IN THE HIGH COURT OF SOUTH AFRICA
(EASTERN CAPE DIVISION, MTHATHA)

CASE NO. CA 29/2022

In the matter between:

APHILISIWE SIKOTA obo [S] Appellant

and

THE MEMBER OF THE EXECUTIVE COUNCIL
FOR THE DEPARTMENT OF HEALTH,
EASTERN CAPE Respondent

JUDGMENT

Rugunanan J

[1] In an action instituted in the high court, Mthatha, the appellant (plaintiff) claimed delictual damages on behalf of her minor child [S] against the

respondent, the Member of the Executive Council for Health, Eastern Cape Province (the defendant). For convenience the parties' trial designations will be retained in this judgment.

[2] The claim arose from the child having suffered a brain injury by an occurrence known as an intrapartum hypoxic event during the plaintiff's labour and delivery on 25 – 26 December 2012 in the St Barnabas Hospital (the hospital).

[3] The court a quo (Da Silva AJ), by agreement between the parties, was called upon to decide only the question of liability on the merits and in a judgment delivered on 27 August 2020, dismissed the claim.

[4] The merits involved a determination of whether the plaintiff succeeded in establishing on a balance of probabilities causal negligence on the part of the clinicians and/or the hospital staff of the defendant which caused the injury to S.

[5] The appeal is with the leave of the learned judge.

[6] The effective basis upon which the trial court found against the plaintiff is evinced in its judgment by findings: (i) relevant to the failure to treat and monitor the plaintiff and her unborn child with the required and applicable standards, the delay between the diagnosis of foetal distress and the performance of a caesarean procedure on the plaintiff being attributed to the lack of resource availability at the hospital; and (ii) the occurrence of an unforeseeable sentinel event consequent to the plaintiff's negative reaction to spinal anaesthesia while undergoing the procedure.

[7] The matters aforementioned were essentially supported by the evidence of Dr Brannigan, an expert who testified for the defendant, the plaintiff

contending that same were not heralded in the defendant's plea, and presented a departure from joint minutes between obstetricians and as between paediatricians, Dr Brannigan being neither and thus not in a position to contradict from an expert point of view the effect of the common cause facts set out in the joint minutes. The plaintiff contended moreover that the trial court did not properly direct itself to the significance of the joint minutes.

The procedural context for the determination of the appeal

[8] Common cause at the hearing of the appeal was that its prosecution did not comply with the prescripts of Uniform Rule 49, this occasioning an application by the defendant declaring the appeal to have lapsed in terms of rule 49(7)*(d)*. In opposition thereto the plaintiff, in answer, sought condonation and reinstatement.

[9] It is not intended to sprawl the length of this judgment by extrapolating every minute detail of non-compliance, suffice to state that the key provisions of rule 49 which are undeniably in breach are sub-rules (6)*(a)*; (7)*(a)*; (9); (13) *(a)* and *(b)*; and (15). Among the fundamental complaints raised by the defendant are: the absence of a properly compiled record having been served and filed; the failure by the plaintiff to have filed security; and her failure to have taken any steps to seek condonation despite a considerable lapse of time.

[10] In brief, the defendant's stance asserted prejudice compounded by the flagrant non-observance of the prescripts of the rule, the lack of diligence and attention to the matter, and the delay in seeking condonation – all of which not being adequately explained in the plaintiff's answering papers, in particular the egregious default being incapable of the court's indulgence.

[11] The answering affidavit by the plaintiff's attorney Mr Thulisile Mjulelwa does little to explain the delays in the prosecution of the appeal and the failure

to have complied with the abovementioned sub-rules. Where he relies on information supplied to him by other persons, no confirmatory affidavits have been filed.

[12] The key explanation put forward is that the matter was channelled through a case management process. The plaintiff was granted leave to appeal on 12 November 2021 and was obliged to file the appeal record by 15 February 2022. The case management procedure took place during May 2022 long after the obligations placed on the plaintiff by rule 49 had lapsed.

