IN THE CONSTITUTIONAL COURT OF SOUTH AFRICA
HELD AT BRAAMFONTEIN

Case No: CCT202/2020

SCA Case No: 1118/2019

High Court Case No: A5010/2018

In the matter between:

MODIANANG, NV obo MODIANANG VK Applicant

and

TEMBISA HOSPITAL First Respondent

MEC FOR HEALTH AND SOCIAL DEVELOPMENT, GAUTENG PROVINCE Second Respondent

---

APPELLANT'S HEADS OF ARGUMENT

TABLE OF CONTENTS

INTRODUCTION **3**

JURISDICTION **6**

Arguable points of law of general public importance *6*

Constitutional issue *9*

FACTUAL BACKGROUND **10**

LITIGATION HISTORY **12**

The trial court proceedings *12*

The application for leave to appeal in the High Court *17*

The Full Bench judgment *20*

The refusal of the petition by the SCA *28*

FACTUAL CAUSATION WAS SATISFIED **28**

Applicable legal principles *28*

The trial court's understanding and application of the test for causation was correct *33*

THE RELIANCE ON THE FACTUAL FINDINGS FROM THE DECISIONS IN *AN* AND *M v MEC* WAS IMPERMISSIBLE **35**

CONCLUSION **43**

INTRODUCTION

1 This matter arises from a brain injury suffered by a baby boy, Victor Modianang.

2 Victor was born on 4 April 2009 at Tembisa Hospital. He was born with hypoxic ischemic encephalopathy, which developed into cerebral palsy.

3 During Ms Modianang's labour, the hospital staff failed to provide her with proper care. In particular, towards the late stages of her labour, the nurses and midwives failed to monitor the foetus for 1.5 hours (from 3h15 to 4h45).

4 The respondents expressly conceded that they had been negligent in the manner in which Ms Modianang had been treated and that there had been a failure to monitor the foetus during the late stages of Ms Modianang's labour. The sole question before the trial court was accordingly whether that negligence was causally related to Victor's brain injury.

5 The trial court said "yes". The Full Bench, on appeal, disagreed.

6 The present application raises two legal issues. Both are of considerable importance not just for this case, but for other cases.

6.1 First, there is the question of the legal test for factual causation that applies in the context of cases concerning the negligent omissions of hospital staff in the monitoring and care of mothers who are in labour. The courts have applied different rules and considered different factors when determining factual causation. The issue requires resolution by this Court.

6.2 Second, there is the legal question of a whether a trial court is entitled and obliged to apply the factual findings of another court in a separate and unrelated matter, even where to do so would be to override the expert evidence given before the trial court in the matter at hand. We submit that this is plainly not permissible. Yet, this is precisely what the Full Bench did.

7 Ms Modianang seeks leave to appeal against the Full Bench's order in this Court.[1] She does so on the basis both that this matter raises constitutional issues and that it raises arguable points of law of

[1] On 31 March 2021, the Chief Justice issued directions setting this application down for hearing. Written argument was required on both the application for leave to appeal and the merits of the matter.

general public importance.

8 The merits of the matter clearly favour Ms Modianang. The unchallenged expert evidence before the trial court states that, had proper monitoring been conducted, the medical staff would likely have detected that the foetus was in distress, instituted emergency measures to “buy time” for the foetus and conducted an emergency caesarean section earlier in the night. Had they done so, the harm to Victor would likely have been avoided or mitigated. As such, factual causation was established.

9 In these submissions, we address the following issues in turn:

9.1 The grounds upon which this Court has jurisdiction to entertain the appeal;

9.2 The relevant factual background;

9.3 The litigation history of the matter and reasoning of the lower courts;

9.4 The misunderstanding by the Full Bench of the test for legal causation; and

9.5 The impermissible reliance by the Full Bench on factual

findings in other matters.

JURISDICTION

10 This Court has jurisdiction to decide—

10.1 Constitutional matters; and

10.2 Any other matter that raises an arguable point of law of general public importance which ought to be considered by the Court.[2]

11 This matter falls within each of these categories.

Arguable points of law of general public importance

12 This matter raises arguable points of law of general public importance.

13 First, the Full Bench decision makes clear that there is confusion in the courts regarding the test to determine factual causation in cases of medical negligence, particularly where there is a negligent omission to properly monitor a mother in labour and an acute

[2] Section 167(3) of the Constitution.

profound hypoxic ischemic event occurs.

13.1 This includes confusion about the effect of this Court's judgment in *Lee* in a context such as the present and also the division in the SCA between the three judge majority and two judge minority in the matter of *M v MEC.*[3]

13.2 The minority judgment of Majiedt J (Tshiqi J concurring) in *M v MEC*, held that it was not possible in that case to determine the exact source and time of the acute profound hypoxic ischemic event.[4] This is true of a number of these types of cases.[5] The minority held that the case fell squarely within the ambit of the *Lee*[6] judgment (where the source of the infection could not be identified) and that the *Lee* test for factual causation would apply.

13.3 By contrast, in *AN v MEC,* the SCA held that in these cases the source of the harm is known – it is acute profound

---

[3] *M v MEC for Health, Eastern Cape* (699/17) (2018) ZASCA 141 (1 October 2018) ("*M v MEC for Health, Eastern Cape"*).

[4] *M v MEC for Health, Eastern Cape* at para 41.

[5] *Life Healthcare Group (Pty) Ltd v Suliman* 2019 (2) SA 185 (SCA)("*Life Healthcare Group v Suliman*"), the SCA observed at paragraph 15 that this is a field where medical certainty is "virtually impossible".

[6] *Lee v Minister of Correctional Services* 2013 (2) SA 144 (CC) ("*Lee v Minister of Correctional Services*")

hypoxic ischaemic insult.[7] As such, it held that the traditional "but for" test applied. The latter judgment focused on the existence of the event, while the former focused on the cause and timing of the event.

13.4 In these circumstances, a judgment of this Court is necessary to clarify the law and prevent conflicting decisions in the lower courts.

14 Second, the Full Bench relied extensively on the factual findings of the majority of the SCA in *M v MEC*. It appeared to treat those factual findings as though they established a legal rule.

14.1 The permissibility of this approach itself raises an arguable point of law of general public importance.

14.2 It concerns whether one court may permissibly elevate the findings of another court on the facts of a separate and unrelated matter into legal rule, even where to do so would be to override the expert evidence given before a trial court.

[7] *AN v MEC for Health, Eastern Cape* (585/2018) [2019] ZASCA 102 (15 August 2019)("*AN*"), at para 8.

Constitutional issue

15 This matter also raises a number of constitutional issues.

15.1 The legal question is inherently linked to the constitutional rights of children[8] and the right of access to adequate health care.[9]

15.2 It concerns the test for factual causation in relation to negligent omissions by public healthcare workers, when they care for mothers in labour. If the restrictive, binding rule imposed by the Full Bench is adopted, a number of mothers and children will be denied compensation for the harm that they have suffered as a result of receiving sub-standard care before and during birth.

15.3 This matter also implicates the constitutional norms of accountability and responsiveness.[10] It concerns the standard of care that is afforded to pregnant mothers during the delivery of their children.

---

[8] Section 28 of the Constitution stipulates that in all matters concerning children, the best interests of the child are of paramount importance.

[9] Section 27 of the Constitution.

[10] *Lee* at para 30. These norms are set out in section 1(d) of the Constitution.

15.4 Lastly, the question of whether one court may permissibly elevate the findings of another court on the facts of a separate and unrelated matter into legal rule raises the section 34 right to a fair hearing. Cases are meant to be decided on the basis of the facts and expert evidence led before the court concerned – not the facts or expert evidence led before a different court in an unrelated matter.

16 In the circumstances, this Court has jurisdiction to entertain this appeal. Given the pressing public importance of the issues for consideration, we respectfully submit that this court should do so.

FACTUAL BACKGROUND

17 Ms Modianang was admitted to Tembisa Hospital on 3 April 2009. She was transferred to the labour ward, where the nursing staff completed a partogram[11] to track the progress of her labour and the foetus's heart rate.[12]

18 The medical records show that at 1h10 on the morning of 4 April

[11] A partogram is a pre-printed document that makes provision for the monitoring of the mother and foetus, including the pulse and heart-rate. Address by Mr Strydon, Record, vol 1, p 73 ln 22 – p 74, ln 3.

[12] HC judgment, record: vol 9, p 895, para 7.

