THE SUPREME COURT OF APPEAL OF SOUTH AFRICA

JUDGMENT

Not Reportable

Case no: 380/2019

In the matter between

THE MEMBER OF THE EXECUTIVE COUNCIL FOR HEALTH & SOCIAL DEVELOPMENT OF THE GAUTENG PROVINCIAL GOVERNMENT	**APPELLANT**

and

TM obo MM	**RESPONDENT**

Neutral citation: *The MEC for Health & Social Development, Gauteng v TM obo MM* (380/2019) [2021] ZASCA 110 (10 August 2021)

Coram: SALDULKER, NICHOLLS and MBATHA JJA and LEDWABA and ROGERS AJJA

Heard: 8 March 2021

Delivered: This judgment was handed down electronically by circulation to the parties' legal representatives by email, publication on the Supreme Court of Appeal website and release to SAFLII. The date and time for hand-down is deemed to be at 09h45 on 10 August 2021.

Summary: Claim by mother on behalf of child suffering from cerebral palsy in consequence of acute profound hypoxic ischaemia intrapartum – whether hospital staff was negligent in failing to perform caesarean section more promptly – whether hospital was negligent in not having second theatre for caesarean sections – whether staff was negligent in the way the theatre was used during the day in question – whether staff was negligent in failing to refer mother to neighbouring hospital – whether staff was negligent in failing to apply intrauterine resuscitation – negligence not proved – in any event, not proved that non-negligent action would have averted the acute profound hypoxic ischaemia.

ORDER

On appeal from: Gauteng Division of the High Court, Johannesburg (Fisher J sitting as a court of first instance):

(a) The appeal succeeds.

(b) The order of the high court is set aside and replaced with an order in the following terms:

'The plaintiff's claim is dismissed.'

JUDGMENT

Ledwaba AJA (Saldulker JA concurring) (dissenting judgment):

[1] The appellant is the Member of the Executive Council for Health and Social Development of the Gauteng Provincial Government (the MEC). The respondent is Ms TM, who instituted an action against the MEC in her representative capacity as the mother and natural guardian of her minor child, MM, who was delivered by caesarean section (C-section) on 28 August 2010 at Charlotte Maxeke Johannesburg Academic Hospital (CMH). The MEC is appealing the judgment of the Gauteng Division of the High Court, Johannesburg (the high court) per Fisher J,

who held the MEC liable for any damages proved or agreed. Fisher J granted leave to appeal to this Court.

[2] In the particulars of claim Ms TM alleged that on 28 August 2010, the MEC had a duty to render medical care, treatment and advice to her and her unborn child. She further alleged that the MEC and/or its employees or authorised representatives were negligent in that they failed to timeously perform a C-section to deliver the child. The child suffered an intrapartum hypoxic-ischemic brain injury,[1] which resulted in permanent brain injury.

[3] The grounds of negligence by the MEC and/or its employees and/or its authorised representatives have been set out in Ms TM's particulars of claim, *inter alia*, as follows: (a) he failed to permanently, alternatively, temporarily employ the services of suitably qualified and experienced medical practitioner who would be available and able to examine, manage and/or give appropriate advice in respect of patient's labour and to timeously perform a C-section if and when required at the aforesaid hospital; (b) he failed to ensure that at least one suitably qualified and experienced medical practitioner was in attendance at all material times; (c) he 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 the plaintiff's labour; (d) he failed to ensure that the CMH was suitably, adequately and/or properly equipped to enable the timeous and proper performance of a C-section if and when required; and (e) he failed to take any and/or all reasonably required steps to ensure proper, timeous and professional

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[1] A deficiency of oxygen during birth or delivery.

assessment of patients, their monitoring and management of labour and assistance at the birth process.

[4] The grounds of negligence in the particulars of claim have been stated in a general form. In my view, the stated case and admission made crystallised and amplified the pleading. Furthermore, the issues that the high court had to deal with were identified and recorded by the parties. The purpose of the pleadings is not to mention all the facts in detail and the names of the people involved in the pleadings. In my view, the essence of the plaintiff's cause of action and the defendant's defence were set out in a clear, concise, and lucid form.

[5] Even though evidence during the trial emerged in a haphazard way, it is the duty of the court to determine if, from the presented evidence, there are enough facts to justify the upholding or dismissal of the appeal.

The MEC in his plea denied any negligence on his part and pleaded that the complications in respect of the child occurred solely as a result of the negligent conduct of Ms TM, alternatively, that her negligence also contributed to the complications. I think I should mention at this early stage that there is no merit in the MEC's plea that Ms TM's negligence contributed to the complications of the foetal condition because Ms TM is not claiming damages in her personal capacity but on behalf of her minor child. Contributory negligence cannot be raised against the child.

The MEC's legal issues

[6] The MEC in his heads of arguments raised three issues in respect of his appeal which have been phrased in the form of questions, namely: first, assuming that the sub-optimal use of the theatre was negligent, may an MEC be held liable in delict to a plaintiff even though such negligent conduct occurred at a stage prior to the plaintiff being admitted as a patient, and accordingly prior to the MEC's duty of care to the plaintiff arising; second, may an MEC be held liable in delict for such sub-optimal use if that sub-optimal use had occurred at a time when there was no indication that the plaintiff would need to undergo a C-section; and third, does poor management of resources, even if established translate into negligent conduct for the purposes of delictual liability?

Brief factual background

[7] The relevant facts to this appeal are largely common cause. Ms TM was 25 years old when she first visited an antenatal clinic on 8 July 2010 at 33-35 weeks of her pregnancy. According to the entries in her antenatal record there were no complications with her pregnancy and midwife delivery could take place.

[8] When she went to the clinic on 30 July 2010, her blood pressure was taken and the foetus heartbeat was checked. The nurses told her that the baby was growing well. The next appointment was for 20 August 2010 at Hillbrow Clinic. On 20 August 2010, she went to Hillbrow Clinic and it was closed because the nurses were on strike. She went to the clinic again on 27 August 2010 and the clinic was still closed because of the ongoing strike.

[9] Later in the afternoon of 27 August 2010 she experienced some abdominal pains. On 28 August 2010, she went to the Hospital and was admitted as a patient to the maternity section at about 12h55. According to the medical records, she was in her early active stage of labour. Regular foetal monitoring of heart beats by way of cardiotocography (the CTG) was conducted. The foetal heart rates, which were plotted on the partogram at half hourly intervals between 13h00 and 15h00, were within the normal limits. Progress of the cervical dilation was adequate. However, at 15h45 the CTG records showed abnormalities, as a result of which a decision to perform a C-section was made at about 16h00.

[10] The C-section could not be performed on Ms TM immediately because there was a patient, Ms DM, who was undergoing a C-section. She was in the theatre from 15h50 to 16h25. Crucially a C-section had already been booked to be performed on another patient, Ms G, after the operation of Ms DM. Ms G occupied the theatre between 16h45 and 17h55. Ms TM was admitted to theatre at about 18h15 and her C-section was finalised at about 19h20. Ms TM's C-section commenced about two and a quarter hours after the decision for the C-section was made.

[11] The medical experts agree that the Apgar scores recorded were low and indicated that the baby was born in a depressed condition. The baby had suffered an intrapartum hypoxic-ischemic injury which resulted in permanent brain damage. A medical term spastic-dystonic quadriplegia was mentioned by the medical experts to describe the condition of the baby. According to the radiologist, an MRI scan performed when the baby was three years and three months confirmed that the baby suffered from cerebral palsy.

[12] The theatre records showed that on 28 August 2010 the theatre had not been utilised between the following times 04h35-06h05, 07h05-09h30 and 11h40-14h15.

The high court proceedings

[13] When the trial commenced the parties agreed to present a stated case to the court, which incorporated the agreement reached in a pre-trial conference. The issues to be adjudicated on were recorded in the agreed stated case as follows:

'(a) whether the plaintiff herself was negligent;

(b) whether that negligence was the cause of the outcome and contributed to the outcome;

(c) whether the nurses and doctors were negligent in their care or by not performing the caesarean section earlier given the circumstances in which they found themselves on the day in question particularly having regard to what facilities and personnel were available;(d) whether both the Plaintiff and the Defendant fall to be liable for the outcome.'

