

SOUTH AFRICA / JUDGMENT

A.M obo K.M v Member of the Executive Council for Health, Eastern Cape (726/14) [2017] ZAECMHC 6; 2017 JDR 0598 (ECM) (30 March 2017) [2017] ZAECMHC 6

COURT

Eastern Cape High Court, Mthatha

BEFORE

Z.M. Nhlangulela

CASE / FILE NUMBER

726/14

Source: saflii.org · Research copy typeset by Esheria. Not court-issued or certified.

Source record

SAFLII

Note: Certain

personal/private details of parties or witnesses have been
redacted from this document in compliance with the law
and SAFLII

Policy

Reportable

IN

THE HIGH COURT OF SOUTH AFRICA

[EASTERN

CAPE LOCAL DIVISION, MTHATHA]

CASE

NO: 726/14

Delivered

on: 30/03/17

In

the matter between:

A.
M. obo K. M.
Plaintiff
and
MEMBER
OF THE EXECUTIVE COUNCIL FOR
HEALTH,
EASTERN CAPE
Defendant

JUDGMENT

NHLANGULELA DJP

- [1] The plaintiff, an adult female, issued summons against the defendant claiming payment in the sum of R15 093 000,00 as and for damages, under various heads, suffered by the plaintiff and her son, K., and arising out of an alleged medical negligence on the part of the staff and/or doctors serving as the employees of the defendant at All Saints Hospital, Engcobo, Eastern Cape.
- [2] This judgement seek to address the issue of liability pursuant to an agreement made by the parties to separate the trial on such issue from that of quantum as is envisaged in Rule 33 (4) of the rules of this Court. I agreed to the separation of the issues as sought by the parties.
- [3] The issues falling for decision of the plaintiff's claims can be stated as whether, in the first place, the cerebral palsy suffered by K. was caused by the wrongful (negligent) conduct, or omission, of the medical staff and/or doctors of the defendant's hospital; and whether, in the second place, such negligence caused cerebral palsy. Since the plaintiff's claims are premised on the law of delict, the onus of proof that the defendant was negligent will be resolved by application of the test as is stated in the case of *Kruger v Coetzer* 1996 (2) SA 428 (A) at 430 as follows:

"For the purposes of liability culpa arises if -

- (a) a diligens paterfamilias in the position of the defendant -
- (i) would foresee the reasonable possibility of his conduct injuring another in his person or property and causing him patrimonial loss; and
- (ii) would take reasonable steps to guard against such occurrence; and
- (b) the defendant failed to take such steps".
- [4] The background facts are that on 04 May 2010 and approximately at 12h40 the plaintiff was admitted at All Saints Hospital (the Hospital). She was then a 17 year old primagravida (pregnant for the first time). She was already 40 weeks pregnant. The hospital records show that she presented to the

Hospital with labour pains, and her blood pressure measuring at . She appeared in good health. The plaintiff

refused vaginal examination, with the result that the strength or frequency of vaginal contractions could not be assessed. Generally,

she appeared in good health. The foetal heart rate was allegedly 138 bpm. The staff did not write an assessment or plan for

further management. She had no history of rupture of the membrane and the placenta, vaginal bleeding and umbilical cord prolapse. The foetal status was in an assuring state.

[5] At 23h44 of the same day, on 04/05/10, there is recorded in the clinical notes a foetal heart rate of 135 bpm. Vaginal

examination was, yet again, not done as the plaintiff refused it. The assessment of the foetal condition and that of the plaintiff was not done between 23h45 to 08h20 on the next day.

[6] The next entries made in the clinical notes were on 05 May 2010 at 08h20, showing that the plaintiff was described as unco-operative and feeling weakness of the knees and refusing to get into the bed. The partogram was started at this point and the foetal head was chartered as above the pelvic brim. Two moderate contractions in 10 minutes were recorded. At 08h50 further two moderate contractions in 10 minutes were observed. The rate of contractions increased as at 09h30 three moderate contractions in 10 minutes were noted. At 09h50 the foetal head was showing when the plaintiff was bearing down. The Partogram shows the head at positions at this point. The foetal heart rate was normal. Half hourly foetal heart rates were recorded as normal on the Partogram on four occasions between 08h20 and delivery at 10h00.

[7] The plaintiff delivered her baby at 10h00 by face to pubis delivery/ Persistent Occiput Posterior (POP). The Apgar scores at 1 and 5 minutes were variably assessed as 5 and 7 out of 10. The clinical notes show no visible abnormalities with the placenta, umbilical cord or membranes and no meconium staining of the amniotic fluid occurred. The plaintiff sustained severe 3rd degree perineal tears from the vagina to the anus, that were later (after 7 hours) repaired by a doctor in surgery. The

clinical notes show only at this time that the foetus was under stress, but the cause is not ascertainable from the hospital records.

[8] The facts as set out above are common cause. Just as it is agreed between the parties that the report of Professor van Toorn, the paediatric neurologist, should be admitted in evidence; and more particularly the conclusion that he drew from neurological

examination that: "K. have a mixed spastic dystonic quadriplegic type of cerebral palsy with post-natal microcephally and severe global developmental

delay....This hypoxic ischaemic injury is supportive of a intrapartum asphyxia.” What this medical conclusion denotes is that the cause of cerebral palsy is a hypoxic ischaemic (H.I.) injury to the foetus that occurred during labour. This conclusion is supported by the MRI findings that were made by Professor Savvas Andronikou, the expert radiologist.

[9] The hospital records were disputed in many respects especially the Maternity Case Record (MCR) (Exhibits 6 the original document), the reconstructed MCR (Exhibit 17), the Road to Health Chart (RTHC) (Exhibit 3) and Partogram (part of the MCR). I first deal with the dispute that relates to the alleged inadmissibility of the hospital records.

