NOT REPORTABLE

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

Case no: 3180/2014
Date heard: 21 April 2016, 1 August 2017, 7 March 2018
Date delivered: 15 March 2018

In the matter between

Z. K. **Plaintiff**

Vs

MEC FOR HEALTH, EASTERN CAPE **Defendant**

JUDGMENT

PICKERING J:

[1] At 13h00 on 3 July 2013 plaintiff, a 41 year old woman, was admitted to Stutterheim Hospital for assessment and examination by doctors and nursing staff for possible induction of childbirth. At 17h01 on the same day plaintiff's baby was delivered by caesarean section. It is common cause that the baby spontaneously stopped breathing approximately 30 seconds after delivery and that, notwithstanding attempts at resuscitation, the baby died, being finally pronounced dead at 18h00.

[2] During August 2014 plaintiff instituted action against the defendant, the Member of the Executive Council for Health in the Province of the Eastern Cape, in which action she claimed the funeral costs in respect of the baby as well as general damages for emotional and psychological trauma. Her claims are founded upon allegations of negligence on the part of the doctors and nurses employed by defendant at Stutterheim Hospital. In the plea, defendant denies

that the medical and nursing staff at the hospital were negligent in the respects alleged or at all and plead further that there was, in any event, no causative link between any conduct of such staff and the death of the baby.

[3] At the commencement of the trial I made an order by consent, separating the issues of the merits and quantum. The trial proceeded before me on the issue of the merits only.

[4] The background to plaintiff's admission to Stutterheim Hospital on 3 July 2013 was or became largely common cause as the trial progressed. This was plaintiff's sixth pregnancy, of which four babies had previously survived. She attended the maternity clinic at Stutterheim Hospital for the first time on 26 April 2013 at which time she was approximately six months pregnant. According to the notes recorded by staff at the clinic she tested positive for syphilis and received the appropriate treatment therefor on 6, 13 and 27 May 2013. She informed the staff that her last menstruation was on 23 September 2012. Her estimated due date was accordingly calculated as being 17 June 2013 which calculation, however, was erroneous as will appear hereunder.

[5] According to the hospital ward notes plaintiff then attended at the hospital on 24 June 2013 complaining of lower abdominal pain and "*a sharp pain on her vagina when walking.*" She now gave the date of her last menstrual period as being 15 September 2012. It became common cause, however, that on 3 July 2013 plaintiff was in fact three days beyond full term.

[6] On 24 June 2013 plaintiff was admitted for treatment of a urinary tract infection and was counselled about the risks of an induction which she had requested. Her pregnancy was normal upon examination. In particular there were no clinical signs of foetal abnormality. She was not in labour. She was discharged the following day and advised to monitor the foetal movements and to return on 3 July 2013 unless she went into labour sooner.

[7] The notes record that plaintiff did return to the hospital on 3 July 2013. At 13h00 she was examined by a nurse who found that she was not in labour and no contractions were evident. A cardiotocograph ("CTG") was put in place at 13h14.

[8] It is common cause that the avowed purpose of a CTG is to enable early identification of foetal asphyxia in the hope of preventing death or long term neurological morbidity, especially cerebral palsy. Whether it achieves that purpose was a matter of considerable debate between the respective counsel and medical experts to which I will return hereunder. A CTG monitors the foetal heart beat variability on a continuous basis and its response to contractions of the uterus. It monitors in particular whether there are early or late "*decelerations*", these being the reflexive response of a foetus to the stresses in labour whereby a foetus protects itself by rapidly slowing its own heart rate to reduce oxygen consumption and to improve its coronary blood flow during intrapartum hypoxic stress, hypoxia being a lack of oxygen. A deceleration, therefore, simply put, is a significant slowing down of the foetal heart rate in the presence of a uterine contraction.

[9] According to the notes during the period 13h14 to 13h24 the CTG recorded typical variable decelerations. At 13h34, however, the CTG recorded a late deceleration which is so-called because, as explained by plaintiff's medical expert, Dr. Nelson, "*the deceleration commences after the contraction commences and it returns to the baseline after the contraction is over.*" In other words the deceleration is late in relation to the onset and completion of the contraction.

[10] At 13h53 another late deceleration was recorded which, in this case, was preceded by reduced baseline variability. It is common cause that a healthy foetal heart beat should normally vary by five beats per minute because a healthy baby is able to respond to changes in its blood flow requirements. In the case of a sick foetus, however, which does not respond normally, the so-called baseline variability as recorded on the CTG is reduced and becomes flatter. It is common cause that a late deceleration accompanied by reduced baseline variability is "*sinister."*

[11] Between 14h13 and 14h22 the CTG was normal except for a late deceleration. For some reason, which could not be explained, the CTG recording then ceased.

[12] It is further common cause that at 15h04 the duty doctor at the hospital, Dr. Valelo, attended upon the plaintiff and gave instructions for plaintiff to be prepared for a caesarean section. At 16h05 plaintiff was taken to the operating theatre, arriving at 16h08. At 17h01 the baby was delivered by caesarean section.

[13] In the light of the CTG recordings plaintiff alleges that defendant's employees were negligent, *inter alia*, in the following respects:

> "*8.4 they failed to react promptly and appropriately to the CTG tracing showing a combination of reduced variability and late deceleration; and*
>
> *8.5 they failed to recognise that the aforesaid combination of symptoms on the CTG tracing was indicative of significant foetal hypoxia and that a very sinister situation was developing for the foetus;*
>
> *8.6 the nursing staff failed to secure the services of the Duty Doctor at an earlier stage; and*
>
> *8.7 the Duty Doctor failed to attend to the patient at an earlier stage, arriving 1 ½ hours after the sinister CTG tracings had manifested themselves; and*
>
> *8.8 they failed to carry out the caesarean section operation timeously, allowing one hour and fifty-five minutes to lapse between the arrival of the Doctor at 15h00 to the time of the delivery of the baby.*"

[14] At the trial plaintiff adduced the evidence of one medical expert, the aforementioned Dr. Nelson, a specialist obstetrician and gynaecologist, whereas defendant adduced the evidence of a nurse, Mrs. Ntengo, and a medical practitioner, Dr. Valelo, who were both on duty on the day in question, as well as the evidence of Dr. van Helsdingen, also a specialist obstetrician and gynaecologist.

[15] During the course of Dr. Nelson's testimony, to which I will return in more detail hereunder, he was closely and forcefully cross-examined by Mr. de la Harpe, who appeared for defendant, concerning the alleged failure of Dr. Valelo to attend to plaintiff at an earlier stage than he did as well as the time taken before the caesarean section was carried out. It was put to him that Dr. Valelo was unable to attend to plaintiff before 15h00 because "*he was doing an evacuation of a patient who was having profuse vaginal bleeding due to a miscarriage when these events first manifested themselves and that after the evacuation he had to attend to a gunshot patient who was brought in by a policeman.*" It was further put that due to logistical constraints at the hospital it was "*simply physically impossible to actually prepare and commence the surgery within any lesser time than was taken."*

[16] This led Mr. Cole who appeared for plaintiff to apply for a postponement in order to inspect the theatre records of the hospital and to investigate the matter. When the trial resumed a very different picture to what had been put to Dr. Nelson emerged. I will deal with this hereunder.

[17] In order properly to assess the expert evidence of Dr. Nelson and Dr. van Helsdingen it is necessary first of all to have regard to the evidence of Mrs. Ntengo and Dr. Valelo.

[18] Mrs. Visisa Ntengo testified that during 2013 she was performing community service as a professional nurse at Stutterheim Hospital, having completed a Bachelor of Nursing degree at Fort Hare University in 2012.