[14] Ms TM testified and two expert witnesses, Dr Linda Ruth Murray, a specialist obstetrician and gynaecologist, and Professor Johan Smith, paediatrician and neonatologist, testified to support her case. Three specialists testified for the MEC: Dr Hlengani Lawrence Chauke, an obstetrician in gynaecology who specialised in maternal and foetal medicine. Dr Chauke is also the clinical head of the Department of Obstetrician and gynaecology at the Hospital; Dr Thomas Matle Marishane, a specialist gynaecologist and obstetrician; and Dr Keith Duncan Bolton, a paediatrician. I do not think it is necessary to summarise the evidence of each witness since the main issues to be

adjudicated have been crystallised. I will refer to the evidence of the witnesses when I deem such evidence necessary.

[15] I had an opportunity to read the judgment of my colleague Rogers AJA and I will comment on some of the important issues mentioned in his judgment.

Appeal issues

[16] The three issues raised in the MEC's heads of argument, including whether the MEC owed a duty of care to Ms TM before she was admitted at the Hospital as a patient, will be dealt with hereunder.

[17] The MEC's counsel argued that the duty of care arose only from 12h55 after Ms TM was admitted to the Hospital. Counsel referred us to *AN v MEC for Health, Eastern Cape,*[2] as authority confirming that a legal duty arises when a patient is admitted to the hospital. The central issue in the said case related to a baby born with brain damage caused during labour. This Court had to decide if the negligent failure of the staff at All Saints Hospital to properly monitor the mother and the foetus during delivery caused brain damage. This Court, correctly in my view, said the legal duty arose when the mother was admitted to the hospital in labour.

[18] The MEC further submitted that non-use or sub-optimal use of the theatre before Ms TM was admitted to CMH cannot constitute negligence. On the contrary, it was argued on behalf of Ms TM, that the MEC owed the public a duty of care, including Ms TM, even before she was admitted as a patient at CMH. Counsel argued that non-utilisation or

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[2] *AN v MEC for Health, Eastern Cape* [2019] ZASCA 102; [2019] 4 All SA 1 (SCA).

sub-optimal use of the theatre before and after Ms TM was admitted to the Hospital constituted negligence and the MEC should be held liable.

[19] In my view, the MEC's employees did not foresee that Ms TM would be admitted to the hospital on 28 August 2010 at about 12h55 and that she would have complications with her pregnancy. On the facts of this matter, I am of the view that the legal duty arose when Ms TM was admitted to the hospital at about 12h55 and the hospital assumed a legal duty of care on her from then onward.

[20] The evidence in the high court also focused on the failure by CMH's employees to utilise the theatre earlier in the day to perform C-sections. The theatre was not used during the following times: 4h35-6h05, 7h05-9h30 and 11h40 -14h15. The total period of non-utilisation of the theatre earlier in the day is the total period of about five hours and forty-five minutes. Rogers AJA refers to the said times as first, second and third down times.

[21] The alleged mismanagement of resources that Ms TM relies upon, that the theatre was not utilised for certain periods should not, on the circumstances of this case, attract delictual liability. Dr Chauke testified that one of the reasons why the theatre was not utilised is because there were no autoclaved sterile gowns. The conduct of the MEC's staff in that respect does not, in my view, constitute negligence justifying that the MEC should be held liable in the circumstances of this case. I think it is then not necessary to elaborate further on what caused the theatre not to be operational during the said periods.

Issue of not having two theatres (the second theatre issue)

[22] Ms TM's counsel further argued that the MEC was negligent in not ensuring that two theatres were operational. Dr Chauke testified that he started working at the CMH in January 2016. He gave an account of the staff that were on duty in the maternity ward in August 2010 and the number of patients that were treated.

[23] Ms TM's counsel further argued that only one theatre was operating and since there is another theatre structure available which was not utilised, the MEC should be held liable for failing to ensure that two theatres were always operational at CMH. This argument was countered by the evidence of Dr Chauke who said that due to budgetary constraints, the monetary costs to cater for the salaries of extra medical staff and the utilisation of the second theatre was not budgeted for. I agree with what the Constitutional Court said in *Soobramoney v Minister of Health (Kwazulu-Natal)*[3] that the provincial administration in a particular province is responsible for the decisions regarding the funding that should be made available for health care. A court should be slow to interfere with rational decisions taken in good faith by the government. In my view there is no merit in the said argument and the utilisation of one theatre at the time cannot be a ground for holding the MEC liable, on the circumstances of this case.

Evidence presented regarding how the patients were admitted to theatre

[24] On careful analysis of the hospital records, on 28 August 2010 and the evidence of Dr Chauke, it seems that the admission to the theatre was

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[3] *Soobramoney v Minister of Health (Kwazulu-Natal)* [1997] ZACC 17; 1998 (1) SA 765 (CC); 1997 (12) BCLR 1696 para 29.

on ‘first come first served basis’ without assessing the urgency of the treatment needed by each patient. To illustrate this, Ms TM was admitted to the CMH at about 12h55. Another patient, Ms CM was admitted at 03h45 and the C-section was performed from 14h15-15h20. The patient, Ms DM, was admitted to the CMH at 08h45. She was referred from Edenvale General Hospital with suspected foetal bradycardia, (abnormal slowness of the heartbeat), and she went to theatre for the C-section from 15h30-16h25. An additional patient, Ms XG, was admitted to the CMH at 09h50. She previously had had two C-sections, and was admitted to theatre at 16h45.

[25] According to the undisputed evidence of Ms TM, she was admitted as a patient to the CMH at 12h55, she was taken to the labour ward at about 14h00, the decision that a C-section had to be performed on her was taken at about 16h00, and she was taken to the theatre at about 18h15. The sequence of the times of admission to the hospital, and when she was admitted to theatre supports the view of ‘first come first served’. In matters where C-section is to be performed, the triage, which serves to classify patients and determine which patient is to receive priority treatment, is crucial. Experienced and qualified medical practitioners should be involved.

[26] Ms G needed a C-section because of a risk of uterine rupture. She was not examined by a doctor until she went to theatre at 16h45. Even though she had had two previous C-sections, the risk of a rupture was only 0.74% and that risk, according to Dr Murray, could be reduced by giving her a tocolytic drug. Dr Murray said she would have probably prioritised Ms TM’s admission to theatre before Ms G. Dr Murray emphasised that the decision of a senior doctor was necessary.

[27] Dr Chauke's opinion was that the principle of obstetric care is that the health of the mother takes precedent over the foetus. When there is reasonable equal emergency threatening the life of the mother on the one hand and the baby on the other, any reasonable gynaecologist will favour the mother. In this matter there is no evidence or record that the emergency situation of Ms G and that of Ms TM were equal. What is on record is that the risk of rupture of Ms G was 0.74% and it could be reduced by giving her tocolytic. Dr Chauke further said he would probably have made the same decision as Dr Sibeko, the surgeon who performed the C-sections. Importantly, there is no record that Dr Sibeko considered and evaluated the emergencies of Ms G and Ms TM. Furthermore, there is no record why she prioritised Ms G's C-section. Dr Murray gave reasons why Ms TM should have been given preference. The condition of Ms G was not dire and could be controlled with tocolytic.

The interim measures

[28] I now deal with the issue of tocolytic medication, giving the mother oxygen mask and getting her to lie on her left side, as mentioned by Dr Murray. During cross-examination it was put to Dr Murray that there is no medical literature that tocolytic and Atosiban are effective means of foetal resuscitation when foetal distress is detected. Her response was that the reason for absence of literature was that one could not perform ethical tests by giving the drug to some women and withholding it from others. She emphasised that intrauterine resuscitation is still recommended and is still implemented by medical doctors.

[29] The hospital records of Ms G show that the interim measures of giving the Atosiban drug and making a patient to lie on her side were implemented on her.

[30] No medical evidence was presented to show that intrauterine resuscitation using tocolytic and atosiban and letting the mother lie on her side would not make the situation of the foetus worse. There is no record and no reason why they were not implemented on Ms TM. For ethical reasons, testing did not allow for the drug to be withheld from other patients.

[31] Dr Chauke justified the administration of Atosiban to Ms G by saying that unlike tocolytics, Atosiban was known to have no harmful effects and there was a small chance that it might be beneficial. No medical evidence was presented regarding harmful effects of tocolytics.

[32] Dr Murray and Dr Chauke stated that the use of oxygen mask improved the condition of the foetus very little and it was not used much in practice. The experts agreed that making a mother lie on her side was a practical measure that might assist. The MEC admitted that it owed Ms TM a duty to ensure the rendering of medical treatment with skill, care and diligence. Medical records of Ms TM do not reflect that Atosiban was administered nor was Ms TM made to lie on her side. It is medically recommended that when a foetus is distressed, Atosiban and making a patient to lie on her side may help the distressed foetus.