[10] It was argued on behalf of the plaintiff that the MCR, including the Partogram and RTHC, are inadmissible documents because the author of these medical records was not called to confirm the authenticity and veracity thereof. Reliance was placed on the case of *Vulcan Rubber Works (Pty) Ltd v South African Railways and Harbours* 1958

(3) SA 285 (A) at 296D-H where the following is stated:

“... No doubt the difference between evidence and hearsay can be said to be an illustration of a board rule favouring the use of the best evidence, but the better way of stating the position is that hearsay, unless it is brought within one of the recognized exceptions, is not evidence, i.e. legal evidence, at all.”

[11] In this case the provisions of s 3 (1)(a) and (vi) of the Law of Evidence Amendment Act 45 of 1988 constitutes one of the recognized exceptions. They read:

“(1) Subject to the provisions of any other law, hearsay evidence shall not be admitted as evidence at criminal or civil proceedings, unless-

(a) each party against whom the evidence is to be adduced agrees to the admission thereof as evidence at such proceedings;

(b) ...

(c) The court, having regard to –

...

(vi) any prejudice to a party which the admission of such evidence might entail; ...”

[12] The plaintiff, who is legally represented, agreed to the introduction and use of the hospital records before and during the commencement of the trial without demur. Not only were witnesses led on behalf of the plaintiff on the hospital records in question but the defendant’s witnesses were also cross-examined. In my view the objection fails on the authority of *Thoroughbred Breeders Association of South Africa v Price Waterhouse* 1999

(4) SA 968 (W). In so far as the objection has been raised after the end of the plaintiff’s case the objection again fails. See: *Gieseche & Devrient South Africa (Pty) Ltd v Minister of Safety and Security* 2012

(2) SA 137 (SCA) and *S v Waldeck* 2006 (2) SACR 120 (NC).

[13] The issue of falsification of the contents of the hospital records constitutes the second string of the bow for the plaintiff. It was contended that the falsification of the MCR is the feature of negligent management of the plaintiff's labour that caused cerebral palsy. In that regard the plaintiff premised its case on the evidence of Mr Michael Irving and Mrs Jennifer Pieterse.

[14] Mr Michael Irving, plaintiff's witness, is a forensic documents examiner who was instructed to examine the MCR to determine whether any alterations and adjustments to the handwritten contents of the document had been made and, in particular, to determine whether there has been any alteration on page 4 of the same document. He testified that on line 14 of page 4 the blood pressure reading of had been originally recorded as ; a paper strip on line 14 reveal handwritten recording of the words: "Aldomet 500mg give to control blood pressure;" and a paper strip on line 20 reveals that there is a recording of BP at instead of 120/80 and a pulse rate of 73 or 43 instead of 93 that appears on the surface. On the Partogram, Mr Irving testified that the plaintiff's labour appeared to be of high level risk in that o/A is recorded as 8 with indecipherable character, that number 136 below the word ROM is insignificant and that management by repair is reference to the third degree tear suffered by the plaintiff. The witness also pointed to handwriting alterations having taken place on the Apgar Assessment on page 13, Resuscitation and Puerperium and Control Chart sections of the MCR. Mr Irving's examination of the MCR as received from the Hospital is portrayed in Exhibit 17, which is in essence a reconstructed Exhibit 6. The tampering with the MCR as revealed by Mr Irving is common cause.

[15] Mrs Jenifer Pieterse is a nursing expert of considerable experience. She currently serves in a Level 1 Hospital as a nursing manager. She was called by the plaintiff to testify on the acceptability and integrity of the MCR. The upshot of her evidence is captured in her evaluation of the document in the following terms at page 784 of the record: "...there does not appear to be any intention to deceive... that the reconstructed document [Exh 17] was an honest one..."

[16] Although the MCR evidence of Mr Irving and Ms Pieterse is accepted as such, Prof Johan Smith and Dr Clifford Brian Hulley, the expert witnesses for the plaintiff, testified that the contents of the hospital records including the tampering thereof illustrate

suboptimal intrapartumecure and the substandard management of the plaintiff's labour.

[17] Prof Smith is a neonatologist of note. The up-short of his evidence is that it was suboptimal intrapartum care on the part of the defendant's staff and/or doctors that created a risk H.I. injury in the foetal brain leading to cerebral palsy. He stated that the defendant's failure to monitor the plaintiff's labour was in breach of the provisions: Guidelines for Maternity Care in South Africa (2007), a maternity care manual for clinics, community health centres and district hospitals. This opinion is based on a number of factors such as that after the hospital admitted the plaintiff on 04 May 2010 it did not do vaginal examination 4 hourly; the staff did

not call for the intervention of a doctor when the plaintiff refused vaginal examination; the plaintiff's companion, her grandmother with whom she arrived at the hospital, was not consulted about the refusal; the plaintiff was not assessed from 23h45 to 08h20 in the morning and the staff did not write an assessment or plan for further management. The witness also testified that unexplained alterations of clinical notes in the MCR and RTHC amount to falsification of information with regard to actual progress of labour as a cover-up for suboptimal care. He stated that had the original information on the MCR not been revealed by Mr Irving the existence of warning signs of abnormal labour would not be known, namely: BP of is marginally high, the plaintiff was palpitated and it was found that the baby lay longitudinally with foetal head lying down cephalic; and that the plaintiff was given Aldomet (an anti-hypertension drug) indicating that the status of labour could not have been normal.