[13] The fallacy in the approach by Mr Mjulelwa is that case management procedures can only apply to appeals once there has been compliance with rule 49. Recourse to case management does not have the effect of reviving an appeal that has lapsed. Asserting (albeit perfunctorily) that prospects of success in the appeal are strong and that condonation will not prejudice the defendant, does not lay a sufficiently candid basis for enabling this court to understand how the default came about. The defendant's position is that the plaintiff was at all times required to demonstrate good cause and where she has failed to do so, she cannot escape the consequences of her attorney's lack of diligence or the insufficiency of the explanation tendered.[1]

[14] The plaintiff adopts the misguided approach that the defendant had to remind her of the stages of non-compliance complained of. In heads of argument she holds the view that whatever deficiencies existed could readily have been rectified upon notice to cure by the defendant. It was at all times the responsibility of the plaintiff to have complied with the prescripts of the rule and to have prepared a record that complied therewith. To contend otherwise is, in the circumstances of the matter, disingenuous.

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[1] *Saloojee v Minister of Community Development* 1965 (2) SA 135 (AD) at 141B-E.

[15] The events in the prosecution of the appeal reveal a disquieting history indicative of a reckless disregard for the rules of court. By way of example, features of this history include:

15.1 A failure to have furnished the defendant with two hard copies of the record;

15.2 An explanation that the defendant was in possession of all documents forming part of the trial record during the trial and that it was considered necessary only to serve the indices of the appeal and leave it to the defendant to compile its own record and attend to pagination in accordance with the indices (Mention is made of the fact that the indices were filed on 10 February 2022. In an exercise inherently prejudicial the defendant incurred substantial costs in trying to match the documents it had with those in the indices. I would add that the indices are wholly inadequate for failure to have identified portions of the transcript applicable to the evidence of the witnesses – a failing that significantly contributed to much frustration and inconvenience in having to navigate through a record with handwritten pagination that was at times dishevelled and illegible, and the record itself comprising of four lever-arch volumes with pages that did not withstand regular use at times becoming plucked from the arch mechanism (even with delicate handling);

15.3 A failure to have taken steps in accordance with rule 49(7) which provides that if the necessary copies of the record are not ready within the period stipulated in rule 49(6)*(a)*, the registrar may accept an application for the date of the hearing of the appeal without the copies of the record provided the application is accompanied by a written agreement between the parties that the record may be filed late or, failing such agreement, the plaintiff delivers an

application together with an affidavit in which the reasons for such omission are set out;

15.4 The inexplicable failure to furnish security in the appeal, despite the unchallenged and clear obligation to do so; and

15.5 A preference for an unusual procedure of seeking condonation and reinstatement in the answering affidavit without having filed a substantive application for such relief.

[16] In raising issues pertaining to the plaintiff's non-compliance with the prescripts of rule 49, the defendant, in my view, was not engaging in an exercise of pedantry for tactical reasons to avoid the appeal being determined on its merits. The plaintiff's insouciant approach justified the stance adopted by the defendant particularly as regards the furnishing of security. The criticism directed at the defendant for not engaging with the plaintiff on this issue is unwarranted. The fact remains that there was no waiver of the right to security, and the plaintiff did not make application to be released from the obligation to furnish security – nor if I might add did the plaintiff seriously dispute the obligation ordained by the relevant rule of court.

[17] With all indications pointing to the conduct of the plaintiff's attorney in failing to prosecute the appeal, counsel for the plaintiff properly conceded culpability of the attorney but urged that the importance of the matter and significantly prospects of success would have a moderating effect.[2]

[18] There is indubitable merit in the stance adopted by the defendant that an acceptance of the opposition put up by the plaintiff would grant *carte blanche* to litigants to ignore the provisions of rule 49. My sense therefore is that the order

[2] *Melane v Santam Insurance Co. Ltd* 1962 (4) SA 531 (AD) at 532E.

at the conclusion of this judgment would signal a deterrent against future infractions of the appeal procedure by litigants or their legal representatives.

[19] Reluctant to order an outright striking from the roll we deemed it expedient in our discretion to hear argument on the merits of the appeal – the parties although differing in their views on prospects of success acknowledged that this was an eminently sensible and pragmatic approach for dealing with the matter.

The pleadings and conduct of the trial

[20] In the particulars of claim the plaintiff asserts:

‘15 As a consequence of the plaintiff’s prolonged and obstructed labour and the non-performance of an emergency caesarean section delivery timeously and appropriately to deliver [S], [S] suffered an intrapartum acute profound hypoxic incident and neonatal encephalopathy as a result of which she sustained severe brain damage which resulted in her suffering cerebral palsy, delayed development milestones secondary to hypoxic ischaemic encephalopathy (HIE) that occurred intrapartum.’

