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

REPUBLIC OF SOUTH AFRICA

IN THE HIGH COURT OF SOUTH AFRICA

GAUTENG DIVISION, PRETORIA

CASE NO: 21623/18

(1) REPORTABLE: NO
(2) OF INTEREST TO OTHER JUDGES: NO
(3) NOT REVISED.

12 June 2024
DATE

[redacted]
SIGNATURE

In the matter between:

MATHE, CAROLINE BRIDGETTE **PLAINTIFF**

and

THE MEMBER OF THE EXECUTIVE COUNCIL FOR HEALTH

OF THE GAUTENG PROVINCIAL GOVERNMENT **DEFENDANT**

JUDGMENT

FRANCIS-SUBBIAH, J:

[1] The plaintiff, Ms Mathe institutes a claim for damages against the defendant, MEC for Health for the Gauteng Province, arising from the alleged medical negligence of its employees at the George Mukhari Academic Hospital ("the Hospital"). Ms Mathe, after giving birth to a baby through cesarean section was given a peripartum hysterectomy (surgical removal of her uterus) on 24 April 2016. The cause of the hemorrhaging that led to the emergency removal of the uterus remains unknown. The plaintiffs second claim relates to the failure to provide her with counselling after the removal of her uterus.

[2] The defendant admits it has a legal duty to attend to and treat the plaintiff with acceptable skills, expertise and reasonable care. But denies negligence and pleads that the removal of the uterus was a life-threatening emergency that arose while conducting the caesarean section. The plaintiff's uterus was removed as a measure to save the plaintiff's life. On the failure to provide post-hysterectomy counselling the defendant contended that Ms Mathe discharged herself on 29 April 2016 from the Hospital before such counselling could be performed.

[3] At the commencement of the trial, as agreed between the parties, the merits were separated from the quantum and only the issues relating to the defendant's liability is adjudicated upon. Quantum of damages, if arises, is postponed sine die.

[4] Four witnesses testified. The plaintiff and her expert witness Dr Pooe testified in the evidence of her claim. Dr Pooe's expertise is she worked in the department of obstetrics and gynecology for 18 years. The defence led the evidence of expert witness Dr Manthata -Cruywagen, who is employed at the One Military Hospital and has a master's degree in obstetrics and gynecology. The fourth witness is Dr Mangwane who is employed at the Hospital since 2012 as a senior clinical executive and gave evidence relating to the hospital records.

[5] The plaintiff testified that she was 25 years old and pregnant for the first time. Upon 23 April 2016, she had reached full term of her pregnancy when at 09h00 her 'water broke', referring to the amniotic fluid flowing out. It was approximately 'half a cup' of fluid. She then attended at the Soshanguve BB Municipal Clinic, ("Clinic") where a vaginal examination was conducted. She was told that her baby is in danger,

there is foetal distress and she must be transferred to the hospital. She was given a referral letter to hand to the Hospital. She went to the hospital with private transportation because the ambulance taking patients from the Clinic to the Hospital was full.

[6] Upon arriving at the hospital, around 16h30-17h00 she was instructed to sit on the waiting bench after handing in her referral letter from the Clinic. No one attended to her, while other patients came in and were assisted while she sat there. At around 19h00, she was still not given any treatment. It was around 23h00 when a student doctor examined her vaginally and found a yellow discharge. He then monitored the baby's heart rate and sighed in relief after detecting it. She was taken for a sonar and cardiotocography (CTG)[1] were done.

[7] She had another discharge of amniotic fluid that splashed onto the floor. The nurse was abrupt with her and she had to wipe up the spillage herself. It was around 02h00, when she was taken to the operating theater for a caesarean section. However, no operation took place, and she was returned to the ward and informed that there were no doctors available to conduct the cesarean section. She then fell asleep and at 09h00 she was awakened and taken back to the theater. She was being given a spinal block but after three injections was told that her spinal cord could not be detected. She underwent general anesthesia, when an anesthetic mask was placed on her mouth and nose, and she fell asleep. She awoke two days later in the Intensive Care Unit ("ICU").

[8] In ICU, a professor and his team of doctors attended her. The professor asked her how many children she wanted and she informed him of three. He then responded that unfortunately she would not be able to give birth to any more children. He also told her that once she is out of the ICU it will be explained to her why they had to remove her uterus. To date she does not know why her uterus was removed. It was never explained to her.