- [18] Prof Smith pointed out certain omissions to bolster his opinion that the hospital staff and/or doctors' actions were sub-standard management in nature in that, between 08h20 – 09h00, the Hospital failed to record the variability of the foetal heart rate and failed to give comment on decelerations and measure uterine contractions despite the observation that the foetal head was at four-fifth above the pelvic brim and two uterine contractions lasting 20 – 40 seconds were observed. At 09h50 when the plaintiff was bearing down apparently due to full cervical dilation, a specific rate of each contraction was not recorded. The active phase of the first stage of labour was not established by the staff members. Although the baby was resuscitated during 8 – 10 hours after birth appropriate interventions were not applied, such as: the A, B and C breathing support, a mask or resuscitation bag were not used. Although a pethidine drug was not given to the plaintiff to relieve pain, narcan drug was given to the baby unnecessarily as he could not have suffered any drug suppressive effect. He stated further that although the uterus wall contracted during operation to heal the 3rd degree tears of the perineum, internal examination of the uterus was not done.

- [19] Prof Smith told the Court that the integrity of the MCR was compromised by overwriting, tippexing, alterations and cancellation

of original information and the filling in of new information. He then opined that the MCR was a falsified document, all speaking to a substandard manner in which the plaintiff's labour was managed. He pointed to certain deficiencies: that the date of admission of the plaintiff shown in the MCR (04/05/2010) is different from the date reflected on the RTHC (06/05/2010); the original pulse rate of the plaintiff recorded on 4/5/2010 at 12 pm was overwritten by an improved rate of 93 pm; the original BP at was altered to ; on 05/05/2010 a raised BP of after birth could have been manipulated to tally with a normal blood pressure at on admission. After delivery of the baby the original Apgar scores of 5 and 7 at 1 minute and 5 minutes respectively were altered to 8 and 8 in 1 minute and 5 minutes with all Apgar variables having been manipulated for the desired final scores; on 10/05/2010 plaintiff's original BP at was adjusted to

- [20] With reference to scientific studies undertaken in the United Kingdom, by Yamada and co-workers: Obstetrics and Gynaecology Research (2015) in New Zealand, Sweden and South Africa, Prof Smith opined that sub-optimal intrapartum care is prevalent worldwide and it is a major intrapartum risk factor for cerebral palsy after excluding well known risk factors, such as placental abruption; uterine rupture and cord prolapse. (See: Exhibit 21 at pages 15 – 44). As regards the role of Apgar Scores as a warning sign that hypoxic ischemic injury was likely, than not, to occur during labour the witness made the following statement: “Taking the OP (Occiput Posterior) position into consideration and the scientific literature in regard to the subject, it is more likely that the 2nd stage of labour was complicated by FHR abnormalities, than not, and therefore I state that in the light of the clear evidence that there was tampering with the Maternity case records, it is more likely that FHR abnormalities were present, but it was not recorded because foetal well-being, including the FHR and its response to contractions, was not properly assessed.”
- [21] Prof Smith expressed an opinion, contradicting Prof Justus Hofmeyer, on the question, not answered in the clinical notes, when exactly the active phase of the first stage of plaintiff’s labour commenced. As there are periods during which foetal monitoring did not occur, that is between 01h40 and 23h44 on 4/5/10 and between 23h45 and 08h20 on 5/5/10. Prof Smith stated that if one extrapolates cervical dilation at a rate of 1 cm per hour counting from 23h45, the active phase of labour would have commenced around 03h50 and foetal abnormality detected had monitoring been done. Prof Hofmeyer’s opinion is that the active phase could have occurred after 08h20 when contractions started to be observed and no foetal abnormality was detected. The medico-legal report of Prof Hofmeyer, defendant’s witness was admitted in evidence without him being called to testify.
- [22] The evidence of Prof Smith does not tally with the report of Dr Yatish Kara, the expert paediatrician for the defendant, that

neonatal encephalopathy could be due to the incident recorded from 5 days after birth. Nevertheless, in the light of the admitted

opinion of Prof Van Toorn their disagreement is insignificant. The MRI scan evidence adduced by Prof Andronikou, based on the examination of K. at age 3 years and 7 months, did confirm the opinion of Prof Van Toorn that the onset of neonatal encephalopathy was due to intrapartum H.I. of acute profound type, mostly likely occurring at term.

- [23] Under cross examination, Prof Smith went on to make some concessions with regard to the foetal status during the labour process. The concessions are the following: The delivery of the baby was a normal vertex birth; the OP presentation was not a risk factor for cerebral palsy; the Apgar scores of at 1 minute and 5 minutes after birth are normal. That is, they would not present a risk for HI to occur. He acknowledged the scientific fact advanced by the American College of Obstetrics and Gynaecology (ACOG) that ≥ 5 score at 5 minutes after birth signifies a normal foetal status. Studies conducted show that babies with Apgar scores as high as or as low as 3 or 4/10 may or may not develop cerebral palsy as cerebral palsy is a