[21] The essence of the claim was that the defendant’s servants who attended to the plaintiff (and by implication her unborn child) were negligent in that they failed to:

‘16.1.1 permanently, alternatively temporarily employ the services of suitably qualified and experienced medical practitioners who would be available and able to manage the plaintiff’s labour and to perform a caesarean section timeously and appropriately as and when required;

16.1.2 permanently, alternatively temporarily employ the services of suitably qualified and experienced nursing staff, including midwives, as well as competent medical personnel who would be able to assess, monitor and/or manage the plaintiff’s labour and deliver the plaintiff’s unborn child expeditiously and appropriately;

16.1.3 ensure that the hospital was suitably, adequately and/or properly equipped to render emergency medical treatment to the plaintiff, including the timeous and appropriate performance of a caesarean section if and when required;

16.1.4 take all reasonably required steps to ensure proper, timeous and professional assessment of patients, in particular the plaintiff, a monitoring and management of labour, and transfer of patients to a suitable hospital or medical facility when indicated; and

16.1.5 implement such steps as could and would reasonably be required to prevent the occurrence of the complication…'

[22] There is much to be said about the measure of generality and lack of clarity in the pleaded grounds of negligence. In *HAL obo MML v MEC for Health, Free State*[3], Wallis JA, in circumstances similar to the present, condemned the failure to have set out the material facts underlying the pleaded grounds of negligence as also the failure to have identified those for whose conduct the defendant is alleged to have been liable, who must at least be identifiable. The particulars of claim were based entirely on the imagination of the practitioner who drafted them, and the learned judge deprecated what he branded 'this diffused, unfocussed approach to the conduct of complex litigation'. These sentiments are apposite in the present context.

[23] For its part, the defendant does not escape the censure attributed to the state of the plaintiff's pleadings. There is also much to be said about how the defendant formulated its plea, the plaintiff's allegations in question having elicited: (i) a bald denial; and (ii) no defence being pleaded by way of a confession and avoidance alerting the plaintiff to a reliance on resource availability/capacity problems or a sentinel event occasioned by anaesthetic complications.

[3] *HAL obo MML v MEC for Health, Free State* [2021] ZASCA 149 paras 189-199.

[24] On these aspects the trial court, obviously not alive to the defendant's failure to have pleaded a confession and avoidance, determined the matter primarily on the evidence tendered by Dr L Brannigan, an expert specialising in anaesthesiology.

[25] Despite Dr Brannigan's caveat that the issue relating to resource availability required extensive data collection it appears that the learned trial judge perfected her judgment by considering the issue to have been fully ventilated. In this regard she erred in doing so, and so too by having regard to the sentinel event without determining whether Dr Brannigan was appropriately qualified to have expressed an opinion thereon.

[26] The report by Dr Brannigan was no substitute for a proper definition of the issues in the defendant's plea preferably narrowed down by a pre-trial conference under rule 37.[4]

[27] The plaintiff testified and closed her case after handing up joint minutes between Dr A Ebrahim and Dr M Songabau, the obstetricians respectively for the plaintiff and the defendant as well as joint minutes between paediatricians Dr A Redfern and Dr W Dibote and joint minutes between radiologists Dr B Alheit and Dr J Swarztberg.

[28] Three witnesses were called for the defendant; Dr Z Madikane who was on duty at the hospital on 25 – 26 December 2012 and Dr B Mlandu who was on call. Last was Dr Brannigan, an anaesthetist with a sub-speciality in critical care.

[29] Except for Dr Brannigan, no other expert witness testified during the trial.

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[4] *HAL supra* para 196.

[30] The trial was conducted upon the acceptance of the joint minutes concluded and signed by the parties' expert witnesses setting out areas of agreement.

The evidence

[31] This is summarised only to the extent considered necessary.

The plaintiff

[32] The gist of the plaintiff's evidence is that she was examined at the hospital on 25 December 2012 at 21h32. She was already in labour and her cervix had been about 8 centimetres dilated. She was unable to deliver her unborn child through normal vaginal delivery and was informed that she required a caesarean procedure. This commenced at about 00h20 on 26 December 2012. Upon administration of spinal anaesthetic, she got dizzy and did not feel well. She recalled that attempts were made to resuscitate her and that she regained consciousness on 27 December 2012. Referring to the hospital records she indicated that the caesarean procedure was completed a 01h20 at which time baby [S] was delivered.

