

Editorial note: Certain information has been redacted from this judgment in compliance with the law.



IN THE HIGH COURT OF SOUTH AFRICA
GAUTENG LOCAL DIVISION, PRETORIA

CASE NO:47586/2017

(1) REPORTABLE: **NO**
(2) OF INTEREST TO OTHER JUDGES:
NO
(3) REVISED **NO**

DATE: 10 April 2023

SIGNATURE.

In the matter between:-

A K M AND K C S Plaintiff

and

MEC FOR HEALTH GAUTENG Defendant

JUDGMENT

KHWINANA AJ

INTRODUCTION

[1] The first plaintiff is A K M a minor male born on the [...] February [...] herein assisted by his mother and natural guardian K C S as an adult female hostess born [...] May [...] currently residing at Tsakane Ext [...], [...], B[...], Gauteng Province.

[2] The second plaintiff is K C S born [...] May [...] an adult female hostess, acting in her personal capacity as S's mother and natural guardian currently residing at Tsakane Ext [...], [...], B[...], Gauteng Province.

[3] The defendant is the Member of the Executive Council (MEC for the Department of Health, Gauteng in his/her capacity as such, responsible for the health care in the Gauteng Province, which responsibility includes the proper administration of the Pholosong Hospital, 1069 Indaba Street Tsakane Brakpan, 1548 (hereinafter referred to as the hospital) defendant's elective address for service is c/o The State Attorney, Salu Building, 316 Thaba Sehume Street, Pretoria, Gauteng Province.

[4] The plaintiffs claim is that as a result of the defendant's negligence, the first plaintiff suffered spastic quadriplegic cerebral palsy caused at his birth asphyxia and hypoxic ischemic encephalopathy due to the defendant's failure to perform a Caesarean section on the second plaintiff timeously and expediently for obstructive labour and foetal distress.

[4.1] In the alternative by assuming responsibility for the rendering of medical services to the first and second plaintiff acting through its employees owed the first and second plaintiff's duty of care to perform any medical services rendered to them with the degree of care, skill and diligence required from a hospital and its employees in similar circumstances.

[5] The plaintiff's claim is that the defendant is in breach of the agreement between the first and the second plaintiff and the defendant acting through its

employees failed to exercise the degree of care and skill required from a hospital in similar circumstances in South Africa.

[5.1] In the alternative the first and second plaintiffs claim that the defendant unlawfully breached the legal duty and the duty of care, as mentioned above, in the respects as set out in particulars of claim.

[6] The first plaintiff as a result of the defendant's breach of the agreement alternatively the defendant's unlawful breach of the legal duty and duty of care and sequelae suffered future hospital expenses R 6,468,000.00 and general damages at R 1,000, 000.00.

[7] The second plaintiff as a result of the defendant's breach of the agreement alternatively defendant's unlawful breach of the legal duty and duty of care and sequelae suffered in the sum of R 2,023,200.00 being future hospital expenses, past loss of earnings, future loss of earnings and general damages at R 1,000. 000.00. The plaintiffs claim in total is the sum of R 9,491,200.00, interest at prescribed rate and costs of suit.

[8] The parties have agreed to separate the merits and quantum and I am ceased with only the merits of this matter.

BACKGROUND

[9] On the day that the matter was to start the defendant submitted a proposed amendment to the plea and pre-trial questions which occasioned the matter to be stood down to the next day for the plaintiff to consider. The said proposals were considered and the plaintiff did not take issue with same and agreed to

the amendment being effected. The court ordered that the said amendments be effected and the matter to proceed.

[10] The plaintiff's counsel informed the court that he was ready to proceed and had prepared a statement of facts wherein he alluded to the issues in dispute and facts of common cause which will assist the court. He further submitted that it was a compilation of pre-trials that were held and that he was proceeding on liability only.

COMMON CAUSE

[11] He submits facts of common cause as the citation of locus standi of the plaintiff, the identity that was admitted, and consequent to that, an application for condonation which presupposes locus standi that was granted. He further submitted that condonation was granted for noncompliance to proper notice being provided. He also submits that the duty of care owed to the plaintiff and the baby A, is common cause.

ISSUES IN DISPUTE

[12] He submits that issues to be determined are that all medical personnel acted in the course and scope of their employment with the defendant and that if I find any negligence and causation, it follows that the defendant is liable. He submits that on 23rd of February 2015 is the date of delivery of the baby A. That Baby A was born in a severely compromised state after probably suffering a hypoxic-ischemic insult suffered suffocation. That there is vicarious liability. That the antenatal course was uneventful. That a mild anaemia was detected and the patient was recorded as HIV positive.

[13] That, at the time of her admission she had a haemoglobin. He submits that evidence will be led of induction of labour. That, Misoprostol, is the type of medication that was used in the afternoon of the 24th to do the induction. That in the morning of the 25th, the process started and the medication was administered. That in the early morning hours of the 26th of February 2015 the cervix was dilated and thus started the second stage of labour. That there is the latent phase, the preceding phase which is the runup to that with contractions and the second stage, the active stage is when the birth actually occurs.

[14] That there was very rapid progress of labour with dilation of about six centimetres in fifteen minutes which constituted precipitous labour. That precipitous labour is something that will feature prominently in this matter and they will lead the evidence but precipitous labour just actually constitutes extremely fast labour. That a severely compromised male infant was born with the umbilical cord wrapped twice around the neck. That the issue of the umbilical cord is a contentious issue. That there was a retroplacental clot recorded which indicated a placental abruption. That the placental abruption will feature prominently in this matter. That a very severely compromised baby was delivered who suffers from cerebral palsy.

[15] That there are two mechanisms of the injury which will be revealed through evidence one is commonly referred to as an acute profound mechanism. That means where the oxygen supply to the foetus is immediately shut off. Whereas the other mechanism is a partial prolonged mechanism which is where the foetus is deprived of sufficient oxygen over a period of time. That the mechanism of the injury is imperative in determining what caused the

injury and therefore it is important for this Court to determine specific issues of causation and negligence.

[16] That the PGT pattern was of some assistance in confirming hypoxic injury but it was non-descriptive. That the MRI's showed no evidence of congenital abnormality, or metabolic disturbance with previous infection of inflammatory diseases. That the focus will be on what caused the hypoxic injury. That the appearance of the brain injury of A M is not consistent with a watershed which is a partial prolonged.

[17] That the radiologists in their joint minute they have excluded congenital or other causes and they have now agreed to exclude a partial prolonged injury. That the plaintiff is dealing with a hypoxic injury which the baby suffered which was caused by a sudden acute oxygen deprivation, that is Accute profound mechanism. That the Court should only consider the acute profound mechanism that caused A 's brain injury is intrapartum related hypoxia an ischemic. That he suffocated in the final stages of birth as a result of something that acutely cut off his oxygen supply.

[18] That the plaintiff experienced hyperstimulation is a contentious issue. "Whether the acute profound brain injury suffered was as a result of the placental abruption." There is a placental abruption in this matter. The plaintiffs will adduce evidence to convince this Court that all of this was related to the augmentation, to the medication which caused hyperstimulation or hyperstimulation caused precipitous labour. That precipitous labour caused placental abruption. That the acute profound brain injury suffered was as a

result of the placental abruption which was most probably the result of the Misoprostol induced precipitous labour.

[19] That the counter side of that coin is whether the placental abruption and the tied umbilical cord, both of which were likely to have been unforeseen and thus not preventative cause. That If the Court finds that the placental abruption constituted a true sentinel event unforeseen, no warning, cannot do anything about it, then the claim must fail. If the Court finds that the placental abruption was a result of Misoprostol, lack of monitoring, hyper stimulation, precipitous labour then I would submit that a finding of liability would be appropriate depending on the negligence obviously. That counsel submits as his view specifically a causation issue.

[20] That whether the treatment and/or monitoring provided or lack thereof in the period 21:30 to 00:15 on 25 to 26 February constituted unreasonable care 20 and if so, whether such unreasonable care contributed to the injury suffered by A. That in the event of unreasonable care, whether the injury to A was preventive if there was reasonable care. That the But for test” be applied to say had there been reasonable care will the baby still have suffered the injury.

[21] Counsel further submitted that there is a lot of clinical data, clinical tests and clinical records which relates to both the time before 09:30 on the 25th and subsequent to the birth of A. That they might in evidence refer to one or two of those 10 documents but that is the let us call it the contentious period, that period from 09:30 until the birth. That, did they do what should they have done, or could have prevented what happened to the baby. That concluded the opening statement of the plaintiffs’ counsel.

[22] Counsel for the defendant confirmed the issues in dispute as alluded to by counsel for the plaintiff and elected not to make an opening statement.

MERITS

[23] Counsel Myburgh proceeded to call the first witness being Emmerentia Jansen van Rensburg a professional nurse who was sworn in. She says she did her training at the University of Bloemfontein where she did her general midwifery and all her other qualifications. She moved from there to Johannesburg Hospital and where she worked in the casualty department and the trauma unit and did see lots of labour deliveries. She says she moved to Pretoria at the then HF Verwoerd Hospital. She says she was in charge of the casualty department where they do not do deliveries but were receiving patients and then after in charge of the outpatient's department that was dealing with maternity issues.

[24] She says she keeps herself updated with research and articles. She says she started in 1979 and finished her degree in four years. She says she did her honours thereafter. She says she has forty years experience. She was referred to the merits bundle and she identified the document as her report which was written in 2018. She further stated that an addendum subsequently. She explains that when she did her first report there were no hospital records available and she only received the hospital records quite recently. She referred to paginated page 21 which is marked annexure A.

[25] She says in terms of the Nursing Act as a nurse you must be registered at South African Nursing Council. The South African Nursing Council gives guidelines on how to work. She says the council deals with the registered

members. She says she used the guidelines reference in her report that are published by the Department of Health and are updated on a regular basis. There is 2007, then it is 2015 and then continuously it is updated. She says she has lots of maternity care, lots of research and updates on maternity events.

[26] Counsel referred the nurse to another file which he referred to as the plaintiff's merits experts at volume 009-139. The nurse says at page 009-135 is her addendum report. It was drawn after she had sight of the clinical records. That the CTG is a cardiotocography that they take in the hospital for a patient where with bands around the abdomen and the purpose of it is to monitor the foetal heartrate and the contractions. It is basically two sensors that are placed on the abdomen that is attached with elastic bands. The sensor for the contraction and the sensor for the foetal heartrate.