multifactoral disorder. Although a foetal heart rate of between 120 and 160 bpm is regarded as normal, a standard deviation of 110 FHR can be regarded as normal. He acknowledged the scientific view, held world-wide and endorsed by ACOG, that Apgar scores are in any event not an exclusive tool for measuring asphyxia. However, without some indicators/fore-warnings it would not be possible for the Hospital staff and doctors to assess the OP foetal head presentation at any other time except at delivery. He acknowledged the scientific fact the delivery with foetal presentation being face-to-pubis can be a normal birth. He conceded that the assessment of the foetus, as reflected on the Partogram at 08h20 on 05 May 2010, showed four measures of the foetal heart rate between 20 and 40 minutes that was indicative of mild cervical contractions. Liquor was recorded as clear, and there was no meconium. There were no clinical indicators of potential problems with the foetus. The opinion by Frances Cohen and co-workers (2003) to the effect that cerebral palsy due to birth asphyxia is not preventable was acknowledged by Prof Smith. He also concedes that in this case the post-delivery Apgar scores did not predict H.I. injury during labour. Electronic foetal monitoring (the CTG) and/or auscultation for the foetal heart rate indicators were not done. Prof Andronikou's finding that scientific tests are absent to prove that K. suffered from atax CP were conceded. And the MRI test was not done to find the presence of milli-organ failure from which to establish the existence of metabolic acidosis in the foetus during labour. He also conceded that the facts of this case did not provide a reason for instrumental birth, and in particular caesarean birth is not done within 1 hour of delivery to prevent H.I. as, per Clark and Hankins, such a step is normally harmful to the mother and baby. In his own estimation, an insult to the foetus, as it was a catastrophic event, would occur between 22 minutes to 146 minutes before birth, and based on the studies by Pusternack, a profound insult would have occurred between 10 – 46 minutes before birth at 10h00.

- [24] Another expert witness to testify on behalf of the plaintiff was Dr Hulley, a general medical practitioners who is qualified in obstetrics and gynaecology. The essential features of his evidence is that since the vaginal examination was not assessed by the Hospital to establish the foetal status between 12h40 and 23h44 on 04 May 2010 and between 12h45 to 08h20 in the next morning the defendant negligently created a risk that led to H.I. and cerebral palsy. He told the Court that he had conducted an interview with the plaintiff who told her that she had abdominal labour pains for which she was vaginally examined, a Doppler test was done to ascertain the active stage of labour, she was caused to walk around the hospital premises aimlessly; and that she was ill-treated when she refused vaginal examination and not assisted when she was crying and being in pain. According to Dr Hulley the plaintiff experienced pain throughout the night and no one cared to speak to her. Based on the information at his disposal and the reading of the MCR and RTHC together with the medical report of Dr Kara he opined that the State's obstetrical care was extremely wanting in this case. He blamed the Hospital for creating "massive degree of risk to mother and child" in its failure to give the plaintiff pethidine or perform an epidural in spite of the fact that the foetus was Occiput Posterior and the vaginal tears had caused "heavy bleeding". He stated that the plaintiff experienced a "disastrous delivery". He lamented the opinion of Prof

Buchman, an expert witness called by the defendant, that the OP delivery was easy in this case saying that “ [I] ... do not know where he could possibly have concluded THIS”. Yet Dr Hulley agreed with Prof Buchmann’s report that foetal distress most likely occurred in the last two hours of labour. Further, Dr Hulley made no attempt to deal with the reports by Prof Andronikou and Prof van Toorn in which they stated that the foetus suffered an acute profound H.I.

- [25] But it soon turned out under cross examination of Dr Hulley that he did not recall exactly what the plaintiff had told him, saying that the report that he compiled and filed in court was based on assumptions of what he was told during the interview and had, in part, relied on the facts deriving from a report by Dr Kara. But there is no evidence to back him up. Consequently, the evidence of this witness must be treated with caution. To that extent the part(s) of his evidence that are untrustworthy and/or inadmissible must be rejected.
- [26] Prof Buchmann testified on behalf of the defendant. He is the expert of international stature specialising in Obstetrics and Gynaecology. He testified that plaintiff’s BP of recorded on 05 May 2010 was normal; the foetal heart rate of 110 – 160 bpm is regarded as normal; the foetal heart rate at 138 recorded at 23h44 was normal and the foetal heart rate at 142 recorded on 05 May 2010 at 08h20 was normal just as the BP of the plaintiff at 142 was normal. He stated that the foetal head was located at above the pelvic trim, two moderate contractions occurred in ten minutes and the Apgar score of 0 was recorded. At 09h50 three moderate contractions occurred and the foetal head was showing when the plaintiff was bearing down. The foetal heart rate was still normal as it was before 08h20. At 10h00 the baby was delivered with normal Apgar scores of and in 1 minute and 5 minutes. The offensive amniotic fluid observed was not stained with meconium. Episiotomy was not

done, but the plaintiff suffered spontaneous 3rd degree tears on the perineum. The delivery of 10 minutes duration was spontaneous, quick and uneventful and foetal abnormalities were not detected. Prof Buchmann stated that the 3rd degree tears were common in POP deliveries such as the one experienced by the plaintiff. He confirmed Prof Hofmeyer’s

study, reported in Turnbull’s Obstetrics (2001), in which it was found that face-to-pubis (POP) delivery can be spontaneous and normal. Briefly, the witness was adamant that in his opinion, based on the materials placed before him, the foetal status was in a reassuring condition during labour until the discovery after delivery that the foetus had suffered an H.I. insult, albeit without fore warning signs.

- [27] Prof Buchman did not agree with the evidence of Dr Hulley and Prof Smith in material respects; especially that sub-standard intrapartum care and/or monitoring on the part of the Hospital occurred that led to H.I. insult to the foetus. He stated that the plaintiff’s refusal of cervical examination at 12h40 and 23h44 did not require labour argumentation by epidural analgesic or sedative injection because the Active Phase of the first stage of labour was not evident. Proof that labour had actually commenced would not have been presented merely by the plaintiff’s refusal, when strong cervical contractions were not evident. According to

the witness the Active Phase could have started at 08h20 due to contractions, not between 7 – 7h30, on 05 May 2010, and the delivery was not a chaotic one as suggested by Dr Hulley; and neither was the second stage of labour prolonged. He did not agree with Dr Hulley's opinion that a prolonged Latent Phase existed resulting in foetal distress (he relying on the work of Magoma and Buchmann – 2002). He opined that it is always safe to avoid interventions/labour augmentation at the Latent Phase in the circumstances, as the present, where the onset of labour is difficult to ascertain.

