THE SUPREME COURT OF APPEAL OF SOUTH AFRICA
JUDGMENT

Not Reportable
Case no: 277/2023

In the matter between:

SN […] obo ON […] **APPELLANT**

and

MEMBER OF THE EXECUTIVE COUNCIL
FOR HEALTH: EASTERN CAPE **RESPONDENT**

Neutral citation: *SN obo ON v MEC for Health: Eastern Cape* (Case no 277/2023) [2025] ZASCA 36 (2 April 2025)

Coram: MOKGOHLOA ADP, WEINER, KATHREE-SETILOANE and KOEN JJA and MOLITSOANE AJA

Heard: 17 February 2025

Delivered: This judgment was handed down electronically by circulation to the parties' representatives by email, publication on the Supreme Court of Appeal website and released to SAFLII. The date and time for hand-down is deemed to be 11h00 on Wednesday the 2 April 2025.

Summary: Delict - Medical negligence - failure to monitor the appellant and foetus during labour - whether hospital staff was negligent - whether negligence causally connected to the child's brain damage - negligence and causation established.

ORDER

On appeal from: Eastern Cape Division of the High Court, Mthatha (Nhlangulela DJP sitting as court of first instance):

1 The appeal is upheld with costs.

2 The order of the high court is set aside and replaced with the following:

'The defendant is ordered to pay the plaintiff's agreed or proven damages with costs'

JUDGMENT

Mokgohloa ADP (Weiner, Kathree-Setiloane and Koen JJA and Molitsoane AJA concurring):

Introduction

[1] The appeal concerns a medical negligence claim in terms of which the appellant (SN), acting on behalf of her minor child (ON), claimed damages in the Eastern Cape Division of the High Court, Mthatha (the high court) arising from the brain injury which ON suffered during the birth process at Madzikane KaZulu Memorial Hospital (the hospital) in the Eastern Cape Province. The claim was lodged against the Member of the Executive Council for Health, Eastern Cape Province (the MEC), who would be vicariously liable for damages caused by the negligent conduct of the hospital staff.

The facts

[2] During 2013, SN was pregnant with her first child. She was 34 years old. She experienced labour pains in the morning of 14 February 2013 and was taken to the hospital where she was admitted at around 07h30. On examination in the labour ward at 07h30, her pregnancy was estimated at 36 out of 40 weeks and her uterine contractions were normal. There are two phases of labour: the latent phase progressing to the active phase. The active phase in turn has two stages, with the first stage beginning when the cervix of a woman in labour reaches a dilation of 4cm and the second stage starting when the cervical dilation is 10cm. The examination revealed further that SM was in the latent phase of labour. The membrane had not yet ruptured. She had a good temperature and pulse. The foetal heart rate (FHR) was 142 beats per minute (bpm). The foetus was in a cephalic presentation and the cervix was 3cm dilated.

[3] The partogram began at 10h00. The examination revealed that labour was progressing well and the maternal condition was good. The FHR was stable at 138 bpm. SN was 4cm dilated and the membrane was intact with no caput nor moulding. A pethidine drug was administered to calm down her labour pains. The Maternity Case Record (MCR) did not show any further assessment after 10h00. However, the partogram form showed that SN was again assessed at 12h00, though Sister Bonga, the nurse that attended to SN, stated that it was between 11h30 and 12h00. I will return to this issue later in my judgment. At this stage, the assessment showed the FHR at 136 bpm; that there were no decelerations; the liquor was broken and there was a tinge of meconium although not recorded whether thick or thin; the head of the baby was down completely; 2 caput and no moulding.

[4] The summary of labour form in the MCR showed that SN was fully dilated at 11h15 and began bearing down at 11h30. A male child was born at 12h00. As regards complications, the summary of labour form revealed that there was a cord which was wrapped thrice around the baby's neck. It was not recorded whether the cord was tight or loose. The neonatal detail showed that a male child was born alive. It is further recorded that his 1-minute Apgar score was 7/10.[1] His score for the heart rate was 2, while he scored 1 for respiration, muscle tone and response to stimulation respectively. He scored 2 for colour. A second Apgar assessment was done 5 minutes after ON's birth; he scored 8/10, again the score for heart rate was 2. There was no improvement on his respiration and muscle tone. His response to stimulation had improved and scored 2. The neonatal assessment described ON as a 'floppy baby' with a weak Moro reflex,[2] and an absent 'cry'. He had to be resuscitated.