Dr Zetu Madikane

[33] She is a former employee at the hospital where she was on duty on 25 December 2012. At 22h50 she took the decision to prepare the plaintiff for caesarean surgery after receiving a call that the patient was in foetal distress. Prior thereto she was busy with another patient for whom she had been inserting a chest drain. The plaintiff presented as a primagravidia and upon assessing her, indications were that the plaintiff's labour was obstructed necessitating a caesarean procedure. She contacted Dr Mlandu for assistance. Dr Malndu was on call but not on site. Surgery commenced at 00h20 on 26 December 2012, the reasons being that Dr Mlandu was in Mthatha about 40 kilometres away from

the hospital, the plaintiff needed to be counselled and, the operating theatre sterilised.

[34] In theatre when the anaesthetic was administered by her, the plaintiff desaturated and her pulse dropped. Her blood pressure read 50/35 at which point the plaintiff was critically ill and the oxygen supply to the foetus was at a critical point. Put otherwise the plaintiff 'crashed' and was near dying. This necessitated resuscitation and discontinuing with the surgery. At the time she was positioned at the head of the plaintiff and was separated by a screen from which side Dr Mlandu worked on the plaintiff's abdomen. Dr Mlandu had to stop the surgery and assist with the plaintiff's resuscitation. Dr Mlandu resumed after the plaintiff was resuscitated. Surgery would in any event had to be stopped even if a third doctor was in attendance.

[35] In cross-examination she stated that it would have been 'nice' to have had another doctor on site, though not necessary as the doctors work according to hours. She accepted that the plaintiff had to deliver with the least delay which meant that surgery had to be undertaken within the hour, namely 23h50 on 25 December 2012. Commenting about the delay from 21h34 on 25 December 2012 to 00h20 on 26 December 2012 in performing the caesarean procedure, she maintained that the delay was beyond her control.

[36] In re-examination she explained that there were two doctors on duty at the material time and that the same situation prevailed on public holidays. Pregnancies and deliveries were managed this way and only one theatre was available at the hospital.

[37] On enquiry from the trial judge she recollected that she had experience of similar incidents on at least five occasions during 2019 but was unable to say whether foetal distress was present.

Dr Banomsa Mlandu

[38] She qualified as a doctor in 2008 and as a paediatrician in 2018. On the night in question the hospital had only one doctor on duty. She was the second doctor on call but was at her home in Mthatha because the hospital did not have accommodation. She drove to the hospital upon being contacted by Dr Madikane. Night-time driving conditions were difficult and it took her about 30 to 40 minutes to get there. On arrival, the theatre staff were in waiting and she delivered the plaintiff's baby by caesarean procedure.

[39] Although not having an independent recollection but gauging from the hospital records, surgery commenced at 00h20 and was completed at 01h20 on 26 December 2012. Approximately 10 minutes after spinal anaesthesia was administered and some 5 minutes after surgery commenced, the plaintiff's oxygen saturation dropped, so did her blood pressure and pulse. Because the plaintiff's condition was critical, surgery was stopped so that the plaintiff could be resuscitated and stabilised. As senior doctor she made that judgment call and proceeded to assist Dr Madikane. Resuscitation is a team effort, requiring a minimum of 4 people, hence Dr Madikane would not have managed by herself.

[40] Commenting on the medical records, she explained that the drop in the plaintiff's blood pressure signified almost no blood supply to the foetus. She agreed with Dr Madikane's description that the plaintiff was a dying patient.

[41] Under cross-examination, she commented that hospital cases tend to peak during public holidays and it would have been ideal to have had an additional doctor on call. She also stated that instant action is required once foetal distress is detected and that Dr Madikane correctly made the call to prepare the plaintiff

for caesarean surgery that had to be carried out within the hour in terms of the maternity care guidelines.

[42] As for the term that the plaintiff 'crashed', she stated that this is not a medical term – it is merely used to describe a patient in need of resuscitation. The plaintiff's compromise occurred approximately 5 minutes after surgery commenced.

[43] At the time of testifying she performed more than 100 caesarean procedures. Hypotension (i.e. the medical term for low blood pressure) is a normal occurrence when spinal anaesthesia is administered. This is not unusual and can be managed. But on the occasion of the plaintiff it was the first time, as a doctor in charge (as opposed to previous occasions when she observed this during training), that she experienced what she described as 'a fully established high spinal' where, in addition to hypotension, the plaintiff's heart rate dropped and her oxygen saturations were lowered which affected her lungs taking oxygen normally. She described this condition as critical maintaining that it could not have been foreseen. In the occurrence of an event such as what the plaintiff had experienced and being on the verge of cardiac arrest, priority is accorded to the mother and not the foetus.

