

SOUTH AFRICA / JUDGMENT

Lomalisa v K.R.M (CIVAPPFB9/2014) [2017] ZANWHC 58 (17 August 2017) [2017] ZANWHC 58

COURT

North West High Court, Mafikeng

BEFORE

R D Hendricks, Samkelo Gura, N Gutta

CASE / FILE NUMBER

CIVAPPFB9/2014

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IN

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CASE
NO: CIV APP FB 9/2014
In

the matter between:

DR.
L. LOMALISA
Appellant
and
K.
R. M.
Respondent
HENDRICKS
J, GURA J & GUTTA J
DATE
OF HEARING
:
26 MAY 2017
DATE
OF JUDGMENT
:
17 AUGUST 2017
COUNSEL
FOR APPELLANT
:
ADV. N.G.D. MARITZ SC with ADV. A.P. ELS
COUNSEL
FOR THE RESPONDENT
:
ADV. H. LEVER SC with ADV. J. STANDER

JUDGMENT

HENDRICKS J

Introduction

- [1] Itokolle-Clinix Private Hospital (commonly known as Victoria Private Hospital) and Dr. L Lomalisa, (the Appellant, in the appeal) were first and second defendants respectively in an action instituted by K. R. M. (now Respondent in the appeal) for damages arising from severe cerebral palsy suffered by her baby L., at the time of his birth. The Appellant who is an obstetrician and gynaecologist as well as the nursing staff of Victoria Private Hospital assisted the Respondent with the delivery of L..
- [2] It was alleged that the condition of severe cerebral palsy was caused by the negligent conduct of the Appellant and the nursing staff of Victoria Private Hospital who attended to the Respondent before and during the birth of L.. The Respondent claimed damages in her personal capacity as well as in her representative capacity as the mother and natural guardian of L.. The Appellant and Victoria Private Hospital are sued on the basis that they are jointly and severally liable for the damages suffered. The merits and quantum were separated. The Victoria Private Hospital settled the claim against it by paying an amount of R1.5 million without prejudice and without admitting liability.

Factual

Background

- [3] The salient facts can be briefly summarised as follows. The Respondent was at all material times a patient of Dr. Ofori, who is a gynaecologist and who attended to her pre-natal care. Dr. Ofori referred her to the Victoria Private Hospital where she was to deliver her baby, L. through an induction process on the 09th December 2008. Upon her arrival at Victoria Private Hospital, she was admitted and attended to by the Appellant and Dr. Opawole. She was admitted to the maternity ward at 07H30 where she was under the care of the Appellant and the nursing staff of Victoria Private Hospital.
- [4] Upon examination by the Appellant it was discovered that the Respondent's cervix was not favourable for labour. The Appellant then prescribed a tablet called Cytotec (100 microgram) for the induction of labour. Half of the Cytotec tablet which consist of 100 micrograms, were to be administered by inserting it vaginally into the cervix. This was done between 10h00 and 10h30 on the 09th December 2008. The Respondent testified that she was informed about the purpose of the tablet but not warned about the side effects thereof. She experienced severe pains and cramps.
- [5] The Appellant examined the Respondent again at 17h00 and found that her cervix was not fully dilated. He then prescribed another 100 micrograms of Cytotec, which was vaginally administered to the Respondent at 17h30. The Respondent experienced severe pains that evening and was left unattended for a considerable period of time by the nursing staff of Victoria Private Hospital. When she was eventually attended to, she also received an injection which alleviated the pains.
- [6] The following morning, being the 10th December 2008, the Appellant visited the Respondent at 08H30. He examined her and ruptured her membrane. According to her, the Appellant inserted another tablet vaginally for the induction of labour. She experienced strong contractions. An infusion (drip) was also administered to her. The Appellant was later called and the baby, L., was born at 15H30 through normal delivery.
- [7] Sometime after the birth of L., a nurse informed the Respondent that the baby was not well. A paediatrician, Dr. Kingela, was summoned to attend to L., who was in an incubator in the Neonatal Intensive Care Unit (NICU). Dr. Kingela informed the Respondent that L. experienced mild respiratory distress during the process of labour. The Respondent was discharged from Victoria Private Hospital on 10th December 2008 but L. remained in the hospital. L. suffered several seizures whilst in the NICU and was only discharged on 29th December 2008 after being diagnosed with severe cerebral palsy.

[8] The trial court held that the Appellant and Victoria Private Hospital are jointly and severally liable, for damages which may be proven by the Respondent, the one paying the other to be absolved. It also ordered that the Appellant should pay the costs of the action and other ancillary relief. The Appellant applied for leave to appeal, which leave was granted by the trial court to the Full Bench of this division; hence the present appeal.

Condonation

[9] A portion of the record was not initially transcribed. Subsequently, after that portion had been transcribed, it was served and filed with the Registrar of this Court. An application for condonation for the late filing of the omitted portion of the record was made. This application for condonation was unopposed. At the hearing of the appeal, the requisite condonation was granted.