2009, she was in active labour. The foetal heart rate was monitored and recorded at 01h15, 02h15 and 03h15.[13] There was no further monitoring of the foetal heart rate.[14] In the trial court, the respondents conceded that the nursing staff's failure to monitor the foetal heart rate after 03h15 constituted a negligent omission.[15]

19 At 04h45, a doctor or midwife examined Ms Modianang. Their notes state that she was fully dilated and reflect a diagnosis of CPD (cephalic-pelvic disproportion), which means that the baby's head was too big for the mother's pelvis.[16] The notes show that, at that time, Ms Modianang was booked for a caesarean section. Ultimately, the caesarean section did not take place. Victor was delivered naturally in the ward at 05h10.[17]

20 Victor suffered an acute profound hypoxic ischemic injury to his brain in the latter stages of labour.[18] This injury has been described as

[13] HC judgment, record: vol 9, p 895, para 7.

[14] HC judgment, record: vol 9, p 894-5, para 4.

[15] This concession was made because the obstetrics experts for both sides agreed that the lack of monitoring was sub-standard. HC judgment, record: vol 9, p 895-5, para 4.

[16] HC judgment, record: vol 9, p 896, para 8.

[17] Around that time, a nurse entered the ward and applied extreme pressure to Ms Modianang' abdomen, forcing her to give birth to Victor. This is not a medically sanctioned procedure. In the action proceedings, Ms Modianang claimed and was awarded damages for the nurse's unlawful conduct.

[18] HC judgment, record: vol 9, p 894, para 1.

follows:

> *"Ischaemia is a restriction in blood supply. Blood supplies oxygen to the brain. A continued restriction in blood supply leads to a lack of oxygen supply. Where this takes place, bradycardia occurs. This is a slowing of the foetal heart rate. Hypoxia results from a sustained reduction in the supply of oxygen to the brain. The injury to the baby is described as hypoxic-ischaemic encephalopathy. This is a form of neurological dysfunction…."*[19]

21 Victor was born with hypoxic ischemic encephalopathy which developed into cerebral palsy.

LITIGATION HISTORY

The trial court proceedings

22 The trial was conducted in the High Court, before Keightley J. The trial court's judgment was handed down on 24 March 2017.

23 Although the respondent initially contested both negligence and causation, it ultimately conceded negligence. The only issue that remained in dispute was that of causation.

---

[19] *AN* at para 9.

24 When considering the question of causation, the trial court considered the unchallenged expert evidence of Dr Pistorius and Prof Kirsten (a neonatologist) that:

24.1 Victor suffered an acute profound hypoxic insult.[20]

24.2 In babies, it is difficult to pinpoint when the hypoxia started in the absence of a known traumatic event (like a prolapsed cord or a ruptured uterus). This is why the monitoring of the foetal heart rate during labour is important, as it can give an indication of when it commenced.[21]

24.3 During the active phase of labour, the midwife must assess the foetal heart rate and response to contractions every 30 minutes. This will allow for changes to be identified. The slowing of the heart rate is a sign of hypoxia. Before the onset of the slowing of the heart rate, there will be changes in the pattern on the CTG. In other words, there will be warning signs.[22]

24.4 Towards the end of the hypoxic episode, the foetal heart rate

[20] HC judgment, record: vol 9, p 900, para 17.

[21] HC judgment, record: vol 9, p 900, para 17. Evidence of Prof Kirsten, record: vol 2, p 135, ln 10 – 25.

[22] HC judgment, record: vol 9, p 900, para 17 and record: p 902, para 22. Evidence of Prof Kirsten, record: vol 2, p 136, ln 4 – 6.

will be slow and delivery needs to be done quickly. If delivery is done quickly enough, it is possible to avoid a hypoxic ischemic episode and the consequent brain abnormalities.[23]

24.5 Midwives should put in place emergency measures to "buy time" for the foetus. This includes moving the mother onto her left side and administering oxygen to her. The midwife should also call the doctor to consider whether medication should be administered to suppress the mother's contractions, which affect the flow of oxygen to the foetus.[24]

24.6 If the above measures are introduced, the foetal heart rate can be improved before an emergency caesarean section is performed.[25]

25 Also relevant was the expert evidence that:

25.1 It is likely that the acute profound hypoxic event occurred in the time between 03h15 and 04h45, during which period there is no recording of foetal heart rate monitoring. The

---

[23] HC judgment, record: vol 9, p 900, para 17. Evidence of Prof Kirsten, record: vol 2, p 135, ln 20 – 25.

[24] HC judgment, record: vol 9, p 900, para 17; Evidence of Prof Kirsten, record: vol 2, p 135, ln 10 – p 136, ln 17; Evidence of Dr Pistorius, record: vol 2, p 187 ln 4 – 15 and record: vol 3, p 204 ln 5 – p 207 ln 15.

[25] HC judgment, record: vol 9, p 900, para 17.

obstetric experts agreed on this point.[26]

25.2 No other cause of Victor's brain injury presented itself other than the acute profound hypoxic injury that he suffered before or during birth. The neonatal neurologist experts agreed on this point.[27]

25.3 Emergency measures by the midwives were not recorded in any of the progress reports. The specialist nursing experts agreed on this point.[28]

25.4 Prof Kirsten's view was that Victor was delivered very close to the time that he would have died (at 05h10).[29]

26 The defendants (i.e. the respondents) elected not to call their experts to give evidence at trial. The evidence of Dr Pistorius and Prof Kirsten, set out above, was not challenged in cross examination.[30]

27 The trial court held that the hospital staff's negligent failure to monitor the foetal heart rate during active labour caused, or materially

---

[26] HC judgment, record: vol 9, p 898, para 14 and record: p 901-2, para 21.

[27] HC judgment, record: vol 9, p 898, para 13.1 – 13.4 and record: p 901-2, para 21.

[28] HC judgment, record: vol 9, p 900, para 16.3.

[29] HC judgment, record: vol 9, p 901, para 18.

[30] HC judgment, record: vol 9, p 901, para 17.

contributed to, the harm suffered by Victor. The trial court reasoned as follows:[31]

27.1 Foetal monitoring every 30 minutes during active labour was essential for the purpose of detecting warning signs of a possible hypoxic episode. This essential monitoring was not conducted. This constituted a negligent omission.

27.2 Had the hospital staff monitored the foetal heart rate as required, it is probable that they would have picked up the warning signs (that probably would have been present) to indicate foetal distress caused by hypoxia.

27.3 Had the hospital staff picked up the warning signs, they would have taken urgent steps to "buy time" for Victor and to speed up the birthing process in order to prevent the injury to Victor's brain.

27.4 It is probable that with the proper emergency measures, Victor's brain injury would not have occurred.

28 The trial court concluded that Ms Modianang had established the necessary causation to found her claim for damages against the

[31] HC judgment, record: vol 9, p 902, para 22.

respondents.

The application for leave to appeal in the High Court

29 The respondents were not satisfied with the outcome and applied for leave to appeal. The trial court dismissed the application for leave to appeal.

30 The respondents attacked the judgment and order in respect of Victor's claim on a number of grounds. The respondents contended (*inter alia*) that, even if there had been foetal monitoring after 03h15, it was doubtful whether it would have been possible to perform a caesarean section quickly enough to prevent the neurological damage of an acute profound event in the time between 3h15 and 4h15.[32] In other words, they contended that the harm to Victor would have occurred, even if the negligent omission had not taken place.

31 In this regard, the respondents referred to point 7 of the joint expert minute of Drs Pistorius and Koll ("the joint minute"). Point 7 of the joint minute noted that:

> *"it is doubtful whether it would be possible to perform a caesarean section quickly enough to prevent neurological*

[32] Notice of application for leave to appeal in the High Court, record: vol 10, p 911, para 6.

sequelae of an acute profound hypoxic event in this time interval."[33]

32 The respondents contended that this showed that nothing could have been done to prevent Victor's brain injury. As such, they claimed that the trial court had failed to properly apply the "but for" test for factual causation.[34]

33 The trial court rightly rejected this argument.

33.1 The trial court noted that the respondents' interpretation of the passage was that *even with* appropriate monitoring, there would not have been time to avoid the brain injury to Victor. However, it concluded correctly that when read in the context of Dr Pistorius's evidence as a whole, the passage meant that *given that there was no monitoring*, there would not have been time *once monitoring resumed*, to take measures to avoid the medical consequences to Victor.[35]

33.2 At best for the respondents, point 7 of the joint minute is ambiguous. But this ambiguity was resolved by the

[33] Joint Minute of Dr Pistorius and Dr Koll, Record: vol 6, p 597.

[34] HC Leave to Appeal Judgment, record: vol 10, p 918, para 8.

[35] HC Leave to Appeal judgment, record: vol 10, p 919, para 10.