[33] Dr Murray’s undisputed evidence is that generally during labour there are recurrent uterine contractions for 40 to 60 seconds. They become stronger, longer and closer together when labour becomes more

advanced. In that process, the blood flow between the mother and the foetus is interrupted. She further testified that tocolysis can be used to stop the contractions for foetal resuscitation when the foetus is in distress. The other method used by medical practitioners to maximise placenta blood flow and oxygen delivery was to turn the expectant mother onto her left side and to give her a drip.

[34] In the agreed stated case, the expert gynaecologists acknowledged that the Guidelines for Maternity Care in South Africa 2007 recommended that C-section should be performed within one hour of the decision to operate. The delivery interval of 155 minutes was unacceptably long and contrary to local and international guidelines. There was no record of any treatment that was administered on Ms TM between 16h00 to 18h00. Furthermore, there is no record that her serious condition was discussed with any consultant doctor.

[35] Dr Murray's opinion was that an omission to render the recommended medical treatment constitutes substandard care and mismanagement of a patient who is in labour. When Dr Murray was cross-examined, she said that practice at the Tygerberg Hospital, in the Western Cape, dictates that when the hospital is busy, a consultant doctor would be present on the floor triaging the cases and every case is discussed with the consultant. If there was a problem, advice would be sought from the superintendent of their hospital. They would further phone the surrounding hospitals so that they can divert emergency cases, and the organisation of facilities and resources would assist to resolve some problems.

[36] Ms G, who was admitted at 09h50, according to the hospital records, was not seen by a doctor until she went to theatre at 16h45. I should further mention that when Dr Chauke testified, he said he thought that Ms G's admission to theatre was given preference to the admission of Ms TM because under the triage system it is more important to save the life of the mother, rather than the life of an unborn baby. Dr Chauke's view was that the staff did not neglect their duties and that they followed the standard procedure.

[37] Ms TM pleaded that the MEC had a duty to render medical care and treatment to her. In the stated case, the MEC admitted that it owed Ms TM a duty of care and had to render medical care and treatment to her. Dr Sibeko, the registrar on duty on Saturday, 28 August 2010 was deceased when the trial commenced. There is no hospital record that was discovered that recorded all the events and patients in the maternity unit. This case should be decided on the available evidence and records. I cannot speculate about the triage decisions, if any, which Dr Sibeko took on that Saturday.

[38] The hospital record of Ms TM, after the decision for the C-section was made, does not reflect that she received any medical attention. Whether she did receive medical attention or not, it should not be assumed that she was medically treated but same was not recorded. Medical treatment regarding Ms G about the Atosiban drug given to her and that she was turned on her side was recorded. If she received the treatment that was given to Ms G why was it not recorded? I am inclined to find that Ms TM was not given the treatment recommended hence it was not recorded.

[39] The high court said that there was one working theatre and it was expected that cases which were not pressing would be attended to first so that the theatre should be available for dire emergencies. The high court further said this was an elementary feature of triage. I disagree. In my view, triaging is mainly about prioritising more serious cases that need attention at that moment, not to first clear cases that are not more pressing.

[40] The high court ruled in favour of Ms TM on the first, second and third downtimes. Dr Chauke's reasons for the downtimes are reasonable. In my view, the negligence of the MEC should be determined based on what happened when Ms TM was referred to theatre.

[41] The legal position in claims involving negligence is that in order to be liable for the damages suffered by someone else, the act or omission of the defendant must have been wrongful and negligent and have caused the loss. The standard to be applied is not that of the reasonable person but that of a reasonable organ of state. In *Moshongwa v PRASA,*[4] the Constitutional Court stated that 'the standard of a reasonable person was developed in the context of private persons' and given the fundamental difference between the State and individuals, 'it does not follow that what is seen to be reasonable from an individual's point of view must also be reasonable in the context of organs of state'.

[42] The wrongfulness of the MEC's conduct depends on the existence of a legal duty. It is clear in the agreed stated case that the MEC admitted that:

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[4] *Mashongwa v PRASA* [2015] ZACC 36; 2016 (2) BCLR 204; 2016 (3) SA 528 (CC) para 40.

'2.9 [S]he owed the plaintiff a duty of care to ensure the rendering of medical care, treatment and advice to the plaintiff with such skill, care and diligence as could reasonably be expected of medical practitioners and nursing staff in similar circumstances, obliging the defendant to ensure that proper, sufficient and reasonable health services are provided to members of the public (particularly those who could not make use of the services of a private hospital).

…

6.6 … the aforementioned staff undertook to render medical examinations, care, treatment, and advice to the plaintiff and to monitor her labour as was reasonably required in the circumstances.

…

7.2 … (subject to the availability of resources) the medical practitioners and nursing staff were individually under a duty of care to render medical care, treatment and advice to the plaintiff (particularly, but no necessarily limited to, the need for and/or performance of a caesarean section to deliver her unborn child), to accurately ascertain, monitor and record the progress of the plaintiff's gestational age, and to monitor the plaintiff's labour with such skill, care and diligence as could reasonably be expected of medical practitioners and/or nursing staff with reasonable and appropriate obstetric knowledge in similar circumstances.'

[43] If the theatre was booked, the MEC should have checked with other hospitals in the area if they could render assistance. Dr Murray testified that in the Western Cape if there is no space, patients are diverted to other facilities. The MEC in the reply to Ms TM's notice in terms of rule 35(3) stated that there was no protocol for the transfer of patients to other hospitals. Contrary to the MEC's response, the Hospital's Policy for Admission of Patients from Casualty dated 14 August 2006, reviewed with no change on 3 September 2008, clearly states that:

'If no space can be found for the patient within the hospital, the clinical executive on call must be contacted so that arrangements can be made for the patient to be transferred to another medical facility or, alternatively, to ensure that additional nursing staff are acquired to provide the necessary nursing care, thus enabling the patient to remain at this hospital.'

[44] It is common knowledge that CMH is in the Gauteng Province which has public hospitals, one of them being Chris Hani Baragwanath Hospital and there are other hospitals within a radius of 30 km.[5] Even though the high court did not make a ruling on the issue of referral to other hospitals, this in my view, is an aspect to be considered in this appeal.

[45] In respect of the further grounds of negligence raised by Ms TM in the particulars of claim, she alleged that the MEC:

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

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

…

7.2.2 failed to monitor Plaintiff's labour and foetal well-being appropriately, with sufficient regularity, or at all;

…

7.2.4 failed to request assessment and/or examination of Plaintiff by a qualified medical practitioner upon her admission to the **Charlotte Maxeke Johannesburg Academic Hospital**.

…

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[5] Checked information on Google maps.

7.2.18 failed to provide and/or render adequate and/or appropriate neo-natal resuscitation immediately after birth of **Mthabile**.'

The MEC in the agreed stated case further admitted that:

'6.4 . . . [B]y virtue of the provisions of Constitution (sections 9, 11 and 27), that she owed the plaintiff a duty of care to ensure the rendering of medical care, treatment and advice to the plaintiff with such skill, care and diligence as could be reasonably expected of medical practitioners and nursing staff in similar circumstances, obliging the defendant to ensure that proper, sufficient and reasonable health services are provided to members of the public (particularly those who could not make use of the services of a private hospital).'

Causation

[46] As a point of departure, the expert gynaecologists acknowledged that the Guidelines for maternity care in SA 2007 recommend that C-section should be performed within one hour of the decision to operate. There should be a good reason why the experts and the Guidelines specifically stated that the C-section needed to be performed within one hour of the decision to operate. The time of one hour after the decision has been made, is regarded as reasonable. The Guidelines which have been in operation since 2007 have not been amended to state that the C-sections needed to be performed as soon as reasonably possible.

[47] Contrary to the interpretation of my colleague, Rogers AJA, that the guidance of 30 and 60 minutes applies to the interval between the decision to operate and the delivery of the baby, rather than the commencement of the operation, the Guidelines clearly state that the operation should be performed within one hour. The administration of anaesthetics should fall with the one hour. I disagree with Roger AJA that on the referral issue the C-section could not have been performed sooner

at a neighbouring hospital than at the CMH theatre. However, there is no direct evidence to suggest that any enquiries were made in this regard.

[48] The medical reports filed are full of medical jargon. Summary of expert evidence of Prof van Toon, a paediatric neurologist, said profound HII was an injury of the brain caused by profound lack of oxygen (hypoxic) and blood flow (ischaemic) to the brain (chronic evolution) 'acute profound' which do not assist the court in determining the issue of causation.