[19] On 3 July 2013 she was on duty in the maternity ward together with four other nursing sisters. There were nine patients in the ward. She was at that time still a student intern. She stated that in the course of her duties she attended to plaintiff after the latter's admission to the ward. She stated that the plaintiff's CTG had been started by a sister Sivanelo. When Sivanelo went off duty the sister in charge was sister Xulubana. Mrs. Ntengo's duties included monitoring the CTG recording (Exhibit A) but she was unable to remember when she had seen it for

the first time or where exactly it had progressed to when she looked at it. She stated that during her studies she had learned about CTGs which, she confirmed, was an important part of nursing training. She knew how to use a CTG and she had learned in her studies about "*variability, beat to beat, decelerations and contractions.*" Under cross-examination, however, she stated with regard to the day in question:

> "*That time I was still learning, I had one month in maternity. I was new neh? I wasn't sure about CTG's and all those procedures. I was early from school neh*."

And

> "*I was still learning and I was doing everything slowly… I didn't know everything… even the CTG we were taught in class about CTG, all those features, but we did not write it on the test, we did not write it on exams, imagine, and even in the practical we don't look on the CTG we only focus on the deliveries we need to have. So imagine I had only one month and I am still learning the CTG, I am not sure about the CTG, so please consider that.*"

[20] She added that she "*felt unqualified to do the job*" and was "*a bit overwhelmed by all this.*"

[21] Because of her training, however, she was able to recognise any abnormality in the CTG tracing. At some stage she looked at the CTG on the instructions of Xulubana and noticed a late deceleration. She accordingly informed Xulubana of what she had seen. Xulubana in turn instructed her to phone Dr. Valelo. She contacted Dr. Valelo on the internal phone system. He was at that time busy in the casualty department. She told him that "*the child inside is not ok.*" According to her Dr. Valelo then instructed that plaintiff should be put on a drip and should rest on her left side. She should be given oxygen. He said that he would come and see the plaintiff. It is common cause that Mrs. Ntengo did not record the instructions given to her. Questioned about this she

stated that she could not remember whether she had done so or not. Asked why she would not have recorded such important instructions she again stated that she was "*overwhelmed really, because when you are new in the Department, you don't think like everything. You forget some of the things… you don't think about recording, so I think that is what happened.*"

[22] It was put to her that according to Dr. Valelo's entry in plaintiff's record he had given instructions at 15h05 "*to start the IV fluids*" and that it made no sense for him to have given that instruction at that time if in fact he had instructed her earlier to put the plaintiff on a drip and the IV fluids were already in place in accordance with his earlier instructions. She replied that that was Dr. Valelo's plan and how he did things. She stated that at 15h04 Dr. Valelo gave instructions to prepare plaintiff for the caesarean section, which she did. According to a note on the record, at 15h35 plaintiff "*was prepared for caesarean section: IV Fluids and catheter inserted*." Plaintiff was ready for theatre at 16h05. She could not say why plaintiff was only taken to the theatre an hour after the instruction to prepare her for a caesarean section had been given.

[23] She stated that the maternity ward was close to the casualty theatre, less than a two minute walk away. Mrs. Ntengo stated that after each operation in the theatre it would be cleaned and left ready and prepared for the next case.

[24] As recorded on the clinical notes (A12) plaintiff was wheeled to the theatre at 16h05 arriving there at 16h08. She stated that she handed plaintiff over to the theatre sister and returned to the ward to fetch a resuscitator. She returned to the theatre, her duties being to receive the child after delivery.

[25] She confirmed the theatre note (A17) to the effect that "*baby cried at delivery but stopped spontaneously breathing plus minus 30 secs after delivery. Bag mask ventilation begun immediately and continued for plus minus 15 min.*" She confirmed that the bag mask ventilation was applied by the anaesthetist and Xulubana for approximately 15 minutes and that attempts to resuscitate the baby were made but that the baby was pronounced dead at 18h00.

[26] She was asked whether the note to the effect that the baby cried at delivery was correct to which she replied that it was but that "*the cry of the child was not a cry of a child who was healthy.*" She explained that it was "*like a groaning*" and that the baby was "*having gasping respirations.*"

[27] With regard to what had been put to Dr. Nelson earlier, namely, that Dr. Valelo was attending to a patient with profuse vaginal bleeding, Mrs. Ntengo denied that she had given any such instructions to defendant's legal advisors. She denied also that she had given instructions that Dr. Valelo had had to attend to a gunshot patient. She stated that those instructions had come from Dr. Valelo.

[28] Dr. Valelo testified that he commenced employment at Stutterheim Hospital during May 2011. He confirmed that he had examined plaintiff at the hospital on 24 June 2013 and had diagnosed her as having a urinary tract infection. She was admitted to hospital, and given oral antibiotics and analgesics and discharged on 25 June. Plaintiff requested an induction of labour and Dr. Valelo counselled her about the risks thereof. She was told to return on 3 July at the latest. There was some dispute as to how many weeks she was pregnant as at 3 July and whether she was post-mature but it is common cause that she was in fact 40 weeks and 3 days pregnant and nothing turns on this. He conceded, however, that he had recorded in plaintiff's folder that she was post-mature. He confirmed that on 3 July plaintiff had presented at the hospital at 12h59 with lower abdominal pain and a show of blood, which were indications that labour was possibly about to commence. Plaintiff was not, however, at that stage in labour. He gave the following instructions to the nursing staff:

> "*Plan - Admit*
> *CTG stat then 6 hourly stretch and sweep. Possible induction or augmentation with Pitocin mane.*"

[29] He explained that by this he meant that the CTG was to commence immediately. According to him the CTG would run for approximately twenty minutes whereafter, if there were no problems, it would be removed and repeated

after six hours. He explained further that "*stretch and sweep*" entailed putting fingers inside the cervix and stretching the membranes in order to separate them from the cervix, thereby stimulating labour. He stated that his training encompassed the use of CTGs and that he was required to have proper regard to any abnormalities such as "*late deceleration and poor beat to beat.*"

[30] Having examined the plaintiff at 13h00 he proceeded to casualty where he was required to treat a woman suffering from vaginal bleeding who required an evacuation. During the course of this procedure he received a phone call from Mrs. Ntengo concerning the plaintiff.

[31] According to him Mrs. Ntengo informed him that plaintiff was "*having some deceleration*". It was put to him under cross-examination that according to Mrs. Ntengo she had told him that "*the child inside is not ok*." He replied as follows:

> "*If there is a CTG that is not assuring, the sister will phone and say can you please come and see this non-reassuring CTG with decelerations. It's like the way you put it, you are exaggerating.*"

[32] Counsel, however, was not exaggerating and Dr. Valelo eventually, somewhat reluctantly, stated that he did not dispute that that was in fact what Mrs. Ntengo had told him. I should mention at this juncture that it was common cause that the CTG tracing stopped at 14h22. He did not know why it had stopped and he conceded that it would have been very important for him to have kept getting information as to the condition of the child but that did not happen.

[33] Under cross-examination he was reminded of what had been put to Dr. Nelson by Mr. de la Harpe, who appeared for defendant, namely:

> "*And I must tell you that it was put to Dr. Nelson in the context of you had two hours to check the CTG and that just before the two hours was up somebody checked it and they called you. That was the context. Now, at that time it was then put to the witnesses, you couldn't go because you were faced with two emergencies. Do you remember that at least? ... Yes.*

And the emergencies that you were faced with allegedly just before three o'clock on that afternoon were profuse vaginal bleeding due to a miscarriage when these events were reported. Do you remember that? … Yes."

[34] He was then asked whether he had given instructions to defendant's legal representatives that he was faced by an emergency because somebody was bleeding heavily and profusely. In reply he referred to exhibit B where he had stated that the patient in question had been complaining of abdominal pains since the morning and was "*bleeding with clots*." Eventually, after persistent cross-examination, he stated that he had maybe told the legal representative that the patient was bleeding heavily and profusely. Questioned as to whether there was anything in the record to indicate that the patient was bleeding heavily he replied "*like what maybe*?" In other words, there was not.

[35] It was put to him that the patient had arrived at casualty at 09h30 and that he had only seen her at 13h00, nearly four hours later to which he agreed. He was then asked whether it was possible that a woman who was bleeding profusely would have been left in casualty for four hours before getting treatment to which he replied "*no, it is not possible."* He was accordingly asked whether it could be accepted that she could not have been bleeding profusely to which he replied "*Ok*".