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[1] CTG is defined as a "continuous recording of the foetal heart rate obtained via an ultrasound transducer placed on the mother's abdomen. It is widely used in pregnancy as a method of assessing foetal well-being, predominantly in pregnancies with increased risk of complications."

[9] From the ICU she was transferred to the High Care Unit. There the student doctor visited her and said, "please forgive us." After two days in the High Care Unit, she was transferred to the general ward and placed in a separate room. Each nurse attending upon her would say "sorry" after having read her medical file.

[10] After two days in the general ward she was emotional, tired, mixed-up and wanted to go home. The professor stopped her discharge because her pulse rate was high. She was in tears all the time, depressed, stressed, had no energy, could not walk and no nursing staff attended to her. She had the baby by her side and struggled to attend to the baby. She felt that if she could go home, she would be assisted by her family.

[11] The professor had promised for her to get counseling and be attended to by a psychologist, social worker and a gynecologist. However, none of the professionals attended on her in the 7 days she stayed in the hospital. Upon her self-discharge, two doctors spoke to her not to go home as it was against their medical advice. Following her hospital discharge, she was instructed to go back to the hospital after 4 days to have the stitches removed. She did go back to the hospital.

[12] After a year, she received a call from Dr Mabena who was conducting research in writing an article about her case and he told her that he had her file. She then got in touch with her attorney to institute this claim for negligence.

[13] The plaintiff's expert witness, Dr Pooe explained that the rapture of membranes and the leaking of the amniotic fluid commenced at 09h00. From the arrival of the plaintiff at the hospital around 17h00 until the caesarean section at 09h00, the next day, there was a delay of a period of 16 hours. This prolonged time created an emergency that contributed to the uterus being removed.

[14] She testified that the meconium in the amniotic fluid can cause infection. The meconium irritates the uterus and affects the lining of the uterine wall. The yellow colour of the meconium grade II had to be investigated to determine whether there was an infection. Such infection in the uterus could cause a hemorrhage during a

caesarean section. Proper and correct management of the patient had to be proceeded with. Failure to do this is mismanagement of the plaintiff. This sequela notes both maternal and foetal distress and a caesarean section had to be performed as a matter of urgency.

[15] She further agreed that when a uterus is removed there must have been a need to save the mother's life and confirmed that post-partum hemorrhage is a killer if it is not treated on time.

[16] It was submitted in cross examination to Dr Pooe that the absence of pain means that the plaintiff was not in labor. Dr Pooe's response was that even if the plaintiff did not show signs of contractions she can be in labour. She further explained that a first-time mother may confuse pain or may have a high threshold of pain. The plaintiff testified that initially she did not have pain but later at night she felt pain.

[17] Dr Pooe agreed further that although a nurse cannot instruct that an emergency cesarean section be conducted, and a doctor does. The fact that there was a referral letter from the clinic to the hospital which should have been in the plaintiff's file indicates the need for intervention. The presence of meconium in the amniotic fluid indicates there is trouble and a caesarean section be performed. In her opinion the plaintiff was wronged and mismanaged, thus there was negligence.

[18] Dr Manthata-Cruywagen stated that the plaintiff was not yet in labour and had pre- labour rupture of membranes as per the guidelines for maternity care. When asked if the plaintiff was at term with her pregnancy, Dr Manthata-Cruywagen conceded that she was but had to wait for spontaneous labour to occur. Since the plaintiff did not have pains, and uterine contractions did not commence, it was false labour. However, because the water broke, induction for labour should start only between 12 – 24 hours as prescribed in the maternity guideline. She testified that there was no foetal distress, and if it was there for that long, the child would have died or developed cerebral palsy.

[19] Under cross examination Dr Manthata-Cruywagen was speculative that the plaintiff said there were no doctors at 02h00 to conduct the emergency caesarean, which according to her 'does not make sense.' Thus, she could only conclude there were more pressing or prioritized cases that required attention rather than the plaintiff. According to her the hospital staff did everything according to the guidelines and that there was no delay in attending to the plaintiff.