- [28] Stating that the scientific fact, held world-wide, is that the Latent Phase of 20 hours and more is prolonged, Prof Buchmann did not consider it appropriate to support Dr Hulley, that the Latent Phase of 8 hours duration and more is prolonged and that it is associated with adverse neonatal and perinatal outcomes. He stated that the international standard, discussed by Emmanuel Triedman, which finds application in South Africa as well is that the Latent Phase is prolonged if labour endures for 20 hours and more without a prospect of delivery. He stated that, therefore, the Philpot Partogram based on the foetal assessment of the Latent Phase of 8 hour duration serves only as a guide; and moreso it being not ascertained in this case when exactly labour started. He also refuted the correctness of Prof Smith's opinion that assessment of the foetal status based on cervical dilation at less than 1 cm per hour, instead of the average time of less than 3 cm per hour, is a sign of poor progress of labour. Under cross examination Prof Smith agreed with Prof Buchmann in that regard.
- [29] The issue was raised with Prof Buchmann that the hospital records may be interpreted with a slant that since they had been falsified they may be interpreted in a favour of the plaintiff's case. However, he stated categorically that he did not want to be drawn into the issue because he had no knowledge of documents having been falsified.
- [30] The findings made by Prof Andronikou, and adapted by Prof van Toorn, that the MRI scan points to the development of H.I. insult that led to cerebral palsy during labour, make it unnecessary to delve into the state of monitoring of K. after birth. For that reason Prof Smith was prepared to concede that hypoglycaemia and hyperoxia noted after birth as being the possible causes of cerebral palsy have no bearing to the acute H.I. insult at term. In actual fact was common cause that there was no proof that such illnesses were connected to cerebral palsy. It will also help to point out at this stage that the acceptance of the opinion that H.I. insult developing at a time very close to delivery and the acceptance of the scientific fact that instrumental interventions and any form of labour augmentation would be a futile exercise can very well be dispositive of this case. But for the opinion of Prof Smith and Dr Hulley that proper monitoring of the foetal status would have placed the Hospital staff and doctors in a position to pick up warning signs of H.I. developing and take appropriate steps to prevent the insult that ultimately struck to incapacitate K., there is a need for an answer to the question whether there was a warning sign(s) that the staff and doctors could have picked up for cerebral palsy to be prevented. An excerpt from the record at page 1542 – 1543, the statement put to Prof Buchmann by plaintiff's counsel, does

describe the plaintiff's case. I quote it:

"I am going to argue to this Court that on the probabilities this patient arrived there in the hospital, she wasn't assessed she wasn't co-operative as the staff expected here to be, and after that they just decided to let her lie there, and give birth on her own as she eventually did. Without any monitoring of her and then when they saw that oh jeez this is a problem, they just fraudulently completed documents changed what entries they had made to the extent that they thought would suit their defence..."

- [31] The thrust of the opinions given by Prof Smith and Dr Hulley confirm that the plaintiff's complaint against the defendant is that poor monitoring of the plaintiff's labour forewarnings of HI insult could have been picked up and the H.I. prevented. The following statements of Prof Smith show it.

At 1184 of the record:

"I am of the opinion that in the case it probably did, I pointed out that occiputer posterior is likely to be linked to abnormalities in the foetal heart rate, so that there probably was forewarning and then until finally there was no more reserves and acute Hypoxic insult occurred."

At page 1190 he again said:

"... but the forewarning I state to the Court must have been there based on the analysis of probability."

- [32] Prof Smith confirmed that the acute H.I. insult with a known sentinel event usually takes place between 22 - 146 minutes of delivery, and the insult with unknown sentinel event takes place much closer to birth at between 10 to 46 minutes.
- [33] It was argued by Mr Wessels SC, on behalf of the plaintiff, that reasonable medical treatment was not provided in that the Hospital failed to monitor plaintiff's labour during the first 4 hours of admission; failed to follow-up monitoring in the next 4 hours; allowed the latent phase to be prolonged; failed to detect warnings of foetal heart rate abnormalities that went into complete compromise of the foetus; failed to detect that the foetus was lying at POP position which ordinarily results in prolonged and difficult labour that usually requires augmentation of labour by caesarean section or the plaintiff being referred to a larger hospital for assessment and proper treatment. It was argued that sub-optimal/substandard intrapartum care creating a risk of hypoxic insult proves that the defendant caused cerebral palsy for which it must be held liable. The case of *Lee v Minister For Correctional Services* 2013 (2) SA 144 (CC) was referred to, especially the words appearing at para [60] which read as follows:

"... It would be enough, I think to satisfy probable factual causation where the evidence established that the plaintiff found himself in the kind of situation where the risk of contagion would have been reduced by proper systemic measures."

[34] Mr De Bruyn SC, counsel for the defendant, argued that the legal proof of causation has not been satisfied in this matter; in as much as the case of Lee referred to does not apply in this case as it is distinguishable on the facts. I agree because in this case it is not disputed that the Hospital's labour ward systems were not adequate, albeit the Hospital grading status was Level 3. As correctly put by Mr De Bruyn the issue here may not even be about suboptimal care but failure to monitor the foetal condition because suboptimal intrapartum care is defined by Yamuda and co-workers as a: "Delayed reaction to non-reassuring foetal status." And Prof Smith conceded this definition as well as that there can be no delayed reaction in the absence of a non-reassuring foetal condition.