[27] The foetal heartrate is FHR which means it is the heartrate of the foetus before delivery. The heartrate can be determined either by using a CTG or it can in the absence of a CTG you can use a specific stethoscope. It is done to monitor foetal heartrate and contractions. The contractions can be felt using your hand on the abdomen to feel the contractions. Reactive is if you take at CTG, normally a CTG must be taken at least ten minutes but ideal is to do it thirty minutes and then it is to determine the foetal baseline or the decelerations, contractions and baseline. Variabilities, then they say it is reactive and then all that information must be then recorded by the nursing personnel, the midwife in the document in case the CTG get lost.

- [28] Counsel also referred the nurse to trial bundle file at page 6. She says that handwritten document is the CTG, a tracing of a CTG. The top line is where the foetal heartrate is done and the bottom part it is where the contractions is but then it must start on the baseline. This is for explanatory purpose the result of the CTG and what you see is foetal heartrate and contractions. The reactive CTG status is if the foetal heartrate is between 110 and less than 160 and the baseline variabilities is less than – or between five and 25. There is no decelerations and not more than two accelerations within ten minutes.
- [29] Augmentation of labour is a process of labour that is very slow then there are techniques that can be used by the doctor to assist the patient with the progress of labour. Medicine is used to speed up the labour process such as the drug called Misoprostol but says she did not work with it herself. She confirms that Misoprostol is medicine that you use to augment or speed up the labour process. It is important to monitor whilst the patient is receiving the Misoprostol because the purpose of the medication is to increase the contractions and thus it is important.
- [30] She says the side effects of Misoprostol are too many contractions, there must not be more than five contractions in ten minutes. If the intensity of the 10 contractions is too high, more than 40 to 60 millimetres per second, more than 40 to 60 seconds then the foetus will not get time to get enough oxygen which can then cause a problem. Contractions are important to be taken before every dose of Misoprostol. When confronted with a non-reassuring foetal status, you must immediately contact the attending doctor and there are certain measures to be taken is giving the patient oxygen. The patient must

be turned to the left side, start intravenous fluid and it is most important is to immediately call the attending doctor.

[31] She was referred to the trial bundle wherein she looked at the four hourly observation chart for antenatal problems. The last entry made according to that document was done at 22:00 meaning ten o'clock at night on the 25th. She read the vitals at ten o'clock that night as 130/80 and the pulse rate is 100. She said it would be strange that the pulse rate remained the same. She was requested to read page 151 which was read as follows: "The first stage of labour latent phase was diagnosed by the doctor on 24 February 2015 at 09:00. It was also noted at 09:10 by the nursing personnel that continue maternal and foetal monitoring must be done. Although the maternal and foetal monitoring were planned by the nursing personnel no nursing interventions or evaluations were done or recorded. As per guideline for maternity care, maternal monitoring must have been done four hourly and uterine contractions monitoring two hourly. Foetal heart rate must have been done two hourly."

[32] She further read that a CTG was done for the first time at 16:01 up to 16:32 then seven hours later as per the addendum report of Doctor Sevenster. She says according to the nursing records on the 24th February 2015 at 19:30 a CTG was done although no proof is available. On page 152 she read on the 25th of February 2015 at 17:26 a CTG was taken at 17:40. She says it is recorded both CTG's were reactive. She acknowledges the decelerations on the unidentified and undated CTG recording on 25 February at 20:57. She said she could not comment due to the missing aforesaid important

information. There is also no nursing record indicating that a CTG was taken in the nursing records.

[33] There is no evidence that maternal monitoring was done after 22:00 on 25 February 2015 and the last evidence of foetal monitoring of the CTG that was identified with a date and time was done on 25 February 2015 at 17:40. In every two hours monitoring of contractions needed to be done before the next medication was given. The information needed to be recorded in the nursing documents the contractions of the patient must be assessed before each dose of Misoprostol is given. She says from 09:10 up to 16:01 and from 18:50 the maternal contractions were not monitored even when the dosage was increased from 10 millilitres to 20 millilitres from 15:30 until 23:30.

[34] There is no proof that a CTG was performed prior to that item being inserted. The portogram must start at the moment of the latent phase and then when it is in the active phase then you carry it over to the latent phase. She says every four hours must be maternal monitoring must be done and the foetal heart rate every two hours and the contractions must be indicated on the portogram. The last entry was at 22h00 with vitals at 130/87 and pulse at 100 which was similar to one at 00h15. She says "A CTG was done for the first time at 16:01 up to 16:32." The nursing records on the 24 February 2015 at 19:30 a CTG was done although no proof is available.

[35] There is no CTG's and no mention of monitoring in the period half past nine up and until quarter past twelve. The dosage

was increased from 15:30 to 20 millilitres per hour but there was no proper monitoring. She says there is no evidence that proper evaluation of contractions during the induction period and it is clear that the guidelines for maternity care were not followed. The patient will explain the feeling and extend of the pain. Counsel Myburgh concluded his examination in chief.

[36] Counsel Mphahlele cross-examined nurse says she matriculated in 1978 then in 1979 she studied her diploma in nursing at UOFS which was a four-year degree. Community health is part of the course that was done in six months. She could not recall the year she studied trauma course. She did a nursing management course but also do not recall the year between 2005 to 2009. She was studying and also doing practical's. She has lots of experience of maternity and of specifically labour. She worked in the casualty department, did lots of research and continues to read up. She sees herself as an expert because of training, experience, reading articles and research.

[37] She never worked in a labour ward but in 2005 she worked in the out-patient ward. She did not examine the second plaintiff, neither did she work at Pholosong hospital. She has never worked with Misoprostol, neither did she monitor a patient whom Misoprostol has been used. She says the guidelines were not followed neither there is recording but she understand augmentation and induction. She could not

say which section in the Nursing Act has been contravened by the nursing staff at Pholosong hospital. She says records can get lost. The doctor diagnosed and then it was noted by the nursing personnel that they must continue with monitoring. That was the end of cross examination for the first witness of the plaintiff.

[38] Counsel for the plaintiff proceeded to call the plaintiff, K C S who was sworn in. She says the hospital where she gave birth to her child, nobody opened her eyes to the effect that the child was having a problem. She asked the physiotherapist what was wrong with her child and he said the treatment will only start after the period of six months. She says when she was discharged they reminded her that she must get a card for physiotherapy but no one would tell her what was wrong with her child. She says she thought that was going to be a once-off session not continuous. She says that the document she is being referred to completed by the physiotherapist was not completed in her presence as a parent they are given a certain time with the child. She says the child spent a day or two at the ICU and thereafter the child was moved from ICU to the ward 6A.

[39] She says that her child was hospitalized until March and was required to attend the hospital to be seen by different doctors but was unable to tell which specialists were attending her child. She says the doctor would say she must train the child at home and the child was unable to perform the things that he was asked to do. She consulted Dr Sevenster on the 01st of September 2017. She started to have pains on the 23rd of February 2015. She says she went to the hospital where she was told she is three centimeters dilated. She says the doctor said she was overdue to give birth and thus admitted her to the

hospital. She says she was given medication on the 25th of February and that is when she had pains. She says it was after nine that she started having pains as there was a round clock on the wall. She conceded that she was estimating the time as after nine. She says she had consumed the entire bottle when the pain started. She says she had pains at casualty, later maternity, and then the labour ward.

[40] She was transferred to the labour ward, the nurses were on a tea break. She felt something was coming out that is when she called the nurse the water broke and the child followed. She says she was made to wait for thirty minutes as had been left at the door by the nurse. She was not put on a CTG machine in the labour ward and the pains had started at nine until she delivered. She denied being taken with a wheelchair and that pain started at 23h00.

CHRISTIAAN BARTEL VAN ONSELEN SEVENSTER

[41] The plaintiff proceeded to call the second witness being Christiaan Bartel Van Onselen Sevenster who was sworn in and proceeded to testify. He says he is a specialist in the field of obstetrics and gynaecology. He obtained his specialist degree in 1984 from the University of Pretoria Cum Laude. He is a registered medical legal practitioner with SAMLA, the South African Medical Legal Association. He has completed in excess of 500 medical-legal reports, in excess of 90 joint minutes and has testified in 18 to 20 court cases to date. He says when you examine the baby after birth when there was a tight cord around the neck

you will find red markings in the neck, similar to strangulation markings and you will find a dusky face.

[42] A dusky face is a swollen face with bleedings in the eye and subconjunctival bleeding, which are the most obvious signs that you will find when you examine such a baby. That baby would have suffered some extent of hypoxic injury as a result of tight cord. On CaseLines there is a colour photograph so it is a deep red swollen face and it says figure 7 is facial duskieness due to tight nuchal cord. Figure 8, the second photograph refers to petechiae which is small little bleeding in the skin due to this tight cord around the neck.

[43] He opines that the appearance of the brain injury of A M does not have evidence that you would have expected a partial prolonged injury pattern had it been the nuchal cord. He says a patient is in labour and she is not progressing meaning that there is no proper expected dilation of the cervix you augment the process of labour with giving the patient an oxytocic meaning it is a medical substance either vaginally, orally or intravenous to strengthen or speed up the contractions so the big difference between the two, induction, the patient is not in labour, you are putting them into labour, augmentation the patient is in labour but she is not progressing well and then you augment labour but there are certain conditions that have to be met before you do augmentation. Oxytocin is a medicine that is usually given intravenously, it resembles the normal oxytocin which is produced in the brain which then stimulates the

uterine muscle whereas Misoprostol is a tablet that is usually given for stomach ulcers. It is a prostaglandin agonist. It means it acts like a prostaglandin.

[44] He says prostaglandins are substances which also stimulate the womb's muscles whereas Misoprostol is a tablet that can be given in various ways. It can be taken by mouth as a solid tablet or part of a solid tablet or in solution form like it was given to this patient or it can be given vaginally. Precipitous labour means very fast labour, which is defined as when a baby is fully delivered within three hours after contractions have started.

[45] He does not agree with Dr Koll on behalf of the defendant and opines that the plaintiff experienced precipitous labour. He says that hyper-stimulation implies that the medicine that you have given to the patient to either induce labour or augment labour causes five or more contractions in 10 minutes whereas others say more than five. The relevance of this is that the contractions are so frequent on each other that there is no time for that foetus to re-oxygenate itself and it becomes hypoxic meaning there should be a resting phase between contractions so that this foetus can gather enough oxygen to feed its brain. He says Hypoxic means reduced oxygen delivery being the process starts as a sub-threshold procedure or incident and then there is a time where there is no problem and then again a sub-threshold hypoxia and this then accumulates at the end and that causes the final injury.