Grounds of appeal

[10] The appeal is premised mainly on the grounds that the trial court erred in finding that the Appellant neglected his duty of care to properly monitor the respondent and that there is a causal link between such failure or negligence and the administration of Cytotec, which caused the condition of severe cerebral palsy suffered by L..

The Pleadings

[11] In paragraph 18 of the amended particulars of claim, the following is alleged with regard to negligence:

"18. The medical staff and/or second defendant treated the plaintiff and/or L. negligently and were in wrongful breach of their duty of care, alternatively breached the aforesaid agreement in that:

18.1 they failed to monitor plaintiff and/or L. before and after delivery;

18.2 the medical staff failed to remain in attendance;

18.3 they failed to exercise reasonable skill and care;

18.4 they failed to monitor by CTG;

18.5 they failed to observe that the unborn child was in distress;

18.6 they failed to manage the birth process reasonably;

18.7 they neglected plaintiff and L., before and after delivery;

18.8 the treatment and/or medication was inadequate; and

18.9 the medical staff administered medication to plaintiff at a stage when it was not safe to do so, alternatively neglected to administer medication and/or treatment in circumstances when such medication and/or treatment was warranted, to prevent harm or injury to either plaintiff or L.."

This is the case that the Appellant (and Victoria Private Hospital) had to meet.

The Plaintiff's case

- [12] The Respondent (Plaintiff during the trial) testified that she was informed about the purpose of the tablet Cytotec. She was however, not warned about the side effects of the Cytotec tablet. According to her, she was informed by the nursing staff that she would be in labour within eight (8) hours after the administration of the Cytotec tablet and that she would deliver the baby at about 17h00. The Respondent alleged that she experienced severe pains or cramps after the insertion of the Cytotec tablet, which were worse than the pains previously experienced during the delivery of her two other children.
- [13] At 17H00 she was examined by the Appellant. Her cervix was found to be not fully dilated. Upon examination it admitted only one finger. The Appellant then caused another 100 micrograms of Cytotec to be administered. According to the Respondent, she initially received no attention from the nursing staff. Later on, an injection was administered which alleviated the severe pains that she endured. This is borne out by the nursing report in which it is recorded that she complained of severe headache and that she was sedated to relieve anxiety.
- [14] The following day, the Appellant examined her and ruptured her membrane. The fluid was mixed with blood. The bedding was wet and she was made to stand next to the bed for a considerable period of time, unattended. When a nursing sister eventually came to her, she was told by this sister that they (the nursing staff) had forgotten about her. She was then put back onto the bed. She testified that immediately after giving birth, the baby did not cry but only made a sound once. The nursing sister took the baby away and returned with the baby after some time. The nurse told her that the baby was not well and a paediatrician, Dr Kingela, was summoned to attend to the baby.
- [15] Dr. Seventer testified on behalf of the Respondent as an expert witness. He compiled a medico-legal report. He observed that the Respondent went through a rollercoaster of misfortune. According to him, amongst others, the Respondent was given 100 micrograms of Cytotec. Cytotec is a brand name for Misoprostol, which is an extremely dangerous drug because it may cause hyper-stimulation of the uterus with the following side effects:
- (i) severe uterine contractions can start soon after administration of the tablet and may cause a rupture of the uterus in a patient who previously had a caesarean section and in some cases, the rupture occurred in patients who had never had a caesarean section;
 - (ii) that although its purpose in obstetrics is to ripen the cervix, it should be used to induce labour in a patient with a favourable cervix for induction. However, the patient runs the risk of having amniotic fluid embolism, which can kill the mother and the baby if the Cytotec tablet is administered to induce contractions. Amniotic fluid embolism is when the fluid that is around the baby is pushed into the muscle and vessel structure in the uterus and goes into her system when the mother experiences severe contractions;

(iii) the other risk is that the patient could experience hypertonic uterine contractions or uterine hyper-stimulation, which means five or more contractions in 10 minutes or a series of contractions lasting more than two minutes or a series of contractions lasting for a minute. Normally, during normal contractions, the blood supply to the foetus is totally cut off, meaning that the foetus does not receive oxygen in the brain. However, the baby's brain needs 60 to 90 seconds between the contractions to re-oxygenate itself. When there is hyper-stimulation, this process cannot happen and the baby becomes more hypoxic.

