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

CASE NO: 114/2014

NOT REPORTABLE

In the matter between

ZIMBINI MPETSHENI OBO LUYANDA **Plaintiff**

and

THE MEMBER OF THE EXECUTIVE COUNCIL
FOR HEALTH, EASTERN CAPE **Defendant**

JUDGMENT

HARTLE J

[1] The plaintiff claims damages in an action issued out of this court on 3 March 2014.

[2] She sues in her personal and representative capacity as the mother and natural guardian of her minor son, Luyanda ("the child"), who was born on 3 December 2005 at the Madwaleni Hospital ("the hospital"). [1] Her claim is based on the alleged negligence of the medical and/or nursing staff at the hospital during her labour and delivery of the child.

[1] A special plea that the Plaintiff's claim in her personal capacity had prescribed was abandoned at the trial.

[3] The original premise for the hospital staff's negligence is that the plaintiff's labour was unnecessarily prolonged and that they failed to perform, alternatively to timeously perform a caesarean section to deliver the child who suffered a hypoxic-ischemic incident due to perinatal asphyxia ("the complication"). This in turn had caused him to sustain severe brain damage ("the injury") as a result of which he suffers *inter alia* from cerebral palsy ("the sequela").

[4] The further grounds of negligence alleged in the plaintiff's particulars of claim (all denied) are that the defendant, through her servants acting vicariously:

4.1 failed timeously, and/or at all, to render appropriate and proper medical care to her and the child;

4.2 failed to permanently, alternatively, temporarily, employ the services of suitably qualified and experienced medical practitioners who would be available and able to examine, manage and/or give appropriate advice in respect of her labour and to perform a caesarean section if and when required at the hospital;

4.3 failed to permanently, alternatively, temporarily, employ the services of suitably qualified and experienced nursing staff, who would be able to assess, monitor and/or manage her labour;

4.4 failed to take any action and/or reasonably required steps to ensure proper, timeous and professional assessment of her, her monitoring and management of labour and assistance at the birth process;

4.5 failed to implement such steps as could and would reasonably be required to prevent the occurrence of the complication; and

4.6 failed to avoid the complication when, by the exercise of reasonable care and diligence, she could and should have done so.

[5] On 29 July 2014, and under pain of bar, the defendant filed a plea denying that any of the hospital's staff acted negligently and pleading nescience regarding the allegation that the child suffers from cerebral palsy, mental retardation and epilepsy. Also pertinently disavowed are the allegations of a prolonged labour or the alleged (or any) complication. A causal link between the supposed negligence on the part of the hospital staff and the injury was also firmly placed in contention.

[6] The plaintiff's pleadings were amended during the trial (which commenced in May 2018) to broaden the scope of the alleged negligence to include the defendant's failure to perform, alternatively to timeously perform, an appropriate intervention to deliver the child or to prevent the hypoxic-ischemic event due to perinatal asphyxia, but confining the period in contention to the plaintiff's prolonged labour at "the second stage of the active phase" thereof.[2]

[7] The amendment was not objected to, the defendant's plea of a bare denial abiding, albeit it had been conceded by the defendant by then, only on the second day of trial and quite co-incidentally, that the injury was a hypoxic-ischemic one which was sustained in the intrapartum phase which led to significant brain damage causing cerebral palsy.[3]

[8] This concession was a significant one because on 26 August 2016, when the parties held their pre-trial conference, the defendant was not at all amenable to admitting that the child was asphyxiated during the plaintiff's delivery or that he presently suffers from cerebral palsy. The defendant was not even prepared to admit that Luyanda was diagnosed with HIE[4] Grade II although this diagnosis, made by hospital staff, appears quite plainly from pediatric notes maintained by the hospital regarding the treatment of him after his birth (albeit the entry is dated 18 September 2006 and was made contemporaneously with his later admission to the hospital for the management of this sequela). The plaintiff's attorneys had made the latter document available to the defendant's attorneys pursuant to the provisions of Rule 35 (14) of the Uniform Rules of Court before the defendant's plea was delivered. The small bundle made available by the plaintiff's attorneys included a Road to Health Chart, a clinic card or "passport" of sorts, which is carried by the mother after the birth of the child to record the baby's birth information and

---

[2] The plaintiff's case is that this period commenced at about 16h00 on the day in question. The second stage of labour commences after the cervix is dilated to 10cm and continues until deliver.

[3] Whilst Mr. Brown was leading the plaintiff and eliciting the necessary evidence to deal with the issue of the child's cerebral palsy, which is denied on the pleadings, Mr. De Bruyn rose to place on record that the defendant does not deny that the child has cerebral palsy or that he suffered a hypoxic ischemic event intrapartum. This led to an abrupt conclusion of the plaintiff's evidence in chief.

[4] This is the acronym for Hypoxic ischemic encephalopathy and refers to a brain injury caused by lack of oxygen (hypoxia) and/or a lack of blood flow (ischaemia) in the brain.

development as well as vaccination plan and follow ups for growth measurements etc. In it, under the "Health Worker Consultation Sheet" section, an entry appears (ostensibly made by a staff member of the hospital) on 15 December 2005, coinciding with the plaintiff and the child's discharge after his birth, recording as early as then that the child had "progressed (from severe low Apgars of 2-5 at his birth) to HIE grade 2"; the indicators for such finding; that HIE was the formal assessment made; and concluding with the relevant plan towards this end.

[9] It also transpired from an affidavit deposed to by Mr. Sabelo Mgujulwa, the attorney to whom the file was allocated by the State Attorney representing the defendant, made in support of an application to postpone the trial at its commencement, that the first of the documents referred to above had been provided to the Defendant's legal advisor as early as April 2014 under cover of a letter addressed to the hospital CEO, Mrs. Kopeshe, by the Area Manager Maternity, Mrs. Dangazele, in pursuit of the State Attorney's request to make the necessary medical records available to their office so that they could consult and draft the defendant's plea. In my view it is a fair assumption to make that the diagnosis of HIE Grade II was known to the defendant when she pleaded, at least from the documentation made available by the plaintiff's attorneys in time before the plea was delivered. It is also relevant to mention that Mr. Mgujulwa claims to have continued to impress upon the defendant's legal advisor that he should follow up with regard to the outstanding hospital records even after delivery of the plea so that he could "amend (it) based on the information available from the (elusive) records', but the defendant failed to get to grips with the damage causing incident until the trial was well upon her and the late concession of a hypoxic-ischemic injury sustained during the birth process leading to significant brain damage was ultimately made under the circumstances referred to above.

[10] An as an important aside, it is necessary to deal with the absence of the hospital's records relating to the plaintiff's confinement and birth of the child. In the letter to the hospital's CEO, which is dated 9 April 2014, the Area Maternity Manager explains the absence of these as follows:

"According to the unit records (delivery register), on the 3rd December 2005, Miss. Zimbini Mpetsheni, 18 years, IP No. 2743/05, gave birth to a male infant, apgar score was 2/10 in 1 minute to 7/10 in five minutes, birth mass 3230gms. Mode of delivery was normal vertex delivery. Labour was conducted by registered midwife Ngoloma B.G.

After five years of shelf life due to space limitation, I decided to remove the patient files of up to the year 2005 from the unit to a place called Cellar, underneath General ward. The Hospital does not have a formal, Archive structure. I have tried to look for the file in Cellar as requested but only found 10 files out of which 08 were deliveries, that of Zimbini Mpetsheni is not amongst those." (Sic)

[11] The birth records never came to the fore at the trial, not even the delivery register from which Mrs. Dangazele's information must have been sourced.[5] Mr. Mgujulwa explained in his affidavit that on the advice of counsel he had asked for the source document at least (he attached a copy of a letter addressed to the hospital dated 9 March 2015 to vouch for this), but that this had failed to yield any positive outcome and that Mrs. Dangazele herself had since retired, leaving nobody to assist him.

[12] Rather surprisingly, given the discrepancy with the second Apgar score in five minutes referred to by Mrs. Dangazele in her synopsis of the plaintiff's admission to and treatment administered in her ward as being 7/10 whereas it appears openly from the pediatric notes and the plaintiff's Road to Health Clinic Card that this score

[5] At the very least a Delivery Register exists in which the essential fact that there was a normal vertex delivery must appear as well as the other facts reported by the Area Manager in her letter to the hospital's CEO. Why it was ultimately not discovered boggles the mind. Although the single midwife is named, it is not apparent that she (neither any of the other staff members on duty at the time) assisted in any kind of reconstruction of the maternity unit's records. I imagine that it would have been useful to consult the paediatric unit head as well in order to glean if the file might not have been transferred with the child for treatment of his HIE, but that objective seems not to have been considered or pursued on behalf of the defendant. Little imagination appears to have gone into the pursuit of the elusive records and those involved, and responsible, seem to have been let off the hook way too easily.

remained low in five minutes at 5, consistent with an assessment of HIE Grade II,[6] the plaintiff entered into an agreement with the defendant regarding the missing records in respect of which she has indicated her "acceptance" that they could not be found as well as the explanation given by the defendant with regard to their pursuit "as set out by (Mr. Mgujulwa on the defendant's behalf) in the application for postponement."[7] In the agreement she alleges no *mala fides* on the part of the defendant and concurs that it is unnecessary for her to call the relevant witnesses with regard thereto.

[13] The absence of the hospital records was a most unfortunate situation and is becoming an all too regular feature of similar actions against the defendant in this court, leaving much to conjecture and speculation to the great disadvantage of the plaintiff litigant in my view. Mr. Brown who together with Ms. Mduba appeared for the plaintiff urged upon me to make an adverse costs order to indicate the disapproval of this court and to put a halt to the common refrain by the responsible custodians of records of the provincial departments of health that these have been destroyed despite a statutory prohibition on such destruction of these records, but the adverse costs order which I issued when I refused the defendant's application for a postponement on the first day of trial was in part to ameliorate this anomaly already.

[14] The defendant was also tardy in making discovery, doing so only after the plaintiff had launched an application to compel same. The schedule to the only discovery affidavit filed on her behalf reveals however that all that she discovered, additional to the usual pleadings and notices in the action, were the same notes from

---

[6] Dr Gericke, specialist paediatrician, whose report was accepted into evidence by consent, commented on this discrepant score of 7/10 relayed by Mrs. Dangazele asking: "Was this a subsequent alteration of the original record on (the child's) Road to Health Chart?" In my view this concern was validly expressed as the import of the Delivery register's contents as conveyed by Mrs. Dangazele is of an uncomplicated birth with no sequela.

[7] In giving reasons for dismissing the defendant's request for a postponement of the trial I expressed the view that the affidavit filed in support of the application did a dismal job of trying to justify the need for a postponement (based on the absence of the medical records) or to explain convincingly what steps had or would be taken to try and find them. I also criticised the hospital's responsible custodians of these records for their failure to confirm their involvement in trying to locate them or expressing their support that an extension would be of any benefit in the circumstances. The lacklustre attempt at addressing *this* conundrum more than any other was however probably due to the fact that the real reason behind the application was that the defendant's preferred lead counsel was not available on the allocated date of hearing and this put her in a jam.

the maternity unit of the hospital, which do not take the matter any further. Even absent anything of substance to discover however, the defendant appears to have little appreciation of the vital role she is expected to meet in defending medical malpractice suits in a manner that is both respectful to the court and its rules and mindful of the limited resources of the State. This disrespect does not end there but continued throughout the pre-trial processes as I demonstrate below.

[15] At the time of the parties' initial case management conference the plaintiff had served and filed expert notices and/or reports *inter alia* in respect of Dr Phil Pretorius (Radiologist), Dr Diar (pediatrician), and Dr Burgin (Obstetrician and Gynecologist) on the issue of liability, and a battery of others relating to the quantum of her claim. The defendant had given notice to call certain experts of her own, including Dr Yatish Kara (Pediatrician), but had not filed any reports.[8] The plaintiff had apparently also attended certain examinations conducted at the defendant's behest, which reports were outstanding as at the time of the initial conference.