[46] It is preferable to have continuous electronic foetal monitoring, a continuous monitoring of the foetal heart and contractions of the mother. The failure to monitor as you should diagnose hyper-stimulation which could result in a brain insult ending in a brain injury. He is a specialist obstetrician but these guidelines are not only for nurses but also for doctors working in clinics, level 1, level 2 and level 3 hospitals. He also follows the guidelines when he is in private practice. He uses these guidelines as a bible. Tocolysis is the process where you give the patient who is having hyper-stimulation you give her medicine which is given intravenously to stop that contraction.

[47] He says she explained that she started getting painful contractions at 21h00, so that means that the Misoprostol was now starting to give her proper contractions but at 23h00, 11 o'clock it was severe pains and she showed him with her hands, it does not leave me she says. He opines they missed hyper-stimulation of the uterine muscle and thus they did not do tocolysis to prevent foetal hypoxia. If they had diagnosed hyper-stimulation and immediately informed the doctor and started tocolysis that would be roundabout 23h00 and 23h30 when there was hyper-stimulation.

[48] He says if they had noted that and they would have done tocolysis those contractions would have disappeared within 10 minutes or so that is the time when they should have intervened. If they diagnosed for hyper-stimulation through monitoring

and applied tocolysis no injury would have been sustained by the minor. The fact that there are foetal movements does not imply a non-reassuring foetal status. He refers only to a heart rate that was recorded at 00:15 of 160 per minute which is just indicative of a numeric value of the heart rate.

[49] A normal heart rate for a foetus in labour is usually roundabout 135, 145 but says without a CTG or factual monitoring by means of any other form of foetal monitoring being a Doppler or foetus scope one cannot make an assumption. He says he cannot see how there is prolapse of the uterus or the pelvic floor and how that can induce abruption placenta. He opines it is unexplainable how you can get an abruption with a prolapse or laxity of the pelvic floor. He says he can see that it has a role in precipitous labour but not in an abruption.

[50] He says the third possible factor for abruption that was submitted is that of hypertensive disorders, but there is no indication in the clinical records that the patient suffered from hypertensive disorders thus his view is that the hyper-stimulation induced the placental or caused the placental abruption. He says the blood pressure and the heart rate should have changed with a patient in strong or hyper-stimulated labour it would have been different. He opines failure to monitor between 21h00 till 00h00 was the reason for the disastrous end at the moment of the birth of, the occurrence of an abruptio placenta which resulted in a severely compromised baby born and such failure to monitor was unreasonable.

[51] Counsel for the defendant cross-examined the doctor. The doctor says there

is no factual records of hyper-stimulation but during the interview with the patient he says she explained to him the type of contractions she had and he having been in practice a long time and has been in practice in the Gauteng province as well for six years she explained or demonstrated severe pains with her hands, and just by the way that the patient explained to him in words and in gesture it indicated that the patient was suffering from hyper-stimulation. He says she explicitly said that it was not the same as before because she has got a reference point, previous labour and she experienced this labour the pains as something totally different occurring one on the other.

[52] He says CTG could be used to palpate the patient and in this case, it was done until 21h30 and he wonders why it was not proceeded with. He opines it was not been done as the staff would or should have recognised hyper-stimulation and acted timeously so by not doing or acting timeously or diagnosing hyper-stimulation it implied that CTG tracing was not done or regular palpation was not done after 21h30 till delivery. He says he might not have had all records when he prepared the addendum and that as an obstetrician it was difficult to comment with any degree of certainty on

the aspect of negligence.

[53] The primary component of the asphyxia injury occurred during labour while the plaintiff was under the care of the defendant. He says the antenatal records were imperative to exclude other conditions like hypertension that might cause placental abruption thus the importance to go through the abruption of antenatal records to see what happened during the pregnancy. He says it was totally impossible for him in his first report to say that there was precipitous labour present because the patient was not aware of how far she was dilated. He says he saw a CTG without a name which refers to almost the same time. He explains that after 21h30 there was no CTG yet it was imperative to continue monitoring with CTG. He says the manner the patient described the pains is precipitous labour is most probably the result of uterine hyper-stimulation. He says because there other CTG cannot be said to be that of this patient and that there was no CTG after 21h30, the CTG tracing is non-reassuring and indicative of non-reassuring foetal status.

[54] He says “Five decelerations during the hour period. These decelerations present variable type 1 and type 2 decelerations.” and this should have alerted the nursing staff to inform the doctor of the non-reassuring CTG. He agrees that “Oral Misoprostol should have been stopped and intrauterine

resuscitation should have been started by turning the mother on her left side giving oxygen, six litres per minute by the facemask and the balance of intravenous". He says he does not know what it was before contractions because of the manner in which the nursing personnel records. He opines precipitous labour can cause abruption. He says it is most probably precipitous labour here which was induced by the Misoprostol. He denies that placental abruption can be caused by prolapse of the genital floor as opined by Dr Koll. He says if there was not precipitous labour there might not have been, hyper-stimulation there might not have been precipitous labour and thus not placental, abruption placenta.

[55] He says the CTG he did not rely on did not have a name and counsel Mphahlele said that CTG tracing was not provided by the defendant. Counsel Myburgh says he is throwing his junior under the bus as same was provided by the defendant and they only discovered it. He says he does not base his findings on the adverse CTG only but on the probability or the time that hyper-stimulation most probably started in with this patient. He says "CTG tracing 99-105, hand paginated 67 plus 68 done on 25 February 2015 around 20:27 and 20:30 it was non-reassuring CTG. A total of five decelerations and variables in appearance and thus indicative of probable umbilical cord compression." He says the doctor should have been informed based on this information and IUR started and augmentation stopped. He says there is no factual records of CTG tracing

after 21h30 and that Misoprostol was administered between 21h30 and 23h30. He says that is the period where hyper-stimulation of the uterus could have started. He says that the cord around the neck can get a little bit tighter and it can cause hypoxia but it cannot and it did not cause an acute profound injury. He says Sub-threshold hypoxia versus severe hypoxia, there is a vast difference between the two.

[56] He says if there was continuous CTG tracing after 21:30 and these contractions were getting now more intensive and more frequent there would have been signs of variable decelerations, but we cannot say that because we do not have a CTG tracing after 21:30 so the effect of the contractions on a cord around the neck whether it is once or twice or three times it will give you on CTG tracing the picture of variable decelerations. Decelerations occurring before a contraction, after a contraction, before a contraction, two or three or after, it is variable, it is not like a type 1 deceleration which is when there is a contraction you have the heart rate coming down, going back, a type 2 deceleration where the heart drops after a contraction and then it goes back to the baseline but here you have variable, in between contractions, everywhere and that is significant to inform you that there is a constriction or compression of the umbilical cord.

[57] Counsel objected to the response which counsel

Myburgh replied it is an opinion with the cord around the neck as he had explained as the labour process carries on with the contractions the cord around the neck can become tighter and there is compression on the vessels within that cord especially because there are two arteries in a cord and one vein. The vein is the one that is supplying the oxygen. When you are born the veins usually carry deoxygenated blood but in the foetus the vein, carries the oxygen from the placenta to the foetus. Now that can get compressed in between contractions and when that happens there is sub-threshold hypoxia, not complete hypoxia, sub-threshold because the contractions come and go but when the contractions become more frequent it can become more pronounced so that is what sub-threshold hypoxia is. He agrees that the acute profound brain injury was as a result of the placental abruption which was most probably the result of Misoprostol induced precipitous labour.

[58] He says that he does not agree with Dr Koll as there is no evidence that there was no uterine hyper-stimulation present, there is no factual record of either Doppler or foetal scope, foetal heart rate monitoring as expected and indicated by the Guidelines of Maternity Care, the foetal heart rate should be monitored half an hourly during the active phase of labour. He says this partogram is a visual report of the progress of labour through

the active phase. He says at 00:15 there is just one heart rate recorded and if she was present in the cubicle there should have been, a recording of a heart rate half an hour later or even better, 15 minutes later. He asks if she was there, why was there only one heart rate monitoring.

[59] He says there is no monitoring, no indication of the descent of where the foetal head was. She should have examined the patient and felt how much of the leg is still above the pubic bone or the symphysis. He says there is nothing, absolutely nothing. He opines that this patient was not examined. He says the deduction he makes from this is that the patient was not properly monitored in the labour rooms. There should have been foetal heart rate monitoring half an hour later that is quarter to 1 and also most probably one at the time that she delivered, 01:15. He says it is not here on this partogram and there are no contractions. He reiterated that the midwife does not have to leave the patient as the file will be with her. He agrees that there might have been some partial hypoxic injury.

[60] In re-examination he says the pains described aligns with his view. He says the cord around the neck was an insult. He says Labour is a hypoxic process, a labour process is hypoxic process. He says his opinion is that because of the hyper-stimulation and precipitous labour the patient developed the abruption that resulted in the acute profound brain injury. He explained that

if they had monitored the patient as they should have according to Maternal Guidelines and they would have timeously identified hyper-stimulation, did tocolysis and prevented precipitous labour, placental abruption most probably would not have occurred, the tragic outcome would not have taken place. He says that in the active phase of labour, that is from four centimetres till full dilation the foetal heart rate should be monitored half hourly, the contractions should be monitored half hourly, the descent of the foetal head should be monitored but the most important during that time is the foetal heart rate and the contractions.

[61] Both counsels did not have a question on the court's question. The doctor was excused. The plaintiff closed its case and the counsel for the defendant requested that the matter proceed the next day the 18th of October 2022 at 10h00' o'clock.

[62] Counsel Mphahlele SC opens the defence case by calling MONICA NOMSUMBULUKO SITHOLE, she was sworn. She used the service of Mr Mogalane a sworn interpreter. She says she is working at Pholosong Hospital as a midwife. Her work entails looking after expectant mothers, assisting with the delivery of babies, giving prescribed medication to patients, looking after delivered babies and also doing work allocated to her by her seniors in the ward. She started working as a midwife in 2015. She obtained a diploma in

nursing in 2013. She says in 2014 she did community health service at Pholosong Hospital. She says her diploma is a four-year diploma

course, which entails midwifery, psychiatry, community health courses and others.

[63] She says on the 25th of February she was on the second shift and arrived at work around 19h00. She says a report is given by those knocking off about the patients, they move from one patient to another. They sign a register that they are on duty. They proceed to check drugs, check the emergency trolley and prepare all the utensils or what is needed in the execution of their duties for the day. She says she was stationed in the maternity ward for mothers who are in the process to deliver and that was 9B. She says the labour ward is adjacent to the maternity ward it takes two minutes to walk there and she was working there on the day in question.

