REPUBLIC OF SOUTH AFRICA

IN THE HIGH COURT OF SOUTH AFRICA

GAUTENG DIVISION, PRETORIA

CASE Number: 9253/2017

10/09/2021

In the matter between:

M[....]: J[....] M[....] **1st Plaintiff**

ADV H KRIEL (obo M[....] M[....]) **2nd Plaintiff**

and

MEMBER OF THE EXECUTIVE COUNCIL (MEC) FOR HEALTH GAUTENG PROVINCIAL GOVERNMENT **Defendant**

JUDGMENT

MBONGWE J

INTRODUCTION

[1] This is an action for damages claim premised on alleged negligent management of the first plaintiff and poor monitoring of the foetal heart-beat rate during the first plaintiff's stages of labour. The plaintiffs allege that negligence on the part of the medical staff in the employ of the defendant at the Natalspruit Regional Hospital, Gauteng Province, had resulted in the first plaintiff giving birth to a cerebral palsied baby, M[....],

on the 20th January 2014.

[2] The defendant denies that its medical staff was negligent. The defendant further contends that even if it were to be found that its staff had been negligent, such negligence could not have been the cause of the condition of the first plaintiffs baby. The defendant consequently denies liability.

[3] By agreement between the parties, the hearings and determination of liability and quantum will be separated in terms of Rule 33(4) of the Uniform Rules of Court. The present hearing is in respect of the determination of liability and quantum will be determined at a later stage. The hearing was conducted virtually in compliance with the directives of the Judge President in response to the Regulations promulgated for the combating, prevention and control of the spread of the infectious covid19 virus.

COMMON CAUSE FACT

[4] It is common cause between the parties that the baby, M[....], was born suffering from cerebral palsy resulting from a sustained deprivation of blood and oxygen supply, at some point(s) during the first plaintiff's stages of labour.

THE PLAINTIFFS' CASE

[5] The plaintiffs' case is that the condition of the first plaintiff's baby was caused by the failure of the defendant's medical staff, particularly the midwifes in charge, to properly manage the first plaintiff and monitor the foetal heart-beat rate in accordance with the Maternal Guidelines of 2007 applicable at the time.

[6] The plaintiffs' approach towards the establishment of its case was summed up by one of its expert witnesses, Professor Theron, in the following terms: The question to be answered is why was it that a foetus that was in good condition at 20h00 was born (a baby) suffering from cerebral palsy at 22h55. It was common cause between the parties that the foetus had sustained a mixed pattern of a partial prolonged and acute

profound brain injury resulting in the cerebral palsy. It was therefore, according to Prof Theron, necessary to focus on the foetal heart rate monitoring during the period just after 20h00 until 22h55 to establish the probable time foetal distress had occurred.

[7] The result of the exercise suggested was that the plaintiffs' case appeared to focus more attention on none adherence by the defendant's staff to the Guidelines. In my view, the plaintiffs incorrectly sought to equate non-compliance with the guidelines to the alleged negligent conduct that caused the cerebral palsy. Essentially as will be shown later in this judgment, the plaintiffs had to prove the causal connection of the alleged negligence to the harm suffered by the baby. With the exception of Prof Theron and Dr Albeit, all the experts who testified or whose joint reports were admitted stated that the cause of the condition of the baby at birth was unknown.

ISSUES FOR DETERMINATION

[8] Resulting from the plaintiffs' approach and allegations, the parties submitted that the two issues for determination insofar as the aspect of liability is concerned were;

8.1 whether the defendant's medical staff in attendance and in charge of the management of the first plaintiff and the monitoring of the foetal heartbeat rate during the labour stages of the plaintiff had been negligent in the execution of their duties and, if so,

8.2 whether such negligence caused the condition of the first plaintiffs baby at birth.

CAUSATION

[9] The evidence of plaintiffs' witnesses poignantly sought to establish non-compliance with the Maternal Guidelines of 2007 as the negligent conduct that was causal to the injury that resulted in the cerebral palsied condition of the baby at birth. This, in my view, was a lost course in light of the common cause fact that it was a prolonged deprivation of blood supply to

the foetus or, put differently, the lack of the exchange of blood and oxygen between the mother and the foetus that ultimately caused the condition of M[....].