[5] Later observations noted that ON was resuscitated with an oxygen mask. The first examination on the neonatal page was completed at 12h30. It recorded that ON was lethargic, hypotonic, tachypnoeic with costal recession and his cry was absent. The nursing notes recorded ON as being critically ill, cyanosed and requiring supplementary oxygen, nostalgic feeding and head cooling. ON was diagnosed with a hypoxic-ischaemic encephalopathy (HIE).[3] Ischaemia is defined

[1] APGAR stands for Appearances, Pulse, Grimace, Activity and Respiration. In the Apgar test, five factors are used to check a newborn baby's health. Each is scored on a scale of 0 to 2, with 2 being the best score. For Appearance the skin colour is checked; for pulse, heart rate; for Grimace, reflexes; for Activity, muscle tone; and for Respiration, breathing rate and effort. The individual scores for the five factors are added up to obtain a score out of ten. The highest score to be achieved is 10 and scores of 7, 8, or 9 out of 10 are normal or good scores. Source: kidshealth.org.

[2] The Moro reflex is an infantile reflex that, inter alia, entails the infant's spreading of the arms in response to a sudden loss of support. In W B Saunders Co's *Dorland's Illustrated Medical Dictionary* 25 ed (1974), Moro reflex is described as follows: '[O]n placing an infant on a table and then forcibly striking the table on either side of the child, the arms are suddenly thrown out in an embrace attitude; called also startle r[eflex]'. W B Saunders Co's *Dorland's Illustrated Medical Dictionary* 25 ed (1974) defines 'hypertonia' as 'increased resistance of muscle to passive stretching'.

[3] The American College of Obstetrics and Gynaecology (ACOG) defines neonatal encephalopathy as a clinically defined syndrome of disturbed neurological function in the earliest days of life of an infant born after 35 weeks of gestation manifest by a subnormal level of consciousness or seizures and often accompanied by difficulty with initiating and maintaining respiration and depression of tone and reflexes.

as a deficiency of blood in a body part due to functional construction or actual obstruction of a blood vessel. Hypoxia results from a sustained reduction in the supply of oxygen to the brain.

In the high court

[6] It was on that basis that the appellant claimed damages from the MEC. In her particulars of claim, SN asserted, inter alia, that the MEC's employees, ie hospital staff, had failed to initiate regular blood sugar or blood pressure monitoring of SN after she was admitted at the hospital; failed to take required steps to ensure proper, timeous and professional assessment, monitoring and management of SN, and failed to take steps to prevent the occurrence of complications when this could have been done by exercising reasonable care and diligence. Furthermore, it was averred, inter alia, that the hospital staff had failed to perform accurate and proper monitoring of the foetal heart rate; failed to record an accurate partogram; failed to monitor the FHR with sufficient frequency, and failed to detect that ON was in foetal distress.

[7] The MEC's plea amounted to a bare denial, denying every aspect of negligence which the appellant had alleged in the particulars of claim. She pleaded, in the alternative, that in the event that the court finds that her nursing staff's monitoring of the labour was substandard, then the baby's brain damage was not caused by such lack of monitoring, but was the result of an acute profound hypoxic ischemic injury caused by an unknown sentinel event. The pre-trial minutes identified the issues for determination as negligence and causation and indicated that the parties agreed to separate the issues of liability and quantum. The trial commenced on 17 February 2020.

[8] At the commencement of the trial, Counsel for the MEC in his opening address referred to the formal admissions that the MEC made in respect of the joint minute of the obstetricians, Dr Ebrahim and Dr Frank dated 29 August 2019. Of relevance at this stage is the admission in paragraphs 6 to 8 of the joint minute which reads:

'6. The Department of Health's guidelines for Maternity care in South Africa (2007) state that the FHR should be checked at half hourly intervals in the first stage of labour, before during and after a contraction. It is also a standard of care to check the FHR after every five minutes or after second push in the second stage of labour.