[20] Dr Manthata-Cruywagen's view was that the clinical *sequelae* of the plaintiff is consistent with that of a patient who had severe intraoperative bleeding (PPH) because of the associated morbidity she had. She opined that the removal of the uterus could have occurred because of infection or a mistake. Due to hospital records being unavailable, one cannot know for sure. However, a complication was encountered intra-operatively and a life-saving procedure had to be performed, had this not been done, the plaintiff would have died.

The medical record

[21] It is trite that expert evidence must not be based on mere speculation giving rise to various but equally feasible possibilities as to what might have resulted in the injury being sustained.[2] Therefore, medical records are crucial in the adjudication of matters involving medical negligence. The absence of medical records makes adjudication and ensuing litigation extremely difficult, while also limiting the expert's ability to give a definitive opinion on the actual cause of medical negligence.[3] The admission of medical records as evidence is regulated in terms of section 3(1) of the Law of Evidence Amendment Act[4] read with section 34(1)(ii) of the Civil Proceedings Evidence Act.[5] There is therefore a duty on the defendant to provide medical records and an obligation to keep the records safe for a certain period of time.

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[2] Van Wyk P445.
[3] *M OBO M V Member of the Executive Council for Health of the Gauteng Provincial Government* [2018] ZAGPJHC 77 at para 40.
[4] 45 of 1988.
[5] 25 of 1965.

[22] This obligation upon the MEC for Health, to keep records, protect such records and provide access to these records is legislated in sections 13 and 17 of the National Health Act[6] (NHA). It provides for the records of clinics and hospitals to be maintained and stored as prescribed.[7] The provisions make it clear that the MEC for Health has a statutory duty to preserve and protect the medical records, failure to do such may lead to imprisonment or conviction of a fine, or both. The legislature has taken a very serious view in the safekeeping of medical records, to prevent falsification, tampering, and disappearance of the medical records. Additionally, the South African Maternity Guidelines emphasize the importance of proper record keeping.

[23] Furthermore, Clause 9 of the Health Professions Council of South Africa 2016 (HPCSA Guidelines) provides guidelines for the duration of retaining and safekeeping of medical records[8]. The NHA and the HPCSA Guidelines are detailed and emphasize the importance, rationale, and seriousness of the safekeeping of medical records as a duty bestowed on health professionals. Therefore, when medical records are not available for evidence, this may lead to a potential breach of duties, the law, and good codes of practice. Thus, in the absence of such records, there must be a *bona fide*

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[6] 61 of 2003.

[7] It provides as follows: -

> ***13 Obligation to keep record***
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> *Subject to National Archives of South Africa Act, 1996 (Act 43 of 1996), and the Promotion of Access to Information Act, 2000 (Act 2 of 2000), the person in charge of a health establishment must ensure that a health record containing such information as may be prescribed is created and maintained at that health establishment for every user of health services.*
>
> ***17 Protection of health records***
>
> *(1) The person in charge of a health establishment in possession of a user's health records must set up control measures to prevent unauthorised access to those records and to the storage facility in which, or system by which, records are kept.*

[8] "*Health records should be stored in a safe place and if they are in electronic format, safeguarded by passwords. Practitioners should satisfy themselves that they understand the HPSA's guidelines with regard to the retention of patient records on computer compact discs. Health records should be stored for a period of not less than six (6) years as from the date they became dormant. In the case of minors and those patients who are mentally incompetent, healthcare practitioners should keep the records for a longer period. For minors under the age of 18 years, health records should be kept until the minor's 21st birthday because legally minors have up to three years after they reach the age of 18 years to bring a claim. This would apply equally for obstetric records … Notwithstanding the provisions … above, the health records kept in a provincial hospital or clinic shall only be destroyed if such destruction is authorised by the Deputy Director-General concerned.*"

explanation for the unavailability and the explanation must be satisfactory as to why the medical records are missing.

[24] The absence of medical records and no knowledge of them was noted in ***Madida v MEC for Health for the Province of KwaZulu-Natal***[9], where the plaintiff claimed for damages arising from negligence. The court held that the defendant is the custodian of the medical records and can access them at all times. Further, the defendant could not provide proper explanation as to why the custodians of the medical records at the hospital were unable to hand them over. Thus, the court held the following with regard to pleading no knowledge:

> *"To plead 'no knowledge' and to put the plaintiff to the proof of facts that should be easily ascertainable was not a plea in good faith. It is hardly the response of a caring health service. Proof as to whether a medical doctor had attended to the plaintiff had to come from the hospital staff on duty at the time and from their records."*[10]

[25] In the present matter there is no acceptable explanation for the missing records. The plaintiff obtained a court order requesting the record, but it was not discovered. The acting CEO of the hospital, John Velaphi Ndimande in an affidavit affirmed that he can safely say that the defendant is not in the possession of the plaintiff's medical record.