Dr L Brannigan

[44] He is a specialist anaesthesiologist with a sub-speciality in critical care. He obtained these qualifications in 2009 and in 2011 respectively. His sub-speciality is in the area of theatre resuscitation medicine in critical care. The purpose of his evidence is best understood from the following extract in the transcript:

'Court: [W]ithout changing your qualifications, but are you the best person to say whether what the surgeon did – the surgeon, was correct?

Dr Brannigan: Yes, I think so, and I will tell you why, because what the surgeon did had nothing to do with surgery, that had to do with my area of expertise.

Court: [F]or her to stop the continuation of the C-section to assist (?)

Dr Brannigan: Yes, and because, because my area of expertise is resuscitative medicine, that is in theatre resuscitation medicine in critical care.'

[45] The excerpt renders it unnecessary to traverse Dr Brannigan's evidence beyond the scope of his expertise.

[46] Testifying that he compiled a report dated 9 November 2019, he commented that it is likely that the foetus was in distress from 21h34 (i.e. on 25 December 2012) and that a caesarean section should have been expedited. In his assessment there was a delay exceeding acceptable limits between the diagnosis of the foetal distress and the performance of the surgery. This delay, he opined, likely placed the foetus at risk for an intra-uterine hypoxic event. However, the intra-operative hypotension and/or cardiac arrest of the plaintiff contributed to the delivery of a child with low Apgar scores and subsequent cerebral palsy (CP).

[47] In addition, the report indicates that it is standard protocol to continue with caesarean surgery during periods of maternal haemodynamic collapse to facilitate the rapid delivery of the foetus to ensure minimal harm thereto. Dr Brannigan notes that there was a delay between 00h30 and 01h05 (i.e. on 26 December 2012) with the delivery of the foetus which is unexplained. (I pause to state that this was not canvassed with Dr Madikane or with Dr Mlandu).

[48] He moderated his report by stating that the delay in delivering the child after the hypotensive and/or cardiac arrest state breaches best practice limits and

requires explanation as to the circumstances in the operating room at the time of the incident. In this regard he referred to context.

[49] What followed was an addendum dated 15 November 2019 consequent to being provided with information as to context. This related to: (i) a high emergency burden in the hospital at the time of the plaintiff's admission; and (ii) at the time of the hypotensive scenario/cardiac arrest, the senior clinician who was the operating surgeon made the decision to un-scrub and assist the junior clinician with the plaintiff's resuscitation, which decision was taken to ensure the survival of the mother.

[50] Testifying in explanation of his first report, Dr Brannigan was of the view that the delay in performing the required surgery on the plaintiff may have primed the foetus for an event that would result in a brain injury. That delay primed the plaintiff's susceptibility to a sentinel event.

[51] A sentinel event is profound in its magnitude and acuity and directly related to the issue in question such as a cardiac arrest on an operating table. Such an event is generally unforeseen or unforeseeable in the sense that there is no accurate way of measuring its expectation.

[52] Once the event interceded, there was a dual responsibility to the mother and to the foetus. The senior clinician had to act aggressively and the first duty was to try and assist the mother because she was near death. The senior clinician took a decision to stop the surgery and to save the plaintiff.

[53] The plaintiff’s management was determined according to the procedure of ‘triage’. In medical terms the procedure requires that resources be applied to the patient who is in most dire need thereof. This meant that resources had to be allocated to the plaintiff because her situation was more compelling. The

resources available in theatre (at the time a scrub sister, and a clinician performing the anaesthesia with a nursing assistant) were utilised for resuscitating her.

[54] In his opinion, the clinician who performed the surgery acted appropriately. She made the correct call, both on an ethical and technical level to stop the surgery and exercised a reasonable choice in assisting with resuscitation which resulted in the survival of the plaintiff. The resources available at the time were consistent with the required standard for the theatre environment (the context) at that particular time.

[55] Dr Brannigan confirmed his reports and expressed the view that the addendum was not inconsistent with the first report.

The joint minutes

[56] These are as between: (i) the obstetricians, Dr Ebrahim and Dr Songabau[5]; (ii) the paediatricians, Dr Redfern and Dr Dibote[6]; and (iii) the radiologists, Dr Alheit and Dr Swarztberg[7].