(unchallenged) evidence of Dr Pistorius. He expressly addressed point 7 of the joint minute during his evidence and clarified that, had proper monitoring taken place and emergency measures been instituted to buy time earlier, it could have improved the prospect of preventing the neurological harm.[36] This was not challenged in cross-examination.[37] Nor was Dr Koll called to dispute or correct Dr Pistorius's clarification.

33.3 Moreover, as the trial court correctly recorded, Dr Pistorius's expert report was quite clear. It concluded that:

> *"There was clearly insufficient monitoring during the latent and active phase of labour. No "sentinel event" was recorded, but a sentinel event would have easily escaped notice, given the insufficient monitoring. The available evidence indicates that there was suboptimal care during labour, resulting in foetal asphyxia and subsequent hypoxic ischemic encephalopathy, which would have been avoided by appropriate monitoring and action."*[38]

33.4 The trial court therefore correctly took view that that Dr

---

[36] Evidence of Dr Pistorius, record: vol 3, p 203 ln 15 – 17 and p 204, ln 1 – p 206 ln 9 and p 225 ln 15 – 22. See also Dr Pistorius's Addendum report, record: vol 5, p 467, ln 25 - 30.

[37] The issue of point 7 of the joint minute was raised, but the clarification that had been made by Dr Pistorius was not challenged. See Evidence of Dr Pistorius, record: vol 3, p 244 ln 11 – 18.

[38] Expert Report of Dr Pistorius, record: vol 5, p 467.

Pistorius's report, the joint minute and Dr Pistorius's evidence were all entirely reconcilable and consistent.[39]

33.5 The trial court noted further that evidence had been led that the international standard for performing a caesarean is 30 minutes. Given the monitoring gap of 1.5 hours (between 03h15 and 04h45) and the undisputed testimony of Prof Kirsten that Victor was delivered close to the time that he would have died (at 05h10), it is probable that emergency measures (including a caesarean section) would have been feasible had proper monitoring taken place.[40] In other words, had monitoring occurred, the warning signs would probably have been picked up earlier and there would have been sufficient time to perform a caesarean section.

The Full Bench judgment

34 After the respondents obtained leave to appeal from the SCA on petition, the matter came before the Full Bench.[41]

---

[39] HC Leave to Appeal judgment, record: vol 10, p 919, para 10.

[40] HC Leave to Appeal judgment, record: vol 10, p 920, para 11.

[41] SCA order granting leave to appeal to the Full Bench, record: vol 10, p 928.

35 The Full Bench, per Thobane AJ, upheld the appeal.[42] With regard to Victor's claim, it reasoned that:

35.1 The trial court failed to apply the "but for" test in determining factual causation;

35.2 The obstetric experts in this case had agreed that, given the fact that there was foetal wellbeing until 03h15 on 4 April 2009, it was unlikely that there had been an event severe enough to cause an acute profound hypoxic event before 03h15. They agreed that the latter must have occurred between 03h15 and 04h45.

35.3 In light of this agreement, the Full Bench observed that "*the question then becomes whether, had there been adequate monitoring, warning signs would have been picked up and that there was enough time to engage proper emergency measures which would have avoided brain injury*."[43]

35.4 The Full Bench observed that this was "*the very question in many of these cases, including AN above*".[44] In this regard, the Full Bench appeared to adopt, without expressly stating

[42] The panel was made up of Thobane AJ, Van der Linde J and Modiba J.

[43] Full Bench judgment, record: vol 10, p 947 – 948, para 18.

[44] Full Bench judgment, record: vol 10, p 947 – 948, para 18.

so, the SCA's factual findings in a different case – the *AN* matter.

35.5 In the *AN* matter, there had been a sudden, sustained, total interruption to the blood supply to the foetus, caused by cord compression. This caused damage to the foetus's brain. The experts disagreed on whether there would have been warning signs of the total interruption to the blood supply and if so, whether monitoring would have detected the warnings.[45] Having weighed up and considered the expert evidence before it, the Court held that there was insufficient evidence to support the conclusion that warnings would have been detected if proper monitoring had been carried out.[46] The Court also referred to peer-reviewed literature that was referred to by both parties, which it held did not support the case that there would probably have been prior warning signs.[47]

35.6 But critically, on the facts of the present case, the expert evidence was to the opposite effect. In this case, the trial

[45] *AN* at para 19.

[46] *AN* at para 21.

[47] *AN* at para 22.

court explained that the expert witnesses before it had come to the opposite conclusion and that their evidence had not been challenged. Prof Kirsten and Dr Pistorius testified that there would be warning signs before the hypoxia; and if emergency measures were put in place to "buy time" for the foetus and the delivery was done quickly enough, it would be possible to avoid a hypoxic ischemic episode and the consequent brain abnormalities.[48] No opposing experts were called by the respondents.

35.7 Despite this, the Full Bench appeared to adopt the factual findings in *AN* and *M,* and applied them in the present case. (As we explain below, this is plainly impermissible.)[49]

35.8 That the Full Bench did so is clear from the manner in which it described the trial court's findings. Thobane AJ noted that there was no indication that the trial court arrived at its conclusion by applying the "but for" test. He observed that:

"The approach of the court a quo appears to be similar to that of the minority judgment per Majiedt and Tshiqi JJA in M v MEC for

[48] Evidence of Prof Kirsten, record: vol 2, p 135, ln 10 – p 136, ln 17; Evidence of Dr Pistorius, record: vol 2, p 187 ln 4 – 15 and record: vol 3, p 204 ln 5 – p 207 ln 15.

[49] In *Life Healthcare Group v Suliman* at para 15, the SCA held that expert evidence in each case must be weighed as a whole and it is the exclusive duty of the court to make a final decision on the evaluation of expert evidence.

Health, Eastern Cape,[50] *where there was, just as was in casu, an acute, catastrophic hypoxic ischemia as opposed to a gradual evolution of hypoxia and where, on the facts of that case, there was lack of proper monitoring. The minority found that:*

> *'[36] The outcome could have been prevented through proper, adequate monitoring. Had there been proper monitoring, the forewarning of foetal heart abnormalities, which must on the probabilities have been present from approximately 07h35 on 5 May 2010, could have been heeded. Urgent intervention would in all likelihood have followed, most probably by way of an emergency caesarean section.'"*

The minority further found that the negligent lack of monitoring and care for extended periods resulted in the risk of hypoxia developing unnoticed. This, the minority found, established factual causation on a balance of probabilities."[51]

35.9 In this regard, the Full Bench noted that the minority in *M v MEC for Health, Eastern Cape* relied on this Court's reasoning in *Lee v Minister of Correctional Services*.[52] In *Lee,* this Court held that factual causation could be determined even where the specific incident or source of infection could not be identified. It would be enough to prove that the plaintiff found themselves in the kind of situation

[50] (699/17) [2018) ZASCA 141 (1 October 2018).

[51] Full Bench judgment, record: vol 10, p 947-8, para 18 – 19.

[52] Full Bench judgment, record: vol 10, p 948, para 19.

where the risk of harm would have been reduced by proper systemic measures. The minority in *M v MEC* held that, on the evidence, it was clear that the absence of proper monitoring created a risk for the mother and child. On a balance of probabilities, the child's injuries would not have occurred had his mother been properly monitored.[53] Thus, factual causation was established.

35.10 The Full Bench observed that the majority in *M v MEC* rejected this reasoning, as did the court in *AN.*[54]

35.11 The Full Bench considered the possible emergency measures that were highlighted by the trial court.

35.12 The trial court had held that, had these emergency measures been put in place, the foetal heart rate could have been improved before an emergency caesarean section was carried out. This would probably have prevented or reduced the damage to Victor's brain.

35.13 The Full Bench rejected this reasoning. It did so on the basis that from the point that the foetal distress was discovered (at

---

[53] *M v MEC for Health, Eastern Cape* at para 42 – 43, quoted in the Full Bench judgment at para 19.

[54] Full Bench judgment, record: vol 10, p 949 at para 20.

04h45) there was insufficient time to carry out an emergency C-section. Therefore, the emergency measures would not have prevented the harm to Victor. In full, the Full Bench held that:

"The possibility of successfully carrying out a caesarean section, and whether it would have yielded positive results, after a CPD was diagnosed at 04h45, was not seriously explored by the court a quo. Such a possibility is what the 'but for' test is all about. That possibility was canvassed with Dr Pistorius, when he testified in chief. His evidence is that from 04h45, which is the time when a diagnosis for caesarean section would have been made, a number of standard protocols would have been expected to be undertaken to prepare for the procedure. The list is lengthy and would have included; obtaining informed consent, preparing the patient for theatre, including applying intravenous infusion, preparing the theatre to receive the patient and to carry out the procedure, and securing the attendance of an anaesthetist, a doctor and an assistant. Where there is a suspicion or conclusion, so he testified, of a form of fetal distress, intra-uterine resuscitation would be performed.