[16] In any event at both the pre-trial conference and in the draft case management order that was put forward by the parties for the case management judge to make an order of court, the agreement was that an arrangement would be made for joint minutes to be filed once the defendant had served and filed her expert reports. (Ironically Mr. Mgujulwa in his affidavit filed in support of the postponement application motivated that the main reason for pursuing the relief sought in that interlocutory application, was "in order to allow (rather belatedly in my view) the legal team to fully prepare for the matter and to engage with the necessary experts to assess (the child) and for them (experts) to prepare written opinions as part of the evidence before this court.". Mr. Ngadlela, who argued the application for a postponement on behalf of the defendant, also assured me that the purpose and intention of the relief sought, if granted, would, *inter alia,* be to enable her to obtain

[8] It emerged from Mr. Mgujulwa's affidavit filed in the postponement application, in a bid by the defendant to justify that he had been unable to meaningfully engage with his experts in the absence of medical records, that although Dr Kara had assessed the child on 25 June 2015, he was writing to the State attorney on 17 May 2018 only, days before the trial was due to commence, to report that he "could not proceed with a report as there were no medical records." One looks in vain in the case management papers for any indication that the defendant's attorneys communicated with the plaintiff's representatives to explain what the problems were with the filing of any of their anticipated expert reports.

an expert report and to allow for a joint minute to come from the corresponding experts, a goal evidently not shared by Mr. de Bruyn with whom he appeared from the second day of the trial, as I will shortly explain.)

[17] After the initial case management conference, the plaintiff filed a further report of Dr Gericke,[9] a Specialist Paediatrician and Geneticist, which ultimately formed part of the evidence given before me.[10] Central to his findings was the report of Dr Pretorius, a Radiologist, evidently commissioned as early as 1 July 2014 already, but which only came to the fore in August 2016.[11]

[18] It is necessary to repeat Dr Pretorius' findings, which were also ultimately accepted into evidence:[12]

> "Findings:
> The following abnormalities were noted:
> - Subtle T2 hyperintensity of the cortex and adjacent deep white matter in the left precentral gyral region, with subtle underlying deep white matter hyperintensity. There is also some subtle deep white matter hyperintensity just deep to the right precentral gyral region.

[9] The summary of his opinions was served on the defendant's attorneys on 12 July 2017. His report is dated a day earlier.
[10] The concession by the defendant that this report could go in as evidence was only made on the second day of trial.
[11] I could not find the notice in terms of Rule 36 (9) (a) in respect of Dr Pretorius in the court file, but the first indication of his MRI report or reference thereto appears from the parties' minute of their pre-trial conference held on 26 August 2016. The minute records in par 1.1 thereof that the plaintiff has provided the defendant with a notice in terms of Rule 36(9)(a) and (b) of Dr Pretorius a radiologist, an expert she intended to call at the trial. This may explain why when Prof Buchmann penned his first report dated 11 May 2016 there is no reference to Dr Pretorius' original findings at all. It was however never explained by counsel how the report, dated in 2014 already, come to light. The fact that it is addressed to the medical officer is perhaps an indication that it was ordered in a hospital context (perhaps because in 2014 the child was having seizures), but it does postdate the issue of the action. Nothing turns on my musings I suppose since the plaintiff put the weight of her case behind his findings and gave early notice to the defendant of her intention in this regard. It was of course open to the defendant, immediately she did so, to seek whatever amplification or clarification thereof as was necessary in the circumstances, a consideration that ostensibly only occurred to the defendant on the third day of trial.
[12] The parties agreed on 3 December 2018 that Dr Pretorius' original report dated 1 July 2014, and an addendum thereto (dated 31 May 2018), which records his conclusion that a magnetic resonance image (MRI) taken of the child's brain is consistent with an acute profound hypoxic ischemic event that occurred intrapartum, could go in as evidence.

- Two oblique linear intensities in the basal ganglia, bilaterally, slightly more prominent on the left, with a small focal hyperintensity of the posterior margin of the basal ganglia bilaterally.
- Subtle bilateral peritrigonal deep white matter hyper-intensities in the posterior parietal lobes, with slight thinning of the white matter in the occipital lobes bilaterally.
- There is a single focal blooming hyperintensity in the right temporal lobe at the grey/white interphase. This could be due to a small calcification, focus of old healed blood products may cause a similar appearance.

No other significant focal or diffuse areas of abnormal signal intensity, mass lesion, areas of restricted diffusion is seen within the grey/white matter in the rest of the cerebral, in the cerebellar hemispheres or the brain stem.

The development of the brain is normal, with normal myelination.

The pituitary gland and fossa, CCJ, IAM's, flow voids within major intracranial vascular structures and paranasal sinuses were normal.

<u>Comment</u>:

The deep white matter, cortical and thalamic changes described above would (be) ***consistent with a perinatal hypoxic ischemic injury.***[13]

The small focus calcification or the old blood product in the right temporal lobe, is of uncertain origin."

[19] Dr. Gericke in his report highlighted the important question to be asked from the radiology experts (which also ultimately formed the essential focus of the trial) namely:

> "whether this (referring to what Dr Pretorius had observed on the MRI), in main complies with an "acute profound" type of injury with features of a "partial prolonged" injury as well, i.e. a mixed injury pattern.

[13] This comment ostensibly influenced Dr Burgin to conclude in his very terse report dated 6 November 2014 that "(o)ne must assume that a period of anoxia occurred" which "gave rise to the brain damage, resulting in CEREBRAL PALSY."

[20] It is not clear that Dr Gericke formed a firm view in this respect. He appeared to accept however that the small focal calcification was probably attributable to haemorrhagic transformation of the ischemic injury, and explains in this respect that the temporal lobe, where this old blood product was noticed, is the most common neonatal haemorrhagic stroke to localization.

[21] He explains why the type of injury exhibited on the neuroimage is important to typify and how it is identified:

> "These distinctions assist with estimating the duration of and determining the causal contribution to the insult to the fetal brain before delivery.
> All the features observed with neuroimaging can, therefore, in general, be linked with an asphyxic insult resulting in hypoxic ischemic encephalopathy. Specifically this excludes other prenatal causes of a cause different from intrapartum asphyxia in this instance.
> When the baby suffers severe or total hypoxia/asphyxia, the insult is called acute/profound or profound (near total asphyxia). With very severe insults, there will usually be a central pattern of focal neuronal injury (deep gray nuclei injury) to many levels of the central nervous system, with diffuse and pronounced neuronal necrosis. When the insult is relatively abrupt and severe, there will be injury to the deep nuclear structures, such as the basal ganglia, thalamus and brain stem, because total asphyxia prevents the adaptive mechanism of shunting. Thus the cerebral cortex will typically be spared from injury. Placental abruption, uterine rupture, prolapsed umbilical cord and terminal bradycardia (slow heart rate) are examples of conditions that can cause acute profound asphyxia, and are usually recognizable as "sentinel" events in cases where regular pre-delivery fetal monitoring has occurred.
> When a baby suffers an insult in which the oxygen deprivation/ischemia is moderate to severe and relatively prolonged, there is a cerebral deep nuclear pattern (injury to deep parts of the brain), and there might be at least some degree of shunting. These types of insults usually cause damage to the cerebral cortex and deep nuclear structures, especially the putamen and thalamus."

[22] He ruled out the possibility of any underlying pre-existing predisposition to birth asphyxia in the case of the child and observed that acute intrapartum asphyxia remains the primary recognizable cause of neonatal encephalopathic HIE findings on MRI neuroimaging clinically associated with a spastic cerebral palsy outcome.

[23] Despite the fact that in this instance an examination of the plaintiff's placenta appeared not to have been undertaken so as to confirm with the benefit of pathology what exactly caused the birth asphyxia, he was confident to assert in conclusion at least that:

> "There are no congenital/genetic factors ascertainable with the current information which predisposed baby LM to a birth injury.

[24] He suggested the further steps to be taken and the vital documentation to be reviewed in order to determine whether there had been substandard obstetric management in the events leading up to the cerebral palsy outcome and if this might have been causal to the birth asphyxia:

> "In order to reconstruct a chain of events from the moment LM's pregnant mother arrived in hospital, leading to a cerebral palsy outcome and whether, or not, there had been substandard obstetric management, the full hospital records and detailed notes and opinion of the obstetric expert based on comprehensive factual information will have to be obtained. During litigation procedures, ideally it is necessary to have access to a readable CTG, a well-documented partogram, a complete analysis of umbilical cord gasses, placental pathology investigations and an intensive clinical workup of the newborn. Absence of the data wastes valuable court time due to cross-questioning related to debating fundamental and sometimes peripheral aspects of birth asphyxiation, as well as the likelihood of unrelated causes when the basic information underlying any assumption remains nebulous." [14]

[14] This observation turned out to be quite a portent in the present instance.

[25] Absent the birth and neonatal records, Dr Gericke had been furnished with a brief narrative of key events concerning the plaintiff's labour and delivery, evidently not by the plaintiff herself but by Mrs. Nondiwele Mpethsheni who had accompanied the child to his rooms in Johannesburg for purposes of consulting with him. I assume (from the context of his report) that this is the plaintiff's mother or perhaps a sister. He noted further that although communication had been conducted via an interpreter at the examination, it was "somewhat difficult". He would also have looked in vain to Dr Burgin's report (one of the reference documents made available to him) for any narrative because the details furnished to him too were very sketchy. It is not clear from the latter's report incidentally from whom *he* obtained the very brief history indicated therein. This has some bearing on the premise the obstetric experts who ultimately testified at the trial relied upon, as will appear below.

[26] I digress to deal with the management of the litigation. By 10 May 2017 already the plaintiff's attorneys had declared that the matter was trial ready and had filed a certificate in compliance with a general case management directive dated 13 October 2016, issued by the deputy Judge President. The plaintiff was ready to proceed on both liability and quantum, but an order was issued by Van Zyl DJP on 9 November 2017 separating liability and quantum and directing that the registrar allocate a trial date in the second term of 2018. Importantly the following further aspects were recorded by Van Zyl DJP in his directive:

> "1. The plaintiff is ready to proceed to trial.
> 2. The plaintiff has filed all expert reports with regard to the issue of liability.
> 3. The defendant has failed to comply with the directive to file his expert reports by the end of October 2017.
> 4. No reason has been provided for the aforementioned failure."

[27] The earlier case management directive, dated 22 September 2017, confirms that Van Zyl DJP directed the defendant to file her expert reports by the end of October 2017. No explanation was ever forthcoming for the defendant's failure to comply with such injunction.

[28] The matter was duly enrolled for hearing on 22 May 2018 by which date the defendant had still not filed any expert reports. Despite lengthy notice of the trial date and the defendant being aware of her so-called predicament concerning the absence of medical records and the unavailability of her preferred senior counsel for the trial, she delayed until the first day of trial to bring an application for a postponement of the trial. I refused the request for an extension and directed her to pay costs on the scale of attorney and client. The trial commenced before me with the plaintiff's testimony being given on the first day. When the matter stood down to the following morning, Mr. de Bruyn made a late appearance to conduct the defendant's defence and lead Mr. Ngadlela.

[29] On the morning of the third day of the trial after the plaintiff's testimony had already been adduced, and the parties only now paying heed to Dr Gericke's suggestion that it was necessary that the MRI images be reviewed, counsel approached me in chambers and informed me that they required the action to be postponed, by agreement, pending such investigation. I reluctantly issued such an order and directed that the costs were to be costs in the cause.[15]

[30] On 31 May 2018 Dr Pretorius provided an addendum to his report which reads in simple terms (without any reasons for his supplemented finding) that:

> "Review of the images would indicate that the incident would have been a profound hypoxic ischemic event during the perinatal period in a near to term fetus or infant."

[31] This supplement was filed of record by the plaintiff on 15 June 2018.

---

[15] I had noted in my reasons for refusing the postponement the immense prejudice to the plaintiff and the child by granting the defendant the indulgence sought by her to look for records, employ experts out of time and to enable her to retain the counsel of her choice. I further remarked that I would be failing in my duty both to look out for the best interests of the child and to promote the effective, efficient and speedy finalisation of the matter if I were I to grant the postponement. Although the plaintiff aligned herself with the present continuance sought, the defendant was in my view being opportunistic and creating a space to do and consider what she ought to have much earlier during the pretrial processes.

[32] On 9 November 2018 the plaintiff filed a notice of withdrawal of her notice in terms of rule 36(9)(a) in respect of Dr S Burgin who had been on standby to testify in the first few days of the hearing. A few days later both the plaintiff and the defendant filed notices in terms of rule 36(9)(a) and (b) in respect of Dr C Ndjapa-Ndamkou and Professor EJ Buchmann respectively, both obstetricians and gynecologists.