[64] She says that the layout is a big ward with two cubicles and three sidewards. She says on the side there would be a wall separate up to the end of this witness stand and then there would be a passage then on the other side of the wall there would be another cubicle. Also there, would be a wall separating, the passage will go down accordingly. She says there is no wall between the cubicles and the passage. She says one cubicle has nine beds. The staff was made up of a

senior, two juniors, two comserve and a staff nurse. Her cubicle was seven by seven meters and the beds were close to each other. Patients could hear as people talk. The patient in *casu* was in her cubicle. Her name is similar to hers but she is not related to the plaintiff neither did she know her prior that day.

[65] She says working on patient number one entails taking the history of the patient, checking her how she is as to whether she has pains that she is experiencing and then checking whether the child in the womb is playing and in general any other complaint. She says when done with the history from the patient, she will do a physical assessment with the hands and check vital signs. In the event, the patient complained that she is experiencing pain she will do PE vaginal examination.

[66] She will give prescribed medication if any and focus on the baby using a cardiograph machine which checks the heart rate of the child in the womb. She says if all is well, she will move to the next patient. However, if there are any abnormalities thereon, she will phone the doctor. She will cause the mother to lie on a left lateral position for resuscitation of the baby in the womb and then she will go to the next patient. She says she repeats the same process moving along to the next patient.

[67] She says it is important to check pains as some have false labour pains. She says CTG is a tracing. It is referred to as reactive. It can be any of the four features, a baseline of 110 to 160, there has to be that beat variability of not less than five beats per minute, there has to be accelerations and there ought not to be decelerations. She says when supra is not present the CTG is non-assuring maybe two or three of those being referred to are absent we refer to it as pathological tracing. The right way to check the heart rate of a child is by using a CTG machine. She says in the two cubicles they had three CTG machines. When she started her shift there were 33 patients. She says all patients must be put on the CTG machine and their names must be punched into the machine and in the event, you forget you must write the name by hand.

[68] Counsel refers the nurse to the trial bundle and she identified

the document as the clinical card which the patient will use whilst attending clinic until she delivers. She read that it belongs to K S, hospital number was 790505, date of birth 1979/05/05, address [...], Extension[...]. She also read that in 2005 K gave a normal delivery of a boy baby, 3.5 kilograms being the weight of that child and there were no complications. She says the patient was on induction which started on the 25th February. She acknowledged a document she is being

referred to by counsel and that one of the signatures that appears is hers. She says on the 25th at 09:30 in the morning she was started with 10 millilitres being a low dose and then again at 11:30 she was given 10 millilitres, once on 13:30 being 10 millilitres and then at 15:30 she was given 20 millilitres. At 17:30 she was given 20 millilitres and then at 19:30, it was 20 millilitres and again on 21h00 until 23:30.

[69] She checked whether the previous tracing was done because before she would have to check the heartbeat of the child then having satisfied herself that there were no abnormalities she dispensed with that dosage and then it was after the mother had said that she does not have any pains. She says you dispense with this Misoprostol as long as the mother does not have pains until when she remarks that she is in pain and then you check what is the dilation. She says once you have satisfied yourself that she is now in labour you dispense with Misoprostol. She says the last dosage was at 23h30 and no dosage was given at 01h30. She stopped the dosage after checking patient and found that she was four centimetres dilated. She says she then transferred her to the labour ward.

[70] She read the details being 35 years old para 1 gravida 2 who was attending clinic at Calco Dlepu, she started having labour pains at 21h30 she received her last dosage of Misoprostol. She says she then completed documentation as

required. She says the water had not broken and was still in the membranes. She says she checked the patient and recorded that Rhesus was positive which is normal, syphilis test was non-reactive, negative and as she was HIV positive, it was recorded active and she was on heart treatment. She says she asked the patient about pains which she said were not so strong. She says she did general examination on the patient and recorded her pulse as 100, BP at 130/87, 40 weeks, palpitation being 39 and presentation being cephalic (head). She says she palpated the tummy and realised that the pains were moderate not severe. She says before the last dosage the patient is put on the CTG and in this case she did put her on CTG. She could not say where the said CTG results were. She says the child was coming normal and the head was vertex. After a lengthy discussion the parties agreed that the CTG without a name should be disregarded.

[71] She says in the cubicle doing her duties and in the event the patient was in severe pain she would have informed her. She was informed that K said she was given a bottle of Misoprostol that she was to drink every four hours and she said it is seven years ago she cannot recall but usually it is two hours. She says she would not have delivered the patient without the latest CTG result that is reactive when told that patient says it was not done after 21h30. She denies that she left the patient at the door of the labour ward to talk to the

midwives in the labour ward. She asked which door was the patient left at and ultimately says she did not leave her at a door. She denied not giving reasonable care and says she did what was expected of her in the circumstances. That ended examination in chief.

[72] Cross-examination began, she says there were 33 patients when she started to work and when she was knocking off they were 4. The report was received from the outgoing staff. She says they also prepare a report when they leave for those that will be starting their shift. She says she got the information from the litigation department. She says parts of her testimony are what she recalls and what she generally does in her workspace. She says she personally recalls talking to K and monitoring the baby. She says Maternal Guidelines says a patient who is on Misoprostol must be on continuous foetal monitoring at two hour rate. She says the patient was not monitored with CTG machine at two hours as there were other patients that needed the machine. She says she administered the Misoprostol at 19h30 as the CTG had been done. She says she did tracing at past 23h00 but that recording is missing in the file. She says if it is normal there is no need to record. She says not all the time do they give patients Misoprostol to administer themselves. She says she is in the cubicle and the patient would be done CTG prior the administering of Misoprostol. She refused to answer where she

was not on duty to show that no tracing existed. She says with her before she administers Misoprostol she will ensure that the CTG results are obtained. She recorded that the patient was in labour since 19h30 as told by the patient. She says she will still check the patient as it is not fair to merely rely on what the patient said. She says the patient was in the active phase of labour since 21h30 as per her record. She says she did the full assessment at 00h15 and the effect of using CTG is to check heartrate. She says she did vital signs, abdominal examination and PV being temperature, blood pressure, temperature, pulse.

[73] When confronted about the similar vital results she says it is odd but does not know why, she took others whereas others were taken by a staff nurse. She says that the readings were indeed higher before labour. Counsel put to her that she did not take the vitals but recorded them after the patient was transferred to the labour ward. She says she could not recall whether the bottle of Misoprostol was given or that she administered it. She conceded that she could not deny that K was given the bottle to administer herself. She says the records or entire file goes missing at times. She says the tracing would have revealed that there was hyper-stimulation. But same is not available. She conceded that she testified about what she did not recall but she was telling the honest truth. She denies that the monitoring was

inadequate between 21h30 and 24h00. She says all patients under induction are monitored and Ms S was monitored like all other patients.

[74] She says a statement that when not in labour you should not monitor is false. She says Misoprostol is stopped as soon as the patient is in labour active. She agrees that she administered Misoprostol at 23h20 and she signed. She denies that she would record false information. She accepts that Misoprostol was administered whilst was already in labour however says she was the only nurse in the cubicle with many patients and it was 00h15 that she arrived at the patient k. She says that is when she learned of the pains and she was then transferred to the labour ward. She says she did put the patient on CTG then proceeded with other duties. She says she cannot recall that she gave K Misoprostol or that she took it herself. It was put to her that the record is a copy of what had transpired earlier, she refuted that. Cross-examination ended.

[75] Counsel Mphahlele proceeded to re-examine; she says she handed over the patient to the labour ward nurses inside the ward. She says there is no difference between monitoring and assessment. Court asked questions to clarify. Ms S says that Misoprostol might have been taken before she arrived at the patient. She says she was the only nurse allocated the cubicle. There are four cubicles with two nurses, two

comserve and a staff nurse. Both counsel were given an opportunity to ask questions on the court's questions. Counsel Myburgh for the plaintiff declined and Counsel Mphahlele asked. Ms S explained that the comserve would be assisting the mothers that would have delivered babies. She says the other nurse and her would be caring for the high-risk pregnant mothers whilst the staff nurse would be taking vitals for all cubicles. Counsel Mphahlele concluded his re-exam. The matter was adjourned to the 19th day of October 2022 for further evidence.

[76] The matter proceeded and counsel for the defence requested that the matter be heard virtually. The application was vehemently opposed. The application was denied and the matter was adjourned to the 21st day of October 2022 as the expert was arriving from overseas. Costs to be costs in the cause.

[77] On the 21st day of October 2022 the defence proceeded to call Dr Peter Charles Koll who was sworn in. He says he is a gynaecologist who has a gynaecological practice where he lives at Hartbeespoort dam. He says he consults patients and operates on patients in Johannesburg one day a week. He says he is qualified with an undergraduate degree from University of Cape Town in 1979 and he is qualified as a member and was admitted as a member of the Royal College of Obstetricians and Gynaecologists in 1988. He was

elevated to the fellowship in 2003. He says that in England you do not automatically become a fellow of the Royal College, you become a member initially and then after about 15 years if they are happy with everything you have done they invite you to come to London and be elevated to the fellowship unlike in South Africa where you become a fellow upon passing your exams.

[78] His experience entails a house job at Edendale Hospital near Pietermaritzburg where he did six months of medicine, six months of surgery and six months of obstetrics and gynaecology. He then did compulsory military service and was placed on the Swaziland border where he ran rural clinics and a rural hospital so for two years. He was practising rural obstetrics with the nearest major hospital some 120 kilometres away. He says it was an extremely good experience. He says after that he joined Chris Hani Baragwanath Hospital as a senior house officer in obstetrics and gynaecology for six months and then joined the circuit where you rotate through all the hospitals for five years. He says after his exams he worked as a consultant for, just over a year on a full-time basis. He says he then went into private practice and he continued as a part part-time consultant at Chris Hani Baragwanath Hospital for about 10 years.

[79] He says he practised in private practice for just over 30 years. He stopped delivering babies three years ago but still see antenatal patients but only up to 24 weeks of pregnancy and then hand them over to colleagues in Johannesburg. He says the last baby he delivered was three years ago and that was his grandchild. He says he has been giving evidence in court for about ten to twenty times but for the past five years, he has not. He was directed to his report which he recognised and says he prepared it, in 2019. He says the patient presented at about 20 weeks of pregnancy, with nothing significant at presentation, her second pregnancy, first pregnancy ended in a normal vaginal delivery, was known HIV positive and she was also found to be slightly anaemic during the pregnancy. There were no significant antenatal factors.