- [16] Dr. Sevenster was of the opinion that the cerebral palsy suffered by L. was caused by the Respondent being left unattended on the 09th December 2008 after the Cytotec tablet was inserted and was only seen by Dr. L. Lomalisa at 17h30 when it was found that the cervix was only one centimetre dilated and was therefore unfavourable and still not inducible. Furthermore, that severe contractions experienced by the Respondent soon after the administration of the Cytotec tablet, meant that the Respondent had a series of hyper-stimulation of the uterus.
- [17] The Respondent was given another 100 micrograms of Cytotec at 17h30. Thereafter, she experienced severe pains in the evening, which according to the Respondent, were stronger than those she experienced earlier in the afternoon. She was given an injection late in the evening at about 23h00. The pains subsided, because, according to Dr. Sevenster, the effect of the Cytotec tablet would have worn out and a combination of the Pethedine and Aterax injection, 100 milligrams of each, was extremely effective in relieving the pain which is a dosage normally prescribed under those circumstances.
- [18] He further testified that the Pethidine penetrates the placenta and has the effect of suppressing the respiratory efforts of the foetus after birth. He however intimated that to avoid this from happening, the baby is usually given Naloxone immediately after birth. Dr. Sevenster did however concede during cross-examination that there is no evidence besides that of the Respondent, that she suffered severe contractions which occurred frequently and excessively because there is no documentary proof in a form of an electronic monitoring print-out or cardiotocograph (CTG) report. He also conceded that an entry in the post-natal records of Dr. Kingela indicates that Naloxone was administered to the baby, L., after birth.
- [19] He also stated that the use of Cytotec or Misoprostol, in terms of the World Health Organisation (WHO) recommendation and literature on the usage of the Cytotec tablet for induction, should be at the lowest dosage of 25 to 50 micrograms, given vaginally between four and six hourly intervals. In South Africa, the Cytotec tablet comes in 200 micrograms strength and the Respondent was given half a tablet in other words 100 micrograms. He referred to the clinical practice guidelines and protocols contained in a publication where it is stated as a warning that "Misoprostol is a very powerful stimulator of uterine contractions in late pregnancy and can cause foetal death and uterine rupture if used in high doses". It is further indicated that: "... beyond 24 weeks 25mg 6 hourly is usually used. If a higher dose than this is used, then the uterine hyper stimulation with uterine rupture or foetal distress might be the result".

- [20] He further held the view that the Respondent experienced severe hypertonic uterine contractions, because after Dr. L. Lomalisa had ruptured her membranes, he administered another 100 micrograms of Cytotec as well as an infusion (drip) containing Oxytocin or Pitocin which is a contraindication in obstetrics, if given within six (6) hours after the last dose of Misoprostol. According to Dr. Sevenster, it is the duty of the doctor after rupturing the membranes to give strict instructions that the patient be cleaned, put to bed and put on the electronic monitor or CTG and to leave clear instructions that he or she be contacted if there are any abnormalities observed. If he or she is not contacted by the nursing staff within the next two to three hours, the doctor is duty bound to contact the labour room of the hospital and enquire about the progress of the patient.
- [21] Dr. Sevenster testified further that it is furthermore extremely important to run the electronic monitoring or CTG in order to assess or detect any abnormalities of the foetus' heart rate. It is also important to have a nurse in attendance and constantly have a continuous CTG running. The CTG records could not be traced at the hospital although two or three entries of the foetal heart rate were made in the nursing progress report. Even though the CTG was prescribed by Dr. L. Lomalisa, there is no proof that the monitoring was done. Dr. Sevenster testified that as doctors, they were taught that if there is no proof that any form of test was done, then the conclusion is that it was never done.
- [22] There was also no record of a partogram kept in the motherbook. A partogram is a chart that is used to monitor the progress of a patient in labour and the relevant entries regarding the latent phase (at the beginning of labour) and the active as well as the last part of labour which is the action line. According to Dr. Sevenster, the information entered in this chart relates to the cervical dilation, which is a determination of how far the front part of the baby is in the birth channel (the station of the presenting part), the percentage or effacement of the cervix, the duration and intensity of contractions, blood pressure reading, foetal heart rate, temperature and urine specimen tested.

The Second Defendant's case

- [23] The Appellant (Second Defendant in the trial) testified. He is an obstetrician and gynaecologist. He makes it common cause that he attended to the Respondent on the 09th December 2008 at the Victoria Private Hospital. He delivered her baby, L., through a process of induction. He examined her and observed that her cervix was not ready for labour. He prescribed 100 micrograms of Cytotec to be administered vaginally. He left her in the care of the nursing staff of the Victoria Private Hospital with strict instructions that she be monitored and reviewed every four hours. He also ordered the nursing staff to monitor the foetal heart rate by using the cardiotocograph (CTG).
- [24] He again examined her at 17h30 and prescribed another half a tablet of Cytotec, which is 100 micrograms in strength. He explained the purpose of administering the Cytotec tablet to her and also that the nursing staff would monitor the progress of her labour. He then made a note in the Doctor's progress report. He testified that he prescribed the Cytotec tablet

because it is not expensive and it is used in almost all the public hospitals in South Africa for the purpose of inducing labour. A dosage of 100 micrograms was generally administered during 1998 until 2010. The dosage was reduced to 50 micrograms in 2010 after a conference of gynaecologists was held and a resolution taken in that regard. He has been administering the Cytotec tablet on his patients for labour induction and has never had a case of a patient suffering from hyper stimulation of the cervix.

[25] He testified further that he only prescribed one 200 micrograms of the Cytotec tablet, which was broken into half. One half was administered for induction in the posterior phoenix of the cervix at 10h00 and the other half inserted at 17h30 when, on review, he observed that the cervix of the Respondent was only one centimetre dilated. Dr. L. Lomalisa denies ever prescribing and administering

any Cytotec tablet on the Respondent on the 10th December 2008, as alleged. He testified that after rupturing the Respondent's membranes at 11h00, he administered a drip

containing 5 units of Oxytocin (Pitocin) for augmentation of labour, as well as an injection containing a combination of Pethidine and Aterax, which was administered to relieve pain.