Dr Pistorius was of the view that in terms of international standards, the hospital staff had 30 minutes, from the time the decision to refer the patient for caesarean section which in this case was 04h45, to perform an emergency caesarean section. Given that the baby was delivered vaginally at 05h10, the 25 minutes window of opportunity would have been insufficient to perform the emergency procedure. Hence the conclusion that 'it is doubtful whether it would be possible to perform a caesarean

section quickly enough to prevent the neurological sequelae of an acute profound hypoxic event in this time interval.' "[55]

35.14 The Full Bench summed up its finding as follows:

"It is undisputed that the defendant was negligent. It is also accepted that an acute profound hypoxic event took place between 03h15 and 04h45. When a determination was made at 04h45 to perform a caesarean section, on the evidence, there was insufficient time to carry it out. By parity of reasoning, the plaintiff in our view has failed to show that the negligent conduct, which has been isolated as lack of sufficient monitoring, had a causal effect on the neurological sequelae."[56]

and

"the plaintiff has not shown that that the negligence caused the child's condition: the circumstances that caused the cerebral palsy occurred too late to have taken steps that would as a matter of probability have prevented the cerebral palsy."[57]

35.15 We submit that this understanding of the "but for" test for factual causation is fatally flawed. It takes as its starting point the time immediately *after* the negligent omission has occurred and then considers whether, with the correct interventions and conduct, the harm could have been avoided. This point is addressed in greater detail below.

---

55 Full Bench judgment, record: vol 10, p 949 – 951, para 21 and 22.

56 Full Bench judgment, record: vol 10, p 951, para 22.

57 Full Bench judgment, record: vol 10, p 952, para 25.

36 The Full Bench thus upheld the appeal. Ms Modianang's claim was dismissed.

The refusal of the petition by the SCA

37 On 21 October 2019, Ms Modianang petitioned the Supreme Court of Appeal (SCA) for leave to appeal. Affidavits were exchanged before that Court. Ultimately, the SCA issued an order refusing leave to appeal on 6 March 2020.[58]

FACTUAL CAUSATION WAS SATISFIED

Applicable legal principles

38 It is trite law that in order to succeed in a delictual claim, a claimant must prove the following elements: conduct, causation, wrongfulness, fault and harm. In this matter, it was common cause that the medical staff's omission was wrongful and negligent and that Victor suffered harm. In the present case, therefore, only causation was in dispute.[59]

39 In order to establish factual causation, a claimant must prove a causal

[58] Order of the SCA, record: vol 10, p 956.

[59] HC judgment, record: vol 9, p 895, para 5.

link between a defendant's action or omission, on the one hand, and the harm suffered by the claimant, on the other. To determine whether such a causal link exists, the courts apply the "but for" or "*causa sine qua non*" test. Corbett JA provided a clear and comprehensive explanation of this test:

> *"In order to apply this test one must make a hypothetical enquiry as to what probably would have happened but for the unlawful act or omission of the defendant. In some instances this enquiry may be satisfactorily conducted merely by mentally eliminating the unlawful conduct of the defendant and asking whether, the remaining circumstances being the same, the event causing harm to plaintiff would have occurred or not. If it would, then the unlawful conduct of the defendant was not a cause in fact of this event; but if it would not have so occurred, then it may be taken that the defendant's unlawful act was such a cause. This process of mental elimination may be applied with complete logic to a straightforward positive act which is wholly unlawful. So, to take a very simple example, where A has unlawfully shot and killed B, the test may be applied by simply asking whether in the event of A not having fired the unlawful shot (ie by a process of elimination) B would have died. In many instances, however, the enquiry requires the substitution of a hypothetical course of lawful conduct for the unlawful conduct of the defendant and the posing of the question as to whether in such case the event causing harm to the plaintiff would have occurred or not; a positive answer to this question establishing that the defendant's unlawful conduct was not a factual cause and a negative one that it was a factual cause. This is so in particular where the unlawful conduct of the defendant takes the form of a negligent*

omission. [It has been] suggested that the elimination process must be applied in the case of a positive act and the substitution process in the case of an omission. This should not be regarded as an inflexible rule. It is not always easy to draw the line between a positive act and an omission, but in any event there are cases involving a positive act where the application of the 'but-for' rule requires the hypothetical substitution of a lawful course of conduct. A straightforward example of this would be where the driver of a vehicle is alleged to have negligently driven at an excessive speed and thereby caused a collision. In order to determine whether there was factually a causal connection between the driving of the vehicle at an excessive speed and the collision it would be necessary to ask the question whether the collision would have been avoided if the driver had been driving at a speed which was reasonable in the circumstances. In other words, in order to apply the 'but-for' test one would have to substitute a hypothetical positive course of conduct for the actual positive course of conduct."[60]

40 In practice, the test is applied as follows:

40.1 First, the court must mentally eliminate as much of the conduct as (but no more of the conduct than) was negligent. In the case of a negligent omission, this involves eliminating the omission and substituting it with a hypothetical course of lawful conduct.

[60] *Siman & Co (Pty) Ltd v Barclays National Bank Ltd* 1984 (2) SA 888 (A) at 951B–H. Most of this passage was quote by the majority in *Lee v Minister of Correctional Services* at para 48.

40.2 Second, the court must ask whether, if this much, but no more, of the conduct were eliminated (and the lawful conduct is substituted in), would the harm probably still have occurred?

40.2.1 If the answer is 'yes, the harm probably would still have occurred', then the negligent conduct probably was not a factual cause of the harm.

40.2.2 If the answer is 'no, the harm probably would not have occurred' then the negligent conduct probably was a factual cause of the harm.

41 In *Minister of Safety and Security v Van Duivenboden*,[61] the SCA stressed that a plaintiff is not required to establish the causal link with certainty, but only to establish that the wrongful conduct was probably a cause of the loss. The court held that this calls for a sensible retrospective analysis of what would probably have occurred, based upon the evidence and what can be expected to occur in the ordinary course of human experience.

42 This was reiterated by this Court in *Oppelt v Head: Department of*

[61] *Minister of Safety and Security v Van Duivenboden* 2002 (6) SA 431 (SCA) para 25.

Health. This Court held that: *"The rule is not inflexible. Ultimately, it is a matter of common sense whether the facts establish a sufficiently close link between the harm and the unreasonable omission."*[62]

43 In *Lee v Minister of Correctional Services*, this Court held that, in exceptional circumstances, factual causation would be established where the plaintiff has proved that, but for the negligent conduct, the risk of harm would have been reduced.[63]

44 In *Mashongwa v PRASA*,[64] this Court held that *Lee* never sought to replace the pre-existing common law approach to factual causation. It held that the *Lee* test is "*particularly apt where the harm that has ensued is closely connected to an omission of a defendant that carries the duty to prevent the harm*."[65] Where the traditional "but for" test was adequate to establish the causal link, the Court held that it may be unnecessary to resort to the *Lee* test.[66]

---

[62] *Oppelt v Head: Health, Department of Health Provincial Administration: Western Cape* 2016 (1) SA 325 (CC) at para 48.

[63] *Lee v Minister of Correctional Services* 2013 (2) SA 144 (CC).

[64] *Mashongwa v PRASA* [2015] ZACC 36 ("*Mashongwa").*

[65] *Mashongwa* at para 65.

[66] Ibid.

The trial court's understanding and application of the test for causation was correct

45 The Full Bench held that the trial court failed to apply the "but for" test. However, a close reading of the trial court's judgment shows that that is precisely what the judge did and it is, with respect, the Full Bench's approach that confuses the proper test.

45.1 The trial court identified the negligent omission as the hospital staff's failure to monitor the foetal heartbeat between 03h15 and 04h45 on 4 April 2009. The parties admitted this point – it was common cause.[67]

45.2 The trial court then eliminated the negligent omission and substituted in a hypothetical lawful course of conduct. This course of conduct was the monitoring, by the hospital staff, of the foetal heartbeat every 30 minutes after the mother entered into active labour.

45.3 Having eliminated the negligent omission and substituted in lawful conduct, the trial court then asked whether the harm to Victor would probably still have occurred. It correctly

[67] HC judgment, record: vol 9, p 895, para 5.

answered “No”.

45.3.1 Had the mother been properly monitored, the warning signs of foetal distress would have been detected and appropriate action would have been taken. This included emergency measures to “buy time” for the foetus and the conduct of a caesarean section.