[36] After the aforementioned postponement of the trial it became common cause that the alleged gunshot victim who was attended to by Dr. Valelo after the evacuation procedure was not in fact suffering from a gunshot wound but had merely been assaulted on the head with a gun in consequence whereof he had sustained a laceration to the forehead. Dr. Valelo denied having given instructions to the effect that the victim had been shot and conceded that this was not an emergency situation.

[37] He confirmed that he had been sitting in court when Mr. de la Harpe had put to Dr. Nelson that before proceeding to plaintiff he had first to deal with the gunshot victim. He stated that he had not corrected Mr. de la Harpe when he put

an incorrect statement to Dr. Nelson because he did not know court procedures. This was despite his having given instructions to Mr. de la Harpe on a number of occasions during the course of Dr. Nelson's testimony. It was put to him that he had in fact given Mr. de la Harpe the instructions concerning the gunshot victim to which he replied sarcastically "*and did you hear the instructions?*" He then stated that he did not know whether the incorrect facts had come from him but he denied having exaggerated what was actually a relatively minor assault case.

[38] In response to a statement by Mr. Cole that "*you created the sense in this court that you were faced with haemorrhaging of the highest order from two patients, profuse bleeding and a gunshot wound, when it's not true. Am I right?*" He replied "*I don't know*."

[39] He confirmed that at 13h45 he had finished the evacuation and was free to go and check on plaintiff. Asked why in that case he had only gone to check on her at 15h00 he stated that when he got out of the casualty theatre where he had been performing the evacuation he had gone "*straight*" to examine the assault victim. It was put to him that this evidence was false because, according to his earlier evidence, he had in fact only seen the assault victim at 14h15. He conceded that this was so. Asked what he had been doing between 13h45 and 14h15 he stated that he did not know. He did not think that he had gone to lunch.

[40] He agreed that he had received the phone call concerning plaintiff whilst he was busy in the casualty theatre with the evacuation, although he could not remember at what stage thereof the call had come through. He was then referred to defendant's amended plea where it had been pleaded that at approximately 14h15 the aforementioned sister Xulubana had observed the CTG recording of the events at 13h35 and 13h53 and had notified Dr. Valelo thereof, at which time Dr. Valelo was "*occupied in attending to a head wound and an incomplete abortion which required evacuation.*" It had further been put to Dr. Nelson as follows:

> "*Q The witness will say that she checked on the CTG at about 14h15 and that she saw the tracings that had earlier occurred, alerted her*

supervisor, who in turn told her to contact Dr. Valelo and she did so at about 14h15."

[41] It was put to Dr. Valelo that, in the circumstances, if Xulubana had said the call was made to him at 14h15 she was definitely wrong, to which he replied that it was possible that she was estimating. It was then put again that her estimation must be wrong to which he said that he was not sure. He refused to concede that she was wrong. It was again put to him that if he had finished the evacuation by 13h45, and he had got the call before he had finished the evacuation, then Xulubana could not have phoned him at 14h15. He eventually and reluctantly stated "*let me say it is wrong.*" It was in any event clear that it was Mrs. Ntengo and not Xulubana who had phoned him. I should mention that although Xulubana was apparently available to testify and at home she was not called as a witness.

[42] It had been forcefully put by Mr. de la Harpe to Dr. Nelson that according to the Guidelines for Maternity Care in South Africa, 2007 it was only necessary for the nursing staff to check the CTG readings every two hours and that, just before the expiry of that period at 14h55, the CTG had indeed been checked and Dr. Valelo had been phoned and notified thereof. Under cross-examination by Mr. Cole, it was put to Dr. Valelo that the allegation that he only received the phone call at 14h55 was a fabrication clearly designed to dovetail with the aforesaid Guidelines. Dr. Valelo denied that the time of 14h55 had come from him, reiterating that he did not remember when he had been called and stating again that maybe the time of 14h55 was an estimation on the part of whoever had given those instructions.

[43] He stated that because he had not expected any problems with plaintiff having regard to the history that he had got from her and from the previous examination on 24 June, the call to say that the baby was in a bad condition was surprising and unexpected. He was asked whether the call had not in the circumstances made him more concerned or whether he had decided to ignore it. He replied that "*no I was not ignoring, maybe I told myself that I will go when I am ready.*" He was then asked whether he thought "*I wasn't expecting trouble, this couldn't be trouble and so I will go when I am ready. I will take my time*" to which

he replied "*yes, you could say that.*" It was put to him that in fact he had ignored the urgency of the call from the labour ward until he was ready and he again replied "*you could say that.*"

[44] He confirmed that the assault victim was in a stable condition, ambulant, with a laceration of the forehead. Although there was some dispute as to whether he or the nurses had sutured the wound he denied that the nurses would have done so because that would not have enabled him to inspect the depth of the wound. His evidence was confused if not evasive in this regard but it is not necessary to deal therewith. He agreed, however, that there was no basis whatsoever to regard the victim as an emergency case requiring priority treatment. He stated that he had not been involved with this particular patient for more than ten minutes. He confirmed that he was finished with him at 14h30. He was then asked what he had done between 14h30 and 15h04 when he had finally gone to see the plaintiff. He stated that he did not remember and that maybe he had gone for lunch. He then immediately stated that he could not have gone for lunch in circumstances where he had been told that there was a baby who was "*not ok"*.

[45] He stated that he saw the CTG for the first time when he examined plaintiff at 15h04. He confirmed that he had recorded at that time that the CTG was non-reassuring with late decelerations and poor beat-to-beat variability. He conceded that he must have been called by Mrs. Ntengo shortly after the trouble first started at 13h34. It was put to him that in the circumstances his delay in proceeding to examine plaintiff was unacceptable. He agreed that the delay was indeed unacceptable.

[46] He confirmed that having seen plaintiff at 15h00 he had given the instruction "*stat IV Fluids, normal CL.*" His evidence proceeded as follows:

> "*Q Why did you say they should start the IV fluids then? …*
> *A Maybe I was writing my plan.*
> *Q You're giving them an instruction that this is how it should go forward?*

A Yes.

Q But what if they're already started IV fluids? Would you write that?

A No

Q So the evidence that the plaintiff had a drip up in casualty when you arrived is simply not possible?

A It's possible that the drip was on but I was writing as if I was seeing the patient before."

[47] It was put to him in the light of the above that the evidence that plaintiff was already on a drip was "*patently false*" to which he replied, surprisingly, "*its possible.*"

[48] He confirmed that plaintiff's surgery had commenced at 16h55. He was asked why it had taken from 15h04 when the decision to operate was taken until 16h55 to commence surgery. He replied "*I am not sure what was happening there.*" In this regard Dr. Nelson stated that after the decision to operate had been made at 15h04 it should have taken no longer than 15 minutes to prepare plaintiff for the operation, such preparation including obtaining plaintiff's consent; giving an oral antacid liquid by mouth; a maxolan injection and the insertion of a catheter into the bladder.

[49] He stated that the theatre was cleaned after any previous operation; the instruments would be in their sealed packs; there was no delay because of staff problems and the anaesthetist was already in the hospital. Furthermore, the theatre used for plaintiff's caesarean operation was not the casualty theatre in which the evacuation had been performed. He denied accordingly that he had given defendant's legal representatives any instructions to the effect that it was "*simply physically impossible*" to prepare and commence the surgery within a lesser time than was taken. He conceded that from the time the plaintiff arrived in theatre until the administration of the anaesthetic was "*a bit long".*

[50] In this regard Dr. van Helsdingen had stated in his supplementary report that "*the delay in doing the caesar was entirely due to the difficulty the anaesthetist experienced to insert a spinal anaesthetic",* the suggestion being

that plaintiff's obesity had caused difficulty for the anaesthetist in inserting the spinal anaesthetic. This opinion was reflected in defendant's amended plea where it was pleaded that "*the performance of a caesarean section was not delayed and that such delay as occurred was occasioned by difficulties experienced in inserting the spinal anaesthetic due to the plaintiff's obesity.*"

[51] In response hereto Dr. Nelson had stated that plaintiff, although obese, was not morbidly obese and that if the anaesthetist had struggled to insert the spinal anaesthetic because of her obesity this should have been recorded on the theatre notes as a specific problem, which it was not. I will return to this issue hereunder.

