HIGH COURT OF SOUTH AFRICA
(GAUTENG DIVISION, PRETORIA)

CASE NO: 21353/2018

DELETE WHICHEVER IS NOT APPLICABLE
(1) REPORTABLE: NO
(2) OF INTEREST TO OTHER JUDGES: NO
(3) REVISED.
DATE 22 - 03 - 2022
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In the matter between:

M[....] , A[....] N[....] obo Plaintiff

M[....] , O[....]

and

MEC FOR HEALTH, GAUTENG PROVINCIAL GOVERNMENT Defendant

JUDGMENT

HR FOURIE, AJ

1. The plaintiff sues in both her personal capacity and in her representative capacity as the biological mother and natural guardian of the minor child, O[....] M[....] .

2. The plaintiff was admitted to the Thelle Mogoerana Hospital (then known as the Natalspruit Hospital) on 4 November 2012, for the birth of her child.

3. A female infant was delivered by caesarean section at midnight on 6 November 2012 and was found to have suffered a hypoxic ischemic injury. She suffers from spastic quadriplegic cerebral palsy which manifests in, *inter alia*, developmental delays, brain damage, intellectual disability and a history of epilepsy.

4. The plaintiff instituted a claim against the defendant for the recovery of damages suffered by her and the child as a result of the alleged negligent conduct of the medical practitioners and nursing staff, who were all in the employ of the defendant and who attended to the plaintiff when she was pregnant and in labour with the then unborn child, during the period 4 to 6 November 2012.

5. The defendant is cited in her nominal capacity and on the basis that she is vicariously liable for the conduct of her employees who performed their duties whilst within the course and scope of their employment.

6. The plaintiff alleges, *inter alia*, that the aforesaid employees were negligent in one or more of the following respects:

6.1. They failed to monitor the plaintiff and the foetus' condition properly;

6.2. The failed to monitor the plaintiff's contractions and to observe the foetal heartrate ("*FHR*") of the then unborn child every 30 minutes, or at all;

6.3. They failed to monitor and trace the plaintiff's contractions with a cardiotocograph ("*CTG*");

6.4. They failed to plot a partogram;

6.5. They failed to take precautions to guard against the occurrence of a foetal distress;

6.6. They failed to measure and assess the size of the plaintiff's pelvis;

6.7. They failed to perform a caesarean section operation immediately after observing signs of foetal distress and when the plaintiff's cervix was fully dilated.

7. The plaintiff alleges that these omissions by the defendant's employees constitute a breach of the legal duty they had towards the plaintiff and the child.

8. The defendant admits the legal duty of care owed by the doctors and nursing staff at the hospital to the plaintiff and child, and pleads that they rendered

reasonable care, treatment and advice under the circumstances. The defendant further denied any negligence and