45.3.2 If proper monitoring had taken place, there would probably have been enough time to take these measures and the harm to Victor would probably have been avoided.

45.3.3 The trial court came to these conclusions on the basis of the unchallenged expert evidence before her.

46 Therefore, the trial court correctly applied the traditional “but for” test and came to the conclusion that factual causation was established. Moreover, even if there were any doubt on the effect of the traditional test (which there is not), the *Lee* test would have been appropriate and would certainly have led to the same result.

47 It was the Full Bench's approach – rather than that of the trial court – which confused the proper approach to legal causation.

THE RELIANCE ON THE FACTUAL FINDINGS FROM THE DECISIONS IN *AN* AND *M v MEC* WAS IMPERMISSIBLE

48 The Full Bench decision appears to rest on the premise that there would have been no warning signs of the foetus's distress and that proper monitoring would not have made any difference to the outcome.

49 But there was no basis at all for this conclusion on the basis of the evidence before the trial court. The unchallenged evidence of the experts before the trial court pointed led to precisely the opposite direction.

50 For example, Prof Kirsten explained in his testimony:

> *"….During the active phase of labour the midwife must assess the foetal heart rate and its response to uterine contraction every 30 minutes so that you can identify changes in the foetal heart rate.*
>
> *…*
>
> *The conclusion is that it is very easy if there is an obvious catastrophic event during labour such as a prolapsed cord,*

abruptio to identify that as that cause for the acute profound hypoxia insult, but we do know that there is a condition described by Passiner which is called a unidentified sentinel event. It is out of the blue, a baby will start have foetal heart rate abnormalities. Completely normal foetus and which could then be changed into severe bradycardia and if the foetus is not delivered the foetus could die or if delivered too late could have cerebral palsy, but if it is possible to start with resuscitation and deliver the foetus, expedite the delivery you can hopefully prevent hypoxia! brain damage. Sometimes not completely, but at least you can make a difference in the long term neuro-developmental outcome [Indistinct] maybe. So this is unexpected hypoxia of the foetus.

…

… [The rules state that the foetus should be accessed every 30 minutes and if you get warning signs. [Intervenes].

What do you do then? --- Then it would be a few things. Immediately you turn the mother on the left side to improve blood flow to the placenta. Administer oxygen to the mother. You call the doctor immediately and you can give medication to suppress contractions, but that will be in consultation with the attending doctor and you can buy time then. Often by instituting these measures the heart rate can improve and it will. Can give you time to arrange for emergency caesarean section, but the doctor is the person that will take over command of this delivery and he will decide what to do and that is why itis critical that the doctor is summoned immediately to labour ward to take charge of the delivery."[68]

[68] Evidence of Prof Kirsten, record: vol 2, p 134 ln 18 - p 136 ln 17 (emphasis added)

51 But the Full Bench failed to take heed of this evidence. Instead, it relied on the factual findings of the majority of the SCA in the matters of *M v MEC* and *AN v MEC.*

51.1 This appears from the Full Bench's judgment.

51.2 In para 18, the Full Bench explained the question that it had to consider and the effect of the previous decisions:

> *"… [T]he becomes whether, had there been adequate monitoring, warning signs would have been picked up and that there was then enough time to engage proper emergency measures which would have avoided the brain Injury, this being the very question in many of these cases, including In AN referred to above. By emergency measures res we take it to mean performance of a caesarian section."*[69]

51.3 The Full Bench then explained that the trial court's judgment in the present matter was similar to the minority judgment of Majiedt JA (Tshiqi JA concurring) where it was held:

> *"The outcome could have been prevented through proper; adequate monitoring. Had there been proper monitoring, the forewarning of foetal heart abnormalities, which must on the probabilities have been present from approximately 07h35 on 5 May 2010, could have been heeded. Urgent*

[69] Full Bench judgment, record: vol 10, p 947 – 948 at para 18

Intervention would in all likelihood have followed, most probably by way of an emergency caesaean section."[70]

51.4 The Full Bench then emphasised that "*The majority in [M v MEC] rejected this reasoning, as did the Court in AN [v MEC]."*[71]

51.5 The Full Bench went on to rely on the findings of the majority in *M v MEC*:[72]

> *"In M v MEC …, whose facts are to an extent the same as those in casu, Ponnan JA writing for the majority said the following:*
>
> > *'It thus came to be accepted that baby K. suffered a HI event immediately before delivery. At such a late stage in labour, according to Professor Buchmann, the staff would not have been able to make a difference to the outcome. That is because if foetal distress had been detected at that stage, a caesarean section would have taken about an hour to arrange and the appellant would have delivered spontaneously before then as she in fact did at 10 o'clock. Professor Smith agreed. He testified: 'Between 09:00 and 10:00 if you pick up an abnormal foetal heart rate at that point in time expediting delivery with a caesarean section is not going to be of*

[70] Full Bench judgment, record: vol 10, p 948 at para 18, quoting *M v MEC at* para 36.

[71] Full Bench judgment, record: vol 10, p 949 at para 20.

[72] Full Bench judgment, record: vol 10, p 950 – 951 at para 22, quoting *M v MEC at* para 64 – 65.

assistance because it will take much longer to perform a caesarean section.

It was for the appellant to prove on a balance of probabilities that the conduct complained of caused the harm. Assuming in the appellant's favour that the MEC's employees negligently failed to: (i) re-examine the appellant on the 4 and 8 hour mark after her admission and (ii) properly monitor the appellant between 23h45 and 8h20, such failure could have had no causal effect on what happened after 8h20 on 5 May 2010. Whilst such failure may well have been relevant had we been concerned with what has been described as 'a partial prolonged type brain injury' that occurs over hours, it is not for 'an acute profound type', as in this case."

51.6 The Full Bench then concluded that "*By parity of reasoning, the plaintiff in our view has failed to show that the negligent conduct, which has been isolated as lack of sufficient monitoring, had a causal effect on the neurological sequelae.*"[73]

52 We submit that in this approach, the Full Bench acted impermissibly.

53 Lower courts are of course bound by the principle of stare decisis to

[73] Full Bench judgment, record: vol 10, p 951 at para 22.

follow the precedents of higher courts.[74]

53.1 But this only applies to findings of law – not findings of fact.

53.2 As LAWSA explains:

> *"The object of the doctrine is to avoid uncertainty and confusion, to protect vested rights and legitimate expectations as well as to uphold the dignity of the court. Therefore, when a decision on a legal principle has been delivered by a superior court it must be followed by all courts of equal and inferior status, until such time as that judgment has been overruled or modified by a higher court or by legislative authority."*[75]

53.3 This is for obvious reasons. A decision by a court on a question of fact rests on the evidence adduced before that court in that trial between those parties. In cannot be determined by evidence adduced by other parties in other proceedings.

53.4 This applies equally to questions of expert evidence regarding the consequences of an act or an omission. These are questions of fact – not law.[76]

---

[74] *Camps Bay Ratepayers' & Residents' Assoc v Harrison* 2011 (4) SA 42 (CC) at par 28

[75] LAWSA, vol 10, para 520.

[76] An expert witness must provide an opinion on questions of fact, he or she is not permitted to give opinions on questions of law. Holtzhauzen v Roodt 1997 (4) SA 766 (W) at 773C – D.

54 Anything else would lead to the obvious breach of the right to a fair hearing under section 34 of the Constitution.

54.1 A court cannot rely on factual findings made in proceedings between parties A and B for purposes of deciding a dispute between parties C and D.

54.2 This is because parties C and D at no stage had the chance to lead or cross-examine the factual or expert witnesses in the matter between A and B.

54.3 As this Court held recently, albeit in the context of a criminal trial:

> *"…The relevant question is whether the applicant had the opportunity to challenge the textbook evidence. The applicant was plainly denied that opportunity. Likewise, not knowing that such evidence would be relied upon, he was denied the opportunity – if so minded – to adduce controverting evidence. The right to challenge evidence requires that the accused must know what evidence is properly before the court. In the applicant's case, the medical literature relied upon was never adduced at all. This goes to the heart of a fair trial."*[77]

[77] Van der Walt v S (CCT180/19) [2020] ZACC 19; 2020 (2) SACR 371 (CC); 2020 (11) BCLR 1337 (CC) (21 July 2020) at para 33.

55 The factual findings made in *M v MEC* and *AN v MEC* could thus never have been determinative or relevant of whether, in this case, factual causation was satisfied. This is because there were various factual differences. As mere examples, we point the out the following:

55.1 In *M v MEC*, the majority found on the evidence that the baby suffered an HI event "*immediately before delivery*".[78] In this case, the event was suffered sometime between 3h15 and 4h45 - i.e. potentially well before delivery.[79]

55.2 In *M v MEC*, the majority found on the evidence that a caesarean section would have taken about an hour to arrange.[80] In this case, the witnesses testified that the caesarean section could have been arranged in 30 minutes.