[80] Counsel Myburgh alluded to a document the witness took out of his pocket. The witness described as his notes from his report. He proceeded to say the next entry was on 23 September 2015 at 15:30 where she presented with backache and a show. The haemoglobin was found to be 9.3, the presenting part was high and she was referred to hospital. The haemoglobin was checked and it was 10.2 which is very mildly anaemic and he says he did not think of any particular significance in this case. He says Haemoglobin is basically the concentration of red blood cells

in your blood. There is numerous causes why haemoglobin would be low. Pregnancy is one cause. There is a haemodilution in pregnancy in other words the entire blood volume expands by about 30 percent during a pregnancy and the volume of the fluid expands a little bit more than the volume of the red blood cells so you get a physiological haemodilution so pregnant women's haemoglobin tend to be slightly lower than people who are not pregnant. In severe cases it can affect oxygen delivery but in a mild case like this he does not believe that anaemia was a very significant. He says the lower limit is 11 and the patient was 10.2 which is not significantly low haemoglobin.

[81] He says that she was assessed at 18h00 and informed that she was two centimetres dilated. She remained at the hospital. On 24 February at 09h00 the patient was assessed by a doctor, he noted that the CTG that is the cardiotocograph was reactive which would indicate no evidence of hypoxia at that stage. He further noted that he recorded that she was 42 weeks, three centimetres dilated but not in active labour. In such instances the induction would be done. He says a non-stress test was done which means a cardiotocograph at 16h40 on the 24th. He says it is important to mention that NST is done in patient who is not having active contractions. He says the the foetal heart at 16:40 was assessed as between 120 and 140, at 19h00 she

was again assessed and found to be two centimetres dilated in other words there had been absolutely no progress in labour from the time she was admitted until then and the decision was taken quite rightly in his opinion to proceed with the induction of labour.

[82] He says the process of induction was started the next day at 09h30 with the administering of Misoprostol as per protocol. The first dose was given at 09h30 at two hourly rate until 23h30. He says the slight lower dosage was used. He says the next assessment was at 00h15 which indicates that the foetal heart was reactive on a CTG, therefore reassuring heart pattern. He says there is a comment that the patient was on CTG but he did not have sight of the tracing. The patient was in active labour phase and had progressed well at four centimetres and had passed the latent phase. He says that if there a protocol that the patient is not admitted to the labour ward without a tracing of CTG that is a good protocol.

[83] He says a note at 00:15 indicates a normal foetal heart, membranes were intact and contractions were recorded as moderate and three in 10 minutes and a moderate contraction is a contraction lasting between 20 and 40 seconds so when we talk about how strong contractions are and the strength of contractions. He says it is important to point out that we cannot actually measure and quantitate the strength of a uterine contraction. They can measure is

duration and frequency, 20 to 40 seconds is regarded as a moderate contraction and three contractions in 10 minutes is regarded as normal. More than five contractions in 10 minutes is regarded as hyper-stimulation so the recording was of normal contractions and a normal foetal heart at 00:15. The next entry was at 01h00 that indicates that the patient was fully dilated and next to that on the portogram a written note indicating delivered a male infant, floppy, plus Apgar 2 out of 10 and 2 out of 10. That is a markedly depressed neonate with significantly low Apgar scores.

[84] He says the patient was fully dilated at 01h00, that bearing down began at 01h00 and that the baby delivered at 01:10. He says that the foetal heart is noted as present and it is noted that foetal distress was present. He noted that a normal vaginal delivery of an alive male infant born with only heartbeat and gasping respiration, complications indicate the cord around the neck two times, tight and two retroplacental clot, under resuscitation done which indicates that the baby was suctioned and oxygen given via nasal prongs and the birth weight was noted at 3880 which is within the normal range. He says the placental weight was noted to be 790 grams and fourth stage of labour noted that baby was admitted to 6A for severe birth asphyxia.

[85] He says the notes record that the baby was severely depressed at birth, that the cord was tightly around the neck. That he or she suctioned to clear the airways and that the baby was bagged to stimulate ventilation. That the baby was gasping with no symmetrical chest movement, cardiac massage was necessary and the author requested that the paediatric doctor be notified. He notes that resuscitation was continued for five minutes when the baby was put on nasal prong oxygen and kept warm. He says the condition was explained to the mother that the baby's condition was not improving and they await the doctor to assess the patient. He says that there was no record keeping as required hourly and the only indication is the first phase and the second phase is not reflected.

[86] He says there should also have been written notes pertaining to monitoring and assessments during that period that the patient was receiving Misoprostol and other than the CTG which some are legible, some are not, other than the CTG's there is no other notes pertaining to that period and again that is not what one would expect. He says there should have been better note-keeping on maternal and foetal wellbeing in the written notes and not just on the CTGs. In conclusion, he opines there is no evidence of foetal distress in any of the CTG tracings that he was provided with. The last tracing is noted to be at the time that the second last dose of

Misoprostol was given, and no contractions are evidenced on that tracing meaning there were no deviations in that baseline and HIV status it is unlikely that it had a significant influence. He says there is no written notes in the bundle pertaining to assessments made during the induction of labour, no record of foetal wellbeing between 21:30 and delivery at 00:10. The baby was severely depressed at the time of birth and the note records a retroplacental clot which indicates a condition called abruptio placentae where the placenta separates from the uterine wall and a blood clot develops between the uterine wall and the placenta was present and that the cord was wrapped tightly around the baby's neck. It is also noted that the liquor aspirated from the baby's upper respiratory tract was clear.

[87] He says Meconium-stained liquor is when the baby passes stool into the liquor, the liquor is the water around baby and babies commonly do that, it is associated with foetal distress. It is sometimes passed in the absence of foetal distress and sometimes not present with an acute foetal distress episode so the absence of meconium would support a more acute, sudden acute insult rather than a partial prolonged insult. He opines that MRI scan indicates that the most likely cause is an acute profound, a sudden acute insult to the baby which would be compatible with the nuchal cord

and the abruptio placentae. He says that shunting of blood is when the Baby moves blood from non-essential organs to the heart and the brain. He opines that in this case the hypoxic injury appears to have been basal ganglia which is compatible with an acute profound insult.

[88] He says an acute insult is a sudden lack of oxygen to the brain which if it prevents shunting of blood within the brain then the basal ganglia is affected and there is relative sparing of the cortex because the basal ganglia require more oxygen than the cortex. He says that there is no evidence of hyper-stimulation at 00:15 that is in the contemporaneous notes. He says we have evidence of two acute profound insults that could potentially cause this type of brain injury so we have got good foetal wellbeing at 00:15. We have got a compromised baby with a cord tightly around the neck, a separation of the placenta both of which caused acute profound injury and we have got radiologist reporting acute profound injury so to me the logical conclusion is that the abruption and the nuchal cord, exactly what proportion each one contributed is impossible to assess but with two severe acute profound insults with evidence of two severe acute profound insults and an acute profound injury he does not understand how any other conclusion can be drawn. Counsel Mphahlele ends his examination in chief.

[89] Counsel Myburgh begins with cross-examination, Dr Koll says

he has good experience training, he delivered his first baby, in 1977 or so, and in 1976 he was involved in public hospitals, later rural hospitals during his military service and public hospitals, another 10 years as a part-time consultant with Chris Hani Baragwanath and then following that as an external examiner at Wits University up until a few years ago. He says once a patient is in active phase of labour there is no reason not to manage a patient, if the hospital is adequately staffed and he did not know what the situation was or the protocols at Pholosong Hospital but he would think that there is no reason why a patient cannot be monitored in an antenatal cubicle. He says Protocols vary from hospital to hospital, he has never worked at Pholosong hospital. He says the patient should be transferred before she is ready to deliver. This is in active phase of labour four centimetres dilated with regular contractions with progressive dilation of cervix. He concedes that he did not discuss the protocol to transfer at four centimetres in his report.

[90] He says that he presumes nothing if there are no records on monitoring. He says that he indicated that he was not happy with the record keeping but indicated that due to the progressive nature of asphyxia in labour that if we had a normal heart rate at 21:37 and we have a normal heart rate at 00:15, a normal reactive tracing because of the progressive nature of the hypoxic stress on the baby in

labour it is extremely unlikely that severe foetal distress occurred that caused the brain injury and miraculously recovered. He says reactive means a reassuring foetal heart rate tracing in other words with a normal baseline, normal variability, and no decelerations. When asked where that tracing was he said it was not there. He again concedes that the nurse recorded a reactive CTG but he did not see it. He says that he assumed that the CTG was performed at that time unless the sister entered a fraudulent note which is not his expertise and he thought it was reasonable to assume it was done without having sight thereof. He says in the notes the way most people would record it is reactive which would indicate that it is reassuring, if there were variable decelerations, they would say variable. If there were no decelerations, they would say reactive.

[91] He says reactive implies that they looked, at the baseline figure which is not recorded as a range, if variability is more than five beats per minute, the up and down then it is regarded that as a normal variability. He says if the CTG at 00h15 was for the one done at 21h37 then it would be unreliable and have no reference at all. He says it would be fraudulent, but he did not see it as such clinically it does not make sense. He says he is relying on the contemporaneous records as he sees them, has no

reason to doubt clinical records and he is not absolutely certain. He says that he was never provided with the records thus he wrote in his report "It is thus essential that every effort is made to find these records.

[92] He says the fact that the records were not provided does not mean they did not exist and qualifies his answer as follows, he noted during the induction period that there were no notes and he stated that, that is not acceptable, that there should have been notes regarding the monitoring but there no CTG's pertaining to that time so it is known that some monitoring was done during that time so the absence of the recording does not mean that those CTG's do not exist so the absence of writing notes is bad and it should have happened but it does not confirm that there was no monitoring. He says that he is not an investigator and despite that, there was a lack of information he did not deem it necessary to consult with the nurse. He concedes that is there are no records during that period where it is said there was monitoring, if there was no monitoring this would be unreasonable. He agrees that he relied on the document filed on caselines 022-54 with regard to the protocol on the dose of Misoprostol.

[93] He was asked would it be following protocol to give a patient

Misoprostol bottle that has already been prepared for the patient to drink two hourly as it gets busy in the hospital sometimes, he said that would not be acceptable. Counsel rephrased the question and said "The plaintiff testified that she was provided with a bottle and told to take a drink every two hours. If that is correct would that be reasonable?" The doctor reiterated that was unacceptable. He says if the entire bottle was consumed by 23:30 if one adds up the doses, 20, 40, 60, 80, 100, there is 130 millilitres that should have been given the standard protocol is to dissolve a 200-milligram tablet of Misoprostol in 200 millilitres of water. Counsel for the defence objected to the time that was alluded to as the time the bottle was finished. Counsel for the plaintiff decided to leave the question and stated it is on record.