[35] It will help to state the legal test of causation at this early stage as that is indeed the litmus test on which the conduct, or omission, of the defendant's staff and doctors must be judged. In *ZA v Smith* 2015 (4) SA 574 (SCA) Brand JA states it as follows at para. [30]:

"The criterion applied by the court a quo for determining factual causation was the well-known but-for test as formulated, eg by

Corbett CJ in *International Shipping Co (Pty) Ltd v Bentley* 1990 (1) SA 680 A at [1989] ZA SCA (138) at 70)E-H. What it essentially lays down is the enquiry – in the case of an omission –

as to whether, but for the defendant's wrongful and negligent failure to take reasonable steps, the plaintiff's loss would not have ensued. In this regard this court has said on more than one occasion that the application of the 'but-for test' is not based on mathematics, pure science or philosophy. It is a matter of common sense, based on the practical way in which the minds of ordinary people work, against the background of everyday-life experiences. In applying this common sense, practical test, a plaintiff therefore has to establish that it is more likely than not that, but for the defendant's wrongful and negligent conduct, his or her harm would not have ensued. The plaintiff is not required to establish this causal link with certainty."

[36] An assessment of probabilities is not possible without analysing the facts of the case which are contained in oral and documentary

evidence. This must be clarified. The submission on behalf of the defendant that the hearsay evidence of the plaintiff,

who did not testify in the witness box, is inadmissible is correct. There is no need to quote authority for that submission. I have already ruled that the MCR, Exhibit 17, is admissible in evidence. Therefore, the hearsay evidence given by Dr Hulley and Prof Smith that the plaintiff was treated badly and neglected at the Hospital and that the staff did not persuade the plaintiff to submit to vaginal examination is rejected.

[37] The cause and time of cerebral palsy is known. It was the HI injury of acute profound type that took place during term. The injury was acute in nature, and it occurred at a time very close to birth. That the foetal presentation would be POP was unknown until the time of delivery. This is accepted evidence against the backdrop of the scientific fact that not in all cases does POP coupled with 3rd degree tears lead to adversities such as HI. Further, that the

cause of cerebral palsy is not hypoglycaemia and hyperoxia is also known. The delivery of the baby was not accompanied by the known sentinel events such as the rupture of the placenta, rupture of the membrane, umbilical cord prolapse and bradycardia/tachycardia. It was admitted that the placenta was not tested microscopically with result that the cause of asphyxia remains unknown. I accept the evidence of Mrs Pieterse that the contents of the MCR, Exh. 6, were not intended to deceive notwithstanding the fact that it had been tampered with. Prof Smith accepted that the altering of the scores relating to blood pressure and Apgar as presented in both the "doctored" and reconstructed MCR, and measured against scientific studies did not produce a non-reassuring foetal status. I add all the concessions by Prof Smith in so far as they tellingly support the defendant's case that the foetal condition, when assessed, was in a reassuring state until the time of delivery. Consequently, the direct evidence does not assist the plaintiff's case. What remains is the investigation, firstly, of the alleged omissions during the period between 23h45 and 08h20 when the staff and doctors are not shown by the clinical records to have assessed the progress of labour. Secondly, the investigation must be directed to the period between 08h21 to 10h00. It would appear from the evidence of Prof Smith that reliance is placed on some probabilities that warnings of H.I. did

exist showing up once or intermittently which could have been picked up by a non-negligent staff member(s) before it insults the foetus. This notion is a speculation. It is not a proved fact, and is confusing if one has regard to the evidence that the insult could have taken place at between 10 – 46 minutes before delivery. A court of law can only weigh up the proved fact without concerning itself with speculating on evidence that was never adduced, or which does not follow by reasonable inference from the proved facts. The case of *Bates Lloyd Aviation (Pty) Ltd v Aviation Insurance Co.* 1985 (3) SA 916 (A) is instructive. There the appellate court stated as follows at p 939I-J and 940A-B:

"Inference, it was observed by Lord WRIGHT in Caswell v Powell Duffryn Associated Collieries Ltd

[1939] 3 All ER 722 (HL) at 733, must be carefully distinguished from conjecture or speculation:

"There can be no inference unless there are objective facts from which to infer the other facts which it is sought to establish. In some cases the other facts can be inferred with as much practical certainty as if they had been actually observed. In other cases the inference does not go beyond reasonable probability. But if there are no positive proved facts from which the inference can be made, the method of inference fails and what is left is mere speculation or conjecture."

[38] The proper approach to expert evidence is set out in Zeffert and Paizes: *The South African Law of Evidence*, 2nd Edition in the following terms:

At page 329:

“Moreover, expert scientific witnesses tend to assess likelihood in terms of scientific certainty and that is different from what is required for judicial proof. A court does not ask whether a particular scientific thesis has been proved or disproved. In civil proceedings it asks where the balance of probabilities lies on a conspectus of the totality of the evidence.”