56 We therefore submit that the Full Bench's reliance on the factual findings in the M v MEC and AN v MEC decisions, was integral to its conclusions on the causation issue, was impermissible.

57 On this basis alone, the appeal should be upheld.

---

[78] *M v MEC* at para 64.

[79] HC judgment, record: vol 9, p 898, para 14 and record: p 901-2, para 21.

[80] *M v MEC* at para 64.

CONCLUSION

58 In light of the above, we submit that leave to appeal should be granted and the appeal upheld with costs, including the costs of two counsel.

STEVEN BUDLENDER SC

EMMA WEBBER

Counsel for the appellant
7 June 2021

IN THE CONSTITUTIONAL COURT OF SOUTH AFRICA

HELD AT BRAAMFONTEIN

CASE NUMBER: 202/2020

SCA CASE NO : 1118/2019

HIGH COURT CASE NO : A5010/2018

In the matter between

MODIANANG, NV obo MODIANANG VK Applicant

and

TEMBISA HOSPITAL First Respondent

MEC FOR HEALTH AND SOCIAL DEVELOPMENT GAUTENG PROVINCE Second Respondent

---

RESPONDENTS' HEADS OF ARGUMENT

Appeal issue

The injury

1 The fetus suffered an acute profound hypoxic ischaemic insult to the brain. The obstetricians agree that the insult is likely to have occurred after 3:15 and before 4:45 on 4 April 2009. At 4:45 hospital staff employed by defendant,[1] scheduled an emergency c/section operation to deliver plaintiff's baby. The mother started bearing down at 4:50. The minor child was delivered by normal vaginal delivery (NVD) at 5:10. The child was born brain damaged.

[1] In these heads, applicant/appellant is called plaintiff and respondent is called defendant.

The issues

2 Did the omission by hospital staff to monitor the fetal heart rate (FHR) half-hourly between 3:15 and 4:45 cause the insult or the brain damage?

3 Put differently, even if hospital staff monitored the FHR at 3:45 and 4:15, could they have taken the only reasonably available measure (a c/section according to the obstetricians) in time to prevent the brain damage suffered by the minor child?

Were the omissions the cause of the brain injury?

Our approach in these heads

4 On appeal, the complaint is that the FB got it wrong when it relied - on the facts of this case, and on the reasoning on causation in M v MEC for Health, Eastern Cape – for its finding that hospital staff could not have carried out a c/section procedure in time to prevent brain damage.

5 Plaintiff claims damages by way of the aquilian action. So here, conduct, negligence and causation are relevant elements. And, negligence and causation are in issue.

6 We examine those elements against the facts of this case below. We do that first. Because that, we submit, should illustrate that this application should not be entertained by the CC. And if it were inclined to entertain it, the facts do not support the complaint against the FB decision or the arguments.

7 On the facts here: the failure to monitor the FHR at 3:45 and 4:45 was not the cause of the injury; the only reasonable measure available (a c/section procedure) could not be performed in time (30 minutes) to prevent brain damage; no constitutional right has been infringed; there is no arguable point of law of public interest; there are no interest of justice considerations that demand revisiting the FB judgment; and there are no reasonable prospects of success on appeal.

Conduct

8 It is undisputed that hospital staff failed to monitor the FHR between 3:15 and 4:45 on 4 April 2009; i.e. they failed to monitor the FHR at 3:45 and 4:15. Those two omissions amount to a failure to comply with the 2007 Maternal Guidelines requiring that the FHR should be monitored every half-hour in the active phase of labour.

What caused the acute profound insult

9 The failure - to monitor the FHR at 3:45 and 4:15 on the morning of 4 April 2009 - was not the cause the acute profound insult. Plaintiff's neonatologist said that the cause of the insult was a sudden, unpredictable, unidentified sentinel event.

10 The question then is not whether the failure to monitor the FHR caused the insult. The question is this. Even if the FHR was monitored at 3:45 and 4:15, could hospital staff have taken measures that would have prevented or minimized the brain injury?

11 The answer to that question depends on the answer to a second question. It is this. Even if hospital staff were not guilty of those omissions - i.e. even if they had monitored the FHR at 3:45 or 4:15 - could they have implemented the only measure available to them – a c/section procedure - in time to prevent the harm suffered by the fetal brain?

12 The answer to this second question, depends on the nature and timing of the injury; i.e. on the expert opinion evidence in this case.

Nature of the injury

Acute profound insult

13 The radiologists agree:[2]

13.1 The MRI picture of the minor's brain when he was 7 years and 4 months' old, is that of an acute profound HIE injury;

13.2 A review of the clinical and obstetrical records by Neonatology and Obstetric experts is essential in determining the cause/s and probable timing of the injury.

What is an acute profound insult to the fetal brain?

14 It is the total or near total occlusion of oxygenated blood supply to the fetal brain;[3]

15 It is sudden and unpredictable and (as confirmed by Professor Kirsten)

2 V6/600-601

3 V2/132/6-10; V5/423-6

would have been caused here, by an unidentified sentinel event;[4]

16 An unidentified sentinel event manifests by a sudden onset of a severe fetal bradycardia lasting for 10-30 minutes;[5]

17 The normal FHR ranges between 110 – 160 bpm. A severe bradycardia would be a FHR well below 110 bpm and below 100bpm;[6]

18 A severe fetal bradycardia is detected (after it occurs) by monitoring the FHR. The Maternal Guidelines recommend monitoring every half hour during the second stage of labour;[7]

19 An abnormal FHR (i.e. a FHR under 110 bmp or above 160 bpm) is considered to reflect fetal distress or compromise, requiring hospital staff to take measures to treat that distress/compromise;

20 An acute profound insult is a complete or near complete physical obstruction or constriction of oxygenated blood flow from the placenta to the fetus; [8]

21 To unblock the obstruction or constriction requires the removal (delivery) of the fetus from the uterus[9] - here (the obstetricians say) by c/section.

---

4 425/20-21
5 V5/424/18-20
6 V2/134; V2/168
7 V2/134
8 V2/132/6-10; V5/423-6
9 V2/13/17-134/6

Timing (essential chronology) of the injury

Nursing experts

22 The nursing experts agreed on following facts (taken from the hospital records):[10]

22.1 The active phase of labour started at 1:10 on 4 April 2009;

22.2 The FHR was monitored as follows:

22.2.1 At 01:15 – 120 bpm when the mother was 4 cm dilated;

22.2.2 At 02:15 – 115 bpm;

22.2.3 At 03:15 – at 128 bpm, when the mother was 6 cm dilated and her liquor was clear;

22.3 At 4:45 the mother was fully dilated. (Dilatation went fairly quickly here. According to the 2007 Guidelines, normal dilatation takes up to 1cm an hour during the active phase of labour.)[11]

22.4 At 04:45 the mother was assessed by a doctor and a c/section booked.

22.5 The nurses do not refer to this in their joint minute. But the experts accept that the hospital records show that cephalopelvic

10 V7/615-6

11 See p44 of the 2007 Guidelines.

disproportion (CPD) was diagnosed at 4:45.[12]

22.6 (According to the 2007 Guidelines, the treatment for CPD is to deliver the baby by c/section.)[13]

22.7 The second stage of labour (when the mother started bearing down) commenced at 04:50 and delivery was at 05:10;

23 The nursing experts agreed that the CTG tracing is inconclusive and no conclusions can be drawn from it.[14]

The neonatologists

24 They agree that the clinical picture at birth – severe depression requiring extensive resuscitation, the large base deficit after birth, early onset of seizures soon after birth, the MRI scan changes, and the dyskinetic CP - is in keeping with an acute profound hypoxial insult to the fetal brain during labour.[15]

25 The rest of their agreement in the joint minute is not helpful. But the report by plaintiff's expert – Professor Kirsten – confirmed by him when he testified, is instructive when considering the nature of the injury.

26 Professor Kirsten accepts that the fetus suffered an acute profound

12 V2/157-160 V2/183-185 V5/466 V6/516[5] V6/562[10]-[30]
13 Page 44
14 V7/618
15 V6/593

hypoxial insult. He concludes the insult was caused by an unidentified sentinel event. He then goes on to discuss the length of time it takes for brain damage to set in after an acute profound insult.[16] He cites different studies that show that brain damage sets in after acute profound insult lasting 10, 15, 30, 18, 16 and 10-30 minutes.