[57] The minutes have the following essential features:

57.1 The plaintiff was admitted to the hospital at 21h32 – her foetal heart rate was not monitored from 21h34 until commencement of the caesarean procedure;

57.2 There was sub-standard foetal heart rate monitoring during labour until the commencement of the caesarean procedure;

[5] Record, exhibit A.
[6] Record, exhibit B.
[7] Record, exhibit C.

57.3 It is unlikely that the child's cerebral palsy was caused by an antenatal event;

57.4 There was delayed delivery 'both in terms of delivering the baby after the recognition of foetal distress and in terms of delivering the baby once maternal cardiac arrest occurred';

57.5 The delay led to the delivery of an asphyxiated baby with low Apgar scores and signs of depression and required administration of oxygen;

57.6 The MRI scan excluded genetic disorders or previous or current infective or inflammatory diseases as likely causes of the child's brain damage;

57.7 The most likely cause of the child's cerebral palsy was intrapartum asphyxia (i.e. too little blood and oxygen to the brain during labour and delivery);

57.8 The injury was most likely caused during the peripartum period (i.e. the period shortly before, during or immediately after delivery).

Discussion and liability

[58] To begin with, the plaintiff's pleaded case is that baby [S] suffered an 'intrapartum acute profound hypoxic incident' consequent to which she suffered brain damage.

[59] On the pleadings, the plaintiff attributes the incident to negligence: (i) in the form of the defendant's failure to have employed experienced medical practitioners who would have been able to have timeously performed a caesarean procedure; (ii) the defendant's failure to have employed experienced nursing staff who would have been able to have assessed/monitored her labour;

and (iii) the failure by the defendant's hospital staff to have taken reasonable steps to have assessed, monitored and managed her labour.

[60] On appeal the plaintiff's case on negligence was limited to the failure to have adequately monitored the plaintiff during her labour – in particular, the failure to have monitored the foetal heart rate and to have intervened timeously to perform a caesarean procedure.

[61] The failure to have adequately monitored is borne from the joint minutes signifying agreement that there was substandard foetal heart rate monitoring and the evidence by Dr Madikane who effectively conceded negligence where there was a failure to have undertaken monitoring at 30 minute intervals.

[62] On the available evidence negligence appears to be common cause or not realistically in dispute.

[63] The gist of the dispute pertains to causality.

[64] The argument advanced for the plaintiff is that the lack of proper foetal heart rate monitoring and the failure to intervene timeously created a risk of hypoxic damage to the foetus. According to the obstetricians, the risk of foetal distress materialised during labour. While accepting that the lack of adequate monitoring constitutes a negligent omission, factual causation, it was argued, is to be found in the creation of a situation in which the foetus was placed at risk of hypoxia which could have been avoided had there been proper and adequate monitoring.

[65] The opposing position is the defendant's argument that inadequate monitoring in itself would not have averted the hypoxic outcome – it being the consequence of an unforeseeable sentinel event.

[66] The onus was at all times on the plaintiff to prove on a balance of probabilities that the conduct complained of caused the harm. Accepting that the defendant's servants were negligent, the question that arises is, what caused the injury, and when on the probabilities did it arise?

[67] The evidence by Dr Madikane and Dr Mlandu does not answer this question. So too does Dr Brannigan's evidence. I am hesitant to rely on his conclusion/s beyond what he obviously stated was the purpose of his testimony. His expertise is limited to assessing the conduct of the surgeon and assumes no relevance in the enquiry into causality. His views on this issue were rightly criticised during argument.

[68] This brings me to the joint minutes between the parties' experts. It has been confirmed by the Supreme Court of Appeal in *Bee v Road Accident Fund*[8] that where experts have met and compiled a joint minute, the joint minute will be understood as limiting the issues on which evidence is needed – and in the absence of repudiation (i.e. fair warning), the other litigant is entitled to proceed with the case on the basis that the matters agreed between the experts are not in issue.

[69] The effect of the above, informed by the approach in *Thomas v BD Sarens (Pty) Ltd*[9], is that[10]:

69.1 The court is bound by certain facts agreed by the parties in civil litigation even if it is sceptical about those facts.