[26] During the trial the court made various enquiries regarding the missing records. Both experts agreed that there are numerous points of record keeping. Dr Pooe advised during her cross examination that the medical records can still be found, since the hospital is an academic, teaching institution, these registers and records can become available. Dr Manthata-Cruywagen further elaborated on this by stating that there are various registers and records available. This will include the delivery book recording when the baby is born, hospital theatre records relating to the complications, the labour ward record book, the Intensive Care Unit record book and the High Care record book.

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[9] 2016 JDR 0477 (KZP).
[10] Id at para 20.

Piecemeal provision of medical records

[27] Following the expert's testimony, the defendant provided further hospital records in the form of a maternity register and blood reports. Dr Joseph Senzo Mangwane, in reading the record and interpreting it for the court stated that the recordal of MLS 11 explained that the amniotic fluid from the plaintiff was meconium-stained grade 11 and this was the reason for the caesarean section eradicating the speculation. However, the ICU register and High Care record book were not found and the plaintiff's full medical record remained pending. Dr Mangwane testified that the records of the patient must be kept for a period of 15 years.

[28] The missing records are serious as it is *prima facie* proof of the truth of its content. A failure to produce the critical medical record could be the reason why they are not produced, instead piecemeal evidence is being produced such as the refusal for medical treatment and the blood test reports of the plaintiff indicating that nothing was wrong with the placenta. Although this is an indicator for the positive outcome for the baby but fails to shed light on the severe inoperative bleeding of the plaintiff.

[29] The court in ***ZM obo SM v MEC Department of Health, Eastern Cape***[11] was similarly faced with a medical negligent claim where at the trial, the antenatal and maternity records were not tendered, only the "Road to Health Chart" indicating the child's immunization and health interventions was available. The medical records critical to evaluating the standard and extent of care afforded by the defendant's employees were missing. The court held that absent these medical records, there is no objective record of the actual care of the plaintiff and the child.

[30] The importance of producing medical records for evidence was indicated in ***Jayiya v Member of Executive Council for Department of Health, Eastern Cape***[12] and the court took the view that it is not enough for the respondent to allege that the medical records went missing when there is an obligation to give an explanation. A reasoning that the missing records is a neutral factor in that matter had no factual foundation and an adverse inference against the respondent was drawn. Whereas in

[11] [2023] JOL 59131(ECL) at para 8-11.
[12] [2023] 4 All SA 72, at 141.

HAL obo MML v MEC for Health, Free State[13] the court addressed the issue of missing medical records as a neutral factor as it affected both parties. In the present matter the missing records are not a neutral factor, and an adverse inference can be made. Firstly, since piece meal evidence has surfaced, as well as the plaintiff received a call from Dr Mabena who was conducting research in writing an article about her case and he told her that he had her file. The file remains under the control of the defendant.

[31] When statutory obligations are breached without reasonable explanations appropriate consequences are required. In ***Khoza v MEC for Health and Social Development***[14], Splig,J held that:-

> *"In summary the failure to produce the original medical records which are under a hospital's control and where there is no acceptable explanation for its disappearance or alleged destruction*
>
> *a) may result in the inadmissibility of 'secondary' evidence if the interests of justice so dictate, whether such evidence is of a witness who claims to have recalled the contents of the lost document or to have made a note of its contents on another document;*
>
> *b) cannot of its own be used to support an argument that a plaintiff is unable to discharge the burden of proof because no one now knows whether the original records would exonerate the defendant's staff from a claim of negligence;*
>
> *c) may result in the application of the doctrine of res ipsa loquitur*[15] *in an appropriate case;*
>
> *d) may result in an adverse inference being drawn that the missing records support the plaintiff's case in matters where the defendant produces other contemporary documents that have been altered, contain manufactured data or are otherwise questionable irrespective of whether the evidence of secondary witnesses called in support is found to be unreliable or untruthful."*

[13] 2022 (3) SA 571 (SCA) at para 6, 77 and 78.
[14] 2015 (3) SA 266 (GJ) para 47
[15] 'The nature of the negligence reasonably fits within the bounds of the defendant's duty to the plaintiff.'