[33] Dr Njapa-Ndamkou heralded by his summary, without any pertinent focus on the supplemented findings of Dr Pretorius, that he would, against the background of his experience and knowledge in managing obstetric patients in labour with the aim of preventing perinatal mortality and morbidity, and based on a narrative furnished to him by the plaintiff and the limited medical record which he had at his disposal, explain why he thought the treatment and care of the plaintiff fell below par, and how that fact, coupled with the inappropriate use of fundal pressure to the plaintiff's abdomen to deliver the child vaginally may have resulted in the HIE in the circumstances.

[34] Interestingly, what was filed by the defendant in respect of Prof Buchmann, under cover of the notice in terms of rule 36(9)(b), was a "supplementary expert report" dated 7 October 2018. It came to light during the latter's testimony that he had prepared an initial report dated 11 May 2016 already. The plaintiff had not been privy to the contents of this report neither does it appear from the court file than an earlier notice in terms of Rule 36(9)(a) was delivered by the defendant in respect of an anticipated summary to be provided by Prof Buchmann, until in November 2017.

[35] Whilst the conclusion in Prof Buchmann's earlier report advocates that there are many possible explanations for a baby suffering a hypoxic ischemic injury around the time of labour and delivery even in the absence of any substandard care (which he was careful to note could not be excluded), he professed to be unable to confidently assert, in the absence of any clinical notes, that an adverse event in labour (as opposed to any other moment straddling pregnancy to birth) had been causal to the injury. He deferred to the paediatric and radiology experts to suggest a possible cause and timing for the child's injury. He observed that there was no evidence of any sentinel events during the labour but was again astute not to assert the contrary view that their presence could not be excluded. In his view and based

on the limited allegations made in the plaintiff's particulars of claim - it appears that this pleading and the plaintiff's Road to Health Card were his only points of reference, he was of the view that her labour (maximum 17 hours) was in the normal range and therefore not prolonged. He conceded that the pleaded need for the induction of the plaintiff's labour (an allegation in the particulars of claim that appears to have been a mistake and not confirmed in the evidence) might have been a reason or risk factor on admission. More critically, and although not in the loop concerning the exact details of the plaintiff's labour, he pointed to the number of conditions that are difficult to recognize and treat appropriately, regardless of the presence of any substandard care. Finally, he expressed the view that studies on cerebral palsy and caesarians have found that caesarian section is not associated with the reduction in incidence of cerebral palsy especially since the appropriate management, if it is a caesarian section, may not be immediately available, at least not within 20 to 30 minutes.

[36] His later report confirms that he had now had insight into the reports of Drs Gericke, Burgin and Pretorius (including the supplementation so it appears), the hospital statement of Mrs. Dangazele (which as I have indicated above is misleading regarding the actual Apgar score of the child in five minutes) and the court transcripts of the plaintiff's evidence given over the course of the first two days of trial. (This evidence would, for obvious reasons, not have covered the import of Dr Pretorius' supplemented finding.) It is not clear that he had regard to Dr Njapa-Ndamkou's report in compiling his however because, although mentioning the plaintiff's statement that the two nurses who had assisted her at birth had "applied some pressure to the upper part of her abdomen", he does not deal with the allegation of the inappropriate fundal pressure being causal to the injury at all.

[37] Be that as it may his summary (later endorsed in his evidence) heralded that he would, despite his previous deference to the paediatric and radiology experts to suggest a possible cause and timing for the injury, now venture his own firm opinion. He claimed that the reports of the specialists made available to him had assisted him in trying to identify the cause for the cerebral palsy and timing of the causative event. He now, with confidence, asserted that he would ascribe it to a sentinel event, the most probable cause being an umbilical cord accident (compression) which had

occurred in the last thirty minutes before delivery. As such, as is the case with acute profound events in low-risk situations, the damage causing event would have been unforeseeable, of rapid onset and with no warning. He agrees that there appears to have been substandard foetal heart rate assessment throughout the plaintiff's labour but was inclined of the view that even optimal half-hourly monitoring, with identification of the acute profound event, would not have allowed an effective response to prevent the injury.

[38] The nub of his report concerns his explanation why Dr Pretorius' finding of an acute event puts paid to the theory that substandard care on the part of the hospital staff increased the risk of the child suffering the injury, and indeed why the latter's finding is, in the first place, justified in relation to the neuroimaging:

> "2.1.2 **Intrapartum causation**
>
> The child's MRI brain scan shows evidence of a profound (also known as 'acute profound") hypoxic (lack of oxygen) ischaemic (lack of blood flow) brain injury This affects the deep grey matter (basal ganglia and thalamus) and also the associated deep white matter and perirolandic (precentral) gyri of the cerebral cortex. Dr Gericke's report suggests that the injury occurred before birth and during labour. If so, such an injury would have been of severe grade (total or near-total asphyxia) and of short duration (10-25 minutes). In addition, it would have been of sudden onset and not (have) been preceded by a deteriorating (warning) fetal heart rate pattern. Most cases of acute profound brain injury in surviving infants have their onset less than 30 minutes before delivery, showing as a sudden and unremitting drop in fetal heart range from the normal range (110-160/minute) to below 80/minute. This is the nature of intrapartum acute profound brain injury. The other classic injury pattern related to intrapartum hypoxic ischaemic brain injury is 'prolonged partial', which affects the cerebral cortex and subjacent white matter, particularly in the watershed areas. In such instance, the injury is less severe (partial asphyxia) and develops slowly over several hours (minimum 30 minutes), often preceded by a deteriorating fetal heart rate pattern that gives warning of developing hypoxia. *The prolonged partial injury pattern was not observed in this case.*" (Emphasis added)

[39] Before dealing with the evidence which was led at the trial, it is necessary to make certain observations regarding the way the defendant conducted her defence. The plaintiff, to a lesser extent, made herself guilty of delaying interrogating the timing and cause of the hypoxia (and obtaining the detailed history suggested by Dr Gericke), although this was occasioned by the defendant's failure, until it was foisted upon her when I refused the postponement of the trial and Mr. de Bruyn came aboard, to engage meaningfully with experts concerning these aspects.[16] As indicated above, admissions regarding the injury and its sequela could have been made earlier in the day, subject to whatever reservations there were concerning the issue of causality. More importantly, clarification of the radiology report could have been sought at an early opportunity especially since Dr Pretorius' original report has been in circulation since the parties' first pretrial conference. With hindsight other crucial concessions could have been made regarding the substandard care the plaintiff received at the hands of the nursing staff. Instead the real points of contention emerged or morphed into being on a gradual and evolved basis, ever changing the emphasis in the trial, ostensibly in absolute disregard of the rules of court and of practice.

[40] The reports of the opposing experts who ultimately testified were filed without the leave of the court being obtained, but evidently without demur from either party despite the clear provisions of rule 36(9)(a) and (b) which require such a report to be filed "not less than ten days *before* the trial".[17]

[41] The "trial" had, in my view, commenced on 22 May 2018 already and the notices and summaries were filed hopelessly out of time, obfuscating their purpose, which is to obviate any element of surprise at the trial. The defendant also couldn't

---

[16] The plaintiff could and should have been more vociferous about the prejudice caused to her by the defendant's last-minute employment of an expert.

[17] Rule 36(9) provides that:

> "No person shall, save with the leave of the court or the consent of all parties to the suit, be entitled to call as a witness any person to give evidence as an expert upon any matter upon which the evidence of expert witnesses may be received unless he shall- (a) not less than fifteen days before the hearing, have delivered notice of his intention so to do; and (b) not less than ten days before the trial, have delivered a summary of such expert's opinion and his reasons therefor."

even be bothered to follow the scheduling order of the Van Zyl DJP, or to explain her failure to meet this target, let alone seek condonation for her disregard of this court's directive.

[42] Leaving aside the clear provisions of Rule 36, there are two further injunctions concerning expert testimony which direct litigants to seek and find common ground, where applicable, before the trial commences.

[43] The first is provided for in paragraph 2 of the Joint Rules of Practice of this Division ("JROP") which states as follows:

> **"2. Expert Evidence**
>
> (a) The time periods stipulated in Uniform Rules 36 (9) (a) and (b) must be adhered to and, in the absence of agreement between the parties, the Court will only on good cause shown condone any departure therefrom.
>
> (b) The summary of the evidence to be given by an expert witness must contain at least sufficient information to enable the other party to determine the extent to which he agrees or disagrees with the evidence of such expert witness.
>
> (c) Any party will be entitled to request and be furnished with an amplification of the summary of expert evidence delivered by the other party to the extent necessary to achieve the purpose referred to in sub-rule 2 (b) above.[18]
>
> (d) Where practicable, a summary of the points of agreement and disagreement between the experts giving evidence for the parties should be incorporated in the minutes Rule 37. Those minutes should also state whether the parties have agreed or disagreed to exchange the reports of their expert witnesses."[19]

---

[18] This subparagraph is of relevance in the context of the defendant seeking clarification of Dr Pretorius' original findings to distinguish the nature of the injury and to say when it might have been occasioned.

[19] If the defendant had timeously filed Prof Buchmann's summary, this would have invited a discussion of the cause of the injury in relation to the MRI findings specifically by relevant experts.

[44] The second is the Draft Practice Directive in respect of Case Management,[20] applicable in the Bhisho and East London High Courts since 22 October 2013 ("The Draft Practice Directive").[21]

[45] In the context of the present matter, the Draft Practice Directive requires the parties to hold an initial case management within one month of the close of pleadings and to deal with the peremptory provisions set forth in par 6 (4) thereof. The latter paragraph requires the parties to reflect on, *inter alia*, the controlling and scheduling of examinations and expert testimony under Rule 36 (subparagraph (e)), the curtailing of issues in dispute between the experts by their participation in the pre-trial conference or in any other manner (subparagraph (f)), and such other matters as may facilitate the just and speedy disposal of the case (subparagraph (l)). These same issues are expected to be covered again at the final pretrial conference and the expectation is that the parties should be held to their agreements (recorded in the draft case management and final pre-trial orders respectively), which will govern the subsequent conduct of the proceedings. These agreements are to be modified by the Judge only on good cause shown (paragraphs 8 and 12). Indeed, issues and objections not specified in the pre-trial order shall not be available to the parties at the trial (paragraph 13) and the final pre-trial order is expected to be amended only to prevent manifest injustice to the parties.

[46] On 28 February 2014 , after the launch of the pilot case management project in Bhisho and East London, the Chief Justice, pursuant to the provisions of section 165 (6) of the Constitution, read together with the provisions of section 8 of the

---

These provisions must also be read in conjunction with paragraph 1 of the JROP which deals with pretrial conferences. These are ongoing in nature and require the parties to record and reflect upon matters on which agreement has been reached, but also the requests of one party and the replies of the other relating to matters where there is no agreement. The plaintiff was entitled to assume by the time the trial started that the reports put up her in respect of the merits would not be met with any challenge. Indeed, even after the late summaries of the opposing experts were filed there was still no engagement between the parties regarding what was common cause and what was contentious between the experts. Mr de Bruyn instead recorded that he was not inclined to encourage the experts to confer and by necessary implication did not consider the defendant bound to explore ways in which to curtail the duration of the trial.

[20] The Directive accords with the model for case management proposed nationally by the Office of the Chief Justice. It is termed a "draft" because it was implemented on a pilot basis and is yet to be formally incorporated in the Uniform Rules of Court.

[21] This is the date upon which the pilot case management project was launched in these two courts.

Superior Courts Act, no 10 of 2013, by way of Government Gazette 37390, dated 28 February 2014, issued “Norms and Standards” for the exercise of judicial functions of all courts.

[47] The objectives of these are:

> “….to achieve the enhancement of access to quality justice for all; to affirm the dignity of all users of the court system and to ensure the effective, efficient and expeditious adjudication and resolution of all disputes through the courts, where applicable. These objectives can only be attained through the commitment and co-operation of all Judicial Officers in keeping with their oath or solemn affirmation to uphold and protect the Constitution and the human rights entrenched in it and to deliver justice to all persons alike without fear, favour or prejudice in accordance with the Constitution and the law.”

[48] One of the ways in which these objectives are to be met is through judicial case flow management. Paragraph 5.2.4 of the Norms and Standards deals with this core judicial function in more detail:

> “JUDICIAL CASE FLOW MANAGEMENT
>
> (i) Case flow management shall be directed at enhancing service delivery and access to quality justice through the speedy finalization of all matters.
>
> (ii) The National Efficiency Enhancement Committee, chaired by the Chief Justice, shall co-ordinate case flow management at national level. Each Province shall have only one Provincial Efficiency Enhancement Committee, led by the Judge President; that reports to the Chief Justice.
>
> (iii) Every Court must establish a case management forum chaired by the Head of that Court to oversee the implementation of case flow management.