[94] He opines if Misoprostol was given in an excessive dose and if it caused excessive contractions then there would be a nexus between the poor management and the outcome. He says evidence of hyper-stimulation would be more than five contractions in a 10 minute period. He says he did not deem it necessary to consult the patient, his work entails reading the records and giving an opinion. He says he is not a judge. He cannot dispute Dr Sevenster's opinion that those symptoms as presented, as explained constituted hyper-stimulation neither the notes, all he can do is comment. He says he was in court when asked to be in court. He says the first step is the lack of

records is indicative of lack of monitoring and if there was no monitoring then that is evidence of sub-standard care

[95] There are CTG tracings at 17:26 until 18:14 is the one. if there was no CTG monitoring that would not be proper care. He says he has no way of knowing or confirming the fact that a CTG was done. He says he is unable to give an opinion due to a lack of records and says this prevented him from commenting conclusively on sub-standard care. He says if the CTG tracing was not performed prior to the administration of each dose of Misoprostol that was unreasonable, and he agrees that is sub-standard care. The longer the labour progresses the more the functional reserve in the placenta is taken up so once contractions start it is very important to monitor and once there is regular contractions to monitor preferably continuously if a machine is available at the time. So that is the reason why we need to monitor because once contractions start the hypoxic stress on the foetus increases and that is why monitoring becomes more and more important.

[96] The idea of Misoprostol is to get contractions started. Once contractions are established then one should not continue the Misoprostol and any further administration of the Misoprostol would be

unreasonable if the patient is in labour. The plaintiff said she had consumed the whole bottle at 9 o'clock when she was in pain. He says it is important to run a tracing, monitor before a dose of Misoprostol.

[97] He says there is always a need to monitor a patient who is having contractions. He agrees that it is his duty to point out probabilities of hyper-stimulation. It is a recognised complication of induction and augmentation. He conceded it is one of the reasons monitoring should be done. He says Hyper-stimulation can cause precipitous labour. He says there is no factual basis in the clinical records that confirm any one of the possible causes. He opines that the most likely cause of the precipitous labour according to his analysis of the evidence it was just one of those precipitous labours. He says he does not believe there would be a universal agreement as to whether precipitous labour can cause abruption or whether abruption can cause precipitous labour. He thinks the abruption placentae and the nuchal cord contributed but to ascertain percentage is impossible. He says there are two recognised acute profound incidents which could have caused the injury but the proportion cannot be confirmed. His opinion is that the nuchal cord can cause hypoxic injury. You can get a nuchal cord that actually causes strangulation.

[98] He says when you deliver a baby the first thing you do is put finger in a feel the cord and if there is a cord around the

neck you just pull it over the head. If it is tightly around the neck you cut it, you clamp it, cut it and then deliver the baby so it is something they routinely look at and it is something that is very common. It does not cause a problem unless that cord pulls tight and if the cord pulls tight it can cause two different types of injuries. As the head descended into the pelvis that cord was pulled tight and that is the most likely time that a nuchal cord will cause a problem is as the head descends because as the head descends the distance from the placenta to the cord around the baby's neck increases and that increase can pull that cord tight so that is why a nuchal cord can go unnoticed before the second stage of labour or even delivery. By the looks of it with a 10-minute second stage the baby probably came out as babies sometimes do too rapidly for them to feel for a cord.

[99] He says that is a possibility but he could not confirm. He could not say if they felt the cord or missed it. There is definitely a link between hyper-stimulation and precipitous labour. His opinion is that there is no causal relationship because of the type of action with hyper-stimulation that would cause lack of blood supply to the baby and it would cause asphyxia problems in the baby because of lack of blood supply through the placenta as discussed but he does not see a mechanism. He says if there is no evidence of foetal distress then there would not be the urgency to get the baby out

because you have suppressed and resuscitated however if there is evidence of foetal distress at the time he says he would not take a chance, he would get the baby out regardless of the response but if there was no foetal distress and just pure hyper-stimulation he would try to suppress it. in the absence of foetal distress with just hyper-stimulation we try and stop the hyper-stimulation. Hyper-stimulation basically constitutes a massive deprivation of oxygen.

[100] He says prolonged hyper-stimulation almost certainly would eventually lead to foetal distress so it needs to be managed. Again dependent on the functional reserve, if the baby was near the end of the functional reserve the minute hyper-stimulation starts he could be in foetal distress. If the hyper-stimulation came after a very short period in labour, baby is healthy with a good functioning placenta it could take a longer period of time. The umbilical cord would not have caused hypoxic injury if caesarean section had been performed.

[101] He says the blood pressures fluctuates during these phases labour. 00:15 pulse and blood pressure is exactly similar to the four-hour observation of chart at 22h00, not closely similar, exactly similar. He says it is not impossible to get two exactly the same two hours apart but it is unlikely. Counsel Mphahlele cross-examined the witness. He says If she was hyperstimulated from 21h00 until say it is half past 9, half past 10, half past 11, half part 12, come quarter past 1, a baby

would not survive an acute profound. if there was hyperstimulation sufficient to cause foetal distress from 21:30 to delivery, if there was no, if it was just an acute profound event, the baby would have died, and the baby cannot survive that for nearly four hours with the acute profound. There is progressive hypoxic stress placed on the baby from the onset of labour to delivery. He says If the Misoprostol has caused severe enough pains to cause injury, one would have expected more of a combined or a partial prolonged pattern. He says one would not have expected an acute profound event from a hyperstimulation that occurred nearly four hours earlier.

THE LEGAL MATRIX

[102] In order to be liable for the loss of someone else, the act or omission of the defendant must have been wrongful and negligent and have caused the loss.¹ The requirements for a successful claim in delict are well-established. A plaintiff must prove positive conduct or an omission, causation, wrongfulness, fault and harm. A plaintiff must allege and prove the casual connection between the negligent act relied upon and the damages suffered. The onus to prove rests on the plaintiff to allege and prove his damage.² The failure by the hospital staff to conduct adequate monitoring of the foetal heart and to administer a standard of care to properly give medication to the mother is a negligent, wrongful omission.

¹ *Telematrix (Pty) Ltd t/a Matrix Vehicle Tracking v ASASA* [2006 \(1\) SA 461](#) (SCA); [\[2006\] 1 All SA 6](#); [\[2005\] ZASCA 73](#) para 12.

² *Minister of Police v Skosana* 1977 (1) SA 31 (A).

[103] Dr Sevenster opines if they diagnosed for hyper-stimulation through monitoring and applied tocolysis no injury would have been sustained by baby A. He says a normal heart rate for a foetus in labour is usually roundabout 135, 145 but says without a CTG or factual monitoring by means of any other form of foetal monitoring being a Doppler or foetus scope one cannot make an assumption. A heart rate of 160 is just indicative of a numeric value of the heart rate. He says failure to monitor between 21h00 til 00h00 was the reason for the disastrous end.

[104] It is trite that the legal question of factual causation asks the question of whether the wrongful conduct or omission was a factual cause of the loss. In Lee,³ the court described that enquiry as follows:

“The enquiry as to factual causation generally results in the application of the so-called ‘but for’ test, which is designed to determine whether a postulated cause can be identified as a *causa sine qua non* of the loss in question. This test is applied by asking whether but for the wrongful act or omission of the defendant the event giving rise to the loss sustained by the plaintiff would have occurred.”

[105] Dr Sevenster says the acute profound brain injury was as a result of the placental abruption which was most probably the result of Misoprostol induced precipitous labour. He says that he does not agree with Dr Koll as there is no evidence that there was no uterine hyper-stimulation present, there is no factual record of either Doppler or foetal scope, foetal heart rate monitoring as expected and indicated by the Guidelines

³ Lee v Minister for Correctional Services [2012] ZACC 30; 2013 (2) SA 144 (CC); 2013 (2) BCLR 129 (CC) at para 48.

of Maternity Care, the foetal heart rate should be monitored half an hourly during the active phase of labour. He says this partogram is a visual report of the progress of labour through the active phase.

[106] He says at 00:15 there is just one heart rate recorded and if she was present in the cubicle there should have been, a recording of a heart rate half an hour later or even better, 15 minutes later. He asks if she was there, why was there only one heart rate monitoring. Again, this is indicative of the substandard care that was given to Ms S by the nurses at Pholosong hospital. Dr Sevenster opines they missed hyperstimulation of the uterine muscle and thus they did not do tocolysis to prevent foetal hypoxia.

[104] In Bentley, the Court, Corbett CJ enunciated that enquiry:

“The enquiry as to factual causation is generally conducted by applying the so-called ‘but for’ test, which is designed to determine whether a postulated cause can be identified as a *causa sine qua non* of the loss in question. In order to apply this test one must make a hypothetical enquiry as to what probably would have happened but for the wrongful conduct of the defendant. This enquiry 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 a hypothesis the 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 loss; aliter, if it would not have ensued.”⁴

⁴ International Shipping Co (Pty) Ltd v Bentley 1990 (1) SA 680 (A) at 700E-701F.

[105] Dr Sevenster and Dr Koll acquiescence that there should have been foetal heart rate monitoring half an hour later that is quarter to 1 and also most probably one at the time that she delivered, 01:15. Dr Sevenster observed that it was not there on this partogram and that there were no contractions. He stated that the midwife does not have to leave the patient as the file will be with her. He opined that if they had monitored the patient according to Maternal Guidelines and they would have timeously identified hyper-stimulation, did tocolysis and prevented precipitous labour, placental abruption most probably would not have occurred, the tragic outcome would not have taken place but would have been a partial hypoxic injury.

[106] The above test was applied in *Lee v Minister of Correctional Services*, where the Court said:

“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.”⁵

The nexus has been explained supra by Dr Sevenster that monitoring according to Maternal guidelines would have allowed diagnosis of hyperstimulation.

[107] The issue of causality, in medical negligence cases, should be approached on the basis that it is simply a “common sense” approach as suggested in *Lee v Minister of Correctional Services*, which held:

“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 ordinary person’s mind works against the background of everyday-life experiences.”⁶

[108] The human body and its reactions are of such a complex nature that it is important for a plaintiff to provide expert medical evidence regarding the issue of causality. In *Lee*, the Court emphasised that the legal test for causation is not inflexible and had to make provision for situations where “the use of the substitution of notional, hypothetical lawful conduct for unlawful conduct in the application of the “but for” test for factual causation” may lead to an injustice.⁷ The Court held that in some circumstances factual causation would be established where the plaintiff has proved that, but for the negligent conduct, the risk of harm would have been reduced.⁸

[109] Innes CJ in *Van Wyk v Lewis* repeated his earlier statement in *Mitchell v Dixon* 1914 AD 519 at 525 that “a medical practitioner is not

⁵ [2012] ZACC 30; 2013 (2) SA 144 (CC); 2013 (2) BCLR 129 (CC) at para 41.

