



THE SUPREME COURT OF APPEAL OF SOUTH AFRICA
JUDGMENT

Not Reportable

Case no: 697/2020

In the matter between:

**THE MEMBER OF THE EXECUTIVE
COUNCIL FOR HEALTH AND SOCIAL
DEVELOPMENT, GAUTENG PROVINCE**

APPELLANT

and

MM on behalf of OM

RESPONDENT

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

Coram: WALLIS, MBHA, MBATHA, GORVEN and HUGHES JJA

Heard: 16 August 2021

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Summary: Delict – medical negligence – damages – liability in respect of a minor born with brain damage who now suffers from cerebral palsy – whether hospital staff negligent – if so, whether such negligence caused the damage – negligence and causation established – MEC liable.

ORDER

On appeal from: Gauteng Division of the High Court, Pretoria (Nair AJ sitting as court of first instance):

The appeal is dismissed with costs, including the costs of two counsel, wherever so employed.

JUDGMENT

Gorven JA (Wallis, Mbha, Mbatha and Hughes JJA concurring)

[1] On 7 December 2010, a baby boy (OM) was born to the respondent (Ms M). This had been her first pregnancy. She had presented at the Laudium clinic on 12 July that year when she was 18 weeks pregnant. There she was diagnosed as being HIV positive and was prescribed anti-retroviral therapy. At 02h30 on 7 December, her membranes ruptured and she began to experience severe abdominal pain. At 06h00 she was admitted to the Laudium clinic. At 19h25 she was transferred to Kalafong Hospital (the hospital), a level two hospital at which some 500 to 600 babies are delivered each month. At 20h15, the cervix of Ms M was 7 cm dilated. At 21h15, it was 9 cm dilated, at which point it was directed that she be transferred to a delivery ward. OM was born at 21h50. He suffered a hypoxic ischemic injury during the birth process which resulted in cerebral palsy.

[2] Ms M launched an action in the Gauteng Division of the High Court, Pretoria (the high court), against the appellant in this matter, the Member of the Executive Council for Health and Social Development: Gauteng Province (the MEC). She sued both in her personal capacity and as the mother and guardian of OM. The hospital falls under the MEC who is responsible in law for any injury caused by the negligence of staff employed there. In the action, Ms M alleged that the hospital staff had been negligent during the birth of OM and that this negligence caused the hypoxic ischemic injury and its sequelae. As a result, she claimed damages on her own behalf and on behalf of OM.

[3] Nair AJ, in the high court, dealt initially with issues relating to the liability of the MEC. Although the order was not specific, it is clear that the question of negligence on the part of the staff and, if proved, whether that negligence caused the injury to OM, was to be decided.¹ The high court held that the MEC was liable for the agreed or proved damages caused by the injury. The MEC was granted leave to appeal on a narrow issue by the high court. An application was then made to this Court, which granted leave to appeal against the whole judgment.

[4] What emerged without challenge was that, on admission to the hospital, Ms M was a high risk patient. The known reasons for this were twofold. By then, the ruptured membranes had endured for a prolonged period and she was HIV positive. The latter is a risk factor for hypoxia. It is common ground that both of these signalled the need for careful monitoring, *inter alia*, by way of

¹ This Court has repeatedly lamented the failure of trial courts to make orders specifying precisely which issues are to be dealt with separately and initially. Regrettably, this is yet another instance of such failure. See eg *Denel (Edms) Bpk v Vorster* 2004 (4) SA 481 (SCA) para 3 and *ABSA Bank Ltd v Bernert* 2011 (3) SA 74 (SCA) para 21.

a cardiocograph (CTG). This measures foetal heart patterns. If the foetus is not supplied with sufficient oxygen, abnormal heart rates result. There are various warning signs of impending foetal hypoxic distress. Where these are present, the medical staff need to take action.

[5] It is also common ground that the critical period in this matter is the time between approximately 20h30 and 21h34. It was agreed that the injury probably occurred in the period between 21h34 and 21h50 when OM was born. The trial revolved largely around the correct interpretation of the CTG tracings during the critical period. For this, each party employed experts. The experts differed on some of the interpretations. As a result, they also differed on when any action on the part of the hospital staff was required and whether any actions taken then would have prevented the injury to OM.