[49] Prof Smith, when he testified about the timing of the injury, said 'the baby probably sustained its brain injury during the last hour of birth or labour'.

[50] Dr Marishane said in the developing world an interval of one hour from decision to operate until performing of C-section is acceptable in most cases. He said it was difficult to state the effect of the delay in this matter. Importantly, he said that once there is foetal distress, the goal is to deliver the baby as soon as possible.

[51] The final hour hypothesis of Prof Smith is that the baby suffered HII during the period 17h43-18h43. This was not challenged. Dr Marishane said he did not know. There is no basis to reject the final hour hypothesis.

[52] Prof Bolton said that the medical profession does not know how long it takes for damage to occur. The guidance of 30-60 minutes was simply some concoction of history without any scientific basis. Importantly, no reasons were given why the guidelines were to be scrapped because they serve no purpose.

[53] Having regard to the duty that the MEC owed to Ms TM after she was admitted as a patient, the admissions made by the MEC, and the evidence presented in court justify concluding that the MEC acted negligently after Ms TM was referred for C-Section. Her condition should have been monitored regularly and a consultant doctor should have evaluated her condition, together with the conditions of Ms G and Ms DM to determine which C-section was to be prioritised. I am satisfied that the wrongful conduct of the MEC's staff caused the baby to suffer brain damage.[6] On the facts, and based on the admissions made by the MEC in the agreed stated case and the evidence presented in the high court, the order of the high court should not be interfered with. Costs should follow the result.

[54] In the result, I would make an order dismissing the appeal with costs.

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A P Ledwaba

Acting Judge of Appeal

Rogers AJA (Mbatha and Nicholls JJA concurring)

[55] I have read the judgment of my colleague Ledwaba AJA (the first judgment). Unlike him, I have concluded that the appeal must succeed on two grounds: that the respondent failed to prove on a balance of probability (a) the negligence of the appellant and the employed medical

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[6] See also *Minister of Safety and Security v Duiveboden* [2002] ZASCA 79; [2002] 3 All SA 741 (SCA) para 25.

staff; or in any event (b) that MM's injury and cerebral palsy would have been avoided in the absence of the supposed negligence.

[56] In regard to wrongfulness, it is not in dispute that the appellant, acting through the medical staff at the maternity unit of Charlotte Maxeke Johannesburg Academic Hospital (CMH), owed the respondent, Ms TM, a legal duty, upon her admission, to exercise reasonable care, skill and diligence in her treatment. I am also willing to assume, without so deciding, that the appellant, acting through those charged with the management of the maternity unit, had a legal duty, for delictual purposes, to manage the unit's resources with reasonable efficiency and that this legal duty could, in relation to Ms TM, have been breached by acts or omissions preceding her admission at 12h55 on Saturday 28 August 2010.

[57] There are two features of CMH's conduct prior to Ms TM's admission which call for attention. The first is the failure to have a second functioning maternity theatre. The second is the failure to use the single theatre earlier in the day to perform cesarean sections (C-sections) on other patients.

Pleadings and issues

[58] Before considering this and other impugned conduct, I must say something about the pleadings and documentation. When summons was issued in June 2014, the only expert report which Ms TM's advisers had was the first report of the radiologist, Dr Andronikou. He concluded that the pattern observable on the MRI scan of MM's brain was most probably that of an acute profound hypoxic ischaemic insult in a term or premature neonate or foetus. He did not express an opinion on whether the insult

was suffered while the respondent was a patient at CMH or whether the insult was suffered as a result of negligent treatment. It is thus unsurprising that the particulars of claim, which were never thereafter amended, took a scattergun approach. It is likewise unsurprising that many of the pleaded omissions were later shown to be unjustified.

[59] The hearing ranged over many issues, undisciplined by the pleadings. By the end of the trial, Ms TM's case had come to focus on five alleged failings, with particular emphasis on the second. These were:

(a) The failure to have a second functioning maternity theatre, so that when Ms G and Ms TM both needed C-sections at around 16h00, both could promptly be taken to theatre (the second theatre issue).

(b) The failure to use the single theatre earlier in the day to perform C-sections on other patients, including Ms CM, Ms DM and Ms G, so that the single theatre would have been available for the respondent's C-section shortly after 16h00 (the downtime issue). There were three periods on the Saturday when the theatre was not in use: between 04h35 – 06h05; between 07h05 – 09h00/09h30 (the handwriting in the theatre register is unclear); and between 11h40 –14h15. I shall call these the first, second and third downtimes.

(c) The triage decision to take Ms G rather than Ms TM to theatre after 16h00 (the triage issue).

(d) The failure to take interim measures, while Ms TM waited for her operation, to improve the foetus' oxygenation (the interim measures issue).

(e) The failure to refer Ms TM to another Johannesburg hospital when it became apparent that she would have to wait several hours for her operation (the referral issue).

[60] The high court rejected Ms TM's case on the second theatre issue and the triage issue but found for Ms TM on the downtime issue. The high court did not make a finding on the interim measures issue or the referral issue. In this Court, the first judgment agrees with the high court in rejecting the case based on the second theatre issue. The first judgment holds that the high court should not have found for Ms TM on the downtime issue. Instead, the first judgment finds for Ms TM on the triage issue and the referral issue, and also criticises the MEC in relation to the interim measures issue.

[61] None of five issues I have identified was pleaded. This is unsurprising, because when summons was issued Ms TM's legal representatives did not know the facts. In regard to the second theatre issue, there was a generalised allegation that the appellant failed to ensure that CMH was 'suitably, adequately and/or properly equipped to enable the timeous and proper performance of a [C-section] if and when required'. There was indeed a suitably, adequately and properly equipped C-section theatre. The problem was that there was only one. The allegation I have quoted was inadequate, to found a case based on a complaint that the appellant acted wrongfully and negligently by failing to have two (or more) functioning C-section theatres.

[62] In regard to the downtime issue, the respondent alleged that the healthcare professionals 'failed to perform or request to be performed, timeously, a [C-section] on Plaintiff in circumstances where it was

necessary and/or indicated to do so' and 'failed to ensure that the emergency [C-section] was performed without delay'. There were no allegations about what the healthcare workers had done or failed to do earlier in the day in relation to other patients. In regard to the triage issue, nothing was pleaded beyond the generalised allegations to which I have already referred and the further allegation that the healthcare professionals 'failed to provide and/or render the requisite reasonable medical, surgical, nursery and midwifery services with such professional skill and diligence as could reasonably be expected of medical practitioners, nurses and/or midwives in the particular circumstances'. Ms G's name was not mentioned. In relation to the interim measures and referral issues, nothing was pleaded beyond the allegations I have already identified.

[63] While Ms TM's legal representatives cannot necessarily be faulted for being unaware, when summons was issued, of the facts underlying the five issues on which they ultimately relied, the particulars of claim should have been amended once it was decided to advance them. One gets the impression that the thinking of Ms TM's legal representatives on these issues only emerged or crystallised during the course of the trial. It is hardly surprising, therefore, that the documentary and expert evidence was not pertinently directed to these matters.

[64] Insofar as documentary evidence is concerned, the patient records adduced in evidence, apart from Ms TM's, were those of Ms CM, Ms DM, Ms G and Ms N. Why Ms N's record was handed in is a mystery. The records of Ms CM, Ms DM and Ms G were presumably requested because their names appeared immediately before Ms TM's in the theatre register. In total, 13 patients had C-sections at CMH's maternity theatre

on 28 August 2010 – six before Ms CM, and three after Ms TM. There would have been other women in the maternity unit on that Saturday: mothers whose babies were born on the Friday (or earlier) and who had not yet been discharged; mothers whose babies were born on the Saturday by normal vaginal delivery (NVD); and mothers who were in labour but whose babies were only delivered on the Sunday.

[65] Apart from Ms TM's record and those of the four mothers named above, the records of the many patients who needed attention in the maternity unit on the Saturday were not adduced and were apparently not requested. Counsel for Ms TM took us to his client's notices for better discovery dated 21 June and 24 August 2016. The first required production of complete and legible records pertaining to Ms TM's and MM's treatment. The second was wide-ranging, but focused on staffing and protocols.

[66] Save for the interim measures issue, which was dealt with in Dr Murray's report, the reports of the experts contained nothing whatsoever about the five issues, and such oral expert evidence as there was on these matters emerged haphazardly.