⁶ [2012] ZACC 30; 2013 (2) SA 144 (CC); 2013 (2) BCLR 129 (CC) at para 47.

⁷ [2012] ZACC 30; 2013 (2) SA 144 (CC); 2013 (2) BCLR 129 (CC) at para 50.

⁸ [2012] ZACC 30; 2013 (2) SA 144 (CC); 2013 (2) BCLR 129 (CC) at para 60.

expected to bring to bear upon the case entrusted to him the highest possible degree of professional skill, but is bound to employ reasonable skill and care”, and went on to say the following at 444:

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

Dr Sevenster, Nurse Van Rensburg, Dr Koll and Nurse Sithole showed that they all knew their professional work and were able to articulate the issues with the highest degree of professional skill. The fact that nurse Van Rensburg could not recall years when she was doing certain courses did not discredit her evidence. Her evidence was reiterated by all experts even the nurse from the defendant’s side in relation to monitoring of patients during labour. Dr Sevenster’s major concern was monitoring which to which Dr Koll also conceded would be unreasonable and sub-standard care if same was not done. Nurse Sithole failed to employ reasonable skill and care in that she gave Ms Sithole the bottle of Misoprostol to administer herself, failed to monitor the plaintiff as per the Maternal guidelines and failed to keep proper records as expected. This conduct is unacceptable considering the condition the plaintiff was in and that the defendant’s staff had the duty of care for the plaintiff.

[110] In Kruger v Coetzee 1966 (2) SA 428 (A), viz:

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 personal property and causing him patrimonial loss; and (ii) would take reasonable steps to guard against such occurrence; and

(iii) the Defendant failed to take such steps.

.... Whether a *diligens paterfamilias* in the position of the person concerned would take any steps at all and, if so, what steps would be reasonable, must always depend on the particular circumstances of each case. No hard and fast basis can be laid down.

In *casu* what is evident is that the defendant's staff failed to take reasonable measures to prevent the injury. That conduct is indicative of sub-standard care that was given to the plaintiff during the crucial moments of labour. The negligence in entrusting a layman with a bottle of Misoprostol to administer herself without the consequences thereof being explained to her. The causal manner in that Nurse Sithole explained how she might have given the bottle to K S and which conduct this court frowns at as did Dr Koll being the defendant's expert witness.

[112] Wrongfulness involves the breach of a legal duty. The legal duty in the present matter arose when the mother was admitted to the hospital in labour. The staff assumed a duty to care for mother and fetus during the birth process without negligence, in other words, as would reasonable

staff in their position. More particularly, they had a duty to monitor the condition of mother and foetus and act appropriately on the results. They failed to do so, therefore are in breach of that legal duty. Their conduct was thus wrongful. But this, in itself, has never been sufficient to find delictual liability. The wrongful conduct must cause the wronged person to suffer loss. The first step in proving this is to prove that the wrongful conduct of the staff caused the baby to suffer brain damage. The appellant accordingly bore an onus to prove this. Wrongfulness should not be conflated with factual causation.⁹ The defendant had a duty of care towards the plaintiff and it is evident that the maternal guidelines were not adhered to.

[113] In Loureiro, Van der Westhuizen J explained that the wrongfulness enquiry is based on the duty not to cause harm, and that in the case of negligent omissions; the focus is on the reasonableness of imposing liability.¹⁰ An enquiry into wrongfulness is determined by weighing competing norms and interests.¹¹ According to Dr Sevenster and Dr Koll the Misoprostol increases the contractions which could result in precipitous labour. The Misoprostol is administered in order to induce labour and as soon as the patient is in labour same must be stopped.

9

AN v MEC for Health, Eastern Cape (585/2018) [2019] ZASCA 102; [2019] 4 All SA 1 (SCA) (15 August 2019)

¹⁰ Loureiro and Others v Imvula Quality Protection (Pty) Ltd [2014] ZACC 4; 2014 (3) SA 394 (CC); 2014 (5) BCLR 511 (CC) (Loureiro) at para 53. See also Country Cloud Trading CC v MEC, Department of Infrastructure Development, Gauteng [2014] ZACC 28; 2015 (1) SA 1 (CC); 2014 (12) BCLR 1397 (CC) at para 21.

¹¹ Loureiro at para 34.

[114] The criterion of wrongfulness ultimately depends on a judicial determination of whether, assuming all the other elements of delictual liability are present, it would be reasonable to impose liability on a defendant for the damages flowing from specific conduct.¹² Whether conduct is wrongful is tested against the legal convictions of the community which are, “*by necessity underpinned and informed by the norms and values of our society, embodied in the Constitution*”.¹³

[115] In Van Duivenboden¹⁴, Nugent JA stressed that a negligent omission should only be regarded as being wrongful ‘if it occurs in circumstances that causing harm’. The use of the phrase ‘*legal duty*’ in these circumstances means no more than that the omission must not be wrongful as judicially determined in the manner referred to above i.e. involving criteria of public and legal policy consistent with constitutional norms¹⁵.

[116] In the face of an admitted legal duty of care, the applicant needed to show only that the legal duty was breached.³⁰ Molemela AJ stated further: The respondent’s admission of a legal duty to dispense reasonable medical care is properly made. The law requires hospitals to provide urgent and appropriate emergency medical treatment to a person in the position of the applicant. There is no doubt that the legal convictions of the community demand that hospitals and health care practitioners must

¹² Le Roux and Others v Dey (Freedom of Expression Institute and Restorative Justice Centre as Amicus Curiae) [2011] ZACC 4; 2011 (3) SA 274 (CC); 2011 (6) BCLR 577 (CC) (Le Roux v Dey) at para 122.

¹³ Loureiro at para 34.

¹⁴ 7 2002 (6) SA 431 (SCA) para 12.

¹⁵ See Hawekwa Youth Camp v Byrne 2010 (6) SA 83 (SCA) para 22.

provide proficient healthcare services to members of the public. These convictions also demand that those who fail to do so must *incur liability*.¹⁶

[117] In so far as there are factual disputes arising from irreconcilable versions, such should be resolved in the manner described by Nienaber JA in Stellenbosch Farmers' Winery Group Ltd & Another v Martell et Cie & Others¹⁷: 'To come to a conclusion on the disputed issues a court must make findings on

- (a) the credibility of the various factual witnesses;
- (b) their reliability; and
- (c) the probabilities.

As to (a), the court's finding on the credibility of a particular witness will depend on its impression about the veracity of the witness. That in turn will depend on a variety of subsidiary factors, not necessarily in order of importance, such as

- (i) the witness' candour and demeanour in the witness-box,
- (ii) his bias, latent and blatant,
- (iii) internal contradictions in his evidence,
- (iv) external contradictions with what was pleaded or put on his behalf, or with established fact or with his own extra curial statements or actions,
- (v) the probability or improbability of particular aspects of his version,

¹⁶ Para 54

¹⁷ 2 2003 (1) SA 11 (SCA) para 5

- (vi) the calibre and cogency of his performance compared to that of other witnesses testifying about the same incident or events.

As to (b), a witness' reliability will depend, apart from the factors mentioned under (a)(ii), (iv) and (v) above, on (i) the opportunities he had to experience or observe the event in question and (ii) the quality, integrity and independence of his recall thereof.

As to (c), this necessitates an analysis and evaluation of the probability or improbability of each party's version on each of the disputed issues. In the light of its assessment of (a), (b) and (c) the court will then, as a final step, determine whether the party burdened with the onus of proof has succeeded in discharging it. The hard case, which will doubtless be the rare one, occurs when a court's credibility findings compel it in one direction and its evaluation of the general probabilities in another. The more convincing the former, the less convincing will be the latter. But when all factors are equipoised probabilities prevail.¹⁸

[118] When dealing with the evidence of experts in a field where medical certainty is virtually impossible, a court must determine whether and to what extent their opinions ... are founded on logical reasoning. The court must be satisfied that such opinion has a logical basis, in other words that the expert has considered comparative risks and benefits and reached 'a defensible

¹⁸ Makgoka JA in paragraph [53] of *HAL (obo MML) v MEC for Health, Free State* [2021] ZASCA 149 (22 October 2021):

conclusion¹⁹. He says if Misoprostol was given in an excessive dose and if it caused excessive contractions then there would be a nexus between the poor management and the outcome. In *casu* the patient did say she had finished the entire bottle of the Misoprostol when the nurse reached her.

[119] Dr Koll says he relies on records thus he did not consult the patient. In this case Dr Koll did not have the notes but he did not deem it fit to consult the patient, this is tenebrous as to why not. Dr Koll further opines that Misoprostol itself does not put any stress on the baby, the contractions caused by the Misoprostol put the stress on the baby. He reiterates that from the commencement of contractions it becomes very important to monitor, probabilities of hyper-stimulation. it is a recognised complication of induction and augmentation. It is therefore on that basis that I am unable to assimilate why he would differ with Dr Sevenster considering that there is a period that is unaccounted for in terms of monitoring by the nursing staff and that he would fail to allude to the probabilities as narrated by Dr Sevenster.

[120] In this regard, in *Coopers (South Africa) (Pty) Ltd v Deutsche Gesellschaft für Schädlingsbekämpfung MBH*, 6 this Court held: '[A]n expert's opinion

¹⁹ Michael & Ano v Linksfield Park Clinic (Pty) Ltd and Ano 2001 (3) SA 1188 (SCA) paras 36-37]. Mediclinic Ltd v Vermeulen 2015 (1) SA 241 (SCA) para 5].17.9)

represents their reasoned conclusion based on certain facts or data, which are either common cause, or established by their own evidence or that of some other competent witness. Except possibly where it is not controverted, an expert's bald statement of their opinion is not of any real assistance. Proper evaluation of the opinion can only be undertaken if the process of reasoning which led to the conclusion, including the premises from which the reasoning proceeds, are disclosed by the expert.²⁰

Dr Koll says he cannot dispute Dr Sevenster's opinion that those symptoms as presented, as explained constituted hyper-stimulation neither the notes, all he can do is comment, which statement is indicative of an expert failing to again consider the probabilities.