[32] The application of the *res ipsa loquitur* maxim does not find application in cases where there is no evidence of what caused the injury and when it occurred.[16] In order for the maxim to find application, it has to be established what went wrong. In the present matter, what went wrong was the plaintiff's uterus was removed. It was removed because of intra-partem bleeding during a caesarean section. What caused the intra-partem bleeding remains a mystery because of the missing medical records to shed light on what occurred during the caesarean section, as well as a complete record of the plaintiff's treatment from entering the clinic until her discharge at the hospital.

[33] The question of onus is of capital importance and according to the general rule, he who asserts must prove negligence on a balance of probabilities.[17] Success of a delictual claim rests with the plaintiff establishing a link with the wrongful act or omission of the defendant caused the injury. Whether an act can be identified as a cause depends on a conclusion drawn from available facts or evidence and relevant probabilities. In cases where the medical records are missing, it becomes impossible for the plaintiff to provide sufficient evidence on a particular aspect, therefore it is suggested that less evidence will suffice to establish a *prima facie* case.[18]

[34] From entering the hospital around 17h00, the plaintiff testified that she was examined by the student doctor at 23h00. The hospital staff failed to attend to the plaintiff as per the referral note from the municipal clinic when they could have done so. There was an inordinate delay in providing medical care to the plaintiff.

[35] The hospital falls into the category of having properly trained and qualified doctors and nurses, medical equipment, 24-hour theatre to conduct caesarean procedures and proper care. It is also a major regional teaching hospital and the reasonable and achievable period from decision to do a cesarean section delivery to the actual delivery should not exceed one hour, according to the evidence of Dr Manthata- Cruywagen. However, the cesarean section was delayed for a further 10

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[16] *HAL obo MML v MEC for Health, Free State* [2022] 1 All SA 28 (SCA) at para 81.
[17] *Van Wyk V Lewis* 1924 Ad 438 at p444.
[18] HAL obo MML v MEC for Health, Free State [2021] JOL 51403 (SCA) at para 135.

hours. It follows therefore that this conduct falls below the standard of reasonable care in this class of hospital.

[36] Once the inference of negligence has been drawn, the defendant may offer an explanation of how the accident occurred. Such an explanation must be reasonable, and not speculative. Ogilvie Thompson JA held in Arthur Bezuidenhout and Mieny that *"the onus rests on the defendant to establish the correctness of his explanation on a balance of probabilities."*[19]

[37] ***The court in Ntsele v MEC for Health, Gauteng Provincial Government***[20] dealt with exceptional circumstances where the plaintiff had established a *prima facie* case of negligence against the MEC's employees, and in turn, the MEC (defendant) had the evidential rebuttal burden to destroy the probability of negligence by giving a reasonable explanation that the child's injury occurred without the negligence of the defendant. The defendant failed to destroy the probability of negligence and the court held that:

> *"Consequently, because the essence of the treatment accorded to the plaintiff on the 7 September 1996 is peculiarly within the knowledge of the defendant's employees, and the defendant has not adduced any direct cogent evidence to discharge the evidential rebuttal burden of probable negligence, the invocation of the maxim res ipsa loquitur in this kind of exceptional case, given the critical missing clinic and hospital records pertaining to the plaintiff's treatment on 7 September 1996, is legally justifiable having regard to the section 27 of the Constitution."* [21]

[38] In evaluating expert evidence the purpose is to determine whether the opinion advanced by the experts are found on logical reasoning and, if so, to what extent. In ***Price Waterhouse Coopers v National Potato Co-operative Ltd***[22], the court held that *"In the process of reasoning the drawing of inferences from the facts must be based on admitted or proven facts and not matters of speculation."*[23] The examination

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[19] *Arthur v Bezuidenhout and Mieny* 1962 (2) SA 566 (A).
[20] 2012 JDR 2044 (GSJ).
[21] Id at para 124.
[22] [2015] 2 All SA 403 (SCA).
[23] Supra 326.

of the opinions and the analysis of their essential reasoning assists the court in reaching its own conclusion on the issue. If the court concludes that the opinion is one that can reasonably be held based on the facts and the chain of reasoning, the threshold will be satisfied.