[52] When Dr. Valelo was asked whether he could remember how long it had taken to place the patient under anaesthetic he replied "*no I can't but she struggled a bit.*" It appears, however, from the notes of the operating theatre that the anaesthetist was able to place a spinal needle at the second attempt and that she did not record any difficulty with the insertion of the anaesthetic. She was also not called to testify.

[53] Dr. Valelo finally alleged that in all probability the foetus was suffering from a pre-existing condition when plaintiff arrived at the hospital on 3 July and he accused plaintiff of not having told him the truth concerning the foetal movements. It was common cause that thick grade 3 meconium was noted at birth. It is common cause that the presence of meconium in the amniotic sac was an indication that the foetus may be suffering from severe hypoxia. Although Dr. Valelo confirmed that the deceleration noted on the CTG at 13h34 had been a warning of oxygen deprivation and that this was confirmed thereafter by the presence of the thick meconium, he stated that "*but then it doesn't mean it happened after admission*" and stated that it was possible that because plaintiff had not attended clinic prior to coming to the hospital the foetus had been compromised. The following exchange then occurred:

"*Q* *So that is your serious contention that because she didn't attend the clinic and she didn't account to you about the foetal movements, this child was compromised before it came to you?*

A *It is possible yes.*

Q *But very improbable because the CTG scan, when they put it on initially, was perfectly normal. Do you agree with me?*

A *Yes.*"

[54] Mrs. Ntengo was not a particularly impressive witness. Her recall of the events was poor. As she herself said, however, she felt that she was out of her depth. I have grave doubts about the veracity of her evidence in one particular respect and that relates to the instructions allegedly given to her by Dr. Valelo when she phoned him in casualty to inform him that the child was "*not ok*". She knew that it was incumbent on her to record in the notes every action taken in respect of a patient. She knew from her recently completed training how important this aspect of her duties was. She was concerned about plaintiff's baby which she knew was "*not ok*". In these circumstances it is almost inconceivable, in my view, that she would have neglected to record any treatment prescribed by Dr. Valelo. She does not allege that she was rushed off her feet and dealing with other emergencies and that she did not therefore have time to record it. Instead, according to her, it was because of her inexperience that she did not do so.

[55] The probability that the instruction was never given and that her evidence was concocted in an attempt to cover up for negligence on the part of Dr. Valelo is strengthened, in my view, by the fact that on what was initially put to Dr. Nelson the call to Dr. Valelo was only made at 14h55. In those circumstances he obviously could not have given any instruction such as was alleged by Mrs. Ntengo. Furthermore, that probability is strengthened by the note made by Dr. Valelo at 15h04 namely, "*stat IV fluids*." As was submitted by Mr. Cole it is fundamentally improbable that an instruction that plaintiff should be put on a drip would have been given at 15h00 if in fact the drip had already been started.

[56] Dr. Valelo was an extremely poor witness. He was defensive and evasive and, in my view, dishonest, in a number of respects. As set out above, when Dr.

Nelson was cross-examined during his first spell in the witness box, a number of statements were put to him as to what the defence case was. Chief amongst these were that Dr. Valelo was unable to attend to plaintiff before he did because he was involved with two emergency cases. Those instructions could only have emanated from Dr. Valelo. After the relevant documentation had been obtained by plaintiff following upon the postponement those instructions were revealed beyond any doubt to have been false. It is clear, in my view, having regard to the tenor of Dr. Valelo's evidence as a whole that the instructions initially given to defendant's legal representatives were calculated to counter the allegations of negligence made by plaintiff and to conceal the true state of affairs. Even the allegation in the consequentially amended plea to the effect that Dr. Valelo was phoned by Xulubana at 14h15 was false. It is clear that the edifice of the initial cross-examination of Dr. Nelson was largely built on sand.

[57] Once defendant's case has been shorn of all its dishonest elements the following can be accepted:

"*i.* *Plaintiff was examined by Dr. Valelo on 24/25 June 2013 during which examination she was placed on a CTG but no clinical signs of foetal abnormalities were observed.*

ii. *At approximately 13h00 on 3 July 2013 plaintiff was put on a CTG and appropriate treatment was ordered.*

iii. *At 13h34 the CTG showed a late deceleration and Dr. Valelo was advised thereof whilst still engaged in the evacuation procedure in the casualty theatre.*

iv. *That procedure ended at 13h45.*

v. *From 13h45 to 14h15 Dr. Valelo's whereabouts and actions are not known. Despite being one or two minutes' walk away from the maternity ward Dr. Valelo did not proceed to the ward to check on plaintiff.*

vi. *At 14h15 Dr. Valelo attended to an assault victim.*

vii. *At 14h30 Dr. Valelo was finished with the assault victim.*

viii. *Between 14h30 and 15h01 Dr. Valelo's whereabouts are unknown. He did not proceed to check on plaintiff during that period.*

viiii. *At 15h01 Dr. Valelo proceeded to the maternity ward to examine plaintiff whereupon he gave certain instructions for her treatment and ordered that she be prepared for a caesarean section.*

x. *At 15h35 plaintiff was prepared therefor.*

xi. *At 16h05 plaintiff was taken to the theatre, arriving there at 16h08.*

xii. *At 17h01 the caesarean section commenced and the baby was born. The reasons for the delay in commencing the operation after the instructions had been given at 15h01 are not explained by either Mrs. Ntengo or Dr. Valelo.*

[58] But the false instructions given to defendant's legal representatives had a more pernicious effect. Dr. Nelson was obliged, unfairly, to deal under cross-examination with allegations that were grossly misleading and false and which had the effect not only of unsettling him on occasion but also of distorting his cross-examination.

[59] It was for instance put to him that Dr. Valelo had started the evacuation at 13h45 and was still busy therewith when he was phoned by the nurse at 14h15. He disputed that the procedure could have taken half an hour, based on his own experience, stating that it was one of the simplest procedures in gynaecology. The following exchange then occurred:

"*Q* *So if Dr. Valelo says that is what happened you say he is a liar based on your own experience?*

A *Yes, because when I was a young training doctor we did thousands of these procedures and they did not take half an hour.*"

[60] Dr. Nelson estimated that the procedure would have taken no more than fifteen to twenty minutes. As thereafter transpired Dr. Valelo's instructions were false and he had not only not been phoned at 14h15 but had actually finished the evacuation prior thereto at 13h45.

[61] Dr. Nelson had further expressed surprise that plaintiff had waited in theatre for nearly an hour and stated that "*if you have a baby you think is in*

trouble you crash any theatre list that is in progress and you give the foetal hypoxia patient top priority." He had stated further that the delay in commencing the operation was unacceptable as it would have taken no more than ten to fifteen minutes to prepare the theatre room. Thereafter it would not have taken a long time to prepare plaintiff for a caesarean section. He was then taken to task for having stated that it was "*highly unlikely*" that the bleeding patient had been taken to the theatre for the evacuation, because she had not been anaesthetised but had merely been sedated. He was accused of not having read the documentation properly and his evidence was described as "*remarkable*". This was despite the fact that it had earlier been placed on record by defendant that the evacuation procedure had in fact been performed in the casualty theatre and not in the main theatre.

[62] It was put to him in response to this evidence that he, in effect, had no idea whatsoever of the logistical constraints confronting the medical staff at Stutterheim Hospital and the fact that it had been "*simply physically impossible*" to prepare and commence the surgery within any lesser time. In this regard it was put further that the theatre in which Dr. Valelo had performed the evacuation was free by 15h00 but that it had to be cleaned and the necessary instrumentation had to be prepared. He was advised that "*we will give evidence about everything that was done in order to prepare for it and the evidence will be different to what you are saying that it could have been arranged in fifteen minutes.*" In response to this he stated that if it was not possible to perform an emergency caesarean section then the hospital should not offer an obstetric service. He was then taken to task by Mr. de la Harpe in the following terms:

> "*Yes well you are the witness that has expressed these opinions about negligence on the part of the doctors and I am astonished that you have not gone to check and understand what the circumstances were in which you make that judgment.*"

[63] However, the evidence of defendant's witnesses later revealed this to be a most unfair criticism based on dishonest instructions. I hasten to add that this

was through no fault of Mr. de la Harpe who was obviously acting on those instructions.

