**IN THE HIGH COURT OF SOUTH AFRICA**
**GAUTENG LOCAL DIVISION, JOHANNESBURG**

**CASE NO: 17/45375**

REPORTABLE: NO
OF INTEREST TO OTHER JUDGES: NO
NOT REVISED.
08/11/2021

In the matter between:

**M[....], N[....] obo**
**M[....], O[....] S[....]** Plaintiff

and

**THE MEMBER OF THE EXECUTIVE COUNCIL**
**FOR HEALTH, GAUTENG** Defendant

**JUDGMENT**

**INTRODUCTION**

1. The plaintiff claims damages in her personal and representative capacity for harm suffered by herself and her daughter O[....] who was born on 8 April 2014 at Thelle Mogoerane Hospital, previously known as Natalspruit Hospital ("the hospital"), which falls under the area of responsibility of the defendant ("the MEC").

2. The parties agreed that the issue of liability would be decided first, and separately from the issues of quantum.

3. There were complications before the birth (when exactly is one of the issues to be determined) and O[....] sufferered severe birth asphyxia and hypoxic-ischaemic encephalopathy ("HIE") and respiratory distress syndrome. O[....] now suffers from cerebral palsy. Ms M[....] contends that this was caused by negligence on the part of the doctors and nursing staff at the hospital who either attended to her or ought to have attended to her during the birth. She claims damages on her own behalf and on O[....]'s behalf.

4. At the start of the trial it was conceded that the MEC bears the legal duty of care towards Ms M[....] and O[....]. It was also agreed between the parties that the injury suffered by O[....] occurred before he was born, either before or during labour (pre- or intra-partum). The injury to O[....] is also not disputed. The question is when the injury occurred and whether it was caused by the MEC's negligence (including that of the MEC's employees and representatives).

5. Ms M[....] testified, and called the following expert witnesses: Professor Nolte, a midwife; Dr Mbokota, an obstetrician/gynaecologist;

6. The parties had agreed not to call the radiologists, and paediatricians and the two joint minutes of those sets of experts were accepted into the record.

7. The MEC called Dr Harris, a nursing expert; Dr Hlongwa, an obstetrician/gynaecologist; Dr Mokaneng, who was employed at the hospital at the time, as a medical officer in the department of obstetrics and gynaecology; Dr Mogoshoa, a paediatric neurologist and Ms Fatyela who is a nursing Sister and was at the time the acting operational manager in theatre.

**FACTUAL BACKGROUND**

8. The facts set out below are common cause except where otherwise indicated. They emerge from both the pleadings, including the admissions made at the pretrial conferences, and the evidence.

9. Ms M[....] attended at Phola Park Clinic ("the Clinic") on 21 November 2013, after she first knew she was pregnant. The Clinic recorded that she was 24 years

old, HIV positive and not Rh negative. Ms M[....] had not previously been diagnosed as HIV positive. She had had one previous pregnancy but had miscarried at two months. The Clinic recorded that Ms M[....] was otherwise healthy. Ms M[....] has, since O[....]'s birth, had a second child who was born by C-section with no complications.

10. Ms M[....] attended the Clinic on the appointed days thereafter (at 26 and 32 weeks) and the Clinic recorded nothing out of the ordinary and no cause for concern. An ultrasound was done at 18 weeks and it was recorded that the expected date of delivery was 22 April 2014, according to the ultrasound and the "SF height" (symphysis-fundal height, the measurement of the height of the uterus). The SF height is also used to assess the growth of the foetus, as it grows at approximately 1 cm per week. The Clinic records show the growth to be normal. Ms M[....] was told that the baby was fine. Ms M[....] is a short woman of 138cm in height and at the first appointment her weight was 52 kilograms.

11. It is common cause that the care Ms M[....] received at the Clinic was reasonable and sufficient, as was her referral to the Hospital.

12. On 7 April 2014 Ms M[....] noticed a vaginal discharge containing blood and went to the Clinic between 11h00 and 12h00. She was told she was not in labour but was referred to the hospital. According to the Clinic records she was seen at 12h45, the pelvis was tight and it was difficult to do a pelvic examination. She was referred to the hospital for pelvic assessment. It is also noted that a CTG was done and it was reactive, that she had had pain since that morning, and that the membranes were intact. However "show" was noted, meaning the mucus plug of the cervix had started loosening.