69.2 Where experts are engaged by the parties to investigate those facts, and where the experts have met and agreed upon them, a party may not repudiate

[8] *Bee v Road Accident Fund* [2018] ZASCA 52 para 66.
[9] [2012] ZAGPJHC 161 161, and see *Bee supra* at fn 9 para 64.
[10] See also *Malema v Road Accident Fund* [2017] ZAGPHC 275 para 92 wherein the summarised exposition has been approved.

the agreement unless it does so clearly and at the very latest at the outset of the trial.

69.3 Absent a timeous repudiation, the facts as agreed between the experts are cloaked with the same status as facts which are common cause on the pleadings, or facts agreed in a pre-trial conference.

69.4 Where the experts have reached agreement on matters of opinion, the parties are not at liberty to repudiate the agreement – the trial court is not bound to adopt the opinion though the circumstances in which it would not do so are likely to be rare.[11]

[70] In addressing the question posed earlier, the focus shifts to the joint minutes. Beginning with the obstetricians it is necessary for the sake of clarity and completeness to recapitulate their points of agreement in full:

'1. Ms Sikota booked for antenatal care at Majola Clinic at about 24 weeks gestation during her first pregnancy during 2012.

2. She was a low-risk patient as evidenced by her good general health, sober habits and an uncomplicated antenatal course. It is therefore unlikely that her baby's cerebral palsy (CP) is due to an antenatal cause.

3. [Ms Sikota] was admitted to Majola Clinic at 19h20 on 25/12/2012 and was transferred to St. Barnabas Hospital.

4. She was admitted to St. Barnabas Hospital at 21h32.

[11] Such as where the trial court is dissatisfied with the agreement and alerts the parties to the need to adduce evidence on the agreed material: *Bee supra* fn 9 para 73. See further the judgment by Govindjee J in *Jonathan Peter Krebs v Road Accident Fund*, Unreported ZAECQBHC Case No 2734/2020 (25 April 2023) paras 37-39 in particular fn 12 quoting Wallis JA's concurring judgment in *HAL obo MML v MEC for Health, Free State* 2022 (3) SA 571 (SCA) para 229 where the learned judge of appeal explains the position as follows: 'In accordance with *Bee*, if they agree on issues of fact and the appropriate approach to technical analysis, the litigants are bound by those agreements … If the experts have reached agreement on a common opinion on a matter within their joint expertise, that is merely part of the total body of evidence. The court must still determine whether to accept the joint opinion.'

5. At an unknown time (??h50) a diagnosis of obstructed labour was made and an emergency caesarean section was arranged.

6. There was sub-standard heart rate monitoring in labour. The fetal[12] heart rate was not monitored from 21h34 until the commencement of the caesarean section.

7. The caesarean section was delayed by about 3 hours and commenced at 00h20 [on] 26/12/2012 due to operational hiccups (shortage [of] personnel, busy Christmas Eve). The best option could have been a transfer to the nearest facility Mthatha 40 minutes away by ambulance after an intra-uterine resuscitation.

8. Due to such significant delay whereupon a severely asphyxiated baby was delivered. He required resuscitation at birth, supplemental oxygen and admission to the neonatal unit for further treatment.

9. The spinal anaesthetic that was administered for the caesarean section was complicated by severe maternal hypotension which necessitated cardio pulmonary resuscitation and adrenaline injection to the mother.

10. Baby was diagnosed with spastic CP in childhood.

11. Her recent MRI brain scan shows features of brain injury due to acute profound hypoxic ischaemic injury.

12. The most likely explanation for her CP is hypoxic ischaemic encephalopathy due to foetal distress in labour. Fetal distress was not detected because of sub-standard fetal heart rate monitoring in labour and the aggravating effect of a high spinal anaesthetic in Ms Sikota which ought to have been avoided or managed timeously.

13. CP would probably not have occurred if Ms Sikota was monitored and managed appropriately in labour and if the anaesthetic complication was avoided/managed timeously.'

[71] Adverting to the joint minute by the paediatricians, they agree:[13]

[12] As spelt in the joint minutes.
[13] Paras 5 and 6.

‘The most likely time period of hypoxic ischaemic brain injury was the peripartum period (i.e. the period shortly before, during, or immediately after delivery)’

and,

‘… the most likely cause of [S]’s cerebral palsy was intrapartum asphyxia[14].’

[72] Analysis of the joint minutes indicates that it is common cause between the obstetricians that the cerebral palsy most likely resulted from ‘hypoxic ischaemic encephalopathy’ and obvious resultant brain damage ‘due to fetal distress in labour’ that ‘was not detected because of sub-standard fetal heart rate monitoring in labour’.

