IN THE HIGH COURT OF SOUTH AFRICA (SOUTH GAUTENG)

JOHANNESBURG

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DELETE WHICHEVER IS NOT APPLICABLE

(1) REPORTABLE: YES / NO
(2) OF INTEREST TO OTHER JUDGES: YES / NO
(3) REVISED.

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CASE NO: 29703/08

DATE: 2011-02-18

REPORTABLE

(IN THE ELECTRONIC REPORTS ONLY)

In the matter between

KHANYI, THEMBENI MARTHA obo K, PS Applicant

and

PREMIER OF GAUTENG Respondent

J U D G M E N T

WILLIS, J:

[1] The plaintiff claims in her capacity as the mother of P S K. The claim arises from alleged negligence on the part of the Premier of Gauteng in his representative capacity as the Executive Officer in overall responsibility for the affairs of the Provincial Government of Gauteng.

[2] The facts in this case are largely common cause. On 2 December 1999 the plaintiff was admitted to the Pholosong Hospital in Tsakane, Brakpan, for the delivery of the birth of her minor son P S K. Her birth was a so-called breech birth. P became asphyxiated due to the prolonged birth process, and as a result has suffered extensive and serious brain injury. He certainly is permanently impaired and disabled. For example, he will need fulltime care-giving throughout his life which will relate in addition to his being fed, to his use of the toilet; he will have to be

in a wheelchair for the rest of his life; he is unable to speak or communicate. In summary, one has all the facts of a very serious tragedy before one.

[3] The parties have agreed the quantum of damages in the sum of R9,25 million. Accordingly, it is not necessary for the Court to adjudicate that aspect further.

[4] It is common cause that P's mother, Thembeni Martha Khanyi, was admitted to the Pholosong Hospital at about 07:25 on 2 December 1999. She was examined and, in the record of the examination, it is recorded that there appeared to be no abnormalities and that everything was in order. It would appear that, shortly thereafter (probably at around 08:00), Doctor Haacke also performed an examination on the mother and detected no abnormalities.

[5] The hospital records indicate that, during the course of that morning, an abdominal assessment was performed on the plaintiff's mother, and this indicated that the child, P, was presenting as cephalic. In lay language, this means that that it would appear from the examination that P was head-down in the womb ready to be born in the normal way, namely coming head-first into the world.

[6] For reasons that I will deal with later, that assessment was wrong. At that stage P would have been in a breech position. At 11:00 a

further examination was done on the mother. The following notes are made in the hospital record relating to the examination at that time:

> "Inactive labour, foetal heart heard, blood pressure 120/80, per vaginal examination cervix four centimetres dilated, membrane ruptured ... [something] draining clear."

and thereafter a recommendation that she be transferred to the labour ward. That was signed by a midwife or nursing sister who, it would seem, is no longer available to testify, although the exact reasons for this are not clear.

[7] It is also common cause that at 13:30 the mother noticed a foot appearing from what she described as her "private part" (obviously her vagina in the region of her vulva). Nursing aids came to examine. They reported the matter to Doctor Haacke. He made a note that this was a footling breech. A “footling breech” refers to the situation where the baby’s foot has already emerged from the womb before any other part of its body in the process of its birth. The mother was advised not to push.

[8] For reasons which I shall deal with later, a caesarean operation was not performed on the mother. The baby was delivered at approximately 15:20 and, as a result of this prolonged birth as a “breech baby”, the baby was unable to get sufficient oxygen in the process of being born, was indeed purple when he entered the world, had suffered from asphyxia– which it is common cause contributed to the very serious consequences with which this case is concerned.

[9] The evidence is also that the mother attended the Tsakane Clinic very shortly before she gave birth and that although at that time an examination should have been performed to determine whether the baby was in a cephalic position ready to be born, this was not done.

[10] There was only one expert called in this case to give evidence. He was a Cyril van Gelderen, a qualified medical doctor. Everyone was hesitant to call him a retired doctor because, although he is officially retired, he is far from living a life of leisure. He was referred to by counsel as “professor emeritus”. This would indeed perhaps be a better description of the man.

[11] Professor van Gelderen was professor of Obstetrics and Gynaecology at the University of the Witwatersrand. He holds more degrees and professional qualifications than a thermometer. He is highly experienced and in my respectful opinion gave evidence of an excellent quality. His evidence was not challenged in regard to his expertise. One may therefore safely decide this case on the basis of his evidence.