7. FHR monitoring was sub-standard as it was not checked in accordance with these guidelines.

8. It is therefore unknown whether FHR abnormalities were present or not in the first and second stages of labour.'

In effect, the MEC admitted that the hospital staff were negligent in monitoring SN's labour progress.

[9] The evidence adduced before the high court was that of the appellant, the nursing sister who attended to her (Sister Bonga) and two experts. Sister Bonga had no recollection of SN's labour process and the birth of ON. She testified as to what is recorded in the MCR and what her usual practice was in dealing with a patient in labour. The expert witnesses who testified formulated their opinions based on the appellant's medical records, her antenatal card, the partogram, the neonatal records as well as the MRI scan performed by Dr Twetwa on 22 August 2014. The MRI features were considered by the radiologists as diagnostic of hypoxic ischaemic encephalopathy.

[10] The appellant testified and adduced the evidence of two experts, namely Dr Ebrahim, an obstetrician and gynaecologist, and Dr Kara, a paediatrician. The MEC adduced the evidence of Sister Bonga. The MEC's gynaecologist and

obstetrician, Dr Frank, signed a joint minute of experts with Dr Ebrahim, but did not testify during the trial.

[11] In its judgment, the high court outlined the issue for determination as follows:

'[7] As agreed in the pre-trial minute, and repeated during the trial on 18 February 2020, the following issues were identified by the parties as being critical for the determination of this matter. Those are: (1) whether the acute profound hypoxic ischaemic injury that occurred intrapartum was preventable or foreseeable to the nursing staff of the hospital (the negligence issue); and (2) if so, whether the conduct of the nursing staff was the cause of the cerebral palsy (the causation issue).'

[12] Having analysed the evidence of all the witnesses, the high court found that the monitoring of the appellant by Sister Bonga was not substandard. The high court accepted Sister Bonga's evidence that the assessment and examination of the appellant was done at the correct intervals; the foetal heart rate was always normal, the existence of Grade 1 meconium was not an indication of foetal distress, and Sister Bonga did not observe any warning sign which was threatening to the well-being of the foetus. The high court also accepted Sister Bonga's evidence that the cord that was wrapped thrice around the baby's neck was not tight as she managed to put her finger between the cord and his neck to clamp and cut the cord. The evidence of Dr Ebrahim was rejected by the court as being extremely confusing and not fact based. The high court concluded that 'the loose nuchal cord did not cause acute profound hypoxic ischaemic brain injury in this case'. Consequently, the appellant's claims were dismissed with costs. This appeal is with the leave of the high court.

In this Court

Evaluation of expert evidence

[13] The legal principles applicable to the evaluation of expert evidence was outlined by this Court in *AM and another v MEC Health, Western Cape*,[4] as follows:

'. . . The functions of an expert witness are threefold. First, where they have themselves observed relevant facts that evidence will be evidence of fact and [be] admissible as such. Second, they provide the court with abstract or general knowledge concerning their discipline that is necessary to enable the court to understand the issue arising in litigation. This includes evidence of the current state of knowledge and generally accepted practice in the field in question. Although such evidence can only be given by an expert qualified in the relevant field, it remains, at the end of the day, essentially evidence of fact on which the court will have to make factual findings. It is necessary to enable the court to assess the validity of opinions that they express. Third, they give evidence concerning their own inferences and opinions on the issues in the case and the grounds for drawing those inferences and expressing those conclusions.'[5]

[14] That being so, this Court had earlier on in *Michael and Another v Linksfield Park Clinic (Pty) Ltd and Another*[6] cautioned that courts should be slow to conclude that the views genuinely held by competent expert are unreasonable. The Court further warned that a court is not bound to absolve a defendant from liability for allegedly negligent medical treatment or diagnosis just because expert opinion evidence is that treatment or diagnosis was in accordance with sound medical practice.

[4] *AM and another v MEC Health, Western Cape* [2020] ZASCA 89; 2021 (3) SA 337 (SCA)
[5] Ibid para 17
[6] *Michael and Another v Linksfield Park Clinic (Pty) Ltd and Another* [2001] ZASCA 12, 2001 (3) SA 1188 (SCA); 2002 1 All SA 384 (SCA) paras 36 and 39.