(iv) Judicial Officers shall take control of the management of cases at the earliest possible opportunity.[22]

(v) Judicial Officers should take active and primary responsibility for the progress of cases from initiation to conclusion to ensure that cases are concluded without unnecessary delay.

(vi) The Heads of each Court shall ensure that Judicial Officers conduct pre-trial conferences as early and as regularly as may be required to achieve the expeditious finalisation of cases.

(vii) No matter may be enrolled for hearing unless it is certified trial ready by a Judicial Officer.

(viii) Judicial Officers must ensure that there is compliance with all applicable time limits."

[49] As is apparent from the Draft Practice Directive applicable to this court, which is in line with the Norms and Standards, case management envisages the taking of control by the judges of the cases that are issued out of our court from the first issue of the litigation to finalisation of each matter.

[50] Up until the introduction of case management in Bhisho/East London, practitioners controlled the pace of their cases; followed no litigation plan or schedule; and determined when matters would be enrolled for hearing without consideration to the exigencies of the case, the convenience of the court, or the expense to the litigants. As a result, cases were slow to be finalised and caused a deadlock in the system.

[51] Legal practitioners do not own the courts. Neither do judges. Rather, justice belongs to all the people and is an expensive commodity to provide. The duty falls to judges through the core function indicated above to effectively manage that resource. Practitioners in turn are required to assist the court in case management

[22] Due to the peripatetic nature of this Division case management is dealt with by judges at each centre on a roster system whereas in other divisions cases are allocated to single judges from their inception to conclusion.

processes. The ultimate beneficiary of a well-managed system should be the litigant seeking access to justice through our courts. His/her experience should be a fair and swift process and one in respect of which he/she should have every confidence that justice will be dispensed without any delay.

[52] Apart from eliminating backlogs and delays, case management is a valuable tool in the administration of justice. It promotes transparency and offers a better adversarial trial system. The parties are strictly held to a schedule. The trial commences promptly when it is expected to run, and because the issues are succinctly crystalized and there are no surprises or twists and turns, the trial judge can practically almost write his/her judgment premised on what the parties say the case will be about even by the time the trial begins.

[53] The two key objectives of case management are, firstly, to get cases through the system as expeditiously as possible and, secondly, to minimize the costs impact to litigants.

[54] The implementation of case management in the pilot courts of this Division is a well-known phenomenon and is an established practice. Indeed, trial dates will only be allocated after substantial compliance with the Draft Practice Directive and if the case management judge is satisfied that matter is as trial ready as it can be, with the proverbial battle lines drawn. Orders made in this process are also regarded in a serious light.

[55] In this instance not only did the defendant agree that she would co-operate in respect of compiling joint minutes if it came to the employment of her own expert, but gave the impression, by her failure to adhere to Van Zyl DJP's scheduling order in time, without applying for any extension, at least until the specious application for a postponement of the trial, that she would probably not file an expert report at all.

[56] In Skom and Singatha v The Minister of Police and Another, a judgment of the Bhisho High Court,[23] Roberson J had reason to deal with the effect of a case

[23] Cases no 285 & 4/2014 delivered on 27 May 2014.

management order issued by Stretch J at a pretrial conference at which she had directed the parties to address certain pertinent issues in the action and to file an additional Rule 37 minute dealing with these. It suited the defendant's purposes in that matter to submit at the hearing of a special plea that Stretch J was not entitled to make the order which she did in her case managing capacity and that case management is merely "facilitative and does not usurp the law". Instead, the court held, with reference to the Norms and Standards and the objectives to be met thereby, including the obligatory nature of the judicial function exercised by Stretch J in the circumstances, that the case management order was indeed valid and binding on the parties and gave the defendants short shrift for being formalistic in the circumstances. She noted that:

> "This manner of conducting litigation (that is, treating the court's attempt at curtailing the issues in a meaningful way through case management orders as if they were meaningless) is, in my view, unacceptable and disappointing. A court should not be hampered in this way from adjudicating the crucial disputes between parties and reaching a just decision."[24]

[57] The binding nature of agreements reached between litigants in the context of case management (and the expectation that experts should sensibly make them to limit disputes) was also recently pronounced upon by the Supreme Court of Appeal in Bee v Road Accident Fund,[25] albeit in a situation where one of the parties sought to resile from such an agreement:

> "A fundamental feature of case management, here and abroad, is that litigants are required to reach agreement on as many matters as possible so as to limit the issues to be tried. Where the matters in question fall within the realm of the experts rather than lay witnesses, it is entirely appropriate to insist that experts in like disciplines meet and sign joint minutes. Effective case management would be undermined if there were an unconstrained liberty to depart from agreements reached during the course of pre-trial procedures, including those reached by the litigants' respective experts. There would be

[24] Paragraph [20].
[25] 2018 (4) SA 366 (SCA).

> no incentive for parties and experts to agree matters because, despite such agreement, a litigant would have to prepare as if all matters were in issue. In the present case the litigants agreed, in their pre-trial minute of 14 March 2014, that the purpose of the meeting of the experts was to identify areas of common ground and to identify those issues which called for resolution….[26]
>
> Since it is common for experts to agree on some matters and disagree on others, it is desirable, for efficient case management, that the experts should meet with a view to reaching sensible agreement on as much as possible so that the expert testimony can be confined to matters truly in dispute. 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 (i.e. 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.*"[27] (Emphasis added)

[58] Negative attitudes toward case management should not be countenanced and it is clear that even the Supreme Court of Appeal is determined to undergird the objectives of the Norms and Standards through the tools of case management by giving it the necessary teeth:

> "Whatever may have been the attitude to litigation in former times, it is not in keeping with modern ideas to view it as a game. The object should be just adjudication, achieved as efficiently and inexpensively as reasonably possible. Private funds and stretched judicial resources should only be expended on genuine issues."[28]

[59] In the present instance there was, firstly, no excuse to ignore the scheduling order, neither was it open to the defendant to assume that she could keep her

---

[26] Paragraph [65].
[27] Paragraph [66].
[28] Paragraph [67].

options option, forever and a day, to brief experts when she felt herself good and ready or to wake up during the trial and seek amplification of the plaintiff's original report of Dr Pretorius. She could also, if she were mindful of the objectives of case management which required her to meaningfully curtail the issues in dispute, have reflected more seriously on admissions which could have been made. Secondly, it was simply unacceptable once the decision had been taken ultimately to engage the expert testimony of Prof Buchmann to adopt the stance that she would not encourage the participation of her expert with the plaintiff's, especially on the newly evolved issue of Dr Pretorius' finding, to explore common ground and reach agreement on the enduring areas of contention. Mr. du Bruyn simply dismissed from his mind any binding obligation on the part of the defendant to attempt to curtail the issues in dispute between the experts and questioned this courts authority to order the defendant to engage on this basis. I was astounded that when in court I raised this expectation on the part of Prof Buchmann to sit down with Dr Njapa-Ndamkou and work through areas of contention, even *he* furiously shook his head as if to demonstrate that he would not. This intransigence is also in direct contradiction with the parties' agreement reached at their initial case management conference in August 2016 that if and when the defendant appointed an expert there would be a commitment to provide a joint minute. It further set the tone for a standoff and some posturing between the experts, resulting in Dr Njapa-Ndamkou taking offence at what he imagined were slurs against his professional integrity. The expert testimony took up an entire week.

[60] Apart from protracting the proceedings whilst the experts did battle, the defendant's failure to meaningfully curtail the proceedings and to apply her mind to matters of limited substance at the end of the day, i.e. that which turned out to be critical following Dr Pretorius' supplemented finding, also impacted the flow of testimony. Ideally a narrative would be provided to an expert (to be confirmed in the litigant's testimony) which forms the basis upon which he furnishes his opinions and reasons, but in this instance the plaintiff first testified and the need for expert input on the nature of the injury relevant to the factual lead up thereto only became apparent after that juncture. A detailed history was subsequently obtained from her by Dr Njapa-Ndamkou and formed the basis for his report. In some instances, this turned out to be discordant with the testimony given by her at the trial (and to the plaintiff's

other experts but), but then the plaintiff cannot be blamed for not giving as comprehensive a narrative in the first place because the point of real contention only became apparent after the findings of Dr Pretorius were clarified. Indeed, her evidence was not really challenged by the defendant at all, and everyone appeared to miss the import of her reference to the pressing of her tummy as constituting "fundal pressure" or the *Kristeller* Expression as it is known in the medical literature, which gained traction only after Dr Njapa-Ndamkou gave it some significance in reasoning what might have been causal to the hypoxia. This of course led to objections being raised against the plaintiff's supposed inadmissible hearsay evidence to the extent that some of the ground covered by Dr Njapa-Ndamkou in his testimony had not been mentioned by the plaintiff herself in her testimony. As a result, it was necessary for her to be recalled to cover the gaps, but it was so patently inopportune for her make a second appearance in court because she was frail and very ill on the day and clearly made reckless mistakes, such as, for example, regarding the time of the delivery of the child which was at odds with the common cause fact that she was delivered at 22h00 and not 23h00 as she misstated. Another important allegation on the part of the plaintiff that there had been an intimation given to her by a nurse that she would deliver at 16h00 which was consistent in Dr Njapa-Ndamkou's view with the moment the risk factor changed, was glossed over or missed. In my view this was an honest mistake on the part of Mr. Brown who thought it had been dealt with in the evidence. I refer to the following passage in the transcript, when Mr. de Bruyn raised an objection to the plaintiff's testimony in this respect, which bears this out:

> "MR DE BRUYN M'Lady, may I make our position clear, there is no evidence by Ms. Mpetsheni that she was told at 1 o'clock that she will give birth at 4 o'clock, the report of Dr Ndamkou who said that is what she told him. Not in her evidence in May, did she mention that at all, and not yesterday. So there is only this hearsay statement to Dr Ndamkou, there is no evidence that she was told, no acceptable evidence that she was told she was going to give birth at 4 o'clock, that is our case and I am putting it on the table now, there is no acceptable evidence for that.
>
> MR BROWN M'Lady, I will take time and go through the record again and then locate her evidence in that regard. My recollection is that she said

specifically that at 1 o'clock the pain was so severe that she could not even step on her left leg M'Lady, and that is when there was this communication, but I will find it specifically in the record."[29]

[61] If the trial had followed the normal expected trajectory, and the issues in contention properly raised before the evidence had commenced, this confusion would unlikely have arisen.

[62] Another aspect deserving of censure is that complex medical literature was constantly being offered, as the expert testimony wore on, to prove or disprove certain assertions. Instead of committing to a properly formulated bundle at the outset, which both experts could get to grips with before their testimony commenced to avoid unnecessary interruptions, the defendant purported to hand up an open lever arch file (Exhibit E) and to fill it with articles as the wind blew. In some instances, the literature being referred to by Dr Njapa-Ndamkou in his testimony, which had in the first place been brought to his attention by Prof Buchmann and was necessary for Mr. Brown to cover with him in re-examination, was disavowed by the defendant as forming part of her case! His reference to these articles at this juncture resulted in him having to return to court on a third day (after having indicated on the afternoon of the second day a dire need to return to his practice) in order to be subjected to further cross examination, this because Mr. De Bruyn asserted that it was now necessary to *study* the articles overnight (obviously considered by them before because they made them available to the doctor in the first place) in order to re-examine him on interpretations held by him which were contrary to those of Prof Buchmann. This caused me to remark that it appeared that Dr Njapa-Ndamkou was being punished for taking a different view and I daresay this could not have left him with an endearing impression of his experience in court or have affirmed his dignity as a user of the court. The haphazard way the literature came to be introduced is to be deprecated in a court where case management practices dictate that bundles and the relevant status of documents be agreed up front by the parties to facilitate the just and speedy disposal of a matter, more especially when it comes to documents to be relied upon by the expert witnesses. Even the following morning, when cross

[29] This was during the cross examination of Prof Buchmann at pages 318-9 of the transcript.

examination of the doctor resumed, the defendant's papers were not in order and the cross referencing to them was clumsy. This in itself was disrespectful to him, given the premise on which the matter had stood down on the afternoon before.