At page 320, these authorities outline the duties of expert witnesses testifying in court as follows:

“1. Expert evidence presented to the Court should be, and should be seen to be, the independent

product of the expert uninfluenced as to form or content by the exigencies of litigation
(*Whitehouse v Jordan*, [1980] UKHL 12; [1981] W.L.R. 246 at p. 256, per Lord Wilberforce)

2. An expert witness should provide independent assistance to the court by way of objective unbiased opinion in relation to matters within his expertise (see *Polivitte Ltd v Commercial Union Assurance Co. Plc.*, [1987] Lloyd’s Rep. 379 at p. 386 per Mr Justice Garland and *Re J*, [1990] F.C.R. 193 per Mr Justice Cazalet). An expert witness in the High Court should never assume the role of an advocate.
3. An expert witness should state the facts or assumption upon which his opinion is based. He should not omit to consider material facts which could detract from his concluded opinion (*Re J sup.*).
4. An expert witness should make it clear when a particular question or issue falls outside his expertise.
5. If an expert’s opinion is not properly researched because he

considers that insufficient data is available, then this must be stated with an indication that the opinion is no more than a provisional one (*Re J sup.*), In cases where an expert witness who has prepared a report could not assert that the report contained the truth, the whole truth and nothing but the truth without some qualification, that qualification should be stated in the report (*Derby & Co. Ltd, and Others v Weldon and Others*, *The Times*, Nov. 9, 1990 per Lord Justice Staughton)...” (cf: *National Justice Compania Naviera S.S. v Prudential Assurance Co. Ltd*) (cf: *National Justice*)

[39] The statements made in the case of *Menday v Protea Assurance Co.w1w Ltd* 1976 (1) SA 565, 569C-D are apposite. They read:

“Phipson and Hoffmann, op. cit., both point out the dangers inherent in expert testimony. For example, the inability of the Court to verify the expert's conclusions and the tendency of experts to be partisan and over-ready to find and multiply confirmation of their theories from harmless facts (Phipson, para. 1286). Nonetheless the Court, while exercising due caution, must be guided by the views of an expert when it is satisfied of his qualification to speak with authority and with the reasons given for his opinion.”

See also: *Coopers (SA)(Pty) Ltd v Deutsche G.F.S.* 1976

(3) SA 352 (A) at 371F-G.

[40] The case of Munday seems to me to apply to Dr Hulley, whose evidence I must say, with respect, is biased in favour of the plaintiff and the witness exhibited the urge to exaggerate the facts and made sweeping conclusions that are not supported by credible facts and medical research. I agree with defendant's counsel that it was injudicious, if not unprofessional, of the witness to import facts from Dr Kara's

report without verifying them from the plaintiff. I find it unacceptable that the witness should draw medical conclusions without having had sight of the MCR. It was not available to the witness to say that the plaintiff, being in pain, was ill-treated at the hospital by not being given pain tablets, was caused to walk around the premises until she cried, was not assisted in any way and was generally ignored. Such evidence amounts to hearsay, and it is not evidence at all.

[41] To an extent Prof Smith also discredited himself, so it was argued on behalf of the defendant. As I observed the witness in the witness-box he came across as a candid witness who was prepared to make concessions even under compromising situations but still holding to his opinions which are not supported by the facts in a way that is symptomatic of witnesses not tuned to the environment of a court of law. Otherwise this witness has imparted his expert knowledge on the subject matter of neonatal encephalopathy in keeping with the highest level of his area of specialization. However, by making material concessions impacting on the issue of causation, the bases of substandard monitoring as alluded to by Prof Smith escape me.

[42] I accept the scientific evidence that assessment of the foetus was not done due to the fact that the plaintiff could have been sleeping between 23h45 to 08h20. As conceded by the expert witnesses of the plaintiff absence of monitoring during that period was most probably a way of Hospital management of labour by therapeutic rest to sleep and prepare the plaintiff for advanced active labour as envisaged in the study by Betsy et-al (Exh. 32). There are no hard facts present in this case to support an inference, apparently drawn by Prof Smith, that since cerebral palsy occurred, caused by an H.I. event at term and during the detention of the plaintiff in the defendant's hospital, therefore the defendant is liable to make good the damages as claimed. In so far as such reasoning is the invocation of the *res ipsa loquitur* maxim in a wrong setting, this Court rejects the contention advanced on behalf of the plaintiff that the cases of *Ntsele v MEC For Health, Gauteng Provincial Government* [2003] 2 All SA 356 (GSJ) and *Khoza v MEC For Health And Social Development* 2015(3) SA266 (GSJ), which are authorities for a proposition that for the defendant to escape liability it must rebut the presumption

arising from the fact that the occurrence speaks for itself, are applicable to this case. As stated in the case of *Kruger v Coetzee*, supra the plaintiff bears the onus to prove that the defendant's negligence caused cerebral palsy; and as stated in the case of *Goliath 2015 (2) SCA* at 102, para [8] the plaintiff's onus does not shift. In medical negligence law the case of *Buthlezi v Ndaba 2013(5) SA 437 (SCA)* is the reason why the Hospital cannot prove negligence against itself. Ponnann JA in *Goliath* articulates the legal position in the following terms at 103, para. [9]:

"The evident reluctance of our courts to apply the maxim is because, as Lord Denning MR observed in Hucks v Cole

[1968] 118 New LJ 469 ([1993] 4 Med LR 393) -

'with the best will in the world things sometimes went amiss in surgical operations or medical treatment. A doctor was not to be held negligent simply because something went wrong.'

For, to hold a doctor negligent simply because something had gone wrong would be to impermissibly reason backwards from effect to cause (*Medi-Clinic Ltd v Vermeulem 2015*

(1) SA 241 (SCA) ([2014] ZASCA 150) para. 27)."