13. When Ms M[....] arrived at the hospital, her evidence was that she was sent to a room with other pregnant women where she waited, and by that time she thinks she was in labour. They waited for a doctor, and according to her she was only seen by a doctor at around 8pm. The hospital records show that she was admitted at 15h24, referred from the Clinic for assessment of the pelvis, and that her abdomen was large. The foetus was lying longitudinally and with the head down, there was some blood on the glove when she was examined. The SFH was 36cm. It notes that

she was to be admitted for observation and CTG. At 20h00 she was seen by a doctor and it was noted that she was admitted for pelvic assessment. It is recorded that the foetal heart rate ("FHR") was 148 per minute according to the CTG. According to Ms M[....] at 20h00 was the first time she was examined (although the records show she was examined on admission) and that she had been told the doctor was busy in theatre before that. She was however seen for the first time by a doctor at 20h00.

14. Ms M[....] was moved to another ward at 23h00 when it is recorded that her vitals were taken and she was given moral support. There is no record of the CTG readings, if any. There is also nothing which emerges from the hospital records which explains why pelvic assessment had not yet been done.

15. There are no records of Ms M[....] being examined between 23h00 on 7 April and 06h20 on 8 April. Professor Nolte testified from her reading of the records that there was a note at 04h20 but that was a misreading of the time of the 06h20 note. According to Ms M[....] she was in pain and she was told that she was "misbehaving" because she was making a noise. She was crying with pain. At around 06h00 she was taken to what she was told was High Care.

16. It is common cause that the care and monitoring Ms M[....] received between her arrival at the hospital and about 06h00 the next morning was "substandard". It is argued for the MEC, however, that this is insignificant in the context of this case. I deal with that later. In any event it is common cause that the foetal heart rate and contractions were to be assessed at least every 1 or 2 hours, and a vaginal examination to be done every four hours, which do not appear to have been done.

17. At 06h20 it is noted that the cervix was dilated 5-6cm and a note is made that there is good progress. It is again noted that there is a big abdomen and possible CPD. It is noted that the doctor was to be called from the theatre to assess Ms M[....]. It is unclear why she was not assessed for CPD earlier when it was the reason she was referred, and would necessarily mean that, if the baby was too big for her pelvis and/or cervix, she would need a C-section.

18. It is common cause that a CTG is of most value is when it is continuous, because this can show when there is deceleration of the FHR, that is, a drop of more

than 15 beats per minute, during a contraction. A single noting of the FHR is not useful for this purpose. CTG tracings (partogram) were discovered by the defendant for the period 13h00-13h50 on 07 April and 06h10-06h50 on 08 April. Ms M[....] does not remember whether she had on the “belt” which takes the readings before 06h10 and there is no evidence that continuous CTG monitoring was done, although there is a note in her records at 20h00 that she was on CTG although this was before she was sent to Ward 17, which seems to have been at 23h00.

19. The CTG shows a deceleration during a contraction at 06h12 on 8 April. At 06h20 a message was to be sent to the doctor who was in theatre the doctor needed to come and see Ms M[....]. It was noted that she was in the active stage of labour. She was then transferred to the labour ward at 06h40. The doctor did not come and see Ms M[....], and the first time she was seen by a doctor was at 08h30, on the ward rounds.

20. Dr Moroeng who finally saw Ms M[....] ruptured the membrane and found that the liquor was stained with thick meconium. In addition it was clear that she was presenting high and was not about to give birth. Dr Moroeng referred Ms M[....] for a C-section. According to Dr Mbokota, the plaintiff’s obstetric witness, the presence of meconium showed that the foetus was in distress and possibly had been for a few hours, but because the meconium was grade three the insult had possibly occurred in the previous 45-60 minutes. There may not have been any indication previously because the foetus initially compensates for its distress. The meconium was not old, according to the records and this does not accord with a conclusion of intra uterine growth restriction, or with an earlier insult.

21. Dr Mokaneng, who was one of the doctors present when Ms M[....] was assessed at 08h30 in the ward round, and was the scribe on the hospital records, testified that there would usually be two doctors on duty but it appears from the records that on the day there was only one at 06h20, and she could not say why. However she had no independent memory of the day.

22. It is common cause that the C-section ought to have been done within an hour after the diagnosis that it was necessary. In the meantime there are other steps that may be taken to relieve foetal distress, including getting the mother to lie on her side

to improve blood flow to the uterus, and to give her something to stop contractions to reduce stress on the foetus. None of these things were recorded as having been done and Ms M[....], the only witness who was there at the time, testified that the only interaction she had with the nurses while waiting for the C-section was being told she was making noise, because she was screaming form the pain.