[26] According to him, the labour process of the unborn child was progressing well. He did not observe anything untoward in the

condition of the Respondent or the unborn child. Before the delivery of the baby at 15h15, he was never summoned by the nurses to the hospital regarding any deterioration of the Respondent or the foetus' condition. The nurses who cared for and monitored the Respondent were highly experienced. He further stated that the nursing staff, who were his eyes and ears during the monitoring of the Respondent, were negligent in not calling for his intervention, that is, if such a need arose. He examined the respondent at 17h30, and evaluated the cardiotocograph (CTG) printout and found that everything was normal with the condition of the Respondent as well as her unborn child. This concluded the evidence tendered on behalf of the Appellant during the trial in the court a quo. Although it was indicated that Dr. F.J Mashamba would be called as an expert on behalf of the Appellant, Dr. Mashamba did not testify during the trial.

The issues to be determined on appeal

[27] Firstly, it needs to be determined whether the Appellant neglected his duty of care. The evidence of Dr. Sevenster in this regard is to the effect that it is the duty of the doctor after rupturing the membranes to give strict instructions that the patient be cleaned, put to bed and put on the electronic monitor or cardiotocograph (CTG). Furthermore, to leave clear instructions that he or she be contacted if there are any abnormalities observed. If the doctor is not contacted by the nursing staff within the next two to three hours thereafter, the doctor is duty bound to contact the labour room and enquire about the progress of the patient.

[28] It is furthermore extremely important to run the electronic monitoring or CTG in order to assess or detect any abnormalities of the foetus' heart rate. It is also important to have a nurse in attendance and constantly have a continuous CTG running. The CTG records could not be traced at the hospital although two or three entries on the foetal heart were made in the nursing progress report. Even though the CTG was prescribed by Dr. Lomalisa there is no proof that the monitoring was done. The monitoring could be done at least thrice during the prenatal process, although it could be more depending on the circumstances of each case.

[29] Dr. L. Lomalisa handed up as Exhibit A, a notice that he alleges was displayed on the wall of the labour ward which served as a guidance to the nursing staff when monitoring patients under labour induction. It reads as follows:

"MONITORING OF PATIENTS UNDER INDUCTION

1. Before starting induction of labour:
 - a. Make sure that the fetus is in VERTEX position
 - b. Run CTG for 20 minutes.
2. One hour after insertion of prostaglandin tablet or gel, run CGT for 20 minutes.
3. Incase of hyper stimulation (more than 5 contractions in 10 minutes) fetal distress

OR

(Fetal heart rate more than 170 bpm or less than 120 bpm)

Notify the Gynaecologist immediately.

WRITTEN by DR LOMALISA"

[30] According to him, the labour process of the unborn child was progressing well. He did not observe anything untoward in the

condition of the Respondent or the unborn child. Before the delivery of the baby at 15h15, he was never summoned by the nurses to the hospital regarding any deterioration of the Respondent or the foetus' condition. The nurses who cared for and monitored the Respondent were highly experienced. He further stated that the nursing staff, who were his eyes and ears during the monitoring of the Respondent, were negligent in not calling for his intervention, that is, if such a need arose. He examined the plaintiff at 17h30, and evaluated the CTG printout and found that everything was normal with the condition of the respondent and the unborn child.

The finding of the trial court

[31] The trial court found that it may be argued that Dr. L. Lomalisa had a duty to monitor the Respondent or as testified by Dr. Sevenster, that Dr. L. Lomalisa should on his own, have gone to the hospital to assess the progress and condition of the labour process within two to

three hours after administering the Cytotec tablet because, the ultimate responsibility of ensuring that the patient had a safe delivery of the baby lies with the doctor. It can further be argued that failure to adequately monitor the Respondent's labour progress in that regard, would amount to negligence.

[32] In the present case, so the trial court concluded, Dr. L. Lomalisa failed to record or note his observations regarding the condition of the Respondent when he reviewed her at 17h30. He only made a note that the Respondent's cervix was one finger dilated and prescribed another Cytotec tablet. He testified that he made his assessment of the Respondent's condition based on the records available and that the Respondent and the unborn child were fine. The trial court concluded that Dr. L. Lomalisa should at least have made a note about the CTG readings in order to establish whether or not the Respondent's contractions and the foetus were progressing well. The trial court held that Dr. Sevenster's opinion that Dr. Lomalisa ought to have made his observation known by making a note in his progress report is reasonable, especially in view of the fact that at 17h30 there was little progress made regarding the dilation of the Respondent's cervix which was not favourable for labour after almost nine hours after the insertion of the Cytotec tablet.

