REPUBLIC OF SOUTH AFRICA

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

CASE NO: 35055/2016

(1) REPORTABLE: NO
(2) OF INTEREST TO OTHER JUDGES: NO

4 April 2022
DATE

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SIGNATURE

In the matter between:

I O obo
N O Applicant/Plaintiff

and

THE MEMBER OF THE EXECUTIVE
COUNCIL FOR HEALTH AND
SOCIAL DEVELOPMENT OF THE
GAUTENG PROVINCIAL GOVERNMENT Respondent/Defendant

(This judgment is handed down electronically by circulation to the parties' legal representatives by email and uploading it to the electronic file of this matter on CaseLines. The date for hand-down is deemed to be 2022.)

JUDGMENT

MIA, J

[1] This is an appeal against the judgment and order handed down on 16 August 2021. I shall refer to the parties as they appear in the trial. The plaintiff appeals on the grounds that the court misdirected itself in finding that the plaintiff had not proven its case as pleaded in the particulars of claim and had failed to make out a prima facie case. The defendant opposed the application.

[2] The plaintiff asserts that the court erred and misdirected itself on the following grounds:

2.1 Finding that when considering the principles and tests applicable to absolution from the instance, the plaintiff did not prove its case as pleaded in the particulars of claim;

2.2 The court ignored paragraphs 11.4 to 11.7 of the particulars of claim and the unchallenged evidence supporting the allegation of prima facie evidence of aftercare namely procedures of postnatal care breached by the defendant:

2.2.1 the fluid balance chart indicated troubling features of low urine output were completely ignored;

2.2.2 the discrepancy in the information recorded regarding key role players such as the Medical Registrar;

2.2.3 the pulse rate and blood pressure during pregnancy and after delivery through C-section which was completely ignored by the attending staff

2.2.4 the lack of evidence that Mrs. Opperman went to high care;

2.2.5 the lack of complete recordals of blood pressure;

2.2.6. the lack of accuracy in blood loss assessment;

2.2.7. the lack of action taken notwithstanding the fact that the machine not reading is mentioned in the clinical records;

2.2.8. the lack of hospital obstetricians referring Mrs. Opperman to a cardiologist;

2.2.9. the lack of accountability or evidence on the administration of oxytocin and ringus lactate according to the attending doctor's recommendations or instructions;

2.2.10. the lack of adherence to recommendations of Cronje et al, on page 506 regarding triggers to blood pressure reading;

2.2.11. lack of evidence of the mortality committee meeting minutes and the perinatal meeting minutes;

2.2.12 the fact that Mrs. Opperman had four risk factors for post-partum haemorrhage and the ineptitude displayed in the face of these factors by the staff of Chris Hani Baragwanath Hospital;

2.2.13. at the recovery room, bleeding was not checked and nothing was noted and said about uterus contractions;

[3] It was the applicant's contention that the court erred in misunderstanding the factors in paragraph eleven of the applicant's

legal duty by the defendant, instead of the factors used to prove the breach of legal duty. The plaintiff also contended that the court did not understand the test for absolution. The court did not have regard to the definition of the elements of medical negligence and that the defendant owed Mrs. Opperman a legal duty of care pre and post the operation. The applicant's case was based on the grounds mentioned in 2.2.1 to 2.2.13 that there was a breach of care that resulted in the damage and the death of Mrs. Opperman. Consequently, counsel for the plaintiff submitted that there was a reasonable possibility that another court would come to a different conclusion.

[4] Counsel for the plaintiff submitted that whilst the plaintiff did not take issue with the caesarean section operation and the tubal ligation, it was the post-operative care administered to Mrs. Opperman that fell short of what was required and was the cause of death. She had at least four risk factors that predisposed her to post-operative haemorrhaging. He argued that the medical staff ought to have taken this into account when managing her post-operative care. He referred to the failure to administer oxytocin within the first twenty-four hours. He also referred to there being no action taken where there was an observation of low output of urine. Furthermore, Mrs. Opperman's pulse rate and blood pressure were not adequately monitored and she was not referred to the relevant professionals for supportive treatment, namely a cardiologist and pulmonologist. She was also not sent to the high care ward after the operation in view of the risk factors. It was these omissions he argued which led to the damage which caused the plaintiff's wife's death.