[67] When a member of this Court asked counsel for the MEC, with reference to the downtime issue, whether he took any point on the pleadings, he said, very fairly, that he had perhaps been at fault in not objecting to some of the evidence, and that in the circumstances he would not argue that the issue was not open to Ms TM. Although he was not asked the same question about the second theatre issue, the circumstances of the case suggest that his answer would have been the same. On the other hand, he argued that the triage complaint should not be entertained.

[68] In the light of counsel's attitude, I accept that the second theatre issue and downtime issue are not foreclosed by the pleadings. I am doubtful that the other three issues are open to Ms TM, but I shall assume in her favour that we may entertain them. Nevertheless, given the absence of proper pleading and the haphazard way in which evidence on these matters emerged, it would not be fair to place too much emphasis on the supposed evidential burden resting on the MEC to explain the supposed failings. The burden of proof remained throughout on Ms TM.

The second theatre issue

[69] As at August 2010 there was physical space for a second maternity theatre but it was not functional: it was unequipped, and there was not a second staff complement (surgeon, anaesthetist, anaesthesia nurse, floor nurse, scrub nurse, cleaner and porter). A second theatre was commissioned in 2013, but was only functional on Mondays to Fridays during ordinary working hours. This was still the position when Dr Chauke testified in August 2018. Since Ms TM's C-section was performed on a Saturday, there was no practical difference between the 2010 and 2013 regimes.

[70] If the second theatre issue had been pleaded, I would have expected focused documentary and expert evidence on the subject, including evidence from experts on hospital management adduced with reference to detailed financial information. There are many demands on a health department's budget and on particular public hospitals' budgets. The way in which the money allocated to them is used is entrusted by law to the relevant minister and senior officials, not the courts. The range of reasonable decisions is likely to be broad. In these circumstances, a case such as the one based on the second theatre issue is not easily established.

[71] Dr Murray testified that in the urban hospitals where she has worked there were usually two theatres, with the second theatre being for elective surgery. If two patients need immediate surgery, elective operations can be deferred. Clearly such an arrangement is better than having only one theatre, but Dr Murray's evidence did not begin to address the question whether, having regard to budgetary constraints and other demands, it was unreasonable for there not to be a second maternity theatre.

[72] The only other witness who was questioned on this issue was Dr Chauke, a qualified obstetrician and gynaecologist with super-specialisation in maternal and foetal medicine. Since January 2016 he has been CMH's Head of Department of Obstetrics and Gynaecology. Although he was not at CMH in 2010, he produced data of C-sections performed at the hospital in 2010, with reference to which he testified that the prospect of successfully motivating for a second maternity theatre at that time would have been very low. The second theatre opened in 2013 was intended for elective surgery.

[73] On this limited evidence, it is in my view impossible to conclude that the MEC was negligent in failing so to apply the department's money as to ensure that there was, in August 2010, a second functioning maternity theatre at CMH. The high court's finding in this respect cannot be faulted.

[74] It is convenient, here, to mention a related point made by Dr Murray which was not contained in her expert report. She suggested that one did not need a second maternity theatre. A C-section could be performed in a general theatre. The incubator was a mobile unit which

could be moved to a general theatre. She remarked that private hospitals do not have dedicated maternity theatres.

[75] It was not alleged, in the particulars of claim, that the medical staff were negligent in failing to have Ms TM's C-section performed at one of CMH's general theatres. Dr Chauke's response to Dr Murray's remarks was that a C-section is a specialised procedure that has to be performed by a competent surgeon. The maternity theatre is physically separated from CMH's general theatres. The maternity theatre has its own allocation of specialist nursing staff, and is located close to the neonatal unit. General gynaecological operations are performed in the main theatre complex because they do not need the same level of specialisation.

[76] He referred to a Department of Health report concerning maternal deaths in this country.[7] According to this report, one-third of maternal deaths from bleeding during or after C-sections were cases involving a lack of surgical skill. The same report stated that a safe caesarean delivery (CD) service meant having adequate resources 'including adequate numbers of knowledgeable and skilled staff who can manage surgical and anaesthetic complications of CD'. Criteria for accreditation of CD sites had been developed which needed to be implemented, even though this might result in CD services being closed in some facilities. Dr Chauke testified that general surgeons at CMH would not agree to perform C-sections, and that he would not be comfortable asking them to do so.

[77] Once again, the limited evidence on this unpleaded issue does not permit of a finding in Ms TM's favour.

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[7] Department Of Health 'Saving Mothers 2014-2016: Seventh triennial report on confidential enquiries into maternal deaths in South Africa: Executive summary'.

The downtime issue

[78] This was the issue on which the high court found in Ms TM's favour. I shall for convenience refer to the mothers whose C-sections were performed before Ms CM's as X1-X6, because they were the first six C-sections performed on that day. I shall refer to the three mothers whose C-sections were performed after Ms TM's as X11-X13. Between the operations of X6 and X11 were the C-sections performed (in this order) on Ms CM, Ms DM, Ms G and Ms TM.

[79] The first downtime, from 04h35-06h05, need not concern us. When Dr Chauke was led on that subject, counsel for Ms TM interjected to say that her client's complaint was about the second and third downtimes, not the first downtime.

[80] The second and third downtimes occurred between 07h05-09h00/09h30 and between 11h40-14h15. In relation to these downtimes, it is necessary to consider the positions of Ms CM, Ms DM, Ms G and X4, X5 and X6.

[81] Ms CM was admitted to CMH at 03h45. Because she was carrying twins and the leading twin was in a breech position, an NVD was unsafe. Sooner or later, therefore, her babies would have to be delivered by C-section. She was scheduled to have her C-section during the first downtime. Her operation was eventually performed from 14h15-15h20.

[82] Although Ms DM was admitted to CMH at 06h05 with suspected foetal bradycardia, her CMH record shows that the staff initially considered that she could have a NVD. It was only at 13h45 that her baby

was detected to be suffering foetal distress and a C-section became necessary. Her C-section was performed from 15h30-16h25.

[83] Ms G was first assessed at 09h50. Because she had undergone two previous C-sections, NVD posed a risk of uterine rupture. Although the risk is not high, if it eventuates it can be fatal for mother and child. Sooner or later, therefore, her baby had to be delivered by C-section. When seen by a doctor at 16h15, she was 8 cm dilated, the foetal heart rate (FHR) was satisfactory and there was no bleeding. The decision was taken to perform a C-section, which took place from 16h45-17h55.

[84] The C-sections of X4, X5 and X6 were performed between 06h05-07h05, 09h00/09h30-10h10, and 10h35-11h40. According to the theatre register, these were all cases of foetal distress, and it has not been claimed that Ms CM or Ms G should have been prioritised ahead of them. Ms DM had not yet been identified as needing a C-section.

[85] Assuming for the moment that it was negligent to allow the theatre to stand idle during the second and/or third downtimes, and that its use during these downtimes should have been maximised for C-sections, the evidence summarised above suggests the following:

(a) If the negligence applied to both downtimes, Ms CM's operation could have been performed during the second downtime and Ms G's during the third downtime. If this had been done, Ms DM could have had her operation between 14h15-15h30, meaning that the theatre would immediately have been available for Ms TM when her baby's foetal distress was confirmed at 16h00.

(b) If the negligence applied only to the second downtime, Ms CM's operation could have been performed during that downtime. Ms DM's

operation could then have been performed in the slot from 14h15-15h10 and Ms G's operation from 15h30-16h40. This would mean that Ms TM could have been in theatre by about 16h55, and MM would then have been delivered at around 17h23. (This is based on the fact that when Ms TM's operation began at 18h15, MM was delivered 28 minutes later.)

(c) If the negligence applied only to the third downtime, the operations of both Ms CM and Ms G could have been performed during that downtime, which lasted about two and half hours. Ms DM's operation could then have been performed from 14h15-15h20, meaning that the theatre would immediately have been available for Ms TM when her baby's foetal distress was confirmed at 16h00.

(d) If the negligence applied only to part of one or both of these downtimes, these permutations might change.

[86] Turning to the reasons for the second and third downtimes, Dr Sibeko, the registrar on duty on the Saturday afternoon, was deceased by the time of the trial. Dr Chauke testified that CMH has a high turnover of doctors, and they had been unable to trace the other doctors working at the maternity unit on that day. Without the medical records of all the patients in the maternity unit, one cannot reconstruct the day's events. Dr Chauke could not explain from personal knowledge why the second and third downtimes occurred. Without full medical records, even the doctors and nurses who were on duty on 28 August 2010 would not, eight years later, have been able to do so.