[64] In the course of his evidence in chief Dr. Nelson, with reference to the theatre notes (Exhibit A11), stated that although it was recorded that the baby had cried he "*somehow doubted that*". Under cross-examination he explained that it was "*unlikely*" that a baby with a low apgar score would "*have screamed lustily at birth*." The following passage then occurred:

> "*Q* *Doctor you are accusing Dr. Valelo and the nursing staff of collusively creating a note falsely and fraudulently that this child cried, do you have any basis to do that? …*
> *A* *No, I do not I withdraw that statement.*
> *Q* *I am most fascinated as to why you made it in the first place? …*
> *A* *I withdraw the statement.*
> *Q* *I want to know why you said it? …*
> *A* *I withdraw the statement.*
> *Q* *Doctor that is not an answer to my question why would an expert witness say a thing like that? …*
> A *Because it was unlikely a baby with such a low apgar that dies within an hour would have cried. <u>It might have made some sound</u> but maybe they used the wrong expression but I copied it from what was written in the notes. It is not a criticism it is an observation.*" (My emphasis)

[65] As appears from the evidence of Mrs. Ntengo set out above, however, the baby did not in fact cry but groaned and gave "*gasping respirations*" exactly as Dr. Nelson said it would have done and his previously expressed doubts were in fact fully justified.

[66] It is necessary to deal with the challenge by Mr. Cole relating to the admissibility of the evidence adduced by defendant directed at challenging the reliability of the CTG scan.

[67] In his initial report of 8 July 2015 Dr. van Helsdingen commented that the CTG recording of 24/25 June 2013 was normal and that there was no need to do any further foetal surveillance for at least the next week. As regards the second CTG recording of 3 July he commented as follows with regard thereto:

> "*The baseline foetal heart rate was normal but there was a late deceleration soon after 13h34 and again at 13h53 as well soon after 14h13. Prior to the late deceleration at 13h53 there was a period of poor baseline variability of at least thirty minutes. There were minimal contractions throughout the graph except for on those occasions where there were late decelerations.*"

[68] He concluded his report by stating as follows:

> "*One can however not escape the criticism that the nursing staff should have notified the doctors about the non-reassuring foetal heart tracing at approximately 13h24 and certainly at the latest at 13h40. Having viewed the graph at approximately 15h00, I agree with Dr. Nelson that there was an undue delay of some two hours prior to doing the caesarean section.*"

[69] In a supplementary report filed ten court days prior to the commencement of the trial Dr. van Helsdingen stated as follows:

> "*Recent international literature recommends that obstetricians and lawyers be aware of the unreliability of CTGs. The following are some of the causes for being so unreliable:*
> *Although CTG was initially developed as a screening tool to prevent foetal hypoxia, its positive predictive value of intrapartum foetal hypoxia is approximately only 30%. The false positive rate of CTG is at least 60%.*
> *There has been no demonstrable improvement in the rate of cerebral palsy or perinatal deaths since the introduction of CTGs in the clinical practice approximately forty five years ago. Studies consistently show that most cases of cerebral palsy in babies born at or near term are not caused by birth asphyxia.*

Unfortunately existing Guidelines employ the visual interpretation of CTG based on pattern recognition which is fraught with inter- and intra-observer variability. Experienced obstetricians have only mediocre agreement with one another in reading a monitoring tracings, and when shown that same tracing months later, agreed with their previous interpretations even less well.

The United States Preventative Air Task Force rated effectiveness of electronic foetal monitoring as Grade D, the lowest grade possible."

[70] When during the course of Dr. Nelson's evidence Mr. de la Harpe sought to cross-examine him on the reliability of the CTG as a diagnostic tool Mr. Cole objected strenuously to this line of questioning, submitting in particular that the evidence was inadmissible as the issue was never raised on the pleadings, which, on the contrary, were premised on an acceptance of the CTG recordings as too was Dr. van Helsdingen's initial report. At the risk of turning the record into what Schutz JA referred to in S v Ramavhale 1996 (1) SACR 639 (A) at 651c as "*a papery sump*" I provisionally allowed the evidence, more particularly as it seemed to me *prima facie* that the evidence, based on the timeously filed supplementary report of Dr. van Helsdingen, might be relevant to the weight to be attached to the CTG recording when assessing the issue of the medical staffs' alleged negligence.

[71] In my view, with due respect to so eminent a medical specialist, Dr. van Helsdingen's evidence with regard to the unreliability of CTGs was most unsatisfactory. As appears from his initial opinion he had stated that "*the nursing staff should have notified the doctors about the non-reassuring foetal heart tracing at 13h24 and certainly at the latest at 13h40.*" Under cross-examination, however, he stated that the nurses should have done so at 13h53. Questioned about his initial opinion he now stated that he considered the deceleration at 13h24 to be normal, given what he considered to be the satisfactory baseline variability. He stated that he saw no lack of baseline variability "*except for a short spell of five minutes*", which was not problematic because of its short duration. If it had been thirty minutes he would have regarded it as being "*suspicious*". He was then reminded by Mr. Cole of what he had stated in his initial report namely:

"*Prior to the late deceleration at 13h53 there was a period of poor baseline variability of at least thirty minutes*."

[72] Confronted with this glaring contradiction he merely stated "*That is correct. That's why I said this was a suspicious CTG and she should have had intrauterine resuscitation and should have been monitored very regularly.*"

[73] He was asked why then he had initially described the tracing at 13h24 as "*non-reassuring*". He replied "*I don't want to sound facetious but I have learned a little more about CTGs since then, much more*" and that what he had learned since 2015 had caused him to change his opinion. The following exchange then occurred:

"*Q* *In 2015 you weren't up to speed with the necessary knowledge?*

A *No, I was up to speed enough, but not to the extent that I am now because I spent much, much more time and read much more and been to many more lectures about it.*

Q *Well I must put it to you on your own version then, Doctor, as kindly as I can, you've given contradictory evidence, changing it because of a lack of erstwhile expertise.*

A *Fair enough.*"

[74] Dr. van Helsdingen then referred to certain academic literature, the crux of which was that CTGs were unreliable and that their positive predictive value of hypoxia in babies was only 30%. He stated that "*if you really look at the statistics on the CTG you will see just how wrong we are."* The following was then put to him:

"Q *But doctor you didn't raise this did you. You actually interpreted the CTG in July, 2015 and looked at it and never said '*but I am looking at nonsense.' *You aligned yourself with the view that criticism was due on the basis of the CTG.*

A No, you are absolutely right. I knew only too well that it was a waste of time, an absolute waste of time.

Q Did you know that then?

A To try and persuade, I hate to say group of people like this, but my own colleagues, I hate to persuade them because I see it every day.

Q Persuade them what?

A To persuade them that – they see CTGs as so unphysiological and so wrong.

Q Are your colleagues in disagreement with you then?

A Ja.

Q You said yes.

A Yes I do and therefore I, you know, eventually you are old and you have a horrible feeling about it, but you do throw in the towel because you don't want to go to court now and again and say well a baseline variability is not as bad as it sounds. Because you know everybody is going to say you talk nonsense. The books don't say so and so and so and so.

Q Did you know about this five years ago?

A Oh yes.

Q You knew all the time that [interrupted]

A I knew when this case came about I knew all about what's in there."