[33] Dr. Sevenster further gave the opinion that Dr. L. Lomalisa should have visited the Respondent at least after two to three hours after administering the Cytotec tablet, without even having to wait for the nursing staff to call him. The Respondent testified that at about 23h00 on the 09th December 2008, she experienced severe cramps and was given an injection to alleviate the pain. The Respondent furthermore testified

that she was given an injection at night to alleviate pain and was told by the nurses that Dr. L. Lomalisa prescribed the injection. Dr. Lomalisa did not testify on this issue. The trial court concluded that Dr. L. Lomalisa should have attended to the Respondent at that stage in order to assess whether she was experiencing hyper stimulation occasioned by the administration of the Cytotec tablet.

[34] The court a quo concluded that adequate monitoring would have enabled Dr. L. Lomalisa to detect at an early stage whether or not the Respondent was experiencing hyper stimulation of the uterus. Consequently, the foetal distress which probably contributed or caused the baby, L., to suffer from cerebral palsy, could have been prevented. Dr. L. Lomalisa ought to have foreseen the possibility of this occurring,

especially because he was aware of the fact that monitoring was crucial for patients who are undergoing an induction of labour

procedure. When he prescribed medication for pain on the night of the 09th December 2008, he should have reviewed the Respondent to determine whether there was any cause for concern. Instead, when he observed

that the dilation of the Respondent's cervix was slow on the 10th December 2008, he prescribed Pitocin which could have contributed to the hyper stimulation of the uterus of the Respondent with disastrous consequences.

[35] The trial court further concluded:

“However, this does not mean that on the evidence on record, it cannot be found that the negligent conduct of Dr. L. Lomalisa and nursing staff, by administering high dosages of Cytotec and failing to adequately monitor the plaintiff’s [respondent’s] labour progress, would not be causally connected to the harm suffered by L.. I am consequently satisfied that the plaintiff [respondent] has succeeded in proving on a balance of probabilities, that Dr. L. Lomalisa and the nursing staff were negligent in administering a high dosages of Cytotec tablets and other medication on the plaintiff [respondent] and failing to properly and adequately monitor her labour progress.”

[36] As far as the monitoring is concerned, I am holding a different view. It was the duty of the nursing staff of the Victoria Private Hospital to do the cardiotocograph (CTG) and report to the Appellant. Had they properly monitored the Respondent they could have informed the Appellant of any change in the condition of the Respondent and/or the unborn baby, L.. The Appellant left clear instructions to the nursing staff of Victoria Private Hospital to monitor the Respondent and the unborn baby closely. They failed to do so. When they called the Appellant, he responded and the baby was delivered within 15 minutes after the Appellant was called. This is a clear indication that had they called the Appellant, he would have attended to the Respondent. No evidence was presented that the Appellant was called but failed to respond when there was a crisis, which would have amounted to negligence on his part. I am of the view that the Appellant did not neglect his duty of care.

[37] The main ground of negligence on which the Respondent relied during the trial was the allegation that the Appellant administered a very high dose of Cytotec. By far the most time spent in evidence was on the alleged Cytotec overdose. The Court a quo specifically found at paragraph 79 of its judgment that the Appellant was negligent in administering high dosages of Cytotec tablets to the Respondent. The Cytotec was only administered on 09 December

2008. The Court a quo correctly found that no Cytotec was administered to the Respondent by the Appellant on 10 December 2008.

[38] In paragraph 79 of the judgment of the Court a quo it was held that both the second defendant and the nursing staff of the hospital were negligent in administering a high dosage of Cytotec tablets and other medication”, to the Respondent. It was not testified by Dr Sevenster, that the administration of any other medication, but Cytotec, was wrong. There was consequently no basis to find that "other medication" administered to the Respondent was a ground of negligence against the second defendant. Dr Sevenster conceded during his cross-examination that the primary function of Cytotec is indeed to ripen the cervix. The very purpose of an induction is to, by way of medication, induce the delivery process.

[39] Dr Sevenster stated in his expert summary that the appellant administered more than the accepted dose of Cytotec. Dr Sevenster

stated that the maximum prescribed dose of Cytotec was 25 to 50 mcg which should be administered every six hourly. The appellant

specifically testified that Cytotec is widely used by gynaecologists to induce delivery. He testified that he has personally used Cytotec since 1998 in various hospitals including Baragwanath and the Mafikeng public hospital. The appellant testified that the accepted dose of Cytotec in State hospitals since 1998 was 100 mcg administered six hourly. It was only during a conference in 2010 that it was decided by all the relevant stakeholders that the maximum prescribed dose should be lowered from 100 mcg to 50 mcg. This evidence of the appellant cannot be disputed by the plaintiff. It was also not disputed during cross-examination.

[40] It was specifically put Dr Sevenster during cross-examination that the maximum dose for Vagiprost, also known as Misoprostol, is 100 mcg. This could not be disputed by Dr Sevenster, but he added that Vagiprost is, as far as he knows, not registered for use in South Africa. The appellant specifically testified that in his experience that the use of Misoprostol has never caused hyperstimulation of the uterus.