23. The evidence about foetal resuscitation was objected to by Mr Memani for the MEC on the basis that it was not pleaded. I shall deal with that later.

24. At this point there was a delay because there were insufficient gowns in the theatre. Then the wrong patient was taken into theatre before Ms M[....]. She eventually was taken in at 13h45 and O[....] was delivered at 13h53, five hours and twenty three minutes after the need for a C-section was diagnosed, and seven hours after the nurses called for a doctor to assess Ms M[....]. Of the delay, about four hours was caused by the shortage of gowns or theatre linen.

25. O[....] weighed 2.27kg, was 47cm long and had a head circumference of 32cm. The obstetricians/gynaecologists agreed that this was normal for a child from such a small mother, although on the low side of normal. Dr the paediatric neurologist, said that from a paediatric point of view this is low, but he concedes to the obstetricians. Since her growth was proportional it was unlikely that there was growth restriction. O[....] did not cry on birth and had to be resuscitated. She had aspirated meconium which had to be removed. It took 45 minutes to resuscitate her.

26. The records show that O[....] suffered severe birth asphyxia and was “floppy”. Her Apgar scores which show the condition of the baby at birth and also the success of resuscitation were 2/10 at birth and 4/10 at 10 minutes. A healthy child is 7/10 at 5 minutes. O[....] remained in hospital for 20 days.

27. The radiologists agreed that O[....] suffered acute hypoxic ischaemic brain injury, with signs of prolonged hypoxic exposure.

28. According to Dr Mbokota the bulk of the hypoxia took place while Ms M[....] was awaiting the C-section. He and Dr Hlongwa agreed that if the C-section had been done on time a different outcome was likely, and that the C-section should have been done within an hour of it being called for. There was no indication of any

infection before birth. O[....]'s elevated C-reactive Protein levels are consistent with inflammation caused by the various traumas she experienced, and with no other indications there is no reason to believe that there was infection. Dr Mbokota also considered that Ms M[....] was allowed to remain in the latent phase of labour for too long. None of this was contested. Dr Hlongwa testified that the existence of both decelerations and thick meconium was ominous and the likelihood of foetal hypoxia was increased. She also took the view that where there was a high risk pregnancy evidenced by the mother being HIV positive and having a narrow pelvic outlet she possibly ought to have been referred earlier for a C-section.

29. Ms Fatyela testified that there were 8 theatres at the time and 6 were in use. Two were out of use due to "structural challenges". Three were being used for electives and two for emergencies and trauma, in addition to the ob/gyn emergency theatre. She testified that if there is not a patient already on the table an arrangement could be made to delay an elective surgery to accommodate the emergency, but there was no record of any such arrangement. She had no recollection of this case.

**THE ISSUES AND ANALYSIS**

30. It is clear that it was common cause that Ms M[....] was not properly monitored, and that steps were not taken in accordance with the Maternity Guidelines, 2007 to advance her labour, obtain a C-section in time, and to take steps for foetal resuscitation during the delay before the C-section was performed. In addition, Ms Maseko was not assessed for CPD immediately, despite that being the reason she was referred to the hospital.

31. Mr Memani suggests that nothing that happened before Ms M[....] was referred for a C-section is relevant, because it is common cause that the insult probably occurred while she was waiting.

32. This cannot be correct. It is plainly logical that had Ms M[....] been assessed immediately, and monitored correctly, it would have been noticed earlier that she may need a C-section. In particular, the Maternity guidelines require steps to be taken for a long latent phase of labour (more than 8 hours) – nothing was done to

assist Ms M[....]'s labour advancing despite the latent phase being more than 12 hours long.

33. All of these issues were pleaded, in particular the failure to comply with the guidelines, the failure to assess Ms M[....] in line with the clinic's referral, and to assess her pelvis, and the failure to identify the slow progress of the labour timeously.

34. Had all these things done, logic dictates that it is more than probably that steps would have been taken resulting in an earlier C-section. The experts are agreed that had the C-section been done when it was called for the likelihood is that the damage to O[....] would have been less.

35. The "sub-standard" care received prior to 06h12 is therefore relevant. There is no evidence that there was a single insult to the foetus and that all the damage occurred at that point. In fact the unconstested evidence is that the damage occurred due to prolonged distress, and probably during the wait for a C-section.