[12] The professor was critical of the fact that, at the clinic and at the time when the plaintiff's mother was admitted to the hospital, it was not diagnosed that the mother was presenting with a breech birth. His view was that this should definitely have been observed. His evidence was also that, had the presentation in breech been detected at the Tsakane

Clinic, it would have been a simple matter for assistance to have been given to the mother in order to turn the baby so that it was ready for delivery in the normal way.

[13] Similarly, had it been determined that the baby was in breech at the time the mother was admitted to the hospital in early morning on 2 December 1999, arrangements could obviously have been made and would have been made to perform the necessary caesarean operation at the appropriate time. This would have prevented the tragedy with which we are now concerned.

[14] Under probing, Professor van Gelderen conceded that it is possible (although he was reluctant to excuse it), that the examinations of the mother at the early stages of admission to hospital and her being at the Tsakane Clinic would not have shown up that the baby was presenting in a breech position, but he considered it most unsatisfactory.

[15] What is concerning to me is that there is a positive record in the early stages of her admission to the hospital on 2 December 1999 that the baby was presenting cephalically, in other words the baby was presenting head downwards. Professor van Gelderen's expert opinion (upon a matter which I believe all of us know, in any event) is that that could not have been the case.

[16] In other words, a baby could not have been presenting

cephalically and, within a matter of hours in the morning of its birth having been presented, being born in a breech position. A baby does not present head-down immediately before its birth and then do a somersault within the womb to be born “foot-down”. Thus, in my view, and before one goes any further, there was negligence in an erroneous recording of the presentation being cephalic. This is serious, although one accepts that as the dilation of the cervix was slight - *viz*., between one and two centimetres - a mistake could perhaps have been made at the time when the mother was examined at 7.25 in the morning.

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[17] Very much more serious (and, in the end, this is the point upon which the whole case turns), the mother was examined at 11:00 on the morning in question. At this stage her cervix was four centimetres dilated. This self-evidently would have facilitated a proper examination of the presentation of the baby in order to determine whether it was in the correct or normal position for delivery (i.e. “head-down”).

[18] Professor van Gelderen's evidence was emphatic that such an examination (for the presentation of the head) should have been done at
20 that stage. He was also emphatic that had it been done at that stage, it would have shown up that the baby was in breech. He was also emphatic that, at that stage (i.e. the moment a breech birth was obvious), alarm bells should have been sent ringing. The situation would have been urgent. It would have required imperative attention. The doctors in charge should have been alerted. The whole situation should have been closely

monitored and observed - which we know did not occur.

[19] There was considerable examination of Professor van Gelderen concerning accepted medical practice. It seems that since 2001 it has been accepted medical practice that the standard recommended medical procedure upon determination of a breech birth is that there should be a caesarean section. In 1999 the position was not so clear. At that time, the prevailing practice was that one should observe the situation very carefully to determine the appropriate steps to be taken after a close supervision of events.

[20] The professor was adamant - and his evidence was not challenged on this aspect - that in 1999 where there was a footling breech (as occurred in this particular case) then a caesarean section would have been the correct and appropriate medical procedure to have been adopted.

[21] Not only was this Professor van Gelderen's unchallenged evidence, but Doctor Haacke, who was the doctor in charge of the labour ward at the time, agreed that the appropriate intervention once a footling breech had been diagnosed would have been a caesarean section.

[22] Doctor Haacke was cross-examined as to why he did not perform a caesarean section. The medical records indicate that on that particular day there were an unusually large number of persons who

actually underwent caesarean sections at the Pholosong Hospital, namely three. There was an operation booked from 10:30 in the morning till 11:50; and another (which is of critical importance) on a certain Nomcebo Khumalo, from 14:00 to 15:10; and then a further operation on one Pinky Mavundla after 15:30. Clearly, the operation on Nomcebo Khumalo would have coincided more or less with the appropriate time to intervene in respect of the mother of P.

[23] Doctor Haacke, for completely understandable reasons, has no independent recollection of these events which occurred a long time ago. He concedes that the note as to the reason for the operation on Khumalo is not particularly helpful and he said it may be inaccurate. He said that normally the recorded description of the reason for the operation as “cephalopelvic” would have been such that the plaintiff's mother should have received priority, but he said one does not know what the situation was at the time at 14:00. He was convincing that there may well have been a fairly simple explanation for his prioritising the operation on Khumalo, namely that she may already have been under anaesthetic at the time that he became aware of the serious footling breech and would have had to intervene immediately.

