an obvious [interrupted].

Dr Murray: No, they are not typically causing decelerations, which is what you would typically see, so it is all [interrupted].

Mr de Bruin: *Yes, you do not see decelerations?*

Dr Murray: *No*.' (Own emphasis.)

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[13] Tachysystole is a condition of excessively frequent uterine contractions. Dr Murray opined that five contractions and upwards were regarded as tachysystole. (Own footnote.)

[18] Given the various concessions made by Dr Murray on this aspect, there is no basis for disagreeing with Prof Buchmann's testimony that based on the readings of the 2 o'clock CTG monitoring, there were no circumstances calling for the nursing staff to conclude that there was foetal distress. As nothing, at that stage, necessitated that the hospital staff should follow the procedures laid down for dealing with foetal distress in the 2007 guidelines, it was reasonable to discontinue the 2 o'clock CTG monitoring.

[19] It is common cause that after the 2 o'clock CTG monitoring, the next CTG monitoring was done from 06h11 to 06h23 (the 6 o'clock monitoring) and revealed that the baseline heart rate was 175 to 180 beats per minute. In her evidence-in-chief, Dr Murray asserted that the 6 o'clock CTG monitoring was borderline pathological and was a cause for concern. Under cross-examinations, she conceded that even at that stage, the variability was normal and there were no decelerations. The exchange on that aspect was as follows:

'Mr de Bruin: I am sorry M'Lady, I should have referred to it. In your summary doctor you deal with a 6 o'clock hear rate . . .
Dr Murray: In respect [of] the trace performed at 6 o'clock I did refer to variability being reduced.
Mr de Bruin: But still normal.
Dr Murray: No, well I said it was reduced, but what I am saying now in Court is that if I were to look at it more critically, it is probably acceptable.
Mr de Bruin: Yes.
Dr Murray: So I would retract that and call it about five at least on the second half, *but within normal.'* (Own emphasis).

[20] It is clear that even though tachycardia was observed during the 06h11 tracing, there were no decelerations. By Dr Murray's own admission, variability was still normal. Significantly, Prof Buchmann's evidence that there could not have been any significant episode between the 2 o'clock and 6 o'clock monitoring due to the fact that variability was still maintained by 06h00, was not challenged. Once it is accepted that there could not have been any significant episode of foetal distress between the 2 o'clock and 6 o'clock CTG monitoring, the issue of whether the monitoring should have been on a 2-hourly or 4-hourly basis becomes immaterial. This view is fortified by this

Court's judgment in *AN obo EN v MEC for Health, Eastern Cape*,[14] in which it was held that even in circumstances where hospital staff have acted negligently by not monitoring the condition of a woman in labour and foetus and acting appropriately on the results, their wrongful conduct does not, in and of itself, suffice to found delictual liability. It is trite that a successful delictual claim entails the 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.[15] Ultimately, a crucial enquiry in this matter is the cause of AL's injury, an aspect to which I now turn.

The nature of AL's brain injury

[21] In this regard, an important piece of the mosaic of evidence is the nature of the injury that caused AL to develop cerebral palsy. Prof Andronikou, a specialist paediatric radiologist, interpreted the Magnetic Resonance Imaging (MRI) scan of AL's brain. He described the brain injury suffered by AL as an acute profound hypoxic ischemic injury sustained during labour.[16] Of significance is that in his report, Prof Andronikou concluded that the MRI features were 'in keeping with a global insult to the brain due to hypoxic ischemic injury of an acute profound nature occurring at term.' Prof Andronikou's report was admitted into evidence by agreement of both parties. A medico-legal report prepared by another specialist paediatric radiologist, Prof Lotz, was also admitted into evidence by agreement between the parties. These two radiologists' reports were attached to the Rule 36(9) notices filed by the respondent.[17] Prof Lotz concurred with Prof Andronikou's finding that AL's brain injury was an acute profound hypoxic ischemic injury. In addition, he also opined that the brain injury was as a result of severe in utero hypoxia and ischemia that evolved rapidly 'over a matter of minutes.' He concluded that, from an imaging perspective, AL's injury implied 'a sudden and severe sentinel event that rendered the neonate severely hypoxic and ischemic, constituting an obstetrical emergency situation at the time.[18]