36. As far as the failure to take steps for foetal resuscitation is concerned, the steps are listed in the 2007 Maternity guidelines. Ms M[....] pleaded both that she was not monitored in accordance with the guidelines and that her labour was not managed in accordance with the guidelines.

37. None of the ante-natal causes of O[....]'s injury pleaded by the MEC have been proved. They are no more than speculation.

**THE LAW AND ITS APPLICATION TO THE FACTS**

38. It is trite that the plaintiff in a delictual claim bears the onus to prove on a balance of probability that the damage suffered is caused by wrongful negligence of the defendant. The MEC contends that the plaintiff has proved neither negligence nor causation, and to the extent that negligence has been proved, causation has not been proved.

39. It is clear that the plaintiff has proved the following:

39.1. Despite being referred for possible CPD, she was not assessed for that by the hospital.

39.2. Proper monitoring was not carried out for the approximately fourteen hours she was at the hospital before the deceleration was identified.

39.3. The latent phase of labour was allowed to continue too long, and as a result of improper monitoring, it is impossible ot say when the active phase began.

39.4. Despite the nursing staff calling for a doctor to assess Ms M[....] between 06h20 and 06h45, no doctor assessed her until the ward rounds two hours later.

39.5. Despite a C-section being called for, it did not take place within an hour as required by the guidelines, but almost six hours later.

39.6. The cause of the delay included a lack of theatre linen and the wrong patient being taken to theatre in Ms M[....]'s stead.

39.7. There were at least three theatres which were scheduled for use for elective surgery but no effort was made to find out if one could be made available for emergency surgery on Ms M[....].

39.8. No foetal resuscitation steps were taken despite it being agreed that this is best practice and also being required in terms of the guidelines.

40. Ms M[....] has therefore proved negligence on the part of the MEC.

41. As far as causation is concerned, the MEC's reliance on the decelerations noted at 06h12 is misplaced. There is no evidence that this was a "sentinel event" and that anything that happened afterwards would not help. The undisputed evidence is that the foetal distress was prolonged and took place over a few hours, and that had Ms M[....] been treated in accordance with the guidelines, and had the hospital ensured that it was properly equipped with linen and gowns, the damage would likely have been limited.

42. This distinguishes this case from that *Member of the Executive Council for Health and Social Development of the Gauteng Provincial Government v TM obo MM* (380/2019 [2021] ZASCA 110 (10 August 2021) and also *AN v MEC for Health, Eastern Cape* [2019] ZASCA 102; [2019] 4 All SA 1 (SCA), in which the SCA found that the plaintiff had not proved the case. In both those cases the time of the injury was more precisely pinpointed and the relevant hospitals would not have had time to perform the C-section in time to prevent damage.

43. The evidence is clear in this case that there was time which was not used because of the negligence of the hospital, and that the earlier negligence most probably also contributed to the delay.

44. I find, therefore, that the plaintiff has established both negligence and causation.

**COSTS**

45. The hearing of this matter was extended at least three days by the ill-preparedness of the MEC's legal representatives and witnesses. In addition, it is clear that the defence of the case was not based on evidence. Had the defendant merely wished to test Ms M[....]'s version this could have been done more efficiently than raising speculative defenses. In addition it is clear the MEC took no steps to even try to find factual witnesses in good time to plead to the claim, let alone respond to the various pre-trial queries.

46. It is therefore appropriate that the MEC pay costs on a punitive scale.

**CONCLUSION**

47. For these reasons I order as follows:

47.1. The Defendant is liable for 100% of the damages sustained by the Plaintiff and O[....], and to be proven in due course.

47.2. The Defendant is to pay the Plaintiff's costs on the attorney and client scale, including the costs of counsel and the reservation and attendance of the Plaintiff's appointed experts.

**S. YACOOB**
**JUDGE OF THE HIGH COURT**
**GAUTENG LOCAL DIVISION, JOHANNESBURG**

**Appearances**

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|---|---|
| Counsel for the applicant: | Ms G Benson |
| Instructed by: | Jerry Nkeli and Associates |
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| Counsel for the Respondents: | F R Memani |
| Instructed by: | The State Attorney, Johannesburg |
| | |
| Date of hearing: | 31 August 2020 – 09 September 2020, 11 September 2020 |
| Date of judgment: | 08 November 2021 |