[87] Dr Chauke did not find the occurrence of the second and third downtimes remarkable. He testified that Dr Sibeko, as the senior doctor present, would have had to do ward rounds: ward 162 (the obstetric

emergency admission ward), ward 166 (the labour ward), the post-natal wards and ward 194 (the antenatal ward for women with pregnancy complications). Non-theatre emergencies, including resuscitations, could occur, which could not be left to an intern.

[88] Although Ms CM and Ms G were both known to be mothers who would need C-sections sooner or later, it would – in the absence of a full reconstruction of the day's events – be unfair to the MEC and to the late Dr Sibeko to find that the latter was at fault for not performing those C-sections during the second and third downtimes. If she had other duties to perform, including non-theatre emergencies, she might properly have deferred their operations, not regarding either of them as yet urgent. We know that in the event both mothers had unproblematic and successful C-section deliveries. Ms DM was only identified for a C-section at the tail-end of the third downtime. At no stage during the second or third downtimes was it expected that Ms TM would need a C-section.

[89] Since the downtime issue was not pleaded, it would not be right to penalise the MEC for having failed to produce all the medical records and undertake a complete reconstruction. If Ms TM's legal representatives wanted to run this case, they should have called for all the medical records, done the reconstruction, and led expert evidence with reference to the triage decisions which Dr Sibeko took over the course of the day. When counsel for the MEC put to Dr Murray that the case was not about the wrongs and rights of the treatment of other patients, she said that she fully understood this in relation to the individual cases, but added:

'. . . [T]his is a case not simply about our plaintiff but about everything that happened on that day and we cannot really appreciate the lay of the land so to speak without knowing what else was going on, and that is the only reason why I refer to those

cases, not because . . . I am trying to look for fault in other people in other cases, simply because in order to understand what was going on, it is important to look more broadly than the plaintiff.'

In regard to the downtime issue, Dr Murray was correct. But, presumably because the downtime issue had not been pleaded and had not been the subject of proper discovery and expert reports, she did not have access to the full records to give her the 'lay of the land'.

[90] In my view, Ms TM failed to discharge the burden of proving negligence on the downtime issue. I thus respectfully consider that the high court erred in finding otherwise.

The triage issue

[91] This unpleaded issue arose first in Dr Murray's cross-examination. In the context of the fact that Ms G was already known in the morning to be a mother who would need a C-section, and that the decision was only taken at 16h00 to perform it, she said:

'My point being is that there was an indication for her to have that Caesar for the prior six hours, but I do not expect a registrar to make that decision. If you ask me, I would say previous Caesar times two has a 0.74% risk of rupture that is fairly low and she can be tocolysed. I would as a senior have probably chosen a baby in severe distress but that is a decision that a senior person has to make . . . I am not suggesting somebody should rupture a uterus at the expense of another patient. It is all about triage, I mean that is what … working in an emergency setting is about.

. . .

I am not being critical of the . . . I am not suggesting somebody should suffer for somebody else to have a good outcome. I am simply saying we are dealing with [an] important situation . . . [M]y opinion is that if resources are limited and multiple emergencies [arise], senior people should be involved, there should be management involved, there should be overall management of an emergency situation . . . [T]o

have junior doctors making important decisions . . . is not acceptable, I mean it is not . . . it is not ideal but anyway.'

[92] This passage raises two possible criticisms of Dr Sibeko: the decision to prioritise Ms G above Ms TM; and Dr Sibeko's failure to seek the advice of a consultant before making her triage decision. Unless the first criticism receives a clear medical answer that Ms TM should have been prioritised, the second criticism is causally irrelevant, since it cannot be assumed that the consultant, if contacted, would have advised Dr Sibeko to prioritise Ms TM.

[93] Because this issue was not pleaded or the subject of expert reports, Dr Murray's oral evidence about the low risk of Ms G suffering a uterine rupture was not supported with reference to literature. Dr Chauke responded to Dr Murray's criticism by stating that the principle of obstetric care is that the mother takes precedence over the foetus, and that when one has reasonably equal emergencies threatening the mother on the one hand and the baby on the other, any reasonable gynaecologist will favour the mother. He said that he would probably have made the same decision as Dr Sibeko. Many mothers whose CTGs show foetal distress deliver healthy babies, as occurred on this very Saturday.[8]

[94] The views of Dr Marishane, an obstetrician and gynaecologist, accorded with Dr Chauke's. Uterine rupture, he said, posed a threat to the life of both the mother and the baby. In regard to foetal distress, the CTG 'is good in telling you that the baby is most likely okay but it is very bad

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[8] The theatre register reflects that eight of the C-sections on that day (X2, X3, X4, X5, X6, Ms DM, Ms TM and X11) were performed because of foetal distress. Only Ms TM's had a bad outcome. Although the babies of X4, X5 and X6 had low one-minute Apgar Scores, their ten-minute Apgar scores recovered to 9/10 or 10/10.

in telling you that the baby has a problem . . .’. In most cases where the CTG suggests a problem, the baby comes out normal, close to 90% of cases. He would have prioritised Ms G.

[95] Prof Bolton, a paediatrician, had a similar opinion about CTGs. A CTG, he remarked, was ‘a pretty awful way of looking at it but it is what we have got’. The CTG ‘over-diagnoses tremendously’, which results in many unnecessary C-sections. Ms TM’s paediatric expert, Prof Smith, said that the CTG was the best diagnostic device which the medical community had, and all official bodies recommended it: ‘[W]e all criticise it and we all understand its deficiencies . . . You will do [C-sections] unnecessarily, but there is no way of circumventing that at this point in time.’

[96] In my view, therefore, the high court was right to reject the argument that Ms TM should have been prioritised. If the manner of prioritising in such cases is clear, it was probably unnecessary for Dr Sibeko to contact one of the consultants. At any rate, it cannot be found that if she had done so, the consultant would probably have advised her to prioritise Ms TM.

The interim measures issue

[97] On this unpleaded issue the question is whether, given that Ms TM’s operation only started two and a quarter hours after the decision to operate, interim measures should have been implemented to improve her foetus’ oxygenation. Those mentioned in the evidence were tocolytic medication, giving the mother an oxygen mask, and getting her to lie on her left side.

[98] It was put to Dr Murray that tocolytic medication such as Atosiban has not been shown to be effective as a means of foetal resuscitation, particularly in the case of a mother who was already (as Ms TM was) 7 cm dilated when foetal distress was detected. Dr Murray acknowledged that because of the paucity of literature, a recent meta-analysis was 'unable to find proof that tocolysis is beneficial'. The reason for the absence of literature was that one could not perform ethical tests by giving the drug to some women and withholding it from others. However, because foetal condition is linked to uterine contractions, there was logic to the view that suppressing contractions was helpful. Every guideline and international body of which she was aware recommended its use.

[99] Dr Chauke was referred, in cross-examination, to the fact that Atosiban was administered to Ms G. His reply was that unlike certain other tocolytics, Atosiban was known to have no harmful effects, so he could understand its administration, even if there was only a small chance that it might be beneficial.

[100] Dr Marishane said that there was no agreement among obstetricians about intrauterine resuscitation, because there was no research to back up the methods used. The only thing that had been found to be of some value was getting the mother to lie on her side. And in regard to tocolysis, he said that once patients got to dilation of 7 cm or more, tocolytics did not really help and the patients did not seem to respond well to it. In Ms G's case, because she had had two previous C-sections, it was important to stop her contractions to prevent rupture. In the case of foetal distress, however, there was disagreement as to whether it brought about a different outcome, though some would say that there is nothing to lose by trying it.

[101] Since Ms TM's record does not note that Atosiban was administered, we must assume that it was not. Given the evidence that it could do no harm, this failure is questionable. However, the evidence falls well short of showing that its administration would probably have had a material effect.

[102] In regard to giving the mother an oxygen mask, Dr Murray testified that as at 2010 it was part of the standard resuscitation package to give the mother oxygen but that it helped the foetus very little and they did not use it much anymore. Dr Chauke confirmed that the use of an oxygen mask was part of the 2007 Guidelines but said that he did not agree with its use, and the cross-examiner did not press the point, understandably in the light of Dr Murray's testimony.

[103] All the experts agreed that getting a mother to lie on her left side was a practical measure which did no harm and might help. There was no expert evidence about the extent of the help. Dr Chauke testified that this practice was so ingrained that one sometimes does not find it recorded in the nursing notes. Ms TM testified eight years after the event, and it is no criticism of her to say that her recollections were imprecise. No evidence was elicited from her as to how she was lying during the two hours she was awaiting her operation or whether she was advised to lie on her left side. Although in Ms DM's case, the note of 13h50 records that she was placed on her left side, the absence of a similar note in Ms TM's case does not without more justify the inference that she was not placed on her left side. The notes were written by different nurses; the one may have noted it, the other not.