[41] Based on the aforementioned, the Appellant was not negligent in administering a dose of 100 mcg of Cytotec on two occasions on 9 December 2008. In this regard it is important to again emphasise that it was conceded by the first defendant, Victoria Private Hospital, that its employees were negligent as a result of their failure to monitor the Respondent. The failure to monitor the Respondent was obviously relevant after the Pitocin drip had been inserted. If there were severe contractions as a result of the administration of Cytotec, it was still the duty of the employees of the first defendant, Victoria Private Hospital, to monitor the Respondent and to report to the Appellant if there were any abnormal activities.

[42] I have already concluded that the Appellant was not negligent. Even if he were to be, the question is whether such negligence is causally connected to the cerebral palsy. The following facts and circumstances need to be taken into account in this regard. Dr Sevenster conceded that more than 50% of cerebral palsy is simply unexplained. There were no hospital records which recorded any foetal distress. Dr Sevenster conceded that it is only in approximately 2% of all cases that Cytotec causes a hyperstimulation of the uterus. There exists no medical records which indicate that there was in fact a hyperstimulation of the uterus after the administration of the Cytotec.

[43] When the plaintiff's membranes were ruptured on the morning of 10 December 2008 the amniotic liquid was clear, indicating that the baby had not been under stress. It was the standing procedure at the hospital that there should be proper monitoring of the patient and the baby at all relevant times. The nursing personnel of the first defendant clearly failed to monitor the respondent and the baby. The appellant was at all relevant times available to come to the hospital if he was called out by the nursing personnel. When the appellant was eventually called by the nursing personnel at 15:15, he delivered the baby within fifteen

minutes.

- [44] No evidence at all was presented as to what occurred between the period of 10 December 2010 and 29 December 2010, when the baby was discharged from hospital. It is common cause that the baby had various seizures during this period. The effect or cause of the seizures was not even considered. No medical evidence was presented by the respondent which can be relied upon to conclude that, on the probabilities, the appellant's negligent conduct caused or materially contributed to the cerebral palsy.
- [45] No attempt was made by the respondent to present expert evidence in respect of the issue of causality. Dr Sevenster readily conceded that he is not a pharmacologist and that he has extremely limited experience with Cytotec. He testified that he has never used Cytotec in his own practice. His only knowledge in respect of Cytotec is with reference to literature. No evidence was presented by the respondent that 100 mcg of Cytotec would be more dangerous than 50 mcg of Cytotec.
- [46] Regardless of the dose of Cytotec, it was appreciated by the appellant that there was a risk, albeit a small one, that the Cytotec could cause a hyperstimulation of the uterus. It is for this reason that there was a standing order to the nursing personnel of the first defendant to monitor the respondent closely. There is no evidence to suggest that, if the appellant was called out by the nursing personnel at any stage as a result of a hyperstimulation of the uterus, he would not be able to take proper and immediate remedial steps.
- [47] The mere fact that the baby has cerebral palsy is not necessarily an indication that there was a hyperstimulation of the uterus. The respondent failed to present any medical evidence of the fact that the cerebral palsy was caused by a hyperstimulation of the uterus. Specifically as a result of the fact that there are numerous reasons for cerebral palsy of which more than 50% is simply unexplained, the respondent had the duty to present such evidence. The mere fact that there is a hyperstimulation of the uterus does not necessarily mean that there will be cerebral palsy. If there is a hyperstimulation of the uterus the relevant gynaecologist should be informed immediately to enable him to take immediate action.
- [48] Even if it is accepted that the cerebral palsy was caused by a hyperstimulation of the uterus, there is no legal basis to conclude

that this was caused by the appellant. It is common cause that the nursing personnel of the first defendant failed to monitor the

respondent properly. Therefore, if it is accepted that the hyperstimulation of the uterus factually caused the cerebral palsy,

this was caused by the failure of the nursing personnel of the first defendant to monitor the respondent and the baby properly and their failure to contact the appellant.

[49] There is consequently no evidence to suggest that the Cytotec, which was administered on 9 December 2008, could still have any effect on the respondent during the morning of 10 December 2008, when the respondents' membranes were ruptured. Therefore, even if it is accepted that the appellant administered a too high dose of Cytotec, this negligence could not have caused or contributed to the cerebral palsy. There was also no attempt made by the plaintiff to present any evidence when the cerebral palsy occurred. The importance of this, specifically where there are alleged joint wrongdoings, is clearly illustrated in the matter of *Wright v Medi-Clinic Ltd* 2007

(4) SA 327 (C).

[50] In *Buthelezi v Ndaba* 2013 (5) SA 437 (SCA) the following was stated:

"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."

"The human body and its reaction to surgical intervention are far too complex for it to be said that, because there was a complication, the surgeon must have been negligent in some respect. Logic dictates that there is even less room for application of the maxim in a case like this, where it has not been established what went wrong; and where the views of experts are all based on speculation

- giving rise to various, but equally feasible possibilities - as to what might have occurred."

With reference to the facts of this matter it was imperative for the plaintiff to present expert medical evidence as to what caused the cerebral palsy and exactly when this occurred.