[5] Counsel for the defendant submitted the evidence of the plaintiff, the obstetric gynaecologist, and the state pathologist was led. The obstetric gynaecologist testified that the failure to administer oxytocin was the only step not taken to prevent haemorrhaging. She was unable to comment on the causal link between haemorrhaging and the cause of

death in Mrs. Opperman. He also submitted that no further evidence was led that the plaintiff's wife's body was incapable of naturally producing oxytocin. Moreover, he submitted that the gynaecologist conceded under cross-examination, that there were other issues that were relevant namely that Mrs. Opperman had cardiac problems and lung problems. These were issues that needed experts qualified in those fields to testify on how those issues could have contributed to the plaintiff's wife's demise. The obstetric gynaecologist was not qualified to comment on these areas which were not within her expertise.

[6] He argued moreover, that whilst the state pathologist found the cause of death to be due to a pulmonary embolism, a blood clot in the lungs, after conducting the autopsy he found no evidence of the tubal ligation or caesarean section surgery playing any role in the cause of death. This was because the sutures were intact and there was no internal bleeding as a result of the sutures involved in the tubal ligation and the caesarean operation. He, however, found an atonic uterus containing a large amount of blood, after childbirth. The uterus is meant to contract and expel all the contents such as the afterbirth and any blood that remains. In Mrs. Opperman's case, the uterus had failed to contract and was thus atonic.

[7] Counsel for the defendant referred to the pathologist's evidence that he observed a sub endocardial haemorrhage in the left ventricular outlet which was not well understood but had high associations with hypovolemic shock, which is a condition when the patient bleeds out. Mrs. Opperman also only had one lung, and the oxygenation of the lung would also have contributed to the inadequate oxygenation of the blood. The pathologist also expressed the view that the two-centimetre increase in the ventricular heart did not play a role in the death of Mrs. Opperman either.

[8] The plaintiff considers that it had a low threshold to cross in making out

a *prima facie* case and that it had done so. The plaintiff pleaded in paragraph 11 of the particulars of claim that the defendant breached its duty of care to Mrs. Opperman by wrongfully, unlawfully, and negligently performing and failing to perform obligations that it had towards Mrs. Opperman. The caesarean operation and tubal ligation did not appear to be an issue in the cause of death. The plaintiff's case was based on the post-operative care of Mrs. Opperman as the plaintiff alleged in paragraphs 11.4-11.7. and required that evidence be led to prove the causal link between the postoperative procedures, the omissions referred to, and the death of the plaintiff's wife.

[9] The obstetric gynaecologist testified that she was not able to testify about aspects beyond her field of expertise. She identified that there was no oxytocin administered. After the plaintiff's case was closed the evidence was that oxytocin is produced as a normal consequence after delivery to expel the afterbirth and remaining blood. No evidence was led that the plaintiff's wife's body was not capable of producing oxytocin. The pathologist found no problem with the sutures and it appears no problems were linked to the caesarean operation and tubal ligation.

[10] The plaintiff alleges negligence because the plaintiff's wife was not referred to a pulmonologist and a cardiologist. The plaintiff did not lead the evidence of a cardiologist or a pulmonologist indicating at what stage the plaintiff's wife was to be referred to such experts and whether or not such experts ought to have been involved in the operation or post the operation to prevent her death. There was also no causal link between the lack of urine output and the plaintiff's wife's death. Neither was there any evidence explaining how the embolism, which the pathologist stated was the cause of death, was linked to the atonic uterus, if there was any link. The pathologist's evidence was that he found a sub endocardial haemorrhage in the left ventricular outlet which was not well understood but had high associations with hypovolemic shock linked to a patient bleeding out. There was also no evidence

linking the lack of administration of oxytocin, which the body produced naturally to the cause of death.

[11] The test in granting leave to appeal is that the appeal would have a reasonable prospect of success. The applicant's assertion is on the facts that the court ignored the evidence of "low hanging fruit" which would have persuaded another court to refuse the application for absolution from the instance. On this basis, leave is requested to the Full Court of the Gauteng Division.

[12] In view of the above, I make the following order:

1. Leave is granted to the Full Court of the Gauteng Division with costs to be costs in the appeal.

S C MIA
JUDGE OF THE HIGH COURT OF SOUTH AFRICA
GAUTENG LOCAL DIVISION, JOHANNESBURG

Appearances:

On behalf of the applicant	:	Adv K.K Maputla
Instructed by	:	Molema Attorneys Masilomolema@yahoo.co.za
On behalf of the respondent	:	Adv J. Magodi
Instructed by	:	Office of the State Attorney Kmaile@Justice.gov.za
Date of hearing	:	24 March 2022
Date of judgment	:	4 April 2022