[15] Having stated the above. I turn to the claim itself. It is clear that SN's claim is based on the *Lex Aquilia*. The requirements of *Lex Aquilia* are a wrongful act which caused injury or damage.

Damage

[16] As regards injury, it is common cause that ON suffered damage. He is a cerebral palsy (CP) baby. This is confirmed in the joint minute report of both the obstetricians, Dr Ebrahim and Dr Frank and that of the radiologists, Dr Kara and Dr Lewis.

Causation

[17] The question is what caused ON to be a CP baby. There is uncontested evidence that there was a cord around ON's neck. This cord was wrapped thrice around his neck. The MCR recorded the cord around the neck as a complication. Dr Ebrahim opined that 'in the absence of an observable sentinel event, the cord was clearly tightly around the neonate's neck giving signs of near strangulation and WAS the sentinel event.' He concluded that the cord that was wrapped around ON's neck was the more probable cause of the injury as opposed to the cord compression. His reason was that 'tight nuchal cords are more commonly associated with cerebral palsy as opposed to a terminal bradycardia causing sentinel brain damage.'

[18] The above obstetricians' opinion was admitted by the MEC in her formal admissions. The admission was also confirmed by Counsel for the MEC at the commencement of the trial. The admission that there was an occlusion caused by the cord was therefore not simply an admission of the opinion of an expert or the joint opinion of experts; it is free standing and meant that causation was no longer an issue in dispute. Therefore, it was a hypoxic ischaemic event (a reduction or

blockage of blood flow to a specific area of the body, leading to a shortage of oxygen and nutrients) that caused ON's injury.

[19] This brings me to the next issue, namely negligence: whether the cord occlusion could have been detected and steps taken to avoid an ischaemic hypoxic injury timeously.

Negligence

[20] The test as for negligence, is trite,[7] it rests on two bases, namely, reasonable foreseeability and the reasonable preventability of damage and failure to act accordingly. What is or is not reasonably foreseeable in a particular case is a fact-bound enquiry.[8]

[21] The standards that were applicable in clinics and district hospitals in South Africa at the time of ON's birth were those specified in the Guidelines for Maternity Care in South Africa 2007, which emphasise the necessity to monitor a woman in labour. They set out the standard of monitoring that is considered appropriate. The guidelines state that when the patient is in the active phase of labour ie when the cervix is 4cm dilated, the FHR should be checked every half an hour - before, during and after every contraction. However, in this case, SN was assessed at 10h00 and there is no record of any monitoring at 10h30 or 11h00, or when NS was fully dilated at 11h15. There is only one period of monitoring recorded which, on the mental recollection of Sister Bonga, is alleged to have been somewhere between 11h30 and 12h00.

[7] *Kruger v Coetzee* 1966 (2) SA 428 (A); [1966] 2 All SA 490 (A) at 430E-F
[8] *Pitzer v Eskom* [2012] ZASCA 44; 2012 JDR 0507 (SCA) para 24.

[22] Dr Ebrahim explained how the injury normally occurs: According to him, the injury to the brain is caused by an acute drop in oxygen levels in the foetus. He went on to explain what happens in the circulation of the foetus when it is deprived of oxygen. During labour, the foetus is naturally exposed to slight drops of oxygen levels. But a healthy foetus is able to handle that without any changes in its heartbeat. However, when the oxygen levels of the foetus drop to below 50 percent of norm, it affects the cardiovascular response of the foetus. What happens is that the foetus' heart rate slows down in the face of this reduced oxygen supply from the maternal circulation, and this is mainly a defence mechanism for the heart to reduce its oxygen consumption so that the heart does not fail. The foetus slows down the heart, so it works less and therefore consumes less oxygen in the environment of reduced oxygen. As a result, the heart does not function at its normal rate above 110 bpm but rather does so at a reduced level because the normal level requires that it must use up more oxygen.