[121] In this regard: Schutz J²¹ found an expert to be relatively honest - only relatively because his honesty was marred by his well-developed readiness, which one sees in so many experts, to protect the team goal. The judge²² castigated the orthopaedic surgeon for the plaintiff, Mr Williams, for the robust language which Mr Williams had used in dealing with the conduct of the doctor in question, and in dealing with the views of his opposite number. He said this in this regard: I have to say that I find it deeply disturbing to find an expert, however distinguished a surgeon he may be, seeking to "rubbish" the sincerely held, and reasonably expressed, beliefs of those who happen to disagree with him. In *casu* Dr Koll failed to address the probabilities.

²⁰ AM and Another v MEC Health, Western Cape [2020] ZASCA 89; 2021 (3) SA 337 (SCA) para 17

²¹ Orda AG v Nuclear Fuels Corporation 1994 (4) SA 26 (W) 78H-I

²² p240 of his judgement in El-Morssy v Bristol & District Health Authority [1996] Med LR 232 (Q), Turner J

[122] Gorven J²³ held it bears remembering that the required standard is proof on a balance of probabilities. It is also worth noting that, in arriving at their opinions, medical experts frequently apply a scientific level of proof approaching certainty. Courts must guard against adopting this standard.

The test for factual causation is whether the act or omission of the defendant has been proved to have caused or materially contributed to the harm suffered. Where the defendant has negligently breached a legal duty and the plaintiff has suffered harm, it must still be proved that the breach is what caused the harm suffered. In the present matter, it is common cause that the hospital staff did not properly monitor the labour. Accepted guidelines require such staff to take and record the foetal heart rate over certain periods. In well-equipped hospitals, the foetal heart rate is monitored with cardiotocographs (CTGs). The hospital was not equipped with these. In such situations, the monitoring is done by auscultation of the foetal heart.

[123] In *casu* the nurse testified that CTG machines were present and that she did use it on the plaintiff, however the most crucial CTG tracing could not be found safe for contemporaneous notes that surfaced after the file had been missing for a period of time. The case *supra* differs with this matter. Herein the CTG machine was not used optimally by the nurse, there was no proper monitoring of the heart rate for almost an hour before delivery. Every moment counts during the active labour phase. The factual causation to result, it must be shown that if the sentinel event had been detected within a reasonable

²³ MEC for Health and Social Development, Gauteng v MM on behalf of OM (Case no 697/2020) [2021] ZASCA 128 (30 September 2021)

time, intervention within a reasonable time would probably have prevented the brain damage.

[124] I became concerned when I heard that despite that documents were provided for the recording of the monitoring that was not done. Nurse Sithole says she was caring for nine patients in one cubicle. She blames that there were three CTG machines allocated for entire ward. I still cannot assimilate the behaviour of the nurse in a casual manner as she dealt with the birth of A M. What is evident is that she failed to follow protocol in relation to the use of Misoprostol, CTG tracing and recording prior to transferring the patient to the labour ward.

[125] It is not possible to just believe that she did a CTG tracing yet same could not be located. It is concerning that according to all the experts both for the plaintiff and the defendant, vitals must be recorded at the time that are being taken and it is highly unlikely that you would have exactly the same vitals when a person is in labour. The plaintiff testified that when the last CTG tracing was done she had finished the bottle of Misoprostol. She did say she was in pain at 21h00.

[126] Here we have a case of a layman who is told drink this medicine four hourly without knowing the consequences of this medicine. Nurse Sithole does not say she explained to the plaintiff that the medicine increases contractions nor that she must not take the medicine in the event the contractions proceed at a certain speed. This conduct by the nurse is careless, wrongful and negligent. It is evident that the hospital at Pholosong is short staffed and that puts pressure on the nurses at the hospital to the extent that their judgment in administering medicine is impaired. Nurse Sithole was ceased with caring for

at least nine patients and she says it is possible that when she reached the plaintiff before the final dosage she was busy with other patients. What is imperative in this instance was that she should not have given the patient the medicine to administer herself, this would have prevented the drinking of the medicine whilst already in the active phase of labour and before the CTG tracing was done. Nurse Sithole was provided with the documents in which she was to record but she did not use them optimally. I do not believe that the nurse had a choice as to what should be recorded.

[128] Dr Sevenster says he was taught as a medical student, you listen before and after and you write down, the baseline and that there is no decelerations or there is decelerations and you take appropriate action. I want to believe that such crucial training the nurse must also have been taught. It would seem the records were missing at a point but ultimately surfaced. These records revealed that sub-standard care was given to the plaintiff.

[129] In the matter of Mashongwa v PRASA²⁴ the following was stated:

No legal system permits liability without bounds. It is universally accepted that a way must be found to impose limitations on the wrongdoer's liability.²⁵ The imputation of liability to the wrongdoer depends on whether the harmful conduct is too remotely connected to the harm caused or closely connected to it.²⁶ When proximity has been established, then liability ought to be imputed to the wrongdoer provided policy considerations based on the norms and values of our Constitution and justice also point to the reasonableness of imputing liability to the defendant.²⁷

²⁴ 6 2016 (3) SA 528 (CC) para 68 to 69.

²⁵ Neethling above n 56 at 197.

²⁶ Minister of Safety and Security and Another v Carmichele 2004 (3) SA 305 (SCA) para 72.

[130] The nurse when she was told of the severe pains, told the patient to pack up. No CTG was done. The probabilities favour the plaintiff's version. According to the nurse called by the plaintiff if monitoring was done hyper-stimulation would have been detected. Dr Sevenster says the tight cord could be responsible for hypoxic, and it can cause hypoxia, but in this case, it cannot, and it did not cause an acute profound injury. He further said the initial painful contractions were indicative of the Misoprostol starting to give her proper contractions. Dr Sevenster reiterated that monitoring of the heart rate, contractions, and proper record keeping became important.

[131] He opined that was hyper-stimulation of the uterus as the contractions became severe. He says failure of the medical personnel missed hyperstimulation of uterine muscle and thus they did not do tocolysis to prevent foetal hypoxia. The hyperstimulation started precipitous labour. He says proper diagnosis would have stopped contractions especially because Misoprostol complications are hyperstimulation. The doctor of the defendant relied on notes which did not have a CTG, this is inconceivable. The only possible cause of placenta abruption Dr Sevenster found to be hyperstimulation not the abnormalities that he was referred to. I must say I agree with Counsel Myburgh in his deduction that Dr Koll's evidence was that, if it is not recorded, it cannot be proven. The defendant's expert gynaecologist conceded that, had intervention occurred as opined by Doctor Sevenster, the minor child would not have suffered the hypoxic injury he did.

²⁷ Minister for Safety and Security v Scott and Another [2014] ZASCA 84; 2014 (6) SA 1 (SCA) at paras 37-8 and S v Mokgethi en Andere 1990 (1) SA 32 (A).

[132] On a preponderance of probabilities, the plaintiff has established that there was a legal duty which the defendant has breached by failure to monitor the plaintiff whilst using Misoprostol, that she the plaintiff experienced hyperstimulation, which went undiagnosed and untreated due to the failure to monitor. This led to A M being born with cerebral palsy an injury that could have been prevented in the event of monitoring, diagnosing hyperstimulation and taking appropriate steps. The unreasonable care constituted negligence defendant breached a duty of care, such breach being unlawful. I have concluded that was proved by the plaintiff. The creation of risk by the negligence of the hospital staff caused the brain damage suffered by the baby A. The plaintiff has established and proven the liability of the defendant to compensate the plaintiff and the minor. I have considered the order filed by the plaintiff's counsel and I have amended same.

[133] In the result I therefore make the following order:-

1. The Defendant be ordered to pay 100% (one hundred percent) of the First and Second Plaintiff's agreed or proven damages, which damages flow from the neurological injuries sustained by First Plaintiff during labour and delivery at Pholosong Hospital on or about 26 February 2015 and the resultant cerebral palsy (and its sequelae) which the First Plaintiff suffers from.

2. The Defendant shall pay the Plaintiff's taxed or agreed costs of suit, to date, and such costs shall be at the discretion of the taxing master (but not necessarily be limited to) the following:

(a) The costs attendant upon the obtaining of the medico-legal reports and/or addendum reports and/or joint minutes and addendum joint minutes, if any, as well as qualifying and/or reservation fees, if any, of the following expert witnesses:

- (i) Dr J Reid — neurologist;
- (ii) Dr A Keshave —paediatric neurologist;
- (iii) Dr C B v O Sevenster — gynaecologist and obstetrician;
- (iv) Dr Malan van Rensburg -radiologist;
- (v) Sr E Jansen Van Rensburg — nursing expert;
- (vi) Prof J Smith — specialist paediatrician and neonatologist;
- (vii) Dr GS Gericke — specialist paediatrician and geneticist.
- (viii) The costs of any radiological or other special medical investigation used by any of the aforementioned experts.

(b) The qualifying, reservation, attendance and/or preparation costs, if any, as allowed by the taxing master, of the experts or whom the Plaintiff gave notice in terms of Rule 36[9][a] and [b]; including but not limited to:

(i) Dr Sevenster;

(ii) Sr van Rensburg;

(c) The costs attended upon the appointment of senior junior counsel including the reasonable fees for preparation of the heads of argument as well as their full day fees for each day of appearance.

(d) The costs to date of this order, which shall, subject to the discretion of the taxing master, further include the costs of the attorneys which include necessary travelling costs and expenses [time and kilometres], preparation for trial and expenses [time and kilometres], preparation for trial and attendance at court [which shall include all costs previously reserved]. It will also include the reasonable costs of consulting with the Plaintiff to consider the offer, the costs incurred to accept the offer and make the offer an order of court;

(e) The reasonable costs incurred by and on behalf of the Plaintiff in as well as the costs consequent to attending the medico-legal examinations of both parties;

(f) The costs consequent to the plaintiff's trial bundles and witness bundles, including the costs of 8 [eight] copies thereof;

(g) The costs of holding all pre-trial conferences, as well as round table meetings between legal representatives for both the Plaintiff and the Defendant, including senior-junior counsel's charges in respect thereof, irrespective of the time elapsed between pre-trials;

(h) The costs of and consequent of the holding of all expert meetings between the medico-legal experts appointed by Plaintiff [if any].

3. The defendant shall pay interest on the plaintiff's taxed or agreed costs of suit at the prescribed statutory rate calculated from 31 (THIRTY-ONE) days after agreement in respect thereof, or from the date of affixing of the taxing master's *allocatur*, to date of payment.

KHWINANA AJ

FOR THE PLAINTIFF: ADV MYBURGH

FOR THE DEFENDANT: ADV MPH AHLELE SC

ADV M RASEKGALA