[39] In this regard, the court in ***Michael & Another v Linksfield Park Clinic (Pty) Ltd & Another***[24] stated that:

> *"The assessment of medical risks and benefits is a matter of clinical judgment which the court would not normally be able to make without expert evidence and it would be wrong to decide a case by simple preference where there are conflicting views on either side, both capable of logical support. Only when opinion cannot be logically supported at all will it fail to provide 'the benchmark by reference to which the defendant's conduct falls to be assessed."*[25]

[40] Dr Manthata- Cruywagen opinion was the maternity guidelines were followed because the plaintiff was not in labour and had to wait for spontaneous labour to occur. Since the plaintiff did not have pains, and uterine contractions did not commence, it was false labour. However, because the water broke, induction for labour should start only between 12 – 24 hours as prescribed in the maternity guideline.

[41] Defendant's expert conceded that the plaintiff had reached full-term of her pregnancy. There was evidence of a yellow vaginal discharge. The lab report confirmed that the yellow discharge was meconium strain grade II. There was already a vaginal examination conducted on the plaintiff at the clinic. The staff member found reason to transfer the plaintiff to the hospital and not proceeded to deliver the baby vaginally at the clinic. This is indicative of serious risk to both mother and child and provides a reason for the caesarean section.

[42] For the reason that there was already a problem, one cannot wait for spontaneous labour to occur and induce labour between 12-24 hours when the

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[24] 2001 (3) SA 1188 (SCA).
[25] at para 39.

pregnancy was full term, the amniotic fluid was draining and where a caesarean section was conclusive. The opinion of the expert in this respect is rejected. The reasonable inference is the plaintiff should not be left unattended for the prolonged period of time without medical care, as it was testified by the plaintiff. Her evidence remained uncontradicted.

[43] Dr Manthata- Cruywagen's opinion was there was a possible mistake or error during the caesarean section that could have led to the hemorrhaging. Dr Pooe's postulation that the prolonged uterine rapture of membranes and the presence of the meconium strain grade II in the uterus could possibly lead to infection and cause for the hemorrhaging. Her concern that the giving of general anesthesia remains unclear. Whereas the routine practice is to administer spinal anesthesia (spinal block or epidural). This may as well be a contributor.

[44] There is no explanation for the hemorrhaging leading to the removing of the plaintiff's uterus. The defendant failed to call any witness, who had knowledge and was in the defendant's employ at the time.[26] Even though an entry in the birth register records at 09h35 the plaintiff's baby was delivered by Dr Mabele and Dr Thobejane. Advancing no reasons for their decisions is unacceptable and fails to discharge the onus placed on the defendant.

[45] When the factual evidence is compared with all opinions of the experts the most plausible inference is that the injury suffered by the plaintiff was due to some mistake or negligence created by the defendant. The piecemeal records do not explain the critical treatment and care of the plaintiff. The hospital records are missing and this onus rests on the defendant to provide the answers. An adverse inference is drawn against the defendant that the missing records support the plaintiff's case. The invocation of the maxim *res ipsa loquitur* finds application as well. The defendant failed to discharge the onus by not providing the cause and there is no explanation for the hemorrhaging leading to the removing of the plaintiff's uterus or led any conclusive literature on this aspect. The probable inference is that there was no justifiable explanation other than a negligent failure to perform the caesarean section without

[26] *Raliphaswa v Mugivhi and others* 2008(4) SA 154 (SCA), where failure to call a witness can have an adverse inference in particular circumstances.

mistake and timeously, despite the meconium discharge and a full-term rapture of membranes.

[46] In ***Castell v De Greef***[27] *the court held that:*

> *"The test remains always whether the practitioner exercised reasonable skill and care or, in other words, whether or not his conduct fell below the standard of a reasonably competent practitioner in his field. If the "error" is one which reasonably competent practitioners might have made, it will not amount to negligence."*

[47] In this respect the onus fell on the defendant to discharge. The defendant based its defence in managing the plaintiff in terms of the maternity guidelines but placed mammoth emphasis on individualizing each patient. Yet failed to show with evidence that no error was made, or its error is one which reasonably competent practitioners might have made that caused the hysterectomy and therefore its conduct will not amount to negligence.