[75] Dr. van Helsdingen reiterated that according to academic literature the CTGs "*positive predictive value of hypoxia in babies in only 30%*" and stated that "*if you are going to make a decision on them you only have a 30% chance of being right. But 70% of them didn't have hypoxia. How clever is that?*" He stated further that "*I have never been sued for doing an unnecessary caesar. But boy have I been sued for not doing the caesar when it was necessary. So thousands of caesars are done on the basis that they think there is a foetal hypoxia and they know they are going to get sued if the baby is harmed, they are wrong 30, 40, 70% of the cases. Now how academic, how true, and how good is that legally wise if nothing else?*"

[76] In his evidence Dr. Nelson conceded that according to certain academic studies the positive predictive value of the CTGs was given as 30% but stated that in his view it was extremely difficult to do a properly controlled scientific study with regard to foetal monitoring in labour. He stated that there would be a variability of false positive and false negative percentages depending on which studies one consulted. He stated that in the practical sphere in which he operated CTGs were used as "*a simple monitoring device, a red flag and a kind of early warning system*". Based on his vast practical experience as a specialist in the course of which he had performed approximately 5000 caesarean sections he was of the strongly held view that even if the CTG was wrong in its positive prediction in 70% of cases a medical practitioner would ignore continuing sinister signs on the CTG at his or her peril. He stated further that the foetal brain has massive powers of recuperation so that it could be exposed to hypoxia during labour for a while, thereby giving rise to changes in the CTG, but could then return to normal. He stated that albeit looking "*through the retrospectocope, it was 100% correct in its predictability. In the present case where there was a loss of beat to beat variability with a concomitant significant deceleration the positive predictability was much higher than 30%.*"

[77] With respect to Dr. van Helsdingen, if he was of the view, at the very outset of this matter when first approached for his opinion, that CTGs were in effect not worth the paper they were written on, then it is almost inconceivable that he could have based his opinion as an expert on an unqualified acceptance of the CTG recordings and could have concluded accordingly that there had been an undue delay in performing the caesarean section.

[78] Despite his professed disdain for CTGs as being an absolute waste of time Dr. van Helsdingen confirmed that they were routinely used in obstetrics and in maternity wards across the country and that they had been so used for some forty five years. He confirmed too that the Guidelines for Maternity Care in South Africa, 2007, referred to the CTG as one of the diagnostic tools which should be used in maternity cases and he conceded that the CTG was the best such tool that was available in this country.

[79] In the light of the above I am of the view that no weight can be attached to Dr. van Helsdingen's opinion in so far as it seeks to suggest that CTGs are "*an absolute waste of time*" and that, by implication, the nursing and medical staff at Stutterheim Hospital could in effect ignore the signs on plaintiff's CTG tracing indicating that her baby was in trouble. I accept the evidence of Dr. Nelson that whatever the deficiencies of the CTG may be they serve in practice an important purpose as a simple monitoring device and a kind of early warning system which medical practitioners ignore at their peril, even if they lead on occasion to the performance of unnecessary caesarean sections.

[80] It is in any event abundantly clear that the medical staff did rely on the CTG tracings. In particular, it is noteworthy that Dr. Valelo, although conceding that he had in effect ignored the warning sign at 13h34, did not allege that he ignored it because he believed the CTG to be an unreliable diagnostic tool. Both he and Mrs. Ntengo knew from their training that careful regard had to be paid thereto. It is also abundantly clear from their evidence that they failed to do so.

[81] The onus is on plaintiff to establish that defendant's employees at Stutterheim Hospital were negligent in their treatment of her and her unborn child.

[82] In Oppelt v The Department of Health, Western Cape 2016 (1) SA 325 (CC) the following was stated by Molemela AJ at paragraph [69] – [71]:

> "*[69] The proper approach for establishing the existence or otherwise of negligence was formulated by Holmes JA in Kruger v Coetzee and has been endorsed by this court. In that case Holmes JA stated as follows:*
> *'for the purpose of liability culpa arises if –*
> *(a) a diligens paterfamilias in the position of the defendant –*
> *(i) would foresee the reasonable possibility of his conduct injuring another in his person or property and causing him patrimonial loss; and*
> *(ii) would take reasonable steps to guard against such occurrence; and*
> *(b) the defendant failed to take such steps.*

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

[70] In Sea Harvest the following was stated:

'(I)t should not be overlooked that in the ultimate analysis the true criterion for determining negligence is whether in the particular circumstances the conduct complained of falls short of the standard of the reasonable person. Dividing the inquiry into various stages, however useful, is no more than an aid or guideline for resolving this issue … It is probably so that there can be no universally applicable formula which will prove to be appropriate in every case … (I)t has been recognised that while the precise or exact manner in which the harm occurs need not be foreseeable, the general manner of its occurrence must indeed be reasonably foreseeable.'"

[83] At paragraph [108] of Oppelt, *supra* Cameron JA stated:

"*This means that we must not ask: what would exceptionally competent and exceptionally knowledgeable doctors have done? We must ask:* 'what can be expected of the ordinary or average doctor in view of the general level of knowledge, ability, experience, skill and diligence possessed and exercised by the profession, bearing in mind that a doctor is a human being and not a machine and that no human being is infallible.' *Practically, we must also ask: was the medical professional's approach consonant with a reasonable and responsible body of medical opinion? This test always depends on the facts. With a medical specialist, the standard is that of the reasonable specialist.*

[84] See too Goliath v MEC for Health, Eastern Cape 2015 (2) SA 97 (SCA) where the following was stated by Ponnan JA at paragraph 19:

"*[I]t is important to bear in mind that in a civil case it is not necessary for a plaintiff to prove that the inference that she asks the Court to draw is the*

> *only reasonable inference; its suffices for her to convince the Court that the inference that she advocates is the most readily apparent and acceptable inference from a number of possible inferences.*"

[85] In my view, in failing to attend to plaintiff prior to 15h01 in the circumstances as set out above Dr. Valelo was clearly negligent. On his own evidence, despite having been told prior to 13h45 that the plaintiff's baby was "*not ok*" he adopted the remarkable attitude that he would examine plaintiff in his own time when he was ready and that he would take his time to do so. His conduct in ignoring the call from Mrs. Ntengo despite being aware of the urgency of the matter is far removed from the conduct of a reasonably skilled and careful medical practitioner. He had sufficient time and opportunity to proceed to the maternity ward between 13h45 until 14h15 and, again, between 14h30 and 15h00, but, for some reason which he was unable to explain, failed to do so. I should mention that in this regard Dr. van Helsdingen sought to excuse that conduct by stating:

> "*What is half an hour? He had to go and change, he had to go and see the patient, half an hour is not a long time. He's not sitting around having a cup of tea as suggested… I have to wash myself, change my clothes, walk down to the other, so 33 minutes is not unacceptable.*"

[86] The immediate problem with this evidence is that Dr. Valelo never gave as a reason for his failure to attend on plaintiff prior to 15h00 that he was washing and changing. On the contrary, he stated that he did not know what he had been doing and that he might even have had lunch. In my view, with respect to Dr. van Helsdingen, his evidence in this regard betrays an unfortunate lack of objectivity. This lack of objectivity was also apparent in Dr. van Helsdingen's attempts to synchronise the times at which the evacuation and assault procedures were allegedly performed with Dr. Valelo's initial instructions that he had only been able to see plaintiff at 15h00, thereby absolving Dr. Valelo of any negligent conduct. I do not intend to detail this evidence in the course of which Dr. van Helsdingen was obliged to concede that his opinion was wrong based on as it was on times

which were contrary to the times recorded in the various records and to Dr. Valelo's own evidence.

[87] I am also satisfied that the unexplained delay of nearly two hours from the time the decision to operate was taken until such time as the operation was commenced was occasioned by negligence. I have alluded above to the evidence of Dr. Valelo and Dr. van Helsdingen with regard to the alleged difficulties experienced by the anaesthetist in administering the spinal anaesthetic as well as to the fact that Dr. van Helsdingen expressed the view in his supplementary report that "*the delay in doing the caesar was entirely due to the difficulty the anaesthetist experienced in inserting the spinal anaesthetic.*"

[88] When Dr. van Helsdingen was asked where he had got the above information from he replied that it could have been from a letter apparently addressed to him by the Superintendent or Manager of Stutterheim Hospital which contained, so he said, "*a long report*" giving "*an explanation of the staffing and the time and the problems with the anaesthetic.*" He was asked whether he had been in possession of that information at the time that he drew up his first report in July 2015 and replied at first that "*I cannot even to begin to remember*" before conceding that at the time that he compiled the first report he had already been in possession of all relevant documentation and that he had received no further information relevant to the anaesthetic before compiling his second report.