The referral issue

[104] This is, once again, an unpleaded matter. One of Ms TM's notices for better discovery sought production of the CMH protocols, as at August 2010, for the transfer of patients to other hospitals during periods of high patient loads. The reply was that no such protocols existed; that CMH was an academic hospital, and that patients were transferred to, not from, CMH; and that only ICU patients were transferred to other supporting hospitals.

[105] Dr Murray testified that at Tygerberg Hospital they were proactive in emergencies. This might include phoning surrounding hospitals if the patient could not be treated at Tygerberg. Neither Dr Chauke nor Dr Marishane were cross-examined on this question.

[106] In my opinion, the evidence on the referral issue is insufficient to allow the court to reach a fair conclusion. The absence of a general hospital protocol does not mean that the medical staff at CMH's maternity unit would have closed their minds to the possibility of an outward referral for an urgent C-section. The question was simply not raised with Dr Chauke. We do not know what other public hospitals existed, whether an ambulance service was available, what distance each such hospital was from CMH, what their facilities were, how long a transfer would have taken, and whether their facilities were likely to have been available to Ms TM sooner than at CMH.

Causation

[107] I have already dealt with causation in relation to the interim measures issue. And what I have just said about the referral issue shows that Ms TM failed to prove on a balance of probability that her baby

would have been delivered sooner if the possibility of a transfer had been pursued. What I now address is the question of causation in relation to the second theatre issue, the downtime issue and the triage issue.

[108] On the downtime issue, the most favourable scenario for Ms TM is that a theatre would have been immediately available for the operation when the need for it arose. This would also be the position if one found in favour of Ms TM on the second theatre issue or on the prioritisation issue.

[109] To the extent that the MEC contended that a C-section interval of one hour would have been acceptable, I reject the contention in those stark terms. The C-section needed to be performed as soon as reasonably possible. General benchmarks of 30 minutes (in the developed world) or 60 minutes (in the developing world) do not absolve medical staff from acting as quickly as reasonably possible. I should add that it appears from the joint minute of the obstetricians that the guidance of 30 minutes and 60 minutes applies to the interval between the decision to operate and the delivery of the baby, rather than the commencement of the operation. In order to deliver a baby within 60 minutes, one would typically need to start the operation (the administration of anaesthesia) 15-30 minutes earlier.

[110] On this basis, it is reasonable to suppose that the operation could have started at 16h15. Based on the course of the operation later performed, MM would have been delivered by 16h43.[9] For the sake of completeness, I add, with reference to the referral issue, that a C-section

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[9] The respondent's C-section started at 18h15, and Mthabile was delivered at 18h43.The time of delivery was recorded in the joint minute between Prof Smith and Prof Bolton. The obstetricians in their joint minute referenced a time of 18h35, which was when surgery (as distinct from anaesthesia) began. In the summary filed in respect of Dr Murray's evidence, it was recorded that surgery started at 18h35 and that the baby was delivered at 18h43.

could not have been performed sooner at a neighbouring hospital than at an immediately available CMH theatre.

[111] The radiologists identified MM's injury as a hypoxic ischaemic injury (HII) of an 'acute-profound' nature occurring perinatally in a term brain. This was agreed in their joint minute.[10] As to when the insult was suffered, the radiologists did not say more than that it occurred 'perinatally' in a 'term' brain. Neither expression is defined in the record. Online definitions vary, but they all indicate that these expressions may include several weeks before onset of labour and include some period after the baby is born. Within the 'perinatal' period is the 'intrapartum' period, ie from the start of labour until the baby is born. The paediatricians, Prof Smith and Prof Bolton, agreed in their joint minute that the injury was suffered intrapartum.

[112] There is no evidence of mishaps in Ms TM's pregnancy before foetal distress was noted at 15h45 on 28 August 2010. Since foetal distress may be caused by a lack of oxygen, and since this is a known cause of HII, one can accept as a matter of probability that this marked the beginning of the episode which caused MM's brain injury.

[113] A more significant omission in the radiology reports is a definition of an 'acute-profound' hypoxic ischaemic injury. All the experts gave their reports on the basis that one was dealing with an 'acute' insult rather than a 'partial prolonged' insult. Dr Weinstein, the radiologist engaged on behalf of the MEC, noted in his report that although acute HII is usually associated with a 'sentinel event' (in the present case, no such event was

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[10] On the status of such joint minutes, see *Bee v Road Accident Fund* [2018] ZASCA 52; 2018 (4) SA 366 (SCA) paras 64-66 and *Member of the Executive Council for Health, Eastern Cape v DL obo AL* [2021] ZASCA 68 paras 23-24.

recorded), an acute HII can occur without a sentinel event. In Ms TM's summary of the expert evidence of Prof van Toorn, a paediatric neurologist, he agreed with the radiologists' opinion that MM suffered brain injury 'as a result of acute total asphyxia'. He stated that a 'profound' HII was an injury of the brain 'caused by a profound lack of oxygen (hypoxic) and blood flow (ischaemic) to the brain'. (Neither Dr Weinstein nor Prof van Toorn testified.)

[114] Another omission was any explanation of Dr Andronikou's statement that the features of MM's brain injury were those of a 'chronic evolution' of a global insult. In a joint minute, the radiologists, immediately after recording their agreement that the HII was 'acute profound', agreed upon the description 'chronic'. Similar wording by Dr Andronikou in a case which reached this Court as *AN v MEC for Health, Eastern Cape*[11] led the minority to conclude that 'acute' did not necessarily convey that the hypoxia happened over a short period of time. The majority rejected that view.

[115] In the present case, one can glean from Dr Weinstein's report that he used the word 'chronic' as meaning 'old', ie not of recent origin. We do not know whether Dr Andronikou's expression, 'chronic evolution', was likewise intended to convey that the brain damage was old, not new. Another possible explanation for Dr Andronikou's description is this. It appears from a 2014 ACOG report, adduced as an exhibit at the trial,[12] that the pattern of brain damage caused by an acute intrapartum hypoxic insult may only be fully visible on MRI scanning after seven days of life,

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[11] *AN v MEC for Health, Eastern Cape* [2019] ZASCA 102; [2019] 4 All SA 1 (SCA).

[12] 'Neonatal Encephalopathy and Neurologic Outcome, Second Edition: Report of the American College of Obstetricians and Gynaecologists' Task Force on Neonatal Encephalopathy' (May 2014) *Paediatrics* 133(5) at 1482-1488.

and that scans taken in the first 24-96 hours of life may underestimate the total extent of the injury. This suggests that although the insult is of short duration, the brain damage it causes evolves over some days.

[116] But to return to the agreement that the insult was of an 'acute-profound' nature. It was of the greatest importance, in this case, to know when the acute-profound episode began and how long it needed to last to cause the damage noted on the MRI. None of the expert reports addressed this question. In the summaries of Prof Smith's expert evidence, which Ms TM delivered, it was stated that he agreed that the MRI features were those of an acute-profound HII to a term brain. He considered that the insult probably occurred during the intrapartum period, with sub-optimal care (and particularly the delay in performing the C-section) as the most probable causal factor.

[117] In oral evidence, Prof Smith went beyond his expert summaries in a passage of evidence on which the high court relied. He was asked in chief whether he and his counterpart, Prof Bolton, had discussed the timing of the injury. He said no, adding that 'the baby probably sustained its brain injury during the last hour of birth labour'. He said that although the injury had been described as 'acute-profound', it was 'actually more correct to say it is a central brain injury'. In this case there was no sentinel event. Where there is a sentinel event, 'you have got 15 plus minutes . . . , then you have the increasing likelihood of this type of brain injury', it starts occurring 'over a short period of time'. In his experience, however, where there was no sentinel event, this 'sub-acute cause' can take a long period of time, because foetuses are quite resilient and can withstand significant hypoxic events. Here there was a 'non-reassuring foetal condition' (meaning the foetal distress detected at 15h45) '160

minutes before they did the delivery': '[T]hat is sufficient time for sub-acute hypoxia to result in the final crash in the last hour.'

[118] The final-hour hypothesis is thus that MM suffered his HII during the period 17h43-18h43. Counsel for the MEC did not object to this evidence. And perhaps because he had not been precognised of it, and did not appreciate its possible significance, he did not deal with it in cross-examination.