[63] I turn now to deal with the fact of the peculiar nature of the injury that the defendant claims renders it implausible that the substandard management of her labour was causal thereto or that anything the hospital staff did or failed to do were causative factors that played a role in the events leading to the injury suffered by the child. Prof Buchmann sought to pass off the event as an "unlucky one" and merely coincidental, as it were, to the substandard care received by the plaintiff at the hands' of the staff, a below par standard he quite readily conceded.

[64] The premise that the cause of the damage was an acute profound (sentinel) hypoxic ischaemic event that happened intrapartum without warning rests on Dr Pretorius' evidence regarding what the images would indicate. This witness himself did not say anything more than that the incident would have been a hypoxic ischaemic event during the perinatal period in a near to term foetus or infant. The MRI images themselves were not provided and no basis is indicated in his report itself to explain why he comes to this conclusion and certainly no opinion is ventured why the pattern of injury observed by him excludes the possibility of a partial prolonged event as well. It is a mere conclusion which the parties accepted.

[65] The paraphrasing of the MRI report to mean that the cause of the event was a sentinel one, and that it was therefore one that happened suddenly and without warning during the delivery came from counsel. In my view Dr Pretorius 'remarks concern only the nature of the damage observed by him on the MRI images and the timing of the injury.

[66] Dr Gericke did not make any deductions himself although he called attention to the difference between the two types of injury and explained why it is important to make the distinction. This assists with determining the duration of and determining the causal contribution to the insult to the foetal brain before delivery. One gets the impression from reading the latter's report that he wasn't certain that a partial prolonged type of event could be excluded, based on what Dr Pretorius observed

from the images, hence the reservation expressed in my view. The purpose of Dr Gericke's report was ostensibly not to reach a conclusion in this respect. He correctly deferred to the radiology experts to make this call. His objective appears to have been to exclude other prenatal causes of a cause different from intrapartum asphyxia in this instance, a conclusion everyone appears to have been comfortable with and I too am satisfied that we are here dealing with an intrapartum event.

[67] Dr Njapa-Ndamkou without hesitation also deferred any opinion in this regard to the radiologist although he remarked under cross examination that one would unlikely have picked up the features of a partial prolonged asphyxia consistent with his theory of a gradual evolving hypoxia (preceding the acute catastrophic event contended for by the defendant) on the child's brain scan.

[68] Prof Buchmann on this critical aspect said that the partial prolonged pattern injury was *not* observed in this case, but it is not clear if he meant *he himself* could not observe such an injury pattern, or whether he was simply restating what Dr Pretorius had concluded in his addendum, which incidentally is not that a prolonged partial injury pattern was *not* observed. When he testified, he professed to have no knowledge of how to read the MRI and conceded that he would "go with (Dr Pretorius') report". However, he relied on literature to promote his support of Dr Pretorius' supplemented finding as meaning that the likely causal event was one of the recognized sentinel events which can happen intrapartum without warning and exhibiting all the usual features of such an event which Dr Gericke lists above,

[69] One's own recourse to literature makes it plain that mixed patterns do exist and that when energy substrates are depleted in partial prolonged asphyxia (as Dr Njapa-Ndamkou sought to explain in practical terms in describing the possible cause of and lead up to the catastrophic injury as it were), there can be a further assault in the form of near total collapse. This would be seen where there is sudden bradycardia superimposed on a decline in the baby's heart rate that is more gradual. I believe that in addition to the injury from the partial prolonged assault in the so called "watershed areas" or beyond, in more severe insults, the severe bradycardia events cause damage to the putamina and thalamus, and sometimes the hippocampus, vermis and brainstem.

[70] The difficulty I have in discounting any mixed injury pattern is compounded by the fact that there is an absence of any reasons for Dr Pretorius' opinion as a radiologist, vitally necessary to inform and assist the court in this respect. Was he mindful that his opinion was being sought from a medical forensic point of view and that is was necessary to pertinently exclude the possibility of a mixed type pattern as had vexed Dr Gericke or did he just go so far as to confirm the appearance and timing of the injury? Certainly, he did not seek to deal with the cause of such an injury and indeed neither would this be within his field of expertise. I do not know and am hesitant to rely on his conclusion beyond what it obviously states. The absence of any reasons or explanations for his terse conclusion in respect of an aspect so critical to this trial is of great concern to me.

[71] A litigant in an action such as the present one is in a sense confounded by a finding of an acute profound injury as opposed to a mixed one including features of a partial prolonged type, as was demonstrated by Mr. de Bruyn's "Aha!" moment when Dr Ndjapa-Ndamkou appeared to concede that his assessment of the lead up of the child's injury was rather of a classic partial prolonged type of event than one fitting in with Dr Pretorius' supplemented finding of an acute profound injury. This is because (as was spelt out in Prof Buchmann's testimony based on medical literature) the latter injury is limited to a sentinel event, involves an unremitting supply of oxygen to the child's brain for a period of 30 minutes and, more importantly, would come upon unexpectedly and without warning so that, on an application of the applicable legal principles, hypothetical substandard management of the plaintiff's labour would be irrelevant as it would have played no role in the occurrence of the injury. It becomes facile to argue then that such an event would also not have given the staff enough time to perform a caesarian section or other obstetric intervention so as to have successfully averted the outcome. On an argument in support of a partial prolonged type of event however there would be a gradual development of hypoxia and the lack of monitoring would be relevant because there would be ample forewarning of an impending catastrophe if the staff were vigilant and picked up what they ought to have in the peculiar circumstances. An abnormal heart rate would be detected during uterine contractions assuming proper monitoring and a caesarian section could be performed (urgently if necessary) to expedite delivery. The lack of

adequate monitoring (conceded in this instance) would constitute a negligent omission, and factual causation, on this argument would be found in the creation of a situation where the child is placed at risk of, amongst others, hypoxia, which could have been averted by proper, adequate monitoring.

[72] This is demonstrated by the SCA's split finding in Magqeya v MEC for Health, Eastern Cape[30] where the majority of the court held that, following upon the parties' acceptance of the report of the radiologist in that case that the features "are those of a chronic evolution of a global insult to the brain due to hypoxic ischaemic injury, of the acute profound type, most likely occurring at term.", that the failure (even assuming negligence on the part of the hospital staff to examine and properly monitor the mother at the key times) would have had no causal effect on what happened or in causing the hypoxia. In that matter too the court *a quo* had ostensibly not enjoyed the benefit of any specialist neurological input on the typical features of these injuries or their peculiar causes as suggested in literature (or any oral testimony from the radiologist)[31]. In the result the fate of the appellant (plaintiff) was dispensed with (appeal dismissed) on the simplistic basis that:

> "Whilst such failure (the assumed negligence) may well have been relevant had we been concerned with what was described as a 'partial prolonged type brain injury' that occurs over hours, it is not for 'an acute profound type', as in this case."[32]

[73] It is perhaps also relevant to mention that Majiedt JA in the minority judgement in Magqeya had reflected lexically on the wording employed in the radiologist's report and had concluded that it 'appears to be confusing and, on the face of it contradictory', since it alluded to a 'chronic evolution'(the opposite of a disease of sudden onset and brief course), but the majority felt constrained to disagree because "(t)here is simply nothing to gainsay (the radiologist's) conclusion." The report, as in this instance, had been admitted into evidence by consent and no

[30] Case no 699/17 [2018] ZASCA 141 (1 October 2018).
[31] I stand under correction, but it appears that Prof Smith who testified in that matter is a neonatal specialist.
[32] Paragraph [65].

reservations had been expressed about it by any of the experts who testified during the trial.

[74] Interestingly, it was only Majiedt JA's lexical justification that had given him the confidence to conclude that the acute profound hypoxic ischaemia "was not a sentinel event as understood in the medical profession as defined in Stedman's" (the medical dictionary to which he had referred to interpret the concept's meaning), but instead (as the radiology report itself suggested), "hypoxia and foetal distress which developed, undetected due to the lack of monitoring, over some time." [33]This demonstrates an unfortunate recognition that upon a mere label of an acute profound injury the probability of a sentinel event as causing the injury, as opposed to a foetal distress gathering impact gradually, will of necessity attenuate the enquiry into factual causation on the side of the acute profound line, rendering hypothetical negligence practically anecdotal.[34]

[75] I mention that although the plaintiff *in casu* accepted Dr Pretorius' report without question, Dr Njapa-Ndamkou was ostensibly not alive to the forensic import of the distinction or the fuss been created by the SCA judgment. Prof Buchmann, who was involved in testifying as an expert in the Magqeya matter, however, was, and addressed his professional review of the Plaintiff's account of her labour and the birth of the child on the side of the typical features of an acute profound injury.

---

[33] Paragraphs [20]-[21].

[34] Mr. de Bruyn referred me to Mtukhi v MEC of the Gauteng Provincial Government (Case no 2013/27430, Ismail J, delivered on 16 November 2018) which he pointed out was a case different from the present scenario because there the event was a mixed partial prolonged and acute profound or so the imaging in that matter depicted. This is somewhat ironic because, if the initial damage causing event is overtaken by a subsequent one over which no one has any control nor which can be foreseen, why would it be okay for the court to fix liability in that situation, but in a situation where the mixed pattern is not observed on the MRI scan but only the superimposed acute profound injury not? This approach of overemphasizing the import of what the radiologist sees, and the one size fits all pseudoscience, as opposed to applying the ordinary legal principles of negligence and causation to the factual scenario in each case, is to my mind artificial and dangerous. Each case has its own merits and can't be dispensed with on the basis of a stark line between acute profound and partial prolonged. Whilst the imaging is necessary to prognosticate neurodevelopment and to plan the child's treatment, I for one would like to know more in a medicolegal context about the causes and how each of the listed sentinel events play themselves out and result in the hypoxia. The consistency is in the pattern of the injury and while I understand that this can be attributed to what the brain typically does when there is a sudden disruption of substrate supply as occurs in an acute severe asphyxia, based on the distribution of injury reflecting the hierarchy of metabolic needs that are unmet, those footprints do not fill in the gaps about how the brain got to that point.

[76] It is no wonder then that the late supplementation by Dr Pretorius' of his supplemented findings in this instance caused the sharp about turn in the way the defendant conducted her defence from that point onwards.

[77] In any event and bearing in mind the onus on the plaintiff to prove on a balance of probabilities that the conduct complained of caused the harm, I turn to deal with her evidence.

[78] She testified that she was admitted to the hospital on 3 December 2005 at approximately 07h30 after having experienced labour pains from approximately 03h00 on the same day.[35] Her membranes ruptured at approximately 07h30 and she was then admitted to the labour ward at approximately 08h00. There she was assessed by a nurse who did a vaginal examination and auscultated the foetal heart rate (with an unknown instrument) before admitting her to a waiting

bed in the labour ward.[36] She related in her testimony that she was not given any information regarding the condition of her baby nor was she informed of the progress of her labour for the entire day and continued to suffer severe pains in her abdomen and back, although to Dr Njapa-Ndamkou she stated that she had been told at 13h00, after a vaginal examination, that she would give birth at 16h00.[37]

---

[35] There were some discrepancies between her testimony and what she told Drs Gericke and Njapa-Ndamkou although, in her defence, she visited the clinic first then the outpatient division and then was admitted to the labour ward. These times are not really of the essence since the plaintiff changed the focus of the critical period under consideration to the second stage of her labour. I have also expressed above my reservations regarding the circumstances under which her instructions were taken by various parties along the way, some of whom would not necessarily have been sensitive to the effect of discrepancies in a formal forensic context.

[36] She testified that at the clinic they examined her after her water had already broken by testing the foetal heart rate with something on her stomach. This was before they told her that she was near giving birth. To Dr Njapa-Ndamkou she conveyed that at the clinic she was told that she must not even sit, she must immediately go to the maternity ward. She was not checked at the clinic. Her foetal heart rate was tested in the ward with an instrument on her stomach. A vaginal examination was also done, and she was told that she would not give birth "now". This was at about 08h30.

[37] This fact was in serious contention. The assertion by her to Dr Njapa-Ndamkou underpinned the hypotheses that from that point the baby would have been at risk because the plaintiff did not deliver as was prognosticated by a nurse and was also one of the bases upon which it was claimed the labour was prolonged. It is of concern that she never mentioned it before but then on an overall assessment of her evidence and demeanour there were many times that the significance of specific events simply escaped her. For example, she related in her testimony that she only found out that the

[79] She was unattended for the remainder of the day and at approximately 16h00 there was a significant change in the nature and frequency of the pain which she had been enduring, described by her as a "right through pain". She however remained unattended, a nurse merely checking her file and informing her from this source that her time is not coming yet. No further assessments were done on her nor was the condition of her baby monitored in any manner.[38] She was promised by a nurse who came on after shift change that she would come and check on her, but she did not return to do so.