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[14] *AN obo EN v Member of the Executive Council for Health Cape* note 8 above, para 3.
[15] *International Shipping Co (Pty) Ltd v Bentley* 1990 (1) SA 680 (A) at 700F-I.
[16]Acute' is defined as meaning 'of sudden onset' in T L Stedman *Stedman's Medical Dictionary* (2012) at 28. Hypoxia is a prolonged reduction in oxygen supply to the brain. Ischaemia is a restriction in blood supply which leads to a shortage of oxygen.
[17] These notices were filed in terms of rule 36(9) of the Uniform Rules of Court.
[18] Sudden' is defined as meaning 'occurring unexpectedly or without warning' in the Concise Oxford dictionary (2016) at 1153. 'Emergency' is defined as meaning 'unexpected situation' in the Concise Oxford Dictionary (2016) at 382.

[22] Whereas Prof Lotz had opined that the hypoxia and ischemia had evolved over a matter of minutes, Dr Alheit, in his testimony, stated that the sentinel event that AL suffered was a collapse of circulation that happened due to a process that had developed 'over a period of time'. He opined that it was not a sudden, unexpected event. This testimony is plainly irreconcilable with the findings set out in Prof Andronikou and Prof Lotz's respective reports. Dr Alheit seemed to suggest a hybrid of a partial prolonged and an acute profound insult as a cause of AL's injury even though Prof Andronikou and Prof Lotz were agreed that the injury was of an acute profound nature. The high court accepted Dr Alheit's thesis despite the fact that he had conceded that he had no facts specifically relating to this case, on which he based his opinion.[19] It was argued on behalf of the appellant that the high court had misdirected itself by disregarding the uncontested findings of Prof Andronikou and Prof Lotz and preferring the evidence of Dr Alheit despite his evidence being contrary to the former's admitted evidence. As authority for that submission the appellant relied on the provisions of s 15(1) of the Civil Proceedings Evidence Act 25 of 1965, which states:

'It shall not be necessary for any party in any civil proceedings to prove nor shall it be competent for any such party to disprove any fact admitted on the record of such proceedings.' I am not aware of any authority that has deviated from the trite principle enunciated in this provision.

[23] It bears noting that this Court in *Bee v Road Accident Fund*,[20] observed as follows:

'. . . I agree that in . . . cases [where a court deals with contested expert testimony], a court must determine whether the factual basis of a particular opinion, if in dispute, has been proved and must have regard to the cogency of the expert's process of reasoning. Matters are quite different, in my respectful opinion, where experts in the same field reach agreement. In such a case, as I have said, *a litigant cannot be expected to adduce evidence on the agreed matters.* Unless the trial court itself were for any reason dissatisfied with the agreement and alerted the parties to the need to adduce evidence on the agreed material, the trial court would,

[19] See *Coopers (South Africa) (Pty) Ltd v Deutsche Gesellschaft für Schädlingsbekämpfung MBH* at 371G where it was stated that 'except possibly where it is not controverted, an expert's bald statement of his opinion is not of any real assistance.

[20] *Bee v Road Accident Fund* [2018] ZASCA 52; 2018 (4) SA 366 (SCA) para 73.

I think, *be bound, and certainly entitled, to accept the matters agreed by the experts*.' (Own emphasis.)

[24] Based on the passage quoted above, I am of the view that by parity of reasoning, the high court was obliged to accept the nature and mechanism of the injury as agreed upon by Prof Andronikou and Prof Lotz in their respective reports. It was therefore not open to the high court to disregard their findings and to prefer the contrary opinion proffered by Dr Alheit in his testimony. Moreover, he indicated that it would be for the obstetrician to establish what happened in this specific case. The obstetrician, Dr Murray, testified that she did not know what had caused the insult. It is of significance that notwithstanding his earlier evidence, Dr Alheit admitted, under cross-examination, that if there were no signs that the foetus was stressed, then the hypoxic ischemic injury would have been an unpredictable event. Notably, Dr Murray conceded that she did not consider the foetus to be in distress during the 2 o'clock CTG monitoring.[21]

[25] I am inclined to agree that the high court's preference of Dr Alheit's evidence despite it (a) not being supported by facts and (b) being contrary to the findings of the joint minute in relation to the nature of the injury, was not in accordance with the legal principles laid down in the authorities mentioned in the preceding paragraphs and therefore constituted a misdirection. In this regard, it is of significance that Dr Murray admitted that even at 07h20, there was no indication of hypoxia. It must be borne in mind that the determination of negligence is a fact-bound enquiry. Despite the fact that the monitoring of the foetal heart was not in strict accordance with the 2007 guidelines, the facts of this case, cumulatively considered, do not suggest that the nurse who attended to the respondent could, based on the 2 o'clock monitoring, reasonably have foreseen that harm would ensue. Neither do they suggest that a reasonable health professional in the position of that nurse would have foreseen any reasonable possibility of harm ensuing and taken steps to prevent it.