[119] Dr Marishane, like Prof Smith, did not deal with this issue in his report. In chief, he said that in the developing world an interval of one hour from decision to operate until performance of the C-section (I shall call this the C-section interval) is acceptable in most cases. He was asked what effect the delay in the present case beyond one hour would have been. He said that it was difficult to say. Once one has foetal distress, the goal is to deliver the baby as soon as possible. However, sometimes by the time one sees the decelerations on the CTG it is too late.

[120] In cross-examination, Dr Marishane said that they could all agree that the C-section should have been done earlier, but nobody could say when the damage occurred. Counsel for Ms TM then asked him whether he agreed with Prof Smith's final-hour hypothesis. He replied that he did not know: '[I]t would be interesting to know how he [Prof Smith] knows that.' The evidence then continued:

Ms Munro: Well he explained that when the foetal distress starts, that it accumulates and it becomes overwhelming ultimately, and that at some point the injury or the foetus succumbs to the continual contractions and that is why it would not have happened and that is why the one-hour gap, if you can get someone there within the first hour, he should be fine.

<u>Dr Marishane</u>: The one-hour gap is not, you know is not scientific … [I]t is not like it is a cut-off that you know at one hour unless you have done this caesarean at one hour this would happen, no not necessarily . . . [I]t is more like advocacy to say let us get our resources mobilised as quickly as possible when we have . . . to do caesarean sections for foetal distress

. . .

<u>Ms Munro</u>: . . . [A]s soon as the [CTG] starts to show abnormalities, you know that a level of hypoxia is occurring and the proposition put by the plaintiff's experts, both Dr Murray and Prof Smith, is that it is not an instantaneous one hypoxic event, because we all go through that during birth, but it is the accumulation and the eventual exhaustion, if I can put it in layman's terms, of the foetus who then succumbs at a later stage.

<u>Dr Marishane</u>: That is why I say it depends on the course, you understand? That kind of reasoning is depending on what actually is causing the baby to be hypoxic, so you cannot have a blanket statement and say that there is accumulation when at the same time you are saying it was an acute thing. What are you saying?

<u>Ms Munro</u>: No doctor, every baby as I understand it goes through an amount of hypoxia during birth, and a foetus is resilient and can survive that, it is not a problem. It is only when it becomes overwhelming to the foetus that the foetus then suffers a hypoxic event.

<u>Dr Marishane</u>: Exactly the point.

[121] Dr Marishane was saying that the course of events underlying Prof Smith's final-hour hypothesis could not be reconciled with acceptance of an acute insult. The manner in which the views of Dr Murray and Prof Smith were conveyed to him by the cross-examiner painted the picture of a foetus coping with the ordinary intermittent hypoxia caused by labour contractions until at some point it succumbs. However, this coping mechanism would be normal on a CTG, since by definition it is a standard feature of labour. What was noted at 15h45 was abnormal,

something which – on the hypothesis put to Dr Marishane – was signalling the commencement of the succumbing of the foetus to hypoxia. And since the brain pattern was of an acute insult, it is not self-evident why the damage was not irreversible within a relatively short space of time.

[122] The same subject was taken up with Prof Bolton in cross-examination. It was put to him that the correct treatment would have been to take the mother into theatre within 60 minutes. He replied that the medical profession does not know how long it takes for damage to occur. The guidance of 30 minutes or 60 minutes was 'simply some concoction of history', without scientific basis. The cross-examiner then put to him the thesis of a foetus eventually succumbing, using Dr Murray's analogy:

Ms Munro: . . . [I]t is as if you are putting a baby underwater and you push them down and they come up to catch a breath and you push them down and they come up to catch a breath, but if you overwhelm that baby they eventually succumb. Do you disagree with that hypothesis as to that happening here?

Prof Bolton: I think that that is not the scenario M'Lady here, that usually causes a chronic more subacute, a partial prolonged kind of pattern as opposed to the acute profound.

. . .

. . . I disagree with them. I think it is that analogy given is not a good one in my opinion for an acute profound.'

[123] With reference to the swimming pool analogy, Prof Bolton referred to animal tests done on birth asphyxia. One of these unpleasant experiments involved putting newborn animals underwater and keeping them submerged until they died, or pulling them out just before they died and resuscitating them. This revealed brain damage of an acute profound

insult. The judge then put her understanding of the thesis advanced by Ms TM's experts, of a foetus engaged in an ongoing struggle and then succumbing. Prof Bolton replied that this was more likely to cause a partial prolonged pattern.

[124] Prof Smith's reference in oral testimony to a 'sub-acute' cause of longer duration is unexplained. The radiologists used the term 'acute', not 'sub-acute'. As I understand it, this means that the damage was of the kind one would typically see after a sentinel event. The fact that no sentinel event was recorded in this case, and the fact that no sentinel event may have occurred, does not as a matter of logic detract from the fact that the damage was from the asphyxia typically caused by sentinel events, ie profound asphyxia which causes injury over a relatively short period of time (about 15 minutes, according to Prof Smith).

[125] The fact that Prof Smith's final-hour hypothesis was not challenged does not mean that it must be accepted. The cogency of an expert opinion depends on its consistency with proven facts and on the reasoning by which the conclusion is reached. In *Coopers (South Africa) (Pty) Ltd v Deutsche Gesellschaft für Schädlingsbekämpfung MBH* this Court held:

'[A]n expert's opinion represents his reasoned conclusion based on certain facts or data, which are either common cause, or established by his own evidence or that of some other competent witness. Except possibly where it is not controverted, an expert's bald statement of his opinion is not of any real assistance. Proper evaluation of the opinion can only be undertaken if the process of reasoning which led to the conclusion, including the premises from which the reasoning proceeds, are disclosed by the expert.'[13]

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[13] *Coopers (South Africa) (Pty) Ltd v Deutsche Gesellschaft für Schädlingsbekämpfung MBH* 1976 (3) SA 352 (A) at 371F-H. See also *Oppelt v Head: Health, Department of Health Provincial*

[126] While I do not accept the MEC's criticism that Prof Smith lacked expertise to express opinions on pre-birth matters, he was a paediatrician, not (as was Dr Marishane) an obstetrician, so his opinion was on a matter not in his primary area of expertise. Prof Smith did not advance his final-hour hypothesis in the written summaries of his evidence or in the joint minute which he and Prof Bolton signed. When he offered this opinion in oral evidence, he did not refer to any literature in support of it. There was nothing before the high court to show that a respectable body of expert opinion stood behind his conclusion. The notion of a longer-lasting sub-acute cause is inconsistent with the radiological evidence. It appears in this respect to suffer from the same inconsistency which this Court highlighted in *Member of the Executive Council for Health, Eastern Cape v Z M*[14] and which a majority of this Court rejected in *AM obo KM v Member of the Executive Council for Health, Eastern Cape*.[15]

[127] To some extent, Dr Marishane's views on the issue were also unreasoned. However, the burden of proof rested on Ms TM, and in my opinion she did not discharge the burden of proving that MM suffered his HII over the period 17h43-18h43. On the evidence, it is as likely as not that the damage was done by 16h15, ie within 30 minutes of the abnormal CTG. Since an absence of the assumed negligence would, on the best scenario for Ms TM, not have resulted in a delivery earlier than 16h43, she failed to prove that but for the negligence the injury would not have been suffered.

Administration: Western Cape [2015] ZACC 33; 2016 (1) SA 325 (CC) para 36, quoting with approval *Michael and Another v Linksfield Park Clinic (Pty) Ltd and Another (1)* [2001] ZASCA 12; [2002] 1 All SA 384 (A) paras 34-40; *PriceWaterhouseCoopers Inc and Others v National Potato Co-operative Ltd and Another* [2015] ZASCA 2; [2015] 2 All SA 403 (SCA) paras 97-99.

[14] *Member of the Executive Council for Health, Eastern Cape v Z M* [2020] ZASCA 169 paras 27-29

[15] *AM obo KM v Member of the Executive Council for Health, Eastern Cape* [2018] ZASCA 141. See also *AN v MEC for Health, Eastern Cape* [2019] ZASCA 102; [2019] 4 All SA 1 (SCA) paras 20-21.

[128] My ultimate conclusion, therefore, is that despite the tragedy that befell Ms TM and MM, they were not entitled to compensation from the appellant. Counsel for the appellant said that if the appeal succeeded his client did not seek costs. I thus make the following order:

(a) The appeal succeeds.

(b) The order of the high court is set aside and replaced with an order in the following terms:

'The plaintiff's claim is dismissed.'

O L Rogers
Acting Judge of Appeal

APPEARANCES:

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