[23] According to Dr Ebrahim, there is an additional mechanism in the circulation that prevents the vital organs, other than the heart, from being compromised by the reduced oxygen output. This mechanism, preferentially distributes whatever oxygen there is to the vital organs, that is, the brain, the kidneys, and the adrenal glands. The initial response is a drop in the heartbeat, which is called a bradycardia. This bradycardia will last for the duration of the contraction, because the contraction is the cause of the reduced oxygen - transient reduction in oxygen. And when the contraction is over, the heartbeat returns to normal, because it is again getting a normal supply of oxygen. But, if a drop in oxygen does not recover, the bradycardia will remain because the heart is being deprived of oxygen for a prolonged period of time. As a result of that prolonged bradycardia, the eventual supply of oxygen to the brain is also compromised to the extent that the brain suffers acute damage.

[24] The uncontested evidence of Dr Ebrahim was that the injury or the hypoxic ischaemic episode would have manifested itself in decelerations of the FHR which would normally be noted with adequate monitoring. He opined that foetal distress is unpredictable and can occur even in low-risk pregnancies. However, he was of the opinion that FHR abnormalities are the first signs of such foetal distress. Therefore, FHR monitoring is a universal requirement in labour cases. According to Dr Ebrahim, in the face of the foetal distress, the desired preventive action indicated in the maternity guidelines would have been sufficient to expedite ON's delivery and would have prevented his brain injury.

[25] It is clear on the probabilities in this matter that the injury was caused by the cord around the neck of ON. Such injury, according to Dr Ebrahim, could have been prevented by proper monitoring by the nursing staff to determine whether there were FHR decelerations. There was however no monitoring at 10h30 up to 11h00. There was also no monitoring at 11h15 when SN was fully dilated, and none at 11h30 when SN started bearing down and the cord probably tightened. This was a serious and critical period to determine any deceleration in the FHR, yet it is clear from Sister Bonga's evidence that the nursing staff did not take reasonable and necessary steps to monitor the FHR of ON. Sister Bonga's evidence points to clear substandard monitoring that did not accord with the standards set out in the guidelines. According to her evidence, the FHR was 138 bpm at around 10h00 and 136 bpm somewhere around 11h30 and 12h00. On the probabilities, that reading cannot be correct because shortly thereafter ON was born floppy and lethargic.

[26] Of much concern in the evidence of Sister Bonga is that she recorded in the MCR that the cord around the neck was a complication yet she did not indicate whether the cord was tight or loose. She did not indicate whether the meconium,

which is indicative of foetal stress, was thin or thick. She had no recollection of what happened to the patient except for what she recorded in the MCR and what she would normally do in the circumstance. Curiously, she could recall that she got her finger under the cord and cut it yet this was never recorded in any of the hospital records. How she remembered this, remains a mystery.

[27] In my view, Sister Bonga was not an honest and trustworthy witness. Her evidence should have been rejected as being unreliable and not credible. On the contrary, I find the evidence of Dr Ebrahim to be more probable as it is consistent with the probabilities on the evidence viewed as a whole. He gave evidence concerning his 'own inferences and opinions on the issues in the case and the grounds for drawing those inferences and expressing those conclusions.'[9] His conclusions were not unreasonably arrived at. They were based on genuine views and logical reasoning.

[28] In conclusion, nuchal cords wrapped around the neck of foetuses occur frequently[10] but they do not all result in CP births. Few do. This is because they are generally, on probabilities, identified early enough by proper or standard monitoring, picking up the foetal distress shown by decelerations or otherwise, and are then dealt with by timeous interventions. That is what a reasonable member of the nursing staff would have done. The MEC's employees failed to do so.

[9] Op cit fn 4
[10] Peesay, M 'Nuchal Cord and Its Implications' Maternal Health, Neonatology, and Perinatology (2017).

[29] In the result, the following order is made:

1 The appeal is upheld with costs.

2 The order of the high court is set aside and replaced with the following:

‘The defendant is ordered to pay the plaintiff’s agreed or proven damages with costs’

_____

F E Mokgohloa

Judge of Appeal

Appearances

For the appellant:	V Kunju SC
	L Brauns
	C Gqetywa
Instructed by:	Mjulelwa Incorporated Attorneys, Mthatha
	Webbers Attorneys, Bloemfontein

For the respondent:	P J de Bruyn SC
	T Rossi
Instructed by:	Norton Rose Fulbright South Africa Inc, Johannesburg
	Phatshoane Henney Inc, Bloemfontein.