[10] For the alleged negligence to be causal, the plaintiffs have to prove two specific consecutive acts of omission on the part of the defendant' s employees , namely, the failure to foresee the advent of foetal deprivation of oxygen supply and to deliver the baby upon such foresight. The impossibility of such foresight was expressed by the Supreme Court of Appeal in *AN v MEC for health, Eastern Cape* (585 /2018) [2019] ZASCA 102 (15 August 2019) as follows:-

> "The test for factual causation is whether the act or omission of the defendant has been proved to have caused or materially contributed to the harm suffered. Where the defendant has negligently breached a legal duty and the -plaintiff has suffered harm, it must still be proved that the breach is what caused the harm suffered".

[11] There are dynamic principles of law involved, namely, a failure to strictly adhere to the Maternal Guidelines does not necessarily translate to negligence and, even it was, the plaintiffs in this case failed to prove that the omissions to strictly adhere to the guidelines caused the cerebral palsied condition of the first plaintiffs baby.

[12] Broadly speaking, there has to be foetal distress caused by the lack of oxygen supply to the foetus before the need for intervention by the defendant's staff could arise. The role of foetal heart-beat rate monitoring is to detect foetal distress as early as possible and, if foetal distress is detected, to carry out the quickest appropriate mode of delivering the baby to prevent further harm being inflicted on it.

[13] Having excluded the alleged negligence as the cause of the condition the baby was born with, I now consider whether there was negligence that could possibly have contributed to the severity of the injury resulting in the baby being born suffering from cerebral palsy. Hereunder I consider two aspects that, in my view, are key in the determination of the existence or

non-existence of contributory negligent conduct. This consideration is premised mainly on the common cause fact that cerebral palsy results from a prolonged infliction of injury to the foetus, more specifically to the foetal brain.

CONTRIBUTORY NEGLIGENCE

[14] I deem it necessary to traverse the timelines and the conditions that were prevailing at the time foetal distress was detected in order to determine the existence or absence of contributory negligent conduct.

TIMELINES AND THE IMPACT OF PREVAILING CONDITIONS

A. TIMELINES

[15] The undermentioned timelines appear to be noteworthy in this case and tend to address conflicting contentions of the parties.

15.1 It is common cause that the first plaintiff was 7cm dilated at 20h00 and was transferred to the labour ward where she was examined soon upon arrival and found to be 7 - 8cm dilated.

15.2 The first plaintiff's membranes ruptured at 20h40 and the draining fluid was clear. The parties agreed that this was a sign that the foetus was still in good condition at that stage.

15.3 There is no record of foetal heart-beat rate monitoring between 21h10 and 22h00.

15.4 at 22h08 the first sign of foetal distress was detected. There is evidence of a CTG tracing that ran from 22h08 to 22h30 that depicted a recurrent abnormality.

15.5 The medical officer in attendance examined the first plaintiff and the foetus and recorded, at 22h27, that there was foetal distress and directed a caesarean section in theatre. In the period before theatre, the medical officer directed the performance of an intra-partum resuscitation of the foetus.

B. THE PREVAILING CONDITIONS

[16] The evidence of two plaintiff expert witnesses, Profs Nolte and Theron was that the first plaintiff's cervix was fully dilated at 22h00 with the foetal head lying on the floor of the plaintiffs pelvis. Both these witnesses testified that the correct procedure at that stage was for the midwifes to carry out an assisted virginal delivery of the baby by means of obstetric fossils or a vacuum or the delivery of the baby via a caesarean section in theatre.

[17] Evidence presented showed that these options were not free of challenges at that time. The evidence of Prof Nolte was that it is not mandatory that midwifes have the skill to use assisted delivery instruments and that the relevant training in the use of these instruments falls in the radar of an advanced midwifery course. Assisted delivery was not carried out. Both Profs Nolte and Theron testified that the midwifes had been negligent in that regard. The possibility that the midwife(s) in charge lacked the skill to use instruments to effect assisted delivery of a baby cannot be discounted. The allegation of negligence is in the result untenable .

[18] Similarly with regard to the medical officer in attendance at the time, it was not addressed whether he had the skill in the use of obstetric instruments. There is, however, no doubt that assisted delivery using instruments entails the use of some degree of force to extract the foetus. The use of force, in my view, had the potential to cause further harm to an already compromised foetus and was not a viable option. The evidence of Prof Theron that the medical officer had been negligent in not calling a senior doctor to assist with instrument delivery of the baby is bold and does not factor in the possibility of a determined avoidance of the use of force on an already compromised foetus. The last avenue open was the carrying out of a caesarean section in theatre.