[51] In addressing this Court on the aspect of causation. Mr. Lever S.C on behalf of the Respondent, referred to the Supreme Court of England case of *Sienkiewicz v Grief (UK) Ltd Willmore vs Knowsley Metropolitan Borough Council* [2011] UKSC 10. In particular was reference made to paragraphs [16] which deals with the but for test.

In Paragraph [16] it is stated:

"[16] It is a basic principle of the law of tort that the claimant will only have a cause of action if he can prove, on balance of probabilities, that the defendant's tortious conduct caused the damage in respect of which compensation is claimed. He must show that, but for the defendant's tortious conduct he would not have suffered the damage. This broad test of balance of probabilities means that in some cases a defendant will be held liable for damage which he did not, in fact, cause. Equally there will be cases where the defendant escapes liability; notwithstanding that he has caused the damage, because the claimant is unable to discharge the burden of proving causation."

[52] Mr. Lever SC also referred to paragraph [31] in which the following is stated:

"[31] The next step in the story is Wilsher v Essex AHA [1987] UKHL 11; [1988] 1 All ER 871, [1988] AC 1074. A baby boy, born three months prematurely, developed a condition of the retina which rendered him blind. There were five possible causes of the condition. One was the negligent administration of an excessive quantity of oxygen. The other four involved no fault on the part of the

defendant's medical staff. The expert witnesses were unable to say which caused the disease. The Court of Appeal, purporting to apply the principle in b McGhee's case, held in favour of the infant. Mustill LJ expressed the principle, as he understood it, as follows ([1986] 3 All ER 801 at 829, [1987] QB 730 at 771-772):

'If it is an established fact that conduct of a particular kind creates a risk that injury will be caused to another or increases an existing risk that injury will ensue, and if the two parties stand in such a relationship that the one party owes a duty not to conduct himself in that way, and if one party does conduct himself in that way, and if the other party does suffer injury of the kind to which the risk related, then the first party is taken to have caused the injury by his breach of duty, even though the existence and extent of the contribution made by the breach cannot be ascertained.'

However, Lord Phillips went on to state the following in paragraph [32]:

"[32] This analysis of McGhee's case was principled and coherent, but it was of wide general application and fundamentally rewrote the law of causation. It opened the floodgates and, I suspect, this may, in part, be the reason why it was subsequently rejected."

[53] This Court is not bound by this decision of the Supreme Court of England, although it makes interesting reading. Our law with regard to causation is comprehensively set out in the majority judgment in the matter of Lee V Minister of Correctional Services 2013 (2) SA 144 (CC), wherein the following is stated:

"[39] This element of liability is complex and is surrounded by much controversy. There can be no liability if it is not proved, on a balance of probabilities, that the conduct of the defendant caused the harm. This is so because the net of liability will be cast too wide. A means of limiting liability, in cases where factual causation has been established, must therefore be applied. Whether an act can be identified as a cause depends on a conclusion drawn from available facts or evidence and relevant probabilities. Factual causation, unlike legal causation where the question of the remoteness of the consequences is considered, is not in itself a policy matter but rather a question of fact which constitutes issues connected with decisions on constitutional matters as contemplated by s 167(3)(b) of the Constitution."

[40] Although different theories have developed on causation, the one frequently employed by courts in determining factual causation is the *conditio sine qua non* theory or but-for test. This test is not without problems, especially when determining whether a specific omission caused a certain consequence. According to this test the enquiry to determine a causal link, put in its simplest formulation, is whether 'one fact follows from another'. The test —

'may involve the mental elimination of the wrongful conduct and the substitution of a hypothetical course of lawful conduct and the posing of the question as to whether upon such an hypothesis plaintiff's loss would have ensued or not. If it would in any event have ensued, then the wrongful conduct was not a cause of the plaintiff's loss; [otherwise] it would not so have ensued. If the wrongful act is shown in this way not to be a *causa sine qua non* of the loss suffered, then no legal liability can arise.'

- [41] In the case of 'positive' conduct or commission on the part of the defendant, the conduct is mentally removed to determine whether the relevant consequence would still have resulted. However, in the case of an omission the but-for test requires that a hypothetical positive act be inserted in the particular set of facts, the so-called mental removal of the defendant's omission. This means that reasonable conduct of the defendant would be inserted into the set of facts. However, as will be shown in detail later, the rule regarding the application of the test in positive acts and omission cases is not inflexible. There are cases in which the strict application of the rule would result in an injustice, hence a requirement for flexibility. The other reason is because it is not always easy to draw the line between a positive act and an omission. Indeed there is no magic formula by which one can generally establish a causal nexus. The existence of the nexus will be dependent on the facts of a particular case.
- [50] Our existing law does not require, as an inflexible rule, the use of the substitution of notional, hypothetical lawful conduct for unlawful conduct in the application of the but-for test for factual causation.
- [56] Even if one accepts that the substitution approach is better suited to factual causation, the preceding discussion shows that there is no requirement that a plaintiff must adduce further evidence to prove, on a balance of probabilities, what the lawful, non-negligent conduct of the defendant should have been. All that is required is 'the substitution of a hypothetical course of lawful conduct and the posing of the question as to whether upon such an hypothesis the plaintiff's loss would have ensued or not'. What is required is postulating hypothetical lawful, non-negligent conduct, not actual proof of that conduct. The law recognises science in requiring proof of factual causation of harm before liability for that harm is legally imposed on a defendant, but the method of proof in a courtroom is not the method of scientific proof. The law does not require proof equivalent to a control sample in scientific investigation.
- [54] Dr. Sevenster was called as an expert witness by the Respondent. His evidence is not without criticism. The following is evident from his testimony:
- (a) During cross-examination it was put to Dr Sevenster that a logistical factor is an acceptable reason for an induction. Although he conceded this fact, he went on to say that there was no logistical factor in this particular matter because the respondent resided close to the hospital. However, when he was asked where the plaintiff resides, he had to concede that this was not known to him. Dr Sevenster eventually had to concede that he was unable to express any view with reference to the facts of this matter, because he simply does not know