[89] He was then asked why in that case he had not stated in his first report of July 2015 that the entire cause of the delay in commencing the operation was the difficulty in administering the anaesthetic, instead of agreeing with Dr. Nelson that there had in fact been an unacceptable delay. He replied that he had mentioned it in the first report. He was asked to point out where in that report any mention was made thereof and, obviously, was not able to do so because no such mention was made therein. He agreed that it had been incumbent upon the anaesthetist to have recorded any difficulties which she had experienced, which she had not done, and he conceded that on the contrary, according to the notes which she had made, "*the patient was fine*", and that there had been no

complications other than that the first attempt to administer the anaesthetic had been unsuccessful.

[90] Dr. van Helsdingen then conceded that he had in fact had no basis for making the statement and for drawing the conclusion which he had in his supplementary report and retracted that opinion. As was submitted by Mr. Cole, the reliance by Dr. van Helsdingen on an undiscovered letter apparently containing unfounded hearsay allegations must cast very considerable doubt on the reliability of his evidence as an objective expert witness. In the circumstances I accept the opinion of Dr. Nelson, initially concurred in by Dr. van Helsdingen, that there was an unacceptable and unexplained delay of 1 hour and fifty five minutes prior to the caesarean section being performed.

[91] In light of the fact that the nursing staff and Dr. Valelo were aware that the foetus was in all probability suffering from hypoxia and that an emergency caesarean operation was required they were, in my view, clearly negligent in delaying to the extent which they did. Again, in my view, the nursing staff and a reasonable medical practitioner in the position of Dr. Valelo would have foreseen the reasonable possibility of their conduct injuring the plaintiff and causing her loss and would have taken reasonable steps to guard against such occurrence.

[92] That, however, is not the end of the matter.

[93] As was stated in Blythe v Van den Heever 1980 (1) SA 221 (AD) the fact that there was remedial action which could reasonably have been taken by the reasonably skilled and careful medical practitioner is not the end of the matter. It must still be determined whether such remedial action, if taken when the need for it ought reasonably to have been realised, would have prevented the damage suffered by the victim and whether the medical staff failed to take such remedial action. As was submitted by Mr. de la Harpe, even accepting that negligence was established, it was required, for plaintiff to hold the defendant liable, that it be proved on a balance of probabilities that such negligence was the cause of plaintiff's loss. In this regard Mr. de la Harpe referred to the well-known leading

case of International Shipping Co. (Pty) Ltd v Bentley 1990 (1) SA 680 (A) at 700E where the following was stated:

> *"As has been pointed out by this Court, in the law of delict causation involves two distinct enquiries. The first is a factual one and relates to the question as to whether the Defendant's wrongful act was a cause of the Plaintiff's loss. This has been referred to as* 'factual causation'*. The enquiry as to factual causation is generally conducted by applying the co-called '*but-for' *test, which is designed to determine whether a postulated cause can be identified as a* causa sine qua non *for the loss in question. In order to apply this test one must make a hypothetical enquiry as to what probably would have happened but for the wrongful conduct of the Defendant. This enquiry may involve the mental elimination of the wrongful conduct and the substitution of a hypothetical course of lawful conduct and the posing of the question as to whether on such a hypothesis Plaintiff's loss would have ensued or not. If it would in any event have ensued, then the wrongful conduct is not the cause of the Plaintiff's loss; aliter, if it would not have so ensued. If the wrongful act is shown in this way not to be the* causa sine qua non *for the loss suffered, then no legal liability can arise. On the other hand, a demonstration that the wrongful act was a* causa sine qua non *of the loss does not necessarily result in legal liability. The second enquiry then arises, viz. whether the wrongful act is linked sufficiently closely or directly to the loss for legal liability to ensue and whether, as it is said, the loss is too remote. This is basically a juridical problem in the solution of which considerations of policy may play a part. This is sometimes called 'legal causation.'"*

[94] In Oppelt's case *supra* the following was stated with regard to causation at paragraph [35]:

> "*A successful delictual claim entails the proof of a causal link between a defendant's actions or omissions, on the one hand, and the harm suffered by the plaintiff, on the other hand. This is in accordance with the '*but-for' *test. Legal causation must be established on a balance of probabilities.*

The vital question is whether, as a matter of probability, the applicant's paralysis would not have occurred or been rendered permanent had the reduction procedure been performed promptly and within a time that was reasonably likely to prevent permanent quadriplegia."

[95] Mr. de la Harpe submitted accordingly that plaintiff had to prove on a balance of probabilities that had the doctor and nursing staff acted without negligence by performing what was required of a reasonable nurse and medical practitioner, the plaintiff's infant child would have survived. He submitted that that obviously required that the cause of the baby's death be proved and that it be factually established that the baby would not have died but for the negligent actions on the part of the said staff at Stutterheim Hospital.

[96] In this regard I bear in mind what was said in Michael and Another v Linksfield Park Clinic (Pty) Ltd and Another 2001 (3) SA 1188 at paragraph 34:

"*It is perhaps as well to re-emphasise that the question of reasonableness and negligence is one for the Court itself to determine on the basis of the various, and often conflicting, expert opinions presented. As a rule that determination will not involve considerations of credibility but rather the examination of the opinions and the analysis of their essential reasoning, preparatory to the Court's reaching its own conclusion on the issues raised*."

I also bear in mind the following passage at paragraph 40 of Michaels case *supra:*

"Finally, it must be borne in mind that expert scientific witnesses do tend to assess likelihood in terms of scientific certainty. Some of the witnesses in this case had to be diverted from doing so and were invited to express the prospects of an event's occurrence, as far as they possibly could, in terms of more practical assistance to the forensic assessment of probability, for example, as a greater or lesser than fifty per cent chance and so on. This essential difference between the scientific and the judicial measure of proof was aptly highlighted by the House of Lords in the Scottish case of

Dingley v The Chief Constable, Strathclyde Police 200 SC (HL) 77 and the warning given at 89D – E that

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

[97] It was common cause that for some unknown reason no post-mortem examination was conducted on the body of the baby as it should have been given the unnatural circumstances of its death, nor was there any histological examination of the placenta, an examination of which in all probability would have revealed the cause of death. Dr. van Helsdingen was of the view that in the absence thereof it was not possible to determine the cause of death and that it was easier to exclude possible causes rather than to state on the probabilities what the cause of death was. He stated that the reason for the baby's "*profound compromise*" was difficult to understand and that it was far more likely that the underlying cause had been present for several hours, if not days, which begged the questions as to whether earlier delivery would have "*salvaged"* the baby*.*

[98] In this regard Dr. Nelson conceded that is was possible that the contraction and late deceleration recorded at 13h34 was not the first such event. He was of the opinion, however, that in all probability the said contraction was the first experienced by plaintiff more especially as the very purpose of the "*stretch and sweep*" and the administering of Pitocin was to induce labour. As to the late deceleration he pointed out that plaintiff had been monitored with a CTG during her admission to the hospital on 24/25 June and that according thereto the foetal heart rate was normal with no abnormalities noted. No contractions were palpable.

[99] It was put to him that according to Dr. van Helsdingen there was no way of knowing what the cause of death was. He disagreed with this view, stating that because the baby was born with "*thick meconium stain liquor with low apgar scores the probabilities were consistent with it having died of hypoxia.*" In his opinion that hypoxia was indicative of placental insufficiency which could have developed during the last week of the pregnancy causing oxygen deprivation. There were, he said several known causes of placental compromise none of which, however, were relevant to this matter. Without the benefit of a post-mortem examination or the histology of the placenta it was difficult to come to an exact diagnosis. He stated that placental compromise happened suddenly to apparently healthy babies and this was exacerbated by interuterine contractions.