[19] The defence referred the court to a document, with no objection from the plaintiffs' counsel, as proof that the theatre had occupied at 22h00 until about 23h15 on the relevant night and that even then, there was a patient already booked for theatre before the first plaintiff. The first plaintiff gave birth virginally at 22h55, some 20 minutes before the theatre was to become available.

[20] The performance of an interim intervention, the intra-partum foetal resuscitation, had been indicated by the medical official and was confirmed as having been appropriate by Prof Nolte. There was no record that this process was carried out by the midwife(s). Prof Nolte testified that the failure to perform intra -partum resuscitation amounted to negligence.

[21] However, inter-partum resuscitation, according to Prof Nolte's evidence, entails the turning of the mother on either side to prevent contractions that cause the cut-off in the supply of oxygen to the foetus. Both Profs Theron and Nolte testified that the foetal head was already lodged and on the floor of the first plaintiff's pelvis. Whether it would have been appropriate to tum the first plaintiff to the side while the foetus was in the position described without causing it harm was a concern. Out of an abundance of caution, I referred to Google asking if it was safe to perform intra-partum foetal resuscitation at a time when the foetal head was lodge and lying on the floor of the mother's pelvis. The response was an emboldened capital letters NO, followed by an exposition of the harm that the process could cause to the foetus in that position. The evidence that the failure to perform intra-partum resuscitation of the baby constituted negligence is ousted by the impropriety of the procedure at the time and circumstances.

[22] It is common cause that the first plaintiff had been in the second stage of labour for a period of 55 minutes before giving birth. This was said to have been unusual by those experts of both sides who chose to comment on this occurrence. Prof Nolte testified that the first plaintiff was giving birth for the fourth time and should have given birth within the first thirty minutes of the second stage of labour. No evidence was led regarding the cause of and/or the impact the delay may have had on the foetus. In essence , the foetus spent 55 minutes with its head lying in the first plaintiffs pelvis or the foetus navigating *its* way through the birth canal. Prof Theron testified that the journey through the birth canal is the most challenging to the foetus. It is unlikely, therefore, that the lengthy delay would not have had an adverse impact on the already compromised foetus in this case.

FINDINGS

[23] A cut-off in the exchange of blood and oxygen between mother and foetus results in foetal deprivation of essential supplies . The foetus cannot thrive in that situation. A prolonged foetal deprivation of these supplies leads to a more severe condition of the baby at birth. The cause of the cut-off in the supply of blood and oxygen in this case is unknown. The majority experts of the plaintiff and all of the defendant's experts expressed the same view. There is no evidence establishing the alleged negligence, let alone that the negligence was the cause of the cut-off in the supply of blood and oxygen to the foetus. While strict non-compliance with the Maternal Guidelines, particularly between 20h40 and 22h00 has been established, there is no evidence to that it caused the condition the baby was suffering from at birth or the deprivation of the supply of oxygen to the foetus resulting in that condition.

[24] Each form of intervention ordinarily open to the medical staff from the time foetal distress was detected, faced insurmountable hurdles the medical staff of the defendant had no control over. I, consequently, conclude that there was no evidence to prove negligence that could possibly have contributed to the severity of the foetal injury that caused the cerebral palsy.

CONCLUSION

[25] The plaintiffs have not discharge the onus to prove negligence or that the negligence caused the condition of the baby at birth. I can neither find negligent conduct on the part of the defendant ' s employees that could have contributed to the severity of the foetal injury resulting in the cerebral palsy the baby was born suffering from.

ORDER

[26] In light of the findings in this judgment the following order is made;

1. The plaintiffs' claims are dismissed.

M. MBONGWE AJ

ACTING JUDGE OF THE HIGH COURT

GAUTENG LOCAL DIVISION, PRETORIA

APPEARANCES

Heard on:	**31 JULY 2020- 7 August 2020,**
	30 November 2020 and
	10 February 2021
For the Plaintiff:	Adv- G. J. Strydom SC
Instructed by:	Edeling van Niekerk Inc., Johannesburg.
For the Defendant:	Adv. DJ. Joubert SC
	With him: Adv. L. Adams
Instructed by:	State Attorney, Johannesburg

JUDGMENT ELECTRONICALLY TRANSMITTED ON ... **AUGUST 2021**