where the respondent resides.

- (b) He described Cytotec as "an extremely dangerous drug" in his evidence in chief. During cross-examination he conceded that he based this statement exclusively on the fact that there is, according to literature, a 2% risk of hyperstimulation of the uterus. Dr Sevenster clearly decided to over-emphasise the risks associated with Cytotec in an attempt to favour the respondents case.
- (c) He criticised the fact that Pethidine and Atarax were administered to the respondent only to concede in cross-examination that this was an acceptable prescription and that it was the duty of the paediatrician, Dr Kingela, to take remedial steps after the delivery

of the baby.

- (d) During his evidence in chief, Dr Sevenster testified that the respondent was not yet full term when she was referred for an induction. Dr Sevenster made this statement, notwithstanding the fact that he made no reference at all to this in his expert summary. In fact, he stated the following in paragraph 2 of his expert summary:

"The expected date for the present pregnancy was calculated to be the 9th of December 2008."

- (e) During cross-examination Dr Sevenster was asked on what conceivable basis he stated that the respondent was not yet full term. Dr Sevenster then stated that he made this statement based on what was stated by Dr Ofori in a letter dated 28 June 2009, addressed to the respondent's attorney (p 201 of the bundle) where Dr Ofori stated the following:

"She was first seen on 14/06/2008 when she was 16 weeks pregnant."

Dr Sevenster said that, according to his calculations Dr Ofori made a mistake with the estimated due date. This was an extremely wild and speculative allegation made by Dr Sevenster. He did so in an obvious and clear attempt to advance the respondent's case.

- (f) When Dr Sevenster was confronted with the fact that the amniotic liquor was clear and that this was an indication that the baby was not under distress, he indicated that it is not always an indication thereof. It was only later during his cross-examination that he had to concede that green amniotic liquor is in fact the norm if a baby is under distress.

[55] No attempt was made by Dr Sevenster in his expert summary or during his evidence to distinguish between the responsibilities of:

Dr Ofori, who made the decision to refer the respondent to the appellant for an induction, the first defendant, who clearly failed to monitor the plaintiff and the baby, the appellant and Dr Kingela, the paediatrician who attended to the baby after the delivery. There was also no attempt by Dr Sevenster to explain the effect of a dose of 100 mcg instead of a dose of 50 mcg of Cytotec. He was clearly not qualified to do so. There was no attempt made by Dr Sevenster to indicate at which stage the baby was injured. No attempt was made by Dr Sevenster to exclude other possible causes of the cerebral palsy. No attempt was made to consider the events in the NICU

during the period 10 December 2008 to 29 December 2008.

[56] Although Dr. Sevenster made various unqualified concessions during cross-examination, he again qualified those concessions during re-examination. His evidence is simply untrustworthy. Not much reliance should have been placed on it by the trial Court.

Conclusion

[57] In my view, the respondent, who bore the onus to proof her case on a balance of probabilities, failed to do so. In particular it was not established that the Appellant acted negligently or neglected his duty of care. Furthermore, it was not proved that the administration of Cytotec is the cause of L.'s severe cerebral palsy which was diagnosed. Causality between the treatment of L. and the cerebral palsy is not proven. I am consequently of the view that the appeal should succeed. There is also no plausible reason why costs should not follow the result. As a result of the complexity of the matter and its importance to both parties, the costs of two counsel (senior and junior) is warranted.

Order

[58] Consequently the following order is made:

(i) The appeal is upheld.

(ii) The order of the Court a quo is set aside and is replaced with the following order:

“The Plaintiff’s claim against the second defendant is dismissed with costs.”

(iii) The Respondent is ordered to pay the costs of the appeal. Such costs to include the costs consequent upon the employment of two counsel (senior and junior).

R D HENDRICKS

ACTING DEPUTY JUDGE PRESIDENT OF THE HIGH COURT,

NORTH WEST DIVISION, MAHIKENG.

I agree

SAMKELO GURA

JUDGE OF THE HIGH COURT,

N GUTTA

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Prepared on 23 October 2026 · Esheria