27 The insult and its duration occurs from the time of the sentinel event until the baby is delivered. Dr Kirsten confirmed. If the baby is not delivered, it will die in utero. This baby was delivered very close to fetal death.[17] The 10-30 minutes it takes to brain injury happens before delivery. That means that here the insult is likely to have occurred around 4:40-4:35. The obstetricians agree that the insult happened from the time between 3:15 and 4:45. That is consistent with the insult occurring around 4:35-40.

28 The import of the evidence by Professor Kirsten is this. The insult occurred. It then continued to delivery. Brain damage set in 10 – 30 minutes after the insult occurred. That means that the insult must have happened between 10 – 30 minutes before delivery. It is unlikely that the insult happened before then. If it did, the baby would not have survived. As it turned out, this baby survived. But only just. The severe depressed state of the new-born recorded in the clinical observations, confirm Professor Kirsten's conclusion. That is that delivery happened just before the baby would have died if he were not delivered. And it confirms that the insult is

16 V5/424

17 V2/133/17-134/6
See V10/920/11 where this is confirmed in the leave to appeal judgment by Keightley J.

likely to have occurred 10-30 minutes before delivery.

The agreement by the obstetricians

29 They agreed on the following:[18]

29.1 At 3:15 there is evidence of fetal well-being – clear amniotic fluid and a normal FHR, making it unlikely that an acute profound insult had occurred by then;

29.2 It is likely that an acute profound hypoxic event occurred in the time from 03:15 to 04:45;

29.3 It is doubtful that it was possible to perform a c/section quickly enough to prevent the neurological sequelae of an acute profound hypoxic event in this time interval.

30 The time interval referred to in paragraph 7 of the joint minute, is not the period between 3:15 and 4:45. It is the time period it takes to damage to the fetal brain from time of the acute profound insult.

31 The significance of the agreement by the obstetricians is this. If (as according to Professor Kirsten) brain damage takes 10-30 minutes from the time of the insult) there was no time to prevent or minimize brain damage by carrying out a c/section procedure here.

32 Dr Pistorius who is plaintiff's obstetrician testified in practice it would be

[18] V6/597

difficult to perform a c/section in 30 minutes.[19] According to the 2015 Guidelines it should take 1 hour to a c/section.[20]

Negligence

33 In the leave to appeal affidavits[21] (and it appears in submissions at the trial)[22] defendant concedes that the failure to monitor the FHR at 3:45 and 4:15 was negligent because that failure did not comply with the 2007 Guidelines.

34 That concession was wrong. A conclusion (rather than a fact) was conceded. That conclusion is not consistent with the law. As we show later, negligence 'in the air' does not result in liability in delict. In so far as it was conceded that hospital staff did not monitor the FHR at 3:45 and 4:15 in accordance with the 2007 Maternal Guidelines, negligence does not follow from that fact. Consequently, that concession should not stand. [23]

35 The question is never simply - were hospital staff negligent? It is always, were they causally negligent.[24] Causal negligence here requires that the insult should have happened before 3:45 or 4:15. The failure to monitor at those times might have been causally negligent depending on when the insult occurred and when the baby was delivered. But we know from

---

19 V3/239/18-20

20 Page 54

21 V10/1001/[20]

22 Omitted from the record

23 Dengetenge Holdings (Pty) Ltd v Southern Sphere Mining and Development Company Ltd [2013] ZACC 48 at [54] – [62]

24 Eastern Cape v DL obo AL [2021] ZASCA 68 at [8]
Mashongwa v PRASA [2015] ZACC at [63]

Professor Kirsten's evidence that the insult is unlikely to have occurred before 4:15. His evidence is that the insult would have happened between 10-30 minutes before delivery; i.e. 10-30 minutes before 5:10.

36 Keightley J assumed that if hospital staff had monitored the FHR at 3:45 and 4:15, they would have picked up warning signs of a possible hypoxic episode or that 'something was amiss'.[25]

37 That assumption is wrong. According to Professor Kirsten, there are no warning signs. The insult is caused by an unidentified sentinel event that is sudden and unpredictable; i.e. despite the best efforts of staff in a labour ward, they cannot tell that an acute profound will happen, that it is likely to happen, or when it will happen. According Professor Kirsten, nursing staff would know that it has occurred, only after there is a sudden onset of severe persistent fetal bradycardia for 10 – 30 minutes.[26]

38 So what was the likely timing of this insult? We submit it happened at around 4:40. That is because according to Professor Kirsten, it is likely to have occurred between 5:00 and 4:40; i.e. 10-30 minutes before delivery. And according to the obstetricians it is likely to have occurred before 4:45.

39 It follows then that the omission to monitor at 3:45 and 4:15 does not

25 V9/902/[22]

26 V5/424/5-21

establish causal negligence.[27] Had nursing staff monitored the FHR at 4:15, they would not have detected evidence of the insult. The next time they should have monitored the fetus was at 4:45. They did. When they did, a c/section was ordered. According to the obstetricians, the only measure reasonably available to them then, was to deliver the baby by way of a c/section procedure.

40 The question then arising is this. Can a c/section be performed quickly enough to prevent brain damage?

Causation

The test

41 The test for causation has two enquiries. The first is factual. The second is legal. Both though, depend on a factual investigation or enquiry.[28]

42 The factual test for causation is whether the omission to monitor the FHR at 3:45 and 4:15 caused or materially contributed to the brain damage suffered by the child here; i.e. the omissions must be causally related to the harm.

43 Colloquially, it is expressed as the 'but for' test; i.e. whether but for the omissions at 3:45 and 4:15, the brain damage would have occurred. If the omissions did not materially contribute to the harm, plaintiff has failed to

---

27 According to our law, causal negligence, and not negligence unconnected to the harm suffered (negligence in the air) must be established. See, Premier, Wester Cape v Faircape Property Developers (Pty) Ltd 2003 (6) SA 13 [SCA] at [41]

28 See, De Klerk v Minister of Police [2019] ZACC 32 at [24]-[31] where Theron J for the majority restates the test.

prove causation.

44 If defendant's conduct did materially contribute to the harm, the second enquiry is triggered; i.e. is the harm too remote in time and space from the conduct, for the law to impute causation to negligent conduct? The degree of proximity between the conduct and the harm is a question of fact. As a matter of policy, the law does not impute liability in delict for conduct, whatever the consequences. If the harm suffered is a consequence that is not too remote from the conduct, then legal causation has been proved.

Application of the test to the facts

45 The conduct here is the omission to monitor the FHR at 3:45 and 4:15. Those omissions did not cause the insult. But did those omissions result in the failure to take timeous emergency measures to prevent brain damage?

46 There are two answers to that question. The first is that the insult did not occur before 4:15. It could not have been detected by monitoring before that time. The second answer depends on how long it takes to perform a c/section procedure - the only emergency measure contemplated in the joint minute by the obstetricians. Could a c/section procedure have been performed in time, given that here, the insult is likely to have occurred 10-30 minutes before delivery, at around 4:40?

47 Professor Kirsten said that an acute profound insult manifests by way of a sudden onset of a persistent severe bradycardia of 10 – 30 minutes. A

severe bradycardia is a FHR well below 110 bpm.

48 Assume then the following: nurses detect a severe bradycardia; (at best for plaintiff) they detect it shortly (say, after 5 minutes) after it happens; when they detect a severe bradycardia, they call for a doctor; that is because a severe bradycardia is a condition requiring the attention of a doctor; (because this is reasonable) it takes 5-10 minutes for a doctor in a labour ward in a public hospital to arrive and to examine the mother and check the FHR; the severe fetal bradycardia persists; the doctor orders a c/section because s/he takes the view that an emergency measure is necessary, and a c/section is the most appropriate emergency measure in the circumstances.

49 At that stage, the insult would already have endured for some 10-15 minutes. According to the obstetricians it would take longer than 30 minutes to a c/section procedure; i.e. by the time that a c/section is performed, the insult would have endured for at least 40-45 minutes.

50 We summarize the evidence and submit the following:

50.1 The injury is unlikely to have occurred before 3:45 or 4:15. Those are the times when the 2007 Guidelines recommend monitoring of the FHR here.

50.2 It is likely to have occurred around 4:40 – i.e. between 10-30 minutes before delivery and, at worst for hospital staff, around 30

minutes before birth.

50.3 The mother and fetus were monitored at 4:45, in compliance with the 2007 Guidelines.

50.4 At 4:45 CPD was diagnosed and a c/section was ordered. Keightley J found that the diagnosis of CPD and the recording of significant caput and moulding together with the direction that a c/section be carried out, are all indications that there was some fetal distress.[29]

50.5 That conclusion is reasonable. But it does not follow from that conclusion that the fetus had suffered an acute profound insult at 3:45 or 4:15.