[48] The emergency created included the prolonged time to the caesarean section, the administration of the general anesthetic, or an error or mistake during the in-operative procedure, all of which point to holding the defendant liable of negligence. According to the defendant its justifiable cause is the plaintiff's life was saved by removing her uterus. However, this does not mitigate the mistake or error of its clinicians and staff. For these reasons an adverse inference on the assessment and management of the labour and what transpired during the caesarean procedure is made. The defendant failed to discharge its rebuttal burden of probable negligence.

Failure to provide Rehabilitative therapy

[49] The defendant produced records of the plaintiff's self-discharge. It is common cause that the plaintiff took a self-discharge from the hospital. The plaintiff testified

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[27] 1994 (4) SA 408 (C) A

that she was depressed and was not getting help from the hospital and wanted to go home to be in the care of her family who could also assist her and her baby.

[50] In cross examination it was put to the plaintiff that she lost an opportunity to get rehabilitative therapy by discharging herself. She replied that her remaining at the hospital would not have benefited or helped her in any manner, as they had already damaged her, and she had given her written reasons for her discharge.

[51] Dr Pooe explained that *post partem* depression is an emergency. Professional assistance is urgent because a patient can kill herself or her baby. There are guidelines from the Department of Health relating to post-natal depression and need for care posters that are pasted on the walls in the maternity wards which are a reminder to attend to the patient immediately. No evidence was led about the arrangements that the defendant purportedly made for the plaintiff's therapy as pleaded by the defendant.

[52] The evidence of the plaintiff remains undisputed. In this regard, appropriate and timeous therapy and assistance had to be made available to the plaintiff, considering her emotional state and the difficulties she experienced caring for her baby on her own after being placed in the general ward. Not only her physical well-being but equally important was her emotional and psychological well-being. The maternity guidelines provide for this standard of care that the staff at the hospital failed to provide.

[53] I find that the plaintiff's self-discharge does not exonerate the defendant's failure to provide her with reasons and therapy for the removal of her uterus. Rehabilitative therapy could have been provided in the High Care Unit and especially in the general ward. There is no reason advanced why rehabilitative therapy could not have been provided to her as an out-patient. Her healing from the removal of her uterus was on-going. Further, she returned to the hospital four days later, as an out-patient to have the stitches from the caesarean section removed when once again the opportunity for rehabilitative therapy was present.

[54] In conclusion I find that the plaintiff has established on a balance of probabilities, that the defendant's employees were responsible for the care and

treatment of the plaintiff. They failed to exercise the degree of skill and expertise with which they could have and should have done. The plaintiff was healthy and did not have any concerning condition with her uterus prior to the performance of the cesarean section that would necessitate the removal thereof, but for the negligent conduct of the defendant. The defendant further failed to provide the plaintiff with the necessary support and counselling after the hysterectomy despite her self-discharge.

[55] As a result, the plaintiff has suffered and continues to suffer the loss of amenities of life in that she will never be able to conceive another child in her lifetime. This has physically impaired her, emotionally traumatized her and psychologically affected her wellbeing.

Costs

[56] There is no reason to depart from the principle of costs following the result, as the Plaintiff has succeeded to prove on a balance of probabilities on the evidence that the most probable cause of injury to her was caused by the negligence of the defendant's employees.

[57] **The order is as follows:** -

a) In terms of the provisions of Rule 33(4) the quantum of the claim is separated and is postponed *sine die.*

b) The defendant is ordered to pay 100% of the plaintiff's proven or agreed damages suffered as a result of the injury sustained by the plaintiff.

c) The defendant is ordered to pay the costs of the action including the cost of counsel on scale B.

R. FRANCIS-SUBBIAH
THE JUDGE OF THE HIGH COURT
PRETORIA

APPEARANCES:

Counsel for the Plaintiff:	Adv. K Mhlanga
Instructed by:	Maseda S Attorneys.
Counsel for the Respondent:	Adv. L Kalashe
Instructed by:	The State Attorney
Date of Hearing:	29-30 April - 02,03,09,10 & 31 May 2024
Date of Judgment:	12 June 2024.

The Judgment was handed down electronically by circulation to the parties and or parties' representatives by e-mail and by being uploaded to Caselines. The date for the hand down is deemed to be on **12 June 2024.**