[100] He concluded therefore that the baby's "*mechanism of death*" was hypoxia which might have been coming on for some time before 3 July from a cause which could not be identified. In his view there was a degree of hypoxic acidotic brain damage which made resuscitative efforts futile.

[101] In my view Dr. Nelson's opinion, based as it was on his vast clinical experience of more than 40 years of practice encompassing over 14 000 deliveries, is in accordance with the probabilities and can be accepted over the entirely speculative evidence to the contrary of Dr. van Helsdingen.

[102] Accepting that the mechanism of death was hypoxia there was considerable debate during the course of the trial as to the time and extent of the "*window of opportunity*" within which the baby could have been saved. Dr. Nelson in his evidence and report was initially of the view that the event at 13h34 called for immediate surgical intervention. He stated that the foetal heart recordings at that time reflected that the baby was at significant risk of hypoxia for the remainder of the labour and that "*we have seen babies die in untero within an hour or two thereafter.*" He was pressed on the period of time within which he considered the baby was "*salvageable*" after the event at 13h34 and stated "*I would say within an hour.*"

[103] It was put to him that in terms of the aforesaid Maternity Guidelines the nursing and medical staff were only required to monitor the foetal heart rate at two hourly intervals and that having regard thereto the next required monitoring was only at 15h14 by which time, on his evidence, the baby was beyond being saved. He stated, however, that there was a "*reasonable possibility that the child could have been saved if the caesarean section had been done earlier*" and stressed that "*it is not an exact science because the ability of each particular individual baby to withstand sometimes very severe hypoxia is variable. At the end of the day the sooner this child had been delivered by caesarean section the better his chances of survival.*"

[104] It should be remembered that at the time Dr. Nelson was being cross-examined defendant's case was that Dr. Valelo had only been notified of the CTG recording at 14h55. When Dr. Nelson was recalled to testify after the postponement this issue was again raised with him. He stated in reply that "*it can only be a guesstimate at most, because there is no scientific evidence on this, so it was my guesstimate based on my clinical experience of 14 000 babies which I have delivered in 45 years.*" He stated further that not all babies that had hypoxia during labour developed cerebral palsy or died and that not all babies with abnormal CTGs showed signs of hypoxia at birth.

[105] He concluded by stating that in ideal circumstances in an ideal world the baby should have been delivered within an hour of 13h34 but "*certainly within an hour of the doctor seeing the patient at 15h00*" and that had an emergency caesarean been carried out one or two hours earlier the probability was that a healthy baby would result. As he put it "*the quicker you act the better the outcome.*"

[106] In his evidence Dr. van Helsdingen conceded that it was more probable that a baby would be saved "*if you do it quickly*." He agreed that the quicker a caesarean section was performed following upon a CTG scan showing hypoxic non-reassuring tracings the more probable it was that "*the baby will be better off*" and he agreed that this was the reason why in similar circumstances caesarean sections were to be performed quickly.

[107] Mr. de la Harpe criticised Dr. Nelson's evidence as to the latest time at which the caesarean section could have been performed in order to save the baby. In my view, however, such criticism is ill-founded. This is not the type of case where the likelihood of the baby's survival can be assessed *"in terms of scientific certainty.*" As stated by Dr. Nelson obstetrics is not an exact science and there are many variables. It is not a matter which can be measured with mathematical precision.

[108] In my view, given the sinister recordings of the CTG at 13h34 and 13h53 it was incumbent on the nursing and medical staff to act timeously and not to allow a baby with evidence of oxygen deprivation to continue for an unnecessarily long time in labour. In my view on an assessment of the evidence as a whole the most readily apparent and acceptable inference to be drawn is that if it had not been for the unacceptable and negligent delays in performing the caesarean section after the CTG recordings had been noted at 13h34 the baby would have survived. The failure of the nursing and medical staff to act promptly resulted in the delivery of a baby suffering such an extreme degree of hypoxia as to render resuscitation impossible. In my view therefore plaintiff has discharged the onus of proving that the death of her baby was occasioned by the negligence of defendant's employees.

[109] I have referred above to the Guidelines for Maternity Care in South Africa. It is common cause that in terms thereof the nursing staff at a hospital are required to monitor the foetal heart rate at two hourly intervals. This led to what in my view became an entirely unnecessary debate between counsel and Dr. Nelson concerning the requirements of reasonable medical care against which the conduct of the hospital staff was to be judged, it being suggested to Dr. Nelson on the one hand that the staff, having established the CTG at 13h14 when the foetal heart beat was normal were only required to monitor it again at 15h15 and by Dr. Nelson on the other hand that the staff should "*check the CTG every now and then.*"

[110] On the acceptable evidence, however, it has been clearly established that Mrs. Ntengo observed the late deceleration at 13h34 and immediately informed Dr. Valelo thereof. It has not in any way been suggested that having observed that late deceleration Mrs. Ntengo was not required to monitor the CTG thereafter until 15h00. In the circumstances, in my view, the debate over this issue was rendered entirely academic.

[111] There is one final matter requiring comment. At the commencement of the trial the issue of the possibility of a joint minute being prepared by Dr. Nelson and Dr. van Helsdingen arose. Mr. Cole handed in, without objection, an unsigned draft minute prepared by Dr. Nelson detailing certain issues on which agreement between the experts was sought. I was informed that Dr. van Helsdingen had refused to meet Dr. Nelson for purposes of preparing the joint minute and that, despite my expressed disquiet at this development, there was no prospect of a joint minute being prepared. I was informed that the State Attorney had taken issue with a direct approach made by Dr. Nelson to Dr. van Helsdingen, independently of the legal representatives, for the purposes of formulating a joint minute. It was also the view of defendant's legal representatives that what was being sought by plaintiff in the draft minute were in fact "*concessions of liability.*"

[112] This issue was explored by Mr. Cole during his cross-examination of Dr. van Helsdingen. It appears from his evidence that he was advised that he was told to obtain the permission of the State Attorney, Mr. Lategan, before considering a joint minute and was not to comment on any suggestions put forward by Dr. Nelson "*unless he had permission from Port Elizabeth*" although he was perfectly happy to do so especially as he had great respect for Dr. Nelson.

[113] He stated that he had never for a moment thought that by being asked to discuss the draft minute with Dr. Nelson he was being forced to make concessions of liability and he confirmed that "*it was the lawyer who said no.*"

[114] At the conclusion of the trial I was informed by Mr. de la Harpe from the Bar that the State Attorney had indeed taken issue with the direct approach by Dr.

Nelson to Dr. van Helsdingen without his involvement and that "*personalities had unfortunately intruded on this issue and played a role.*" I obviously did not have the opportunity of hearing the State Attorney's side of the matter. In the circumstances I would merely state that it is most regrettable that the matter was handled in the manner that it was. There were a number of issues on which, having regard to the course the trial took and the evidence which was led, agreement could have been reached between the experts thereby curtailing the length of the trial. For instance, it became common cause that the plaintiff's syphilis could be discounted as a factor in respect of the baby's death a matter which could easily have been resolved at the outset without the necessity for the lengthy cross-examination of both experts which ensued on this issue. Dr. van Helsdingen was fully prepared to discuss these issues with Dr. Nelson had he not been prevented from doing so by the State Attorney. Legal representatives should be sufficiently objective to be able to put aside whatever personal animosities may exist between them and their opponents in the greater interests of the administration of justice.

[115] In the circumstances the following order is granted:

1. The defendant is liable to pay to the plaintiff such damages as may be proved or agreed arising out of the death of her child on the 3rd July 2013 at the Stutterheim Hospital.
2. The defendant shall pay the costs of suit such costs to include:
   a. The qualifying expenses, travelling expenses and accommodation expenses of Dr. R. Nelson; and
   b. The costs of preparation of plaintiff's Heads of Argument, prepared at the request of the Court.

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J.D. PICKERING
JUDGE OF THE HIGH COURT

Appearing on behalf of Plaintiff: Adv. S. Cole
Instructed by: Neville Borman & Botha Attorneys, Ms. Bosman

Appearing on behalf of Defendant: Adv. D. de la Harpe
Instructed by: Whitesides Attorneys, Mr. Nunn