[6] As was the case in the high court, the issues before us are twofold. First, whether Ms M proved that hospital staff were negligent. In this context, the test has remained clear:

‘ . . . [I]n 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.’²

Secondly, if so proved, whether that negligence caused or contributed to the injury suffered by OM. Ms M bore the onus of proof on these issues. 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

² *Van Wyk v Lewis* 1924 AD 438 at 444.

frequently apply a scientific level of proof approaching certainty. Courts must guard against adopting this standard.³

[7] All of the experts accepted that the pattern of injury on the Magnetic Resonance Imaging (MRI) scans of OM indicated that the hypoxic ischemic injury was of the acute profound type at full term. Professor van Toorn gave uncontested evidence of the mechanism of damage in the case of an acute profound hypoxic ischemic injury. The foetal brain obtains its oxygen from the placenta. Where the supply of oxygen ceases, an insult to the central grey matter of the brain takes place. Babies can withstand very short periods without oxygen, called insults, by various mechanisms. But when the insults are of a recurrent nature and are continuous, there is a compounding effect. It is this which gives an indication that injury might result. At some stage collapse occurs, causing damage to the central grey matter. This is termed an injury. The key is to take the infant from this unfavourable environment of frequent, persistent insults before the insults result in an injury. In this way,

³ See *Maqubela v S* [2017] ZASCA 137; 2017 (2) SACR 690 (SCA) para 5, where it was said:

‘In *Michael & another v Linksfeld Park Clinic (Pty) Ltd & another* 2001 (3) SA 1188 (SCA) para 40, the important distinction to be drawn between the scientific and judicial measures of proof when assessing expert scientific evidence, was emphasised:

‘Finally, it must be borne in mind that expert scientific witnesses do tend to assess likelihood in terms of scientific certainty. Some of the witnesses in this case had to be diverted from doing so and were invited to express the prospects of an event’s occurrence, as far as they possibly could, in terms of more practical assistance to the forensic assessment of probability, for example, as a greater or lesser than fifty per cent chance and so on. This essential difference between the scientific and the judicial measure of proof was aptly highlighted by the House of Lords in the Scottish case of *Dingley v The Chief Constable, Strathclyde Police* 200 SC (HL) 77 and the warning given at 89D - E that:

‘[O]ne cannot entirely discount the risk that by immersing himself in every detail and by looking deeply into the minds of the experts, a Judge may be seduced into a position where he applies to the expert evidence the standards which the expert himself will apply to the question whether a particular thesis has been proved or disproved – instead of assessing, as a Judge must do, where the balance of probabilities lies on a review of the whole of the evidence.’”

The scientific measure of proof is the ascertainment of scientific certainty, whereas the judicial measure of proof is the assessment of probability.’

the infant can be salvaged. This requires monitoring which can indicate for how long, and how frequently and seriously, insults are occurring.

[8] A joint minute of the two neuro-radiologists agreed that the injury was of the acute profound type:

‘There are no MRI changes to suggest a partial prolonged hypoxic ischemic injury wherein the watershed areas got damaged and this happens over a long time. In this case we only have acute profound damage which usually happens in the 10-40 minutes before birth. The radiologists agree that there was hypoxic ischemic injury that occurred to the brain of the full term infant. According to the radiologists, more than one event took place in the gestational period. The first insult was the infarct on the right temporal lobe followed by the injury which occurred during the birth process being the hypoxic ischemic injury.’

[9] It is as well to deal at the outset with the first mentioned insult. The infarct on the right temporal lobe, commonly called a stroke, probably took place toward the end of the second trimester. None of the experts saw this stroke as having caused the injury on which Ms M sued. Had the stroke caused the damage, the MRI would have looked different.

[10] There were two main elements to the trial. The first related to the interpretation of the CTG tracings. This fuelled the debate as to when any interventions were appropriate and whether such interventions would probably have prevented the injury. An additional, second, matter arose during the trial concerning the histology of Ms M’s placenta. This had been sent for analysis prior to the trial but further analysis was sought by the MEC during the course of the trial by a different expert, Professor Colleen Wright.

[11] This second histological report concluded as follows:

‘Morphologic assessment of the placenta suggests chronic villitis of unknown etiology. . .
...’

Adverse clinical pregnancy outcome corresponds with histologically defined VUE severity (high-grade lesions).’

VUE refers to villitis of unknown etiology. This is associated with the placenta having abnormal blood vessels. The joint minute of the experts concluded:

‘As a consequence of the aforementioned, the placental pathology decreased the baby’s ability to withstand the stress of labour.’

They agreed that this did not cause the injury sued on. It did mean that OM was more vulnerable to being injured than would have been the case of a foetus supplied with oxygen by a placenta without that pathology. Dr Mogashoa, who first suspected placental pathology, supported this conclusion. She agreed that the ‘final insult’, which gave rise to the cerebral palsy, was hypoxic ischaemic in nature.

[12] Counsel submitted that the presence of VUE and the resultant greater vulnerability of OM to stress in labour was unforeseeable. He was correct but it was unclear where that took him. The issue was whether there was proper monitoring of the CTG scans during labour. Assuming in his favour that VUE was a factor in causing OM’s fetal distress, that does not exonerate the nurses for their failure to conduct the monitoring properly. It was not the cause of the foetal distress that mattered but any failure to observe the signs of its presence and take steps to alleviate the stress and accelerate his delivery. The presence of VUE did not alter any of this. In general, in cases of personal injury, the rule is that one takes one’s victim as one finds them as illustrated by the so-

called 'eggshell' skull cases.⁴ The question was not whether there was a predisposition to suffering injury, but whether, even in the absence of knowledge of that predisposition, proper care in the circumstances known to the nursing staff at the time would have avoided the consequences that actually occurred.

[13] The question, then, is whether insults which indicated the need to intervene would have been discernible by reasonable hospital staff during Ms M's labour. The answer to this question depends largely on the interpretation of the CTG tracings during the critical period of 20h30 to 21h32. I say 21h32 because there was consensus that at that time the CTG tracing was pathological. Urgent action was required.

[14] Various expert witnesses led evidence on the CTG tracings. Professor Pattinson, the Clinical Head of the Department of Obstetrics and Gynaecology at the hospital was called by the MEC. Ms M called three experts in this area. Dr Langenegger, a specialist in Obstetrics and Gynaecology as well as a foetal medicine specialist; Professor Anthony, associate professor of the Department of Obstetrics and Gynaecology at the University of Cape Town and head of the Groote Schuur Maternal and Foetal Medicine Unit; and Professor Smith, a neonatologist and professor of neonatology attached to the University of Stellenbosch. Apart from the evidence led in court by these witnesses, certain matters were agreed between various experts.

⁴ *Majiet v Santam Limited* [1997] 4 All SA 555 (C) at 567 A-D.

[15] The nursing experts, neither of whom was called, agreed in their minute that between 20h40 and 20h58 it was expected of the midwife to place Ms M in the left lateral position, check that the CTG probes were making good contact and administer oxygen. It is common cause that none of these steps was taken. In addition, they agreed that: ‘Probable foetal distress was evident from about 20:58.’

[16] Of some importance in this matter is the status of such joint minutes. They recorded areas of agreement and disagreement of the expert witnesses of the parties. A pre-trial meeting agreed that, where there was agreement between two or more expert witnesses, that agreement was binding on the parties. In that regard, this Court has held:

‘Where, as here, the court has directed experts to meet and file joint minutes, and where the experts have done so, the joint minute will correctly be understood as limiting the issues on which evidence is needed. If a litigant for any reason does not wish to be bound by the limitation, fair warning must be given. In the absence of repudiation (ie fair warning), the other litigant is entitled to run the case on the basis that the matters agreed between the experts are not in issue.’⁵

It follows, as a necessary corollary, that where there is no agreement, the minutes must be disregarded. If a party wishes to rely on what a witness records in a minute where there is no agreement, evidence on that point is necessary before it may be taken into account.

[17] It is as well to recap the approach to be taken to expert evidence. Such testimony, in a medical matter, amounts to an opinion on how accepted medical principles apply to the facts. It is admissible where the person

⁵ *Bee v Road Accident Fund* [2018] ZASCA 52; 2018 (4) SA 366 (SCA) para 66.

rendering the opinion is qualified to do so. The opinion must be properly motivated so that the court can arrive at its own view on the issue. Where the opinions of experts differ, the underlying reasoning of the various experts must be weighed by the court so as to choose which, if any, of the opinions to adopt and to what extent. The opinion of an expert does not bind a court. It does no more than assist a court to itself arrive at an informed opinion in an area where it has little or no knowledge due to the specialised field of knowledge bearing on the issues. In this regard, in *Coopers (South Africa) (Pty) Ltd v Deutsche Gesellschaft für Schädlingsbekämpfung MBH*,⁶ this Court held:

‘[A]n expert’s opinion 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.’⁷

With those factors in mind, the expert evidence must be evaluated.

[18] Dr Langenegger explained the basic approach to the monitoring process. This aspect of his evidence was not challenged. The first thing to focus on is the normal foetal heart rate. A normal foetal heart rate is between 110 and 160. The second aspect is baseline variability. The heart rate varies and the average variation is known as a baseline variation. Where the heart

⁶ *Coopers (South Africa) (Pty) Ltd v Deutsche Gesellschaft für Schädlingsbekämpfung MBH* 1976 (3) SA 352 (A) at 371F-G. See also *Oppelt v Head: Health, Department of Health Provincial Administration: Western Cape* [2015] ZACC 33; 2015 (12) BCLR 1471 (CC); 2016 (1) SA 325 (CC) para 36, quoting with approval *Michael and Another v Linksfeld Park Clinic (Pty) Ltd and Another* (1) [2001] ZASCA 12; [2002] 1 All SA 384 (A) paras 34-40; *PriceWaterhouseCoopers Inc and Others v National Potato Co-operative Ltd and Another* [2015] ZASCA 2; [2015] 2 All SA 403 (SCA) paras 97-99.

⁷ Modified to utilise inclusive language. See also *AM and Another v MEC Health, Western Cape* [2020] ZASCA 89; 2021 (3) SA 337 (SCA) para 17.

rate deviates from the baseline variation this tends to show that the foetus has initiated defence mechanisms arising from decreased levels of oxygen. The blood supply is constricted to less important areas and centralised to the more important organs such as the brain. If variability persists it can be a sign that there is a problem. The third aspect is where there are decelerations, which are reductions in the foetal heart rate of more than 15 beats per minute. Delayed decelerations are probably indicative of hypoxia. With prolonged rupture of the membranes, special care is required.

[19] Prof Pattinson testified that there are four stages of labour. This aspect of his evidence was likewise uncontested. The first two have a bearing on this matter. The first stage is divided into a latent phase, from cervical dilatation zero to four centimetres, and an active phase, from four to ten centimetres, which is full dilatation. The second stage is from full dilatation at 10 centimetres to complete delivery of the baby.

[20] In the expert's summary of evidence to be given by Prof Pattinson, it was indicated that he would say:

'Between 20:40 to 21:00 the CTG was suspicious. She delivered at 21:50 after normal second stage. A very short second stage trace shows a heart rate of around 140 with good foetal heart variability and then a fall of the heart rate to about 70 beats per minute for 90 seconds.'

The summary concludes:

'Prof Pattinson will state that he holds the view that the medical practitioners and nursing personnel did what was expected of them and there were no breaches of protocol. Prof Pattinson will in finality conclude that although the minor suffers from sequelae, this could not have been prevented at the Kalafong Hospital.'

[21] It must be said that, as regards the interpretation of the CTG tracings, and whether any action was indicated, Prof Pattinson was an outlier. Most of the other expert witnesses testified that the CTG tracings between 20h40 and 21h00 demanded intervention by the nursing staff and, thereafter, the attending doctor. Far from intervening and monitoring more closely, the CTG was inexplicably disconnected at 21h05 and only reconnected at about 21h30. The effect of all of this is that CTG tracings are only available between 20h30 and 21h05 and again briefly after 21h30. All the experts agreed that the tracing at 21h32, shortly after reconnection, was pathological. Where they differed, accordingly, was on the interpretation of the tracings between 20h30 and 21h05.

[22] Prof Pattinson said that the tracings were not entirely clear. With this, other experts agreed, but testified that they were sufficiently clear for the hospital personnel to detect a clear trend, which should have occasioned concern and action. This was agreed to in the joint nursing minute. Dr Langenegger and Prof Anthony were both called by Ms M. They provided a minute, confirmed during their evidence, which stated:

- ‘(a) At 20h28 the accelerative pattern changes to one in which decelerations develop at 20h28 and 20h33, 20h37 and 20h39;
- (b) At 20h43, the tracing shows a decline in the baseline from 145 beats per minute which persists until a slow return to the baseline at shortly before 20h50. In that 7 minute period fetal heart rate tracing is evident intermittently with all values at least 10 beats per minute below the baseline. This period of tracing has the appearance of a prolonged deceleration lasting for more than 5 minutes.
- (c) At 20h50, the tracing again descends to a nadir of about 60 beats per minute before showing a slow recovery to the baseline at 20h52. Subsequently another 4 similar

episodes are identifiable up to 21h04 with the decelerations at 20h58 and 21h01 being late decelerations.

- (d) The tracing at 21h32 shows a 3 to 4 minute tracing characterised mainly by a single large u-shaped deceleration with loss of variability in the deceleration.’

[23] Prof Pattinson agreed only with item (d) of this minute. His expert summary, responding to this and confirmed by him in court, said:

‘I disagree with these statements. In my view what we see from 20h28 is a woman pushing and in the second stage of labour. This is evidenced by:

1. Rapid progression of the active phase of labour.
2. Evidence of pushing in the middle line of the CTG.
3. Evidence in the notes that the woman had the urge to push.
4. Return to baseline 140 between the contractions and where there was contact.

The trace became suspicious with the slow return to baseline around 20h50.’

[24] He said that Ms M was pushing and that, as a result, ‘we could not get a decent trace’. He also claimed that she was fully dilated or close to fully dilated during that period, even though she was only 7 cm at 20h15 and only 9 cm at 21h15, the second of which falls outside the period concerned. He contended that Ms M ‘was in the equivalent of second stage’. This is not supported by his own evidence that the second stage is only reached when the cervix is 10 cm dilated.

[25] His interpretation that the tracings showed that Ms M was pushing from 20h23 to 21h05 was strongly contested. Ms M testified that she was not doing so. None of the contemporaneous notes recorded this. The only reference at all relevant to pushing was a note at 21h15. This recorded only that Ms M had

the urge to bear down, not even that she was doing so. None of the personnel who attended on Ms M testified.

[26] The other experts were adamant that the tracings did not show maternal pushing. If Ms M had done so prior to the second stage being reached at 10 cm dilatation, she would have been told not to do so. Prof Pattinson did say that if the staff saw that Ms M was pushing, they should at the very least have arranged for a vaginal examination. This was not done. He agreed that if it was not the correct time to push the staff should have told her not to do so.

[27] He interpreted the notes to the effect that at 21h15 Dr Kayzer examined Ms M, who was 9 cm dilated. Dr Kayzer did not testify. Prof Pattinson said that Dr Kayzer noted of Ms M that: 'She must go for delivery because she was pushing, and that was quite correct.' It was pointed out to Prof Pattinson that the entry by Dr Kayzer recorded only that Ms M had reported 'the urge to bear down'. His response was that this meant that 'she wants to push down and she probably has been pushing down.' He was then constrained to agree that doctors are taught to record exactly what occurs. It was put to him that, if Ms M had been pushing, this would have been noted. His response was to say that there are a number of beds in the area and Dr Kayzer was probably in another room. He was brought back to the entry and again said that his 'interpretation of her saying "reports the urge to bear down" is that she wants to push and probably has been pushing.' He finally and reluctantly accepted that this was not what Dr Kayzer had written.

[28] He was then pressed on his having testified that, by 21h15, Ms M had been pushing for 53 minutes. His evidence in court was that the CTG showed

that she first pushed at 20h23. However, in his response to the joint minute, he said that the first push discernible from the CTG tracings was at 20h28. He said in his response to the joint minute that this was shown on the middle line of the tracing but his evidence in court was that it was shown in the contraction line. What was put on his behalf to Dr Langenegger was that he would say that once contractions begin, the tracing shows maternal movement but he later testified that it was a mixture of maternal and foetal movement.

[29] There are other difficulties with his evidence. He was asked why the CTG was disconnected at 21h05 and only reconnected at 21h32. Despite his not having been present at the time, and only interpreting the hospital records, he proffered that it takes time to be transferred to a labour ward. He said of that time that, although there were ‘some suspicious aspects . . . there were reassuring features of heart returning to baseline. So I do not think there was urgency, an excessive urgency, except she was pushing in the second stage. And it, the CTG has to be disconnected.’ As indicated above, Ms M was not in the second stage, according to his own evidence. And the transfer instruction was only given at 21h15, so this, too, was surmise on his part. There was no factual underpinning for either of these aspects of his testimony.

[30] In evidence, he said that the tracing first became suspicious at 20h58. After being taken through the tracing, he conceded that, also at that time, there was ‘a single late deceleration’. He was confronted with his report, where he had said that between ‘20:40 to 21:00 the CTG was suspicious’. He then conceded in evidence that the report was correct and his earlier evidence that the first suspicious trace was at 20h58 was incorrect. When confronted with the fact that he differed from the MEC’s own nursing expert and all of Ms

M's experts that there was probable foetal distress at 20h58, he said he differed because he considered that all of the traces they referred to were second stage traces, where Ms M was pushing. This aspect of his evidence has already been dealt with.

[31] He, alone, testified that he did not accept that an acute profound hypoxic ischemic injury led to the cerebral palsy. That is a position in conflict with the other witnesses called by the MEC and the MEC's concession in this regard. The experts called by Ms M on this issue gave detailed, coherent, and carefully reasoned evidence that led to their opinions, which accorded with all of the known facts.

[32] For all of the reasons mentioned above, the evidence of Prof Pattinson as to when the tracings became suspicious and when action should have been taken must be rejected where it conflicts with that of the agreed nursing minute and Ms M's experts. All of these agreed that, at the very latest by 20h58, action would have been taken by nursing staff with the level of skills and training functioning in a level two hospital. That action would have been to call a doctor. The reasonable doctor in that context would have closely monitored Ms M and, within ten minutes or so, have begun expedited delivery, which could have been achieved in the fifteen or twenty minutes after 20h15. None of these steps was taken. This leads to the conclusion that Ms M proved, on a balance of probabilities, that the hospital personnel were negligent.

[33] All of the expert witnesses agreed that the injury to OM did not occur before 21h34. It took place between then and his delivery at 21h50.

Dr Mogashoa testified that once there is a sustained bradycardia, which is a slowing of the foetal heart rate, one should deliver a baby within 10 to 17 minutes. That is the length of time that a baby can compensate for asphyxia.

[34] If the actions referred to above had been taken, accordingly, the damage would in all probability have been avoided. This means that the damage to OM probably occurred as a consequence of the negligence of the hospital staff. As a result, Ms M proved on a balance of probabilities that the negligence of the hospital employees caused or contributed to the injury and *sequelae* to OM.

[35] All of this means that the finding of the high court that the MEC was liable for the injury sustained by OM during his birth process cannot be faulted. As a result, the appeal must be dismissed. It was conceded that, in those circumstances, the costs of two counsel, where utilised, would be an appropriate costs award. I agree.

[36] In the result, the following order issues:

The appeal is dismissed with costs, including the costs of two counsel, wherever so employed.

T R GORVEN
JUDGE OF APPEAL

Appearances

For appellant: S Joubert SC
Instructed by: State Attorney, Pretoria
State Attorney, Bloemfontein.

For respondent: J J Wessels SC (with him C Vallaro)
Instructed by: Munro, Flowers and Vermaak, Johannesburg
Claude Reid Attorneys, Bloemfontein.