[43] In terms of the Constitutional Court case of *Lee* the application of the but-for test in cases involving proof of negligent omissions the substitution exercise is used in terms of which an enquiry is conducted merely by mentally eliminating the unlawful conduct of the defendant and asking whether, the remaining circumstances being the same, the event causing harm to the plaintiff would have occurred or not. If it would, then the unlawful conduct of the defendant was not a cause in fact of this event; but if it would not have so occurred, then it may be taken that the defendant's unlawful act was such a cause. These statements were quoted, and adopted in *Lee* from the case of *Siman & Co (Pty) Ltd v Barclays National Bank Ltd 1984 (2) SA 888 (A)*. Molemela AJ (Mogoeng CJ, Moseneke DCJ, Froneman J, Khampepe J, Madlanga J, Nkabinde J and Theron AJ concurring) in *Oppelt v Department of Health, Western Cape 2016 (1) 325 (CC)* re-iterated the test as follows at 342:

"[48] While it may be more difficult to prove a causal link in the context of a negligent omission than of a commission, Lee explains that the 'but-for' test is not always the be-all and end-all of the causation enquiry when dealing with negligent omissions. The starting point, in terms of the 'but-for' test, is to introduce into the facts a hypothetical non-negligent conduct of the defendant and then ask the question whether the harm would have nonetheless ensued. If, but for the negligent omission, the harm would not have ensued, the requisite causal link would have been established. The rule is not inflexible. Ultimately, it is a matter of common sense whether the facts establish a sufficiently close link between the harm and the unreasonable omission."

[44] Mr Wessels SC submission on the test used to fix delictual liability seems to be that the case of *Lee*, in using the substitution test in resolving liability for omissions, has introduced a second test to the traditional but-for test as endorsed in the case of *Mashongwe v Prasa 2016 (3) SA 328 (CC)* at para. [65]. Mr De Bruyn SC argued that the case of *Lee* never sought to replace the but-for test. That is, the test applicable in determining factual causation remains

the but-for test. The statement by the Honourable Chief Justice Mogoeng-Mogoeng, writing for the Constitutional Court in Mashongwe at para. [64] brings to our attention the statement of the Constitutional Court in Lee at para. [53] that the substitution test, which is directed only to the normative standards of the wrongfulness element for proof of liability, should not be used to contaminate the factual dimension of the causation enquiry as the substitution test is an approach premised on the flexibility that has always been recognised in the traditional approach. That said, the applicable test in the causation

inquiry is always the but-for test. In addition it might as well be stated that the plaintiff fails even on the substitution test as the Hospital staff and doctors could not have reasonably foreseen a catastrophic H.I. event occurring. Put differently, the hypothetical non-negligent monitoring would still not have produced a better labour outcome.

[45] For the purposes of completeness, the breach of the provisions of the Guidelines by the Hospital staff must be seen in the context of my views as expressed in paragraph [42] above and elsewhere in the body of this judgment for to do otherwise would invoke the undesirable *res ipsa loquitur maxim*.

[46] The entire evidence adduced does not inferentially, or otherwise, disclose the lawful conduct that the defendant must have done to prevent the acute profound H.I. event from occurring. Put differently, the probabilities inherent in the available evidence do not connect the alleged substandard monitoring directly to H.I. that led to cerebral palsy. As submitted on behalf of the defendant the difficulty confronting the plaintiff is that there are not objectively proved facts available from which to infer culpable

conduct on the part of the defendant. As contended by Mr De Bruyn SC in this case the H.I. injury has been proved to be acute (sudden onset), profound (deep/intense) and catastrophic (causing sudden

great damage) in nature resulting in unforeseen (without a warning) injury. The sentinel event accompanying the insult is of unknown and unknowable origin. Such are the reasonable conclusions drawn from the credible opinions as expressed by Prof Buchmann and Prof Andronikou. On the probabilities emerging from the facts of this case it is not likely that the improper monitoring of the plaintiff's labour caused the H.I. that led to cerebral palsy. The evidence does not show that the hypothetical

negligent monitoring of the foetus in the absence of warning signs would have prevented insult from occurring.

[47] Applying the case of *Vuyisile Eunice Lushaba v The MEC for Health, Gauteng* 2015

(3) SA 616 (GJ) does not produce a result favourable to the plaintiff because the facts of the present case are distinguishable from those

of Lushaba where cerebral palsy was caused by a failure on the part of the hospital doctor to apply a caesarean section immediately upon discovering on admitting the plaintiff that abruptio placentae, a risk factor for H.I. insult, occurred that had already put the foetus under stress. In such circumstances a delayed caesarean birth was a cause of cerebral palsy. The same cannot be said in this case.

[48] The net effect of this judgment is that the plaintiff has failed to discharge the onus of proving that the defendant is liable to pay damages as set out in the particulars of claim. But the general rule that the unsuccessful party must pay the costs is difficult to apply in a case such as this. On the consideration of justice and fairness to the plaintiff and her child who very obviously cannot cough up the huge costs of litigation in this matter an order that each party must pay its own costs would, I hope, be appropriate.

[49] In result the following order is made:

1. The plaintiff's claim is dismissed.
2. Each party to pay her/its own costs.

Z. M. NHLANGULELA

DEPUTY JUDGE PRESIDENT OF THE HIGH COURT

MTHATHA

Counsel for the plaintiff : Adv. J. J. Wessels SC

Instructed by : Messrs Nonxuba Inc

Locally represented by : Messrs Potelwa & Co

MTHATHA.

Counsel for the defendant : Adv. V.S. De Bruyn SC with Adv V. Kunju

Instructed by : The State Attorney

Source & reproduction note

Judgment wording, source notices and original paragraph numbers are retained. Esheria supplies the layout and this PDF's page numbers; these are not the source pagination. This is a research copy, not an official or certified court document. Check quotations, citations and publication restrictions against the original source before relying on it.

ORIGINAL SOURCE <https://www.saflii.org/za/cases/ZAECMHC/2017/6.html>

CASE PAGE <https://chat.esheria.ai/case-law/south-africa/am-obo-km-v-member-unknown-topic-aecmhc-2017>

Prepared on 10 October 2026 · Esheria