[24] In any event, there is no reason to disbelieve Doctor Haacke. I certainly cannot find that, as a matter of probability, he was negligent. Nevertheless, as I have said, it is common cause that, had there been a footling breech diagnosed earlier, the proper procedure would have been

to perform a caesarean section operation. This much is clear. This was not only the opinion of Professor van Gelderen but also that of Doctor Haacke.

[25] In summary:

(i) The mother of P should have been examined at 11:00 to determine whether there was a cephalic presentation or not; and

(ii) either this was not done or, if it was done, no record was made of the finding.

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[26] If the examination had been done and it was found that there was a breech it was a matter of such critical importance that it should immediately have been recorded and the expert assistance of someone like Doctor Haacke called at that stage.

[27] Whatever the true position, it is inexcusable that the impending breech birth of P was not diagnosed at 11:00 and that steps were not taken immediately to monitor the situation. The evidence is clearly that the situation at 11:00 was obviously potentially very serious indeed; that
20 the situation should have been closely monitored and that it should have been managed correctly. Certainly at that stage (at 11:00 am), the care and concern for P's mother should have been prioritised. This was the incontrovertibler evidence across-the-board of both the plaintiff and the defendant.

[28] In the light of this evidence, it seems to me that the probabilities are that had the staff at the Pholosong Hospital, more particularly the midwives, done their job properly at 11:00 am in terms of ,not, this tragedy could have been avoided.

[29] Counsel for the defendant referred me to the well-known case of *Mitchell v Dixon*, 1914 AD 519. Mr *Soni* (who, together with Mr *Joubert*, appeared for the defendant) also referred me to the more recent decision of the Supreme Court of Appeal in *Louwrens v Oldwage*, 2006 (2) 161 (SCA) at paragraph [19] (which also referred to the *Mitchell v Dixon* case with approval). In addition, the defendant's counsel helpfully referred me to Michael Jones' *Medical Negligence*, 3rd edition, 2003 (at paragraph 4-015). The observations in this text were quoted with apparent approval in the case of *Van der Walt v de Beer*, 2005 (5) SA 151 (C) (at 160B-C).

[30] In my view, it is unnecessary to ponder, at any length, the legal principles concerned. These legal principles are well known and the fault of the midwives examining the mother at 11:00 on 2 December 1999 was so basic and so serious and so self-evidently negligent that I do not think I need dwell on the matter any further.

[31] Accordingly the plaintiff has succeeded. The case for the plaintiff has been proven on a balance of probability. I asked counsel for the plaintiff to prepare an order that would reflect the Court's intention were I to decide in favour of the plaintiff. He was also requested to

confirm with counsel for the defendant that if the Court were to make a finding against the defendant, that the order would be cast in the correct form. An order is accordingly made in terms of the draft marked X, but for the sake of completeness I will read into the record:

[32] Judgment is granted in the plaintiff's favour in the following terms.

The defendant is liable to pay the plaintiff:

1. The sum of R9,25-million (nine million, two hundred and fifty thousand rands);

2. Costs, which costs are to include the qualifying fees of the following experts:

2.1 Heather Hill

2.2 Doctor H Edeling

2.3 Professor L Jacklin

2.4 Basil Logan

2.5 Professor J Bornman

2.6 Doctor G Saloojee

2.7 Doctor L Marais

2.8 Lance Marais

2.9 Doctor D Strauss

2.10 Doctor L Pistorius

2.11 Professor C van Gelderen

2.12 Doctor I Lissoos

3. It is noted that on 19 October 2009 the defendant was ordered to pay the wasted costs of the plaintiff on the attorney-

and-client scale.

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N. P. WILLIS
JUDGE OF THE HIGH COURT

Counsel for the Plaintiff:	Advocate AP *Bruwer*
Attorneys for the Plaintiff:	Austin Jordaan Inc
Counsel for the Defendant:	Advocate V *Soni* SC, (with him Advocate D *Joubert*)
Attorneys for the Defendant:	The State Attorney
Date of hearing:	16, 17, 18 February 2011
Dater of judgment:	18 February 2011