[26] This brings me to another ground of negligence relied upon by the respondent, namely, that the doctor who performed the caesarean section failed to perform the

[21] See the exchange between Dr Murray and the appellant's counsel, quoted in para 17 of this judgment.

operation within one hour of the decision to operate being made. It is common cause that whereas the decision to perform the caesarean section was made at 07h15, the caesarean section was performed at 08h37. As stated before, A was delivered at 08h40. The respondent is correct in contending that the appellant did not adduce any evidence explaining why the procedure was not performed within one hour as stipulated in the 2007 guidelines. However, Dr Murray's concession that sometimes it was not possible to perform the caesarean section operation within hour of the decision to operate at public hospitals, is a relevant consideration. To get a better perspective of the issue, it is necessary for the provisions of the guidelines to be carefully considered. The following is stated in relation to a caesarean section operation:

'**INDICATIONS FOR CAESAREAN SECTION**

Common indications for caesarean section include:

• Cephalopelvic disproportion
• Fetal distress
• Previous caesarean section
• Failed induction of labour
• Intrauterine growth restriction
• Breech presentation
• Placenta praevia
• Transverse lie
• Previous third-degree tear

THE OPERATION

All hospitals, as described in the chapter on levels of care, must have facilities and staff for the performance of caesarean section. Surgical techniques vary according to the circumstances and the experience of the operator. The following principles should be followed in all hospitals:

• Obtain informed consent for surgery, with the operation and its indication clearly explained to the mother
• Ensure that stored blood for transfusion is available in the hospital
• Ensure that caesarean section can be performed within one hour of the decision to operate
• Check the mother's Hb level
• Just before starting the operation, ensure that:
- If sterilisation is to be done, consent has been obtained

- The fetal heart can still be heard
- The indication[22] for operation is still valid
- The fetal presentation and position are known'

[27] The 2007 guidelines provide that the hospital staff must ensure that the caesarean section can be performed within an hour of the decision to operate. They also stipulate that 'just before' starting the operation, it must be established whether the indication for the operation is still valid. A number of factors would need to be taken into account when assessing whether the delivery of AL, outside the one-hour period constituted negligence. The hospital records show that from 07h15, when it was decided that a caesarean section was to be performed, some steps were being taken by the hospital staff. A CTG monitoring was done at 07h20. The respondent's consent was obtained at 07h30. From 07h30-08h00, the premedication was administered to her in preparation for the operation. She was handed over to the operating theatre staff at 08h00. The anaesthetic was administered at 08h28. Clearly, there was action from the time the decision to operate was taken at 07h15 up to when the caesarean operation was performed at 08h37, culminating in the delivery of the baby, AL, at 08h40.

[28] It seems to me that all the actions that were taken from 07h15, when the decision to operate was made, fall within the scope of ascertaining whether the indications for performing the caesarean section operation were still extant, as contemplated in the provisions of the 2007 guidelines. Under those circumstances, I am not persuaded that the failure to perform the operation within an hour of the decision being made was unreasonable. Notably, Dr Murray conceded that the reaction time of the hospital staff after the decision to operate was made, was not unreasonable.

[29] What is crucial is whether the brain injury suffered by AL would have eventuated, but for the alleged negligence of the hospital staff.[23] In this regard, it bears noting that it was not disputed that the brain injury sustained by AL was an acute

[22] The Merriam-Webster dictionary defines 'indication' as 'a symptom or particular circumstance that indicates the advisability or necessity of a specific medical treatment or procedure'. (Own footnote.)
[23] See the elucidation of the 'but for' test in *Mashongwa v Passenger Rail Agency of South Africa Africa* [2015] ZACC 36; 2016 (3) SA 528 (CC).

profound hypoxic sentinel event that constitutes an obstetric emergency. It was undisputed that the CTG reading recorded at 07h20, a mere 10 minutes before the respondent was brought to the theatre staff, still did not confirm the presence of foetal distress. In response to the question posed by the court at the conclusion of her evidence, Dr Murray stated that she could not say that the sentinel event would not have happened if the operation had been performed within an hour. On this aspect Dr Murray testified as follows:

'Dr Murray: … I think that it is fairly agreed, or it seems to be the case that no one in this matter is really sure as to when the exact injury occurred. We say it occurred, it most likely occurred leading up to the delivery, because we know that acute profound injuries in general usually occur close to delivery. Whether it occurred within the 60 minutes, or within the 86 minutes is hard to say. So the increased time may have made a difference, I do not know. We would then to be able to say that with certainty, we would have to exactly pinpoint as to what minute the injury occurred, but of course with any emergency time is always of the essence. So it may have made a difference, but I cannot say definitively.

Court: It may not?

Dr Murray: It may not.'

This concession by Dr Murray undoubtedly speaks specifically to causation. It leads me to conclude that even if it were to be accepted that some negligence may be found in (a) not monitoring the respondent between approximately 02h00 and 06h00 or (b) failing to deliver AL within 1 hour from the time the decision to perform a caesarean section was taken, the respondent has not shown on a balance of probabilities that any of these omissions had any causal link with the brain injury that was subsequently suffered by AL.

[30] It seems to me that the high court focused on Dr Murray's evidence-in-chief and paid little or no regard to the concessions and retractions she made under cross-examination. The fact of the matter is that the case pleaded by the respondent was fatally weakened by those concessions. As stated before, Dr Alheit's version was inconsistent with the admitted evidence of Prof Andronikou and Prof Lotz. Consequently, his evidence did not take the respondent's case any further. The upshot is that on the respondent's own version, the claim fell to be dismissed. In so far as the high court found to the contrary, it erred.

[31] It is trite that the power of appellate courts to overturn credibility findings made by a trial court is restricted. However, where the findings of a trial court are based on wrong premises, or where relevant facts have been ignored, or where the factual findings are clearly wrong, the appeal court is entitled to reverse them.[24] I am of the view that the credibility findings made by the high court to support its conclusion are not borne out by the conspectus of the evidence on record. It follows that it is open to this Court to tamper with them. This brings me to the appellants' contention that the adverse findings of the high court were tainted by bias.

[32] The facts and allegations upon which the appellant relies in support of bias relate to the remarks made about certain witnesses and incorrect factual findings made in the judgment of the high court. It was argued that those aspects, cumulatively considered, give rise to a reasonable apprehension of bias, alternatively to a conclusion that the factual findings were premised on 'unconscious bias.' The Constitutional Court in *Bernert v ABSA Bank Ltd*[25] held that a mistake made by a judicial officer on the facts, even if correct, is not ordinarily sufficient on its own to give rise to a reasonable apprehension of bias. A mistake on the facts will only give rise to a reasonable apprehension of bias if it is so unreasonable on the record that it is inexplicable except on the basis of bias.[26] Although I have concluded that the credibility findings made by the high court are not borne out by the record and found that it committed errors that amount to a misdirection, I am satisfied that none of those errors and misdirection meet the threshold of bias as laid down in the seminal judgment of *Bernert v ABSA Bank Ltd.* The allegations of bias simply have no merit and this ground of appeal need not detain this Court any further.

[33] The findings made above are dispositive of this appeal. It is therefore not necessary for this Court to pronounce itself on the rest of the submissions made on behalf of the respondent. For all the reasons stated above, the appeal stands to be upheld.

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[24] *R v Dlumayo and Another* 1948 (2) SA 677 (A) at 705 – 706; *R B v Smith* [2019] ZASCA 48; 2020 (4) SA 51 (SCA).
[25] *Bernert v Absa Bank Ltd* [2010] ZACC 28; Ltd 2011 (4) BCLR 329 (CC); 2011 (3) SA 92 (CC).
[26] Ibid paras 102 - 103.

[34] With regard to costs, the appellants' counsel advised us that his instructions are not to ask for costs, both at the trial court and in the appeal. That being the case, there is no reason to apply the general rule that the costs must follow the result.

Order:

[35] The following order is made:

1. The appeal is upheld.
2. The order of the high court is set aside and replaced with the following: 'The plaintiff's claim is dismissed'.

M B MOLEMELA
JUDGE OF APPEAL

Appearances

For appellant: PJ De Bruyn SC

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The State Attorney, Bloemfontein

For respondent: J Mullins SC

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