[73] The plaintiff pleaded that the injury occurred intrapartum, being as the term indicates, ‘during labour’ which coincides with the consensus between the obstetricians that the injury occurred ‘in labour’. This is clearly the period that required scrupulous monitoring of the foetal heart rate, an indicator of foetal distress, to ensure a timely intervention in the latter event. According to Dr Madikane monitoring was necessary at 30 minute intervals. This never happened. Hence negligence was established consequent to poor management of the plaintiff’s labour.

[74] As for the timing of the injury the opinion of the paediatricians attributes the injury to ‘the peripartum period’, which is the period shortly before, during or immediately after delivery. One could probably exclude the last mentioned possibility which finds no basis in the evidence and conclude that the injury occurred shortly before or during delivery. Their opinion is discernably more precise in identifying the timing of the injury (as opposed to the cautious approach of the obstetricians).

[14] The word is misquoted as ‘hypoxia’ in appellant’s heads of argument.

[75] There can accordingly be little doubt that the injury occurred during the period when the relevant clinicians were required (but failed) to properly monitor the foetal heart rate and determine foetal distress.

[76] Common sense and simple logic dictates that the facts contained in the joint minutes and the probabilities emerging therefrom will inform the conclusion arrived at on the question of causation (more accurately, factual causation). In *Minister of Safety and Security v Van Duivenboden*[15] the Supreme Court of Appeal aptly summed up the position in the following terms:

'A plaintiff is not required to establish a causal link with certainty, but only to establish that the wrongful conduct was probably a cause of the loss, which calls for a sensible retrospective analysis of what would probably have occurred, based upon the evidence and what can be expected to occur in the ordinary course of human affairs rather than an exercise in metaphysics.'

[77] I am therefore satisfied that on the available evidence (i.e. the joint minutes) and the probabilities, causation has been established.

[15] *Minister of Safety and Security v Van Duivenboden* 2002 (6) SA 431 (SCA) para 26.

The order

[78] In the result:

78.1 The appeal is upheld with costs including the costs of two counsel.

78.2 The costs shall exclude the preparation of the record on appeal.

78.3 The appellant shall pay the respondent's costs in the application under Uniform Rule 49(7)*(d)*, such costs are to be taxed on the opposed scale and shall include the costs of two counsel where so employed.

78.4 The order of the court *a quo* is set aside and replaced with an order in the following terms:

'It is ordered:

1. In respect of the separated issues relating to the determination of the merits, these issues are determined in favour of the plaintiff and the defendant is ordered to pay damages to the plaintiff in both her personal and in her representative capacities such as are proved in due course, in consequence of the hypoxic ischaemic encephalopathy and brain injury together with the sequelae thereto, sustained by Sanelisiwe during her intrapartum stage.

2. The defendant is ordered to pay the plaintiff's costs of suit in respect of the determination of the merits to date hereof, such costs to include the costs of two counsel and:

2.1 The costs of travelling and subsistence of plaintiff, plaintiff's legal representatives, and plaintiff's expert witnesses for purposes of consultation and trial;

2.2 The costs of reporting, supplementary reporting (if any), preparation of joint minutes, qualifying expenses (if any), and reasonable day reservation fees of plaintiff's expert witnesses;

2.3 Interest on costs at the legal rate from date of allocatur to date of payment.

3. The aforementioned costs are to be paid into the trust account of the plaintiff's attorneys, Messrs Mjulelwa Inc. Attorneys, the details of which are as follows:

Account name: Mjulelwa Attorneys
Bank: Standard Bank, Mthatha West
Account No: 2829 47302
Branch code: 052621'

M. S. RUGUNANAN
JUDGE OF THE HIGH COURT

I agree.

_____

J. E. SMITH

JUDGE OF THE HIGH COURT

I agree.

_____

D. O. POTGIETER

JUDGE OF THE HIGH COURT

Appearances:

For Appellant:	A. G. Dugmore SC and P. Mnqandi
Instructed by:	Mjulelwa Inc. Mthatha Tel: 047-531 2845 / 079 341 2067 (Ref. T. Mjulelwa)
For Respondent:	H. J. van der Linde SC and N. James
Instructed by:	Norton Rose Fulbright c/o Smith Tabata Attorneys Mthatha Tel: 011-685 8998 / 060 553 0510 (Ref: S. Chendip)
Date heard:	13 February 2023.
Date delivered:	11 May 2023