50.6 The evidence relied on by Keightley J is consistent with an acute profound insult having occurred at 4:40; i.e. it is consistent with an acute profound having occurred 10-30 minutes before delivery, which is consistent with the evidence of Professor Kirsten that brain damage sets in 10-30 minutes after the insult.

50.7 At 4:50 the mother started bearing down. That is when the second stage of labour started. The baby was delivered by NVD at 5:10; i.e. the baby was delivered within 20 minutes from the time that

[29] V9/903/[24]

the second stage of labour started, within 25 minutes from the time that a c/section procedure was ordered, and within 30 minutes of the insult having occurred.

50.8 NVD in the second stage here, was well within the 2007 recommended Guidelines. (They recommend that a normal second stage would be if the fetal head has descended into the pelvic floor within 2 hours of full dilatation, and if delivery occurs within 45 minutes of a nullipara and 30 minutes of a multipara bearing down.)[30]

50.9 NVD was quicker than a c/section would have taken. The obstetricians agree. The hospital could not have carried out a c/section in time to prevent brain damage; i.e. here, hospital staff managed delivery even quicker than a c/section.

50.10 On the test for causation endorsed by the CC,[31] the failure to monitor the FHR at 3:45 and 4:15, was not the reason that a c/section (the only measure reasonably available to hospital staff) was not performed timeously, so as to prevent brain damage.

50.11 Even if the insult were detected as it happened or within a short while after it happened, and a c/section ordered immediately or

30 See p52 of the 2007 Guidelines.

31 See, De Klerk v Minister of Police [2019] ZACC 32 at [24]-[31] that follows the causation rule restated in Mashongwa v PRASA and endorses the causation rule laid down in International Shipping Co (Pty) Ltd v Bentley 1990 (1) SA 680 (A) at 700E-I.

within a reasonably quick time after detection, that would not prevent brain damage.

50.12 Keightley J found that had hospital staff properly monitored the FHR, it is probable that 'with the proper emergency procedures … brain injury would not have occurred' here.

50.13 In so far as Keightley J found that the failure to monitor the FHR at 3:45 and 4:15 caused the insult, that finding is inconsistent with the evidence.

50.14 In so far as she found that the failure to monitor the FHR at 3:45 and 4:15 meant that hospital staff failed to take the only emergency measure reasonably available – a c/section – in time to prevent brain damage, that finding too, is inconsistent with the evidence. It is particularly inconsistent with the evidence of Professor Kirsten, Dr Pistorius and the agreements in the joint minutes between the neonatologists and the obstetricians.

50.15 Even if the insult occurred before 4:40, brain damage would have set in after 10-30 minutes of its occurrence. The obstetricians agreed. Here, a c/section could not be performed in time to prevent brain damage.

50.16 Keightley J ignored this crucial agreement between the

obstetricians in her judgment. In her leave to appeal judgment, she found that the agreement at paragraph 7 refers to the period after monitoring had resumed.[32]

50.17 That finding has the appearance of an afterthought. It is also inconsistent with the wording in paragraph 7 read in the context of the joint minute. And it is inconsistent with the evidence. The obstetricians - jointly, or through Dr Pistorius in evidence - did not `qualify paragraph 7 in this way.[33]

50.18 Plaintiff's obstetrician testified that it would take longer than 30 minutes to organize and perform a c/section procedure;[34] i.e. having been ordered at 4:45, it could not have been performed before 5:15. Or, having been ordered after a severe bradycardia is detected by nurses who monitor in accordance with the 2007 Guidelines, it could not be performed within 30 minutes. By that time, on the evidence of Professor Kirsten, it would be too late to prevent or minimize brain damage.

50.19 The baby was delivered by NVD managed by hospital staff at 5:10. As it turns out, here hospital staff acted reasonably quickly in the circumstances, and better than expected by the obstetricians.

<u>Appellant's criticism of the FB judgment</u>

---

32 V10/918-20/[8]-[11]

33 See, V3/204 where Dr Pistorius is under examination in chief.
See, V3/242-246 where Dr Pistorius is cross-examined on the joint minute.

34 V3/204; 206/5-9; 239/11-19

51 So where (according to plaintiff) did the FB go wrong? It should (plaintiff alleges in the affidavits) not have relied on M v MEC for Health, Eastern Cape, for its formulation and application of the causation requirement.

52 Of course, the FB did not apply M v MEC for Health like a template with no attention to the facts here. The FB (unlike Keightley J) was acutely aware of the agreement by the obstetricians. That agreement means that even if nursing staff had monitored the FHR at 3:35 and 4:15, the hospital could not have performed a c/section in time (within 30 minutes) to prevent or minimize brain damage.

53 What did the FB find? At [17]-[21][35] it found and asked the following:

- The experts agreed that the acute profound hypoxic insult was caused by a sentinel event and that a partial prolonged insult was excluded;

- The obstetricians agreed that it was unlikely that the insult occurred before 3:15;

- They also agreed that the insult must have happened between 3:15-4:45;

35 V10/947-950

- If the FHR was monitored at 3:45 and 4:15 and warning signs of the insult were picked up, was there enough time to take an emergency measure (here, a c/section) to avoid the brain injury?

- Keightley J did not arrive at her conclusion that the failure to monitor the FHR at 3:45 and 4:15 caused the brain injury by applying the 'but for' test for factual causation;

- Keightley J appeared to follow the minority judgment in M v MEC for Health (that relied on *Lee.*[36]) The minority found that the source and time of the insult was unknown, largely due to the poor and deceitful record-keeping by hospital staff. The lack of monitoring created a risk. The failure to monitor the FHR resulted in the failure to detect fetal heart abnormalities, as a result of which urgent intervention by way of a c/section would in all likelihood have followed. Consequently, factual causation was proved on a balance of probabilities because the brain injury would not have occurred had there been proper monitoring;

- According to the agreement between the obstetricians and the evidence of Dr Pistorius, a c/section could not be performed within 30 minutes;

---

[36] Lee v Minister for Correctional Services [2012] ZACC 3

- The FB found that here a c/section could not be performed because the baby was delivered by NVD.

54 The significance of the agreement between the obstetricians, is not that delivery happened within 25 minutes of deciding on a c/section procedure.

55 The significance lies in the evidence of Professor Kirsten. That is that it takes 10-30 minutes from the time of the insult to brain damage. The conclusion to be drawn from this evidence (applying the ‘but for’ test) is that even if a c/section were ordered after timeous or proper monitoring, it could not have prevented brain damage.

56 The notion that there were measures - less than and other than a c/section procedure - that could have been taken to prevent brain damage, is inconsistent with the evidence of Dr Kirsten, Dr Pistorius and the agreement between the obstetricians. If the baby is not delivered within 10-30 minutes after the insult, the fetus will die in *utero*.

57 Remember, the injury here was a total or near total occlusion of oxygenated blood supply to the fetal brain. If giving the mother oxygen, rather than delivering the baby by c/section were the, or a, measure that would have prevented brain damage, the obstetricians would have agreed on that measure. Their agreement could not be clearer. Delivery by c/section was required. And it could not have been performed in time to prevent brain damage.

58 The approach (not the test, because the CC clarified in Mashongwa that Lee did not change the test for factual or legal causation) in Lee does not apply here.

59 Lee was concerned with two potential causes of injury where a plaintiff is unable to identify which caused the injury, but both causes are likely to have materially contributed to the injury.

60 Here, we know what caused the brain damage. It was an acute profound hypoxic insult, resulting from an unidentifiable sentinel event that was sudden and unpredictable.

61 That brings us back to the true question before Keightley. It was not: what caused the brain damage? It was: could the injury have been prevented or minimized by performing a c/section procedure (the only measure reasonably available to hospital staff?) Put differently, even if the FHR was monitored at 3:45 or 4:15, could brain damage have been prevented or minimized?

62 The obstetricians said that even if nursing staff here monitored in compliance with the 2007 Maternal Guidelines, there was not enough time to perform a c/section in time to prevent brain damage.

63 The test for causation is the test laid down in De Klerk. That test should be

applied to the facts here. Application of that test to these facts lead to the conclusion that the hospital could not have prevented or minimized brain damage, even if the FHR were monitored at 3:45 and 4:15.

64 The facts in M v MEC are materially different to the facts here. There, the minority and majority of the SCA applied the test for causation to the facts of that case. They came to different conclusions. But it is not those conclusions that apply. The test for causation does. The application of that test to the facts here, confirms that the FB was right in upholding the appeal against the judgment of Keightley J.

T J Bruinders SC
A Mofokeng
22 June 2021