[80] At approximately 22h00 (this must be 21h00) the pains in her abdomen and back became excruciating and unbearable involving both her "front and back" and her left leg was not even wanting to touch the ground so painful was it. [39] She therefore started screaming. A nurse checked her vaginally in order to establish the position of the child's head and informed her that she would give birth soon. She also palpated her on both sides of her stomach.

[81] Two elderly nursing sisters attended to her in the ward ultimately. Earlier one of them had inserted a drip into her hand[40] and went away leaving her for 50 minutes before returning with the second nurse who helped with the birthing process.[41] One of them helped her while she pushed by pressing her on the top side of her tummy, just below her ribcage and pressing down. (It is common cause that the nurses were applying fundal pressure to assist her on this basis.)

---

child was developmentally compromised at nine months when her mother suggested she take him to the hospital because he wasn't crawling or sitting by himself as he ought to do at that age, whereas the Road to Health Chart reflected an early diagnosis of HIE Grade II in an entry made at the time of her and the child's discharge from the hospital after his birth. Comments on this condition are also noted on the chart at regular follow up visits suggesting that she should have known better.

[38] She also testified that the night staff palpated her at 20h30.

[39] In her testimony in chief she said that she had given birth at 22h00. This was also asserted in the particulars of claim. However, when recalled, she said that the birth took place at about 23h00. In my view she was clearly mistaken and in no fit state to testify having come to court from her sick bed.

[40] When she was recalled to testify, she clarified that two drips had been put up, one on each arm.

[41] This timing is not clear. If she gave birth at 22h00, but one factors in the time allowed for the fundal pressure on her version, the nurse couldn't have been absent for as long. She also doesn't say what happened in this interregnum. Contrariwise it seems that when she pushed on her own, before assistance was lent, the nurses were present.

[82] She had been told to push to deliver the baby and did so on the instructions of the nurses and for a long while to no effect. When it became apparent that the baby was not being delivered (she was informed that it was not going through the birth canal but had crowned, its head being visible to the nurse attending to her from that end) that nurse performed an episiotomy on her vagina and it was then that the other one started pushing on her abdomen to force the baby out. This pushing was continuous and hard, lasting for approximately five minutes at a time with intervals of approximately five minutes in-between during which time she was made to breathe and rest. [42] The procedure was repeated thrice and on the third occasion the child was delivered vaginally. She mentioned that there were two occasions when she pushed upon feeling the urge to do so when she was purportedly not supposed to, as a result of which they admonished her by slapping her once on her abdomen and on another occasion on her thigh.

[83] Under cross examination she explained why her recall of how long the nurses had pushed on her abdomen for each time was so clear to her still. She explained that this is because they discussed among themselves before they began that they would embark on this five minutes on, five minutes off, pushing on her abdomen.

[84] The baby did not move or cry when he was born and was placed on her abdomen. A doctor was called, and he attempted to resuscitate him by hitting him on his hand, but he did not respond and was removed to the neonatal intensive care unit where he remained for a period of more than two weeks.

[85] She had not been given any medication for pain during her ordeal from admission to the birth of the child. She ate some food at13h00 and had also had water and a cooldrink during the day.

[86] The evidence of the plaintiff was not really challenged during her cross examination on both occasions that she was called to give evidence. There is merit in Mr. Brown's submission on her behalf that since her evidence stands

[42] Something might have been missed in translation regarding the measure of force applied, but certainly from the manner in which the court interpreter conveyed what the plaintiff was seeking to demonstrate, about the fundal pressure being applied, it was hard or with force.

uncontradicted it must therefore be accepted as true. He asserted that any flaws or inconsistencies as there may be are not material and may be explained by the elapse of time and the fact that she was suffering tremendous pain and therefore not concentrating on remembering every detail of her ordeal. Her evidence is also the only factual evidence before me.

[87] I have already alluded above to the fact that it is not clear from whom Dr Burgin obtained the brief history recorded by him, and that it does not appear that the plaintiff herself furnished the relevant history to Dr Gericke. In any event the discrepancies between those narratives and her oral testimony are in my view not material to the important period under contention. Further despite the discrepancies, such as they are, I am not inclined to disbelieve her. She did not appear to me to be capable of fancy imagination. She related basic facts and not the consequences. Her explanations were almost turgid and without any passion. She distinguished a doctor from a nurse as someone wearing a necklace around his neck. When she was asked what the child looked like after he was born, she said he looked just like a baby as one would expect, except he did not cry. She understood that there were issues with the baby after his birth and that he was slow but was told to expect this because he did not cry at birth. She didn't question this. Her observations and descriptions of things happening to her and around her made sense logically (such as her descriptions of the labour pains at the various stages, and the kinds of discussions that were had with the nursing staff), but these were not offered spontaneously. She answered what was asked. As bizarre as her testimony was about the application of the fundal pressure, she clearly had no inkling even that the pressing on her tummy was of any significance in the whole scheme of things. The thought that she could contrive something so creative just does not fit in with my assessment of her demeanour. Likewise, her testimony that she was told by a nurse that she would give birth at 16h00 cannot be questioned. I expect it is a detail that came to mind when she was being interviewed by Dr Njapa-Ndamkou, rather than spontaneously. Again, she would not be capable of fantasying about a prolonged second stage of labour and the implications of that for this trial.

[88] In the main the critical moments and events of the second stage labour are not seriously in contention save for the plaintiff's unconfirmed intimation to Dr Njapa-

Ndamkou that she was informed at 13h00 that she would give birth at 16h00, which assertion the defendant submits constitutes inadmissible hearsay evidence. I have referred above to Mr. Brown's oversight in covering this aspect when he recalled the plaintiff. I was not asked to admit it on the basis that it is in the interests of justice to do so. I believe that the plaintiff would have confirmed it had Mr. Brown brought it to her attention and had he not labored under the misimpression that he had led her evidence in this respect. In the light of the defendant's submission that she was prejudiced by Dr Njapa-Ndamkou's reference to it in his testimony I will for present purposes attach no weight to it. Fortunately, there is other evidence that supports the plaintiff in respect of the timing of her second stage of labour which I will shortly allude to.

[89] The evidence of Dr. Njapa-Ndamkou can be summarized as follows:

89.1 the failure to assess and monitor the condition of the plaintiff and the child was substandard;

89.2 the rupturing of her membranes changed her risk profile on admission to the hospital placing her in a higher risk category necessitating an assessment by a doctor and frequent and stringent monitoring of the foetal condition by way of continuous cardiotocograph ("CTG") monitoring;

89.3 the rupture of the membranes for a period of more than twelve hours was prolonged and exposed the child to the risk of injury, therefore he should have been delivered by caesarean section if the labour could not be expedited by other means;

89.4 the period of labour especially in the active phase was prolonged as the child should have been delivered by 18h00 or 20h00 at the latest if one extrapolated the normal expected rate of dilatation and the duration of her first stage of labour (this is the alternative evidence regarding the timing of the second stage of labour);

89.5 that if foetal and maternal monitoring had been done, the need to expedite the delivery of the baby would have been identified and an appropriate intervention such as the administration of oxytocin, vacuum

extraction, forceps delivery or a caesarean section could have been performed.

89.6 that the early rupture of the membranes exposed the child to hypoxia and ischemia due to cord compression and other birth complications as the protective environment provided by the amniotic fluid was not present for an extended period of time;

89.7 that although the foetus is able to adjust or compensate for the periods of hypoxia caused by the normal contractions (called autoregulation), its ability to recover from the intermittent episodes of hypoxia was compromised by extended exposure to such hypoxia.

89.8 that such extended exposure to the intermittent hypoxia in combination with the cord compression would lead to a failure of the autoregulation of blood distribution by the foetus leading to a catastrophic acute profound hypoxic ischaemic incident.

89.9 that in his view the application of fundal pressure in the manner described by the plaintiff was incorrect, compromised the child's wellbeing, may have contributed to a cord compression (or placental abruption which in itself amounts to a traumatic labour), alternatively a narrowing of the ventricles in the foetal brain due to excessive compression of the cranium of the child (which constriction causes a decrease in the delivery of oxygen resulting in hypoxia and ischaemia) during the prolonged process of delivery through the vaginal canal; and

89.10 that the nurses had failed in their duties to give proper care by:

89.10.1 failing to monitor the plaintiff and the child;

89.10.2 failing to call the doctor when they realized that the labour was not progressing adequately in order to assess the position;

89.10.3 their failure to properly assess if it was safe or appropriate to apply fundal pressure to deliver the baby; and

89.10.4 applying fundal pressure in the manner in which they did.

[90] Dr Njapa-Ndamkou's review was practical in every respect and based on nothing more than the plaintiff's narrative to him in relation to what is (or at least was) to be expected from the nursing staff regarding the management of the plaintiff's labour at the relevant time based on the national guidelines. His explanations were sensible and physiologically plausible. He referred to several "sentinel events", deferring to the terminology employed by Prof Buchmann in his report, (although at times semantically confusing this with risk factors such as for example the early rupture of the plaintiff's membranes) that could have been causal to the acute hypoxia, namely a ruptured placenta, traumatic injury (indicated by the need for the episiotomy and assistive fundal pressure) and an umbilical cord accident (compression),the latter in his view being the most probable. He had no hesitation in ascribing the injury to the way the delivery was conducted by the nurses at the specific point in applying the fundal pressure.

[91] In his opinion and based on the plaintiff's explanation of what she experienced at 16h00 he was confident that she must have been in active first stage labour at that stage. That would mean that the delivery at 22h00 was delayed. If she had been properly assessed, then by 20h00 at the latest, she should have been delivered by caesarean section.

[92] He did not share Prof Buchmann's view that the plaintiff's delivery was spontaneous because of the episiotomy and fundal pressure intervention that ensued. He was also appalled at Prof Buchmann's hypothesis that the substandard care made no causal difference to the child suffering the acute profound brain injury and was concerned by the message conveyed by such a statement.

[93] As for the time within which a caesarian section can be performed, he asserted that, in the case of an emergency: "if the theatre is empty and we have (the theatre), the nurses, the drip is in, the anesthetist is in, … there is no reason why a caesarian section cannot be done in 30 minutes." In this instance there would have been more than enough time, between 20h00 and 22h00 that night to assess whether the child should rather have been delivered by caesarian section.

[94] As for the damage causing event supposedly being unforeseeable or the situation been low risk, he opined that the lack of purposeful monitoring would have converted a low risk situation to a high-risk one.

[95] Asked under cross examination to reconcile his hypothesis of an inappropriate application of fundal pressure with prof Buchmann's theory of an unremitting clamping of a compressed cord to coincide with an acute profound rather than a partial prolonged event, he reasoned that if one continuously causes pressure, the temporary recovery of the clamping releasing effort by way of autoregulation (when the mother's contractions subside and the pressure itself ceases) will become less effective until eventually it no longer happens.

[96] He agreed that it would be normal for a mother to feel tired in the process of delivery but asserted that the application of fundal pressure because of its mechanism and natural physiological impact to a body (adding an extra work load on to her contractions) would make her more tired, which fitted in with what the plaintiff had related to him of her own experience.

[97] He confirmed that there is literature to support his theory that pressure on the blood vessels in the child's head could lead to hypoxia, but it is common cause that this was not referenced during his cross examination. This he explained was because he verily believed that such an outcome accords with the laws of natural physiology. Confronted by a medical review article by Kent D Heyborne[43] which in the defendant's view puts paid to his hypothesis in this respect and which promotes a contrary conclusion that the foetal brain is well protected from extracranial forces that occur during labour, he pointed out that (a) there are articles that say a different thing and (b) that the reservation is expressed that this would be so only "in the absence of foetal hypoxia," which in this case is not the position.[44]

---

[43] A Systematic Review of Intrapartum Fetal Head Compression: What is the Impact on the Fetal Brain? Published in Thieme Open Access medical review journal (March 20, 2017). The conclusion in this review article states that: "A review of the literature indicates that fetal intercranial pressure is well protected from extracranial forces. Available data do not support intrapartum fetal extracranial pressure as a cause of fetal brain injury."

[44] The last paragraph of this article notes that: "Although (head compression as a cause of brain injury) has become a popular legal theory, there remains no scientific basis for the notion that cerebral ischemia caused by the pressures of labor *and in the absence of fetal hypoxia*, is a cause of cerebral palsy." The emphasis is what Dr Njapa-Ndamkou latched on to.

[98] He eschewed an approach of isolating out a single event reminding the defendant that there were several factors at play in the present instance and that one had to look at the cumulative effect of all the risk factors to determine what might have contributed the acute event. As for bringing this all under the mantle of an acute profound event he explained how each compromise would have made it difficult for the autoregulation to continue although he agreed that if one continuously puts pressure on the cord at the specific time of delivery this (as an act on its own) will cause hypoxia (of the acute profound kind).

[99] Dr Njapa-Ndamkou was happy to agree that the use of electronic foetal monitoring ("EFM") has its own shortcomings. He was also prepared to agree with the proposition set forth in the second edition of Neonatal Encephalopathy and Neurological Outcome[45] which suggests that the use of continuous electronic foetal monitoring was not associated with a significantly lower rate of cerebral palsy or neonatal mortality. He was however firm that CTG's should not be discarded as a tool in the management of labour patients. To the contrary they play a vital role in detecting pathological heart rates. He also agreed with the statement in AGOG that there is no evidence to support the ability of practitioners to predict neonatal neurological injury, cerebral palsy or still birth using electronic foetal monitoring.[46]

[100] He accepted a 20-hour high water mark in the latent phase of the first stage of labour before it becomes prolonged, and 12 hours for the active phase of the first stage. As for the second stage there is no contention between the parties and their experts that this period, before labour becomes prolonged, is two hours after full cervical dilatation. However, he was astute to emphasize that one should always be guided by what the monitoring dictates rather than holding the line that because the World Health Organization says you can wait for twenty hours, you do so at the expense, for example, of CTGs showing decelerations within that time period.

---

[45] The American College of Obstetricians and Gynaecologists ("AGOG") at page 10 Exhibit E.
[46] Page 13 Exhibit E

[101] He explained that the use of sedation in labour could assist to relax the mother's uterus which is what one would strive towards, otherwise hypertonic contractions might overstimulate the uterus and cause the foetal heart rate to drop.

[102] He confidently asserted, despite whatever medical literature might say regarding targets for performing an emergency caesarian section and having regard to his numerous years of experience of performing such procedures, that a baby in trouble can be delivered within thirty minutes, from decision to incision. He went so far as to suggest that articles which suggest the contrary (as was sought to be promoted by the defendant during the trial) are a fallacy.

[103] Although he did not advocate that fundal pressure should never be used (it has its place for rare and strictly indicated cases), or that it wasn't a technique open to nurses to use at the time of the child's birth, he was not comfortable with the proposition suggested to him that there were indications to have used it in the present scenario or that it was appropriately applied as described by the plaintiff. As for the mechanism of the technique it is a gentle light pressure (not a fight with the mother) and is to be applied synchronously with contractions. There must in any event always be a prior assessment of its necessity before embarking upon such an intervention and a close monitoring of its efficacy. It is certainly not a routine procedure and you would not use it if there was a blockage in the birth canal. Another contraindication would be a cord compression. (Co-incidentally Prof Buchmann suggested that one would use the technique to cause the foetal head to pop up, whereas in this scenario the head had crowned already by the time the fundal pressure was commenced. The nurse at the time had also suggested that the baby was not passing through the birth canal, although she could see its head, suggesting an awareness of a blockage which is a contraindication for the use of fundal pressure.)

[104] The plaintiff was recalled after Dr Njapa-Ndamkou testified, so her explanation of the five minutes on five minutes off application of the fundal pressure was not put to him to theorize. However, it is abundantly plain from her testimony in this respect (which this court accepts for the reasons indicated above) that this pressure was not applied synchronously with her contractions. To the contrary, the plaintiff was

admonished according to her testimony by being slapped on her abdomen and thigh for pushing when she felt the urge to do so. There was also no prior assessment of her or the child's wellbeing before the nurses embarked upon the maneuver, the nurses simply discussing among themselves what action would be taken. A doctor was not called until after the fact. The plaintiff clarified that by the time the episiotomy was cut, the nursing sister had said that the child's head was visible to her while she was pushing. It follows from this that the head had crowned (the moment of "initial success" in the delivery as Prof Buchmann referred to this concept in his evidence) and that the application of the fundal pressure followed after a recognition on the part of the nurses of a failure to deliver.

[105] Far from trying to find a natural causal connection between events during the plaintiff's labour and the unfortunate outcome, Prof Buchmann in his testimony sought to justify the plaintiff's narrative of what happened during her labour within the narrow parameters of the scientific explanation for the features an acute profound hypoxic injury. It was evident even from the cross examination directed at Dr Njapa-Ndamkou before his testimony commenced that it was going to be an all or nothing situation with him. If the doctor could not justify a causal possibility within this framework, he rejected it.

[106] He conceded that the monitoring of the plaintiff and the child was substandard yet opined that because of the nature of an acute profound injury and its defining features, the inadequate monitoring could not have been a causative factor or did not play any role in the events leading to the injury which the baby suffered. In his view the nursing staff who attended to the plaintiff, despite having acted negligently in the way they carried out the management of her labour, would not have been able to prevent the injury, again by reason of the unique features of an acute profound event. As for the application of fundal pressure, he spent much time extolling its value in the context of labour management as being accessory to normal delivery. Although Dr Njapa-Ndamkou had never sought to suggest in his testimony that the maneuver was prohibited in clinical practice in South Africa (he merely reviewed whether in the plaintiff's situation its application was problematic), Prof Buchmann unequivocally endorsed its use. He asserted that in his experience it is used routinely in the delivery of babies by doctors and midwives (even though its current

day use is evidently not encouraged) and that this certainly was the case at the time of the child's birth. As for its mechanism, according to him, fundal pressure by its very nature has to be hard to be effective. Despite this belief, according to him there is no evidence in the available literature to support the opinion by Dr Njapa-Ndamkou that fundal pressure is not safe and can cause brain damage (even if applied incorrectly or inappropriately). He was at great pains to discount the absence of any data that this was the case and again referred to literature underpinning his disavowal that its use could in any way have been causal to the injury.

[107] He refuted the notion of a prolonged labour and, based on the plaintiff's narrative, thought that the description of her pain fitted in with a transition into the second stage at 21h00 when she started to scream, and from the latent to the active phase of the first stage of labour at 16h00. On this reasoning he can't be faulted in my view for suggesting that the second stage could not have been prolonged, but of course there was no monitoring of the situation from 13h00 until the vaginal examination undertaken closer to the birth so it is unclear what caused the plaintiff to scream or at what stage of her labour she really was at that point. I emphasize though that the head crowned very soon after 21h00 as this development was noted by the nursing staff before the episiotomy was cut which renders it highly unlike that second stage labour only commenced at 21h00. (Dr Njapa-Ndamkou's assessment of it having commenced at the 18h00 is more plausible having regard to the known rate of dilatation of a primigravida calculated from when the plaintiff's membranes were ruptured.)

[108] Prof Buchmann was not in agreement that there was any indication for a caesarian section, not even with hindsight, but this is based on the anticipated lengths of the plaintiff's labour. He conceded though that there was an obvious absence of any information on the foetal wellbeing to support that it was ever indicated. Despite his reliance on several articles which look at mean intervals of 48 minutes to perform a caesarian section in urgent cases (only 15.7 % being within 30 minutes), it appears that he overlooked the statement made in his initial report of a caesarian section being possible within 20-30 minutes.

[109] With regard to his understanding of how the child's injury had occurred he placed his absolute confidence in the "objective fact" of Dr Pretorius' report. He explained why the scan report is reliable and conclusive:

> "So that is very useful information and without that one could not have an understanding at all of what happened in this case.
> Mr Du Bruyn: Would that be a good indication, the scan and the report of what happened? ---
> Witness: The MRI scan has made it possible in the last 30 years to have a very good understanding of what happens, because there is nothing else that gives that picture on an MRI scan of a child showing those changes in the deep grey matter and in those specific parts of the cerebral cortex."[47]

[110] He was adamant that the plaintiff's description of how the fundal pressure had been applied, at equal intervals with gaps in-between so to speak, to allow for autoregulation, was entirely at odds with the mechanism and typical features of an acute profound event.

[111] He stressed that the "available information" concerning the plaintiff, in the absence of the placenta having been microscopically tested, does not allow accurate identification of what sentinel event occurred *in casu* - not that he believed it was even necessary to know the cause for a sentinel event to occur, yet reasoned that an umbilical cord accident (compression) was the most probable, because, and this explanation appears to be a self-defeating one in my view, the other causes "are usually clinically apparent and would have been reported in at least some of the documents (there are of course none) or court evidence. To the contrary Dr Njapa-Ndamkou mentioned the possibility of a placental abruption or a traumatic delivery apart from a cord compression as being possibly causal, neither of which

[47] Pages 232-3 of the transcript.

possibilities Prof Buchmann gave the impression he wished to engage with. (As an aside the likelihood of a uterine rupture was explicitly ruled out by both experts)

[112] Prof Buchman appeared to skirt around the bizarre details of the application of fundal pressure as constituting a cause for the injury or contributing to the final acute profound injury although he accepted ultimately (begrudgingly so) that the way the plaintiff says it was done was totally inappropriate. Still he remained resolute that nothing done by the staff could have caused *an acute profound event* or that the fundal pressure could have any relation to such catastrophic event. I refer to an extract from his evidence (in two separate places in the transcript) which demonstrate his insistence in bringing the emphasis back to the acute profound picture with its so-called typical features:

> "(Mr. De Bruyn and the witness): In your opinion, Professor, from what you've heard with heart, fundal pressure and the other evidence, what is your opinion? Could fundal pressure in this matter have any relation to an acute profound event? --- No, M'Lady.
>
> For fundal pressure to cause an acute profound, how long would you need that pressure continuously or intermittent or what? What is the position? --- Acute profound asphyxia as described in the literature and as supported in the MRI report we have requires at least 10 minutes of continuous cut-off of blood supply to the brain, that we call ischemia, and to do that with fundal pressure you have to provide enough pressure on the uterus to cut off blood supply to the foetal brain. I cannot imagine how one would do that. You would have to push from all sides with incredible pressure continuously for 10 minutes. It's something I've never seen and something I don't think I would be able to do if I was alone. I cannot imagine that that could happen.[48].....
>
> MR. DE BRUYN Now in this case what we've heard let's accept the 5 minutes and then 5 minutes rest, 5 minutes, 5 minutes rest. On what you've said could that have caused acute profound? --- No, M'Lady, *that's not how acute profound works*. It's a continuous unremitting cut off of blood supply to the brain which shocks the brain immediately so that the central metabolically

[48] Pages 256-7 of the transcript.

active areas get damaged first and that's what is seen on the MRI. [49]
(Emphasis added)

[113] Still under cross examination by Mr. Brown he remained unyielding in this respect:

"Yes and you agree doctor that if there was any indication, even in those 30 minutes that this baby was suffering any form of distress, there would have been an opportunity to then intervene? --- *I need to take the Court back to this being an acute profound event*.[50]"

[114] Far from being amenable to any other causes (than a cord compression) possibly even coming within the meaning of a "sentinel event", his reply to Mr. Brown under cross examination demonstrates his biased approach of fundal pressure not conducing to cerebral palsy:

"But let's now look at our case. What in your opinion was the reason for fundal pressure to be applied to (Ms. Mpetsheni)? --- I do not know. I've given the possible reasons. Poor advancement of the head and/or concern about the foetal heart rate.
Yes, what about the maternal exhaustion? --- That is one of those that is related to poor advancement of the head. The woman is simply too tired to push that baby over the last and then there is an attempt to correct that or to help her by pushing the whole uterus down and succeeding with fundal pressure.
Now according to your evidence here maternal exhaustion, the poor effort was one of the criteria for application of fundal pressure in this study? --- That's correct.
So then why did you try to exclude Luyanda from this group who ended up in the ICU? He fits the (profile), (his) case would fit those criteria. --- The children in the Egyptian study had low

[49] Pages 257-8 of the transcript.
[50] Page 303 of the transcript.

Apgar scores for whatever reason. There is no evidence, in fact it is pseudoscience or incorrect to attribute any outcomes of the babies to the fundal pressure procedure because where fundal pressure was chosen those babies were systematically different from where fundal pressure was not done. They had, in thirty percent of labours, foetal distress before. You are going to have an expected low apgar score rate, higher in that higher in that group because there was foetal distress, expect found in thirty percent, 29%. This is a classic case of an observational study where causation cannot be inferred, only association. That is why we do randomised control trials as the one, the two from Turkey that we have presented.

Well doctor I'm going to argue the exact opposite. I'm going to argue that Luyanda's case fits the criteria in this study and I'm going to argue that you are attempting to exclude Luyanda from those criteria because it does not fit the defendant's case. --- I said that Luyanda would have had a (sentinel event) event which started in the last half hour before delivery. I have said that fundal pressure could not have interfered with blood flow to the brain, from the placenta through the cord as a result of that because (the plaintiff) would have had to have fundal pressure continuously applied for ten to fifteen minutes to cause that sentinel event with the complete cut off. That is not what was done in this study in any way. This study, ja so that is why I exclude Luyanda. Not because of this study in particular, although the study tells me that fundal pressure used in the way it was used in Egypt showed no reports of hypoxic ischemic encephalopathy, neonatal death or baby's brain injury. So that aside, Luyanda's case is a special one. (He) is an individual. I don't know what happened exactly there. (He) had a sentinel event. I remain saying that fundal pressure cannot explain sentinel event because it would have had to be applied continuously for ten to fifteen minutes in a way that would have interrupted brain circulation and there are no case reports

> anywhere of that having happened from the literature that I've searched so I simply cannot describe an incident that has never happened in the literature or that is not even plausible because I have to imagine how fundal pressure would interrupt the brain blood flow.[51]

[115] In response to a question by the court whether the added pressure of fundal pressure, assuming a cord compression already in the vaginal cavity where the head appeared stuck, might not have been causal to the acute profound injury, he reiterated two things: one, the need for this scenario to be going on for ten to fifteen to twenty minutes before delivery to qualify as it were as a sentinel event and, two, that there is just no data on this.

[116] He denied any high-risk factors in the plaintiff's case and expressed the view that the early morning rupture of the plaintiff's membranes was a normal occurrence in the labour process, with no risk occasioned to her or the child *per se* thereby.

[117] Prof Buchmann's staunch reliance on what the significant features of an acute profound injury are and how it correlates with neuroimaging which shows a more or less consistent pattern of brain injury, appears to be indicated in three seminal articles concerning case studies of such a syndrome and a textbook on the neurology of a neonate he referred the court to, rather than on his own empirical experience of cerebral palsy outcomes. His unrelenting promotion of the defendant's case that because the scan shows an acute profound pattern the injury was unforeseeable, could not be prevented and was not caused by the acts or omissions of the nurses who attended to the birth of the child prompted Mr. Brown to submit that Prof Buchmann did not give objective or unbiased evidence. I am inclined to agree with such a submission. Not only was he inflexible, but extremely reluctant to make concessions or engage with any possibilities beyond what the constraints of an acute profound typical scenario allow for. Where he did make concessions, these were mostly followed by a compulsion to mitigate the impact thereof soon thereafter. Where he referred to articles, it was only to support single or separate aspects

[51] Pages 369-371 of the transcript.

therein that advanced the defendant's case, ignoring valuable information in them that co-incidentally favoured the plaintiff's case.

[118] This is not the hallmark of an expert witness whose function is to assist and guide the court in respect of matters where certain expertise is called for. In Twine & Another v Naidoo and Others[52] the court restated the principles applicable in evaluating expert testify. Among the obvious that a court is not obliged to accept the evidence of an expert unless it is based on opinions properly brought forward and on foundations justifying such conclusions is the admonishment that:

> "Expert witnesses who repeatedly provide expert opinions to parties- and sometimes only for plaintiffs or defendants should be careful not to burden the court with what some justices of the U. S. Supreme Court called "*expertise that is fausse and science that is junky*." Evidence which is repeated from case to case or an opinion that is mildly altered from case to case is in danger of falling foul of this principle. The court should scrutinize these opinions very carefully and should not hesitate in refusing them admission nor should they be swayed by the impressive scientific qualification of the experts for these are irrelevant…"

[119] This caution commends itself to me, given the flourish with which the defendant pursued her defence on the issue of causation hot on the heels of the Department of Health's success in the Magqeya matter in which Prof Buchmann was also involved, pushing the same line regardless of the staff's substandard care and injudicious use of fundal pressure on the apparent basis that because this is an acute profound picture, its game over and simply bad luck for the plaintiff.

[120] It is misleading to suggest that the parties are "*ad idem* that the cause of the damage was an acute profound (sentinel) hypoxic ischaemic event that happened intrapartum without warning." The defendant has put her own spin on this and paraphrased the parties' agreement that is recorded in Exhibit "C". Although the plaintiff (a) conceded the report of Dr Pretorius and his views of what the images

---

[52] [2018] 1 All SA 297 (GJ) at par [18].

represent or depict, and (b), accepted (apparent from concessions made by Dr Ndjapa-Ndamkou without hesitation during cross examination) what the typical features are of a sentinel event and how this would conduce to an acute profound injury, he had his own views and explanation for what happened *in casu*.

[121] Regarding that theory, Professor Buchmann reluctantly concurred with him on the mechanism or manner in which hypoxia develops and can lead to an acute profound hypoxic ischaemic encephalopathy, more particularly how, after a time, the auto regulation system of the foetus will fail if exposed to prolonged periods of intermittent hypoxia. Prof Buchmann also conceded, again very grudgingly, that such prolonged and repeated incidents of intermittent hypoxia superimposed as it were by a sentinel event would not invariably manifest or show on MRI scans as partial prolonged hypoxic ischaemic injuries, thus in my view still leaving a mixed injury open as a possibility. In the light of the lack of certainty that a partial prolonged injury would leave a separate footprint where acute near total asphyxia superimposes itself and presents a picture of the all-encompassing brain damage, I find Dr Njapa-Ndamkou's assessment of what caused the injury to be entirely plausible and probable in all the circumstances. It was accepted between the experts that an umbilical cord compression probably occurred in the last 30 minutes before delivery and caused the acute profound hypoxic events resulting in the cerebral palsy although Dr Njapa-Ndamkou reckoned that this event, albeit it occurred right at the end, could not be viewed in isolation and certainly had a natural association with the acts and omissions on the part of the hospital staff .

[122] It is so that unless the placenta has been tested microscopically, the cause of the sentinel event will be unknown, but in this respect, it is not scientific certainty that is the standard of proof in civil actions. [53] Each of the risk factors highlighted by Dr Njapa-Ndamkou in a cascading manner point to a causal connection between the inappropriate management of the plaintiff's labour, including (more especially) the injudicious and untimely application of the fundal pressure in a situation where the child was already in a compromised position, and the superimposed acute profound hypoxic result.

---

[53] MEC for Heath, Eastern Cape v Evelyn Klaas, Bhisho Case no 25/2018, delivered on 20 November 2018. See para [37].

[123] The civil onus rests on the plaintiff to satisfy the court that her version is more probable and consists of credible evidence as compared to that of the defendant. The conclusion preferred should be the more natural or plausible from several conceivable ones, even though that conclusion may not be the only reasonable one.

[124] I am satisfied that the plaintiff has established the issue of causation on a balance of probabilities.

[125] The element of negligence was never really in issue, the defendant conceding that the management of the plaintiff was substandard and contrary to the guidelines of the national Department of Health in the several respects highlighted in the evidence. The defendant also conceded, quite perplexingly, that there is a skills disparity in staff employed at rural hospitals, such as Madwaleni Hospital is, in relation to the city. Examples of substandard management would relate to the staff's failure to assess and monitor the plaintiff and the child's wellbeing at the critically required stages of her labour, (especially the child's foetal heart rate) with the simple tools at their disposal -vaginal examinations, blood pressure monitors, CTG's Doptone/Pienaar stethoscope or other electronic foetal heart rate equipment which the defendant did not gainsay exists at the hospital, thereby missing important cues and "red flags" regarding the plaintiff's progress; the staff's failure to plot and track the progress of the deliver (it is evident from the plaintiff's evidence that the nurses made reference to her "file" to proclaim that labour was either imminent or not so these tools were plainly there for their use); their failure to have performed a caesarian section in any event (or to have offered her this as an alternative)[54] once the first stage of labour had dragged on (calculated from when her water broke early morning)[55] or once it became apparent in the second stage of her labour that her bearing down efforts had not produced a result within 45 minutes,[56]their

[54] Prof Buchmann conceded this as a reasonable proposition and quite plainly had this caution galvanised the staff into action the child would have been safely delivered and spared the difficult delivery that ensued as well as the unfortunate outcome.
[55] Prof Buchmann concede that 1 cm per hour is the minimum rate of dilatation (or at least was at the time of the child's birth) before being concerned
[56] Prof Buchmann accepted this as a reasonable proposition too based on the plaintiff's evidence that she had pushed by her own efforts, the baby had not made its exit whereupon there was this resort to an episiotomy and the fundal pressure, both measure undertaken indicative of a recognition on the part of the nurses that there was a problem getting the baby out some while after the commencement

inappropriate, indiscriminate and untimely application of the fundal pressure to the plaintiff's abdomen after the head had crowned and was causing a blockage at the vaginal opening,[57] and (finally) their failure to assess and diagnose the plaintiff's relative cephalopelvic disproportion by the fact that the head was stuck in the birth canal and had not progressed within the timeframe it ought to have and not taking appropriate measures there anent to rectify the emergency and intervene appropriately (for example, by administering oxytocin, changing her position, intrauterine resuscitation, vacuum extraction or forceps delivery, or ultimately caesarian section).

[126] It follows the plaintiff succeeds in respect of the issue of liability. I set out above in some detail the several disturbing features concerning the way the defendant conducted her litigation. As a mark of this court's displeasure, and as a curative measure, I intend to award costs on the higher scale of attorney and client. I would have penalized the defendant by depriving her of her costs even if she were successful in her defence.

[127] There remains one final aspect to be dealt with and that is the reserved costs of the proceedings on 13 December 2018. The matter was postponed until this date for argument before me during the recess. Mr. Brown could however not secure a flight in time from Johannesburg to East London and informed Mr. De Bruyn of his predicament at 06h00 on the morning in question after the latter had already travelled to East London from his chambers in Port Elizabeth and had spent the evening here in paid accommodation. Mr. de Bruyn accepted Mr. Brown's *bona fides* but still held out for a *de bonis propriis* costs order against him. I understood the basis to be that if the judgment did not go in the plaintiff's favour this would mean that Mr. Be Bruyn's travelling and accommodation costs would not ultimately be recovered. I am not inclined to grant such an order and certainly not for such a reason. The tender by the plaintiff of the defendant's party and party costs in this respect (including special costs) are in my view adequate recompense for the unfortunate absence of Mr. Brown due to no fault of his own. If I recall correctly, SAA

---

of second stage labour (even on his assessment of this stage only commencing at 21h00 when the plaintiff screamed).

[57] Prof Buchmann conceded that fundal pressure applied as the plaintiff described in her testimony would conduce to a negative outcome.

might even have been bumped him off his flight that morning which had been booked in time. Certainly, no disrespect was intended, at least not on his part.

[128] I issue the following order:

1. I find in favour of the plaintiff on the issue of liability;
2. The defendant is liable to the plaintiff for the damages found proven in due course;
3. The plaintiff is entitled to her costs of the separated trial, such costs to be on the higher scale of attorney and client, and to include the costs of second counsel where employed;
4. The plaintiff is directed to pay the wasted costs occasioned by the postponement on 13 December 2018 on the ordinary scale of party and party. The wasted costs will include but not be limited to the travelling and reasonable accommodation costs incurred by the defendant's counsel in travelling to (and overnighting in) East London at the request of the court to submit closing arguments on the arranged date of 13 December 2018. The wasted costs in this respect shall include the costs of second counsel, if applicable.

_____

B HARTLE
JUDGE OF THE HIGH COURT

DATE OF HEARING : 22 - 24 May, 3 - 7 and 19 December 2018

DATE OF JUDGMENT: 15 March 2019

Appearances:

For the plaintiff: Advocates D Brown and T Mduba instructed by Dudula Inc. care of Dandala Attorney, King William's Town (ref. Messrs. Y Dudula/ M Lindwa).

For the defendant: Advocates PJ De Bruyn S.C. and ND Ngadlela instructed by The State Attorney, East London (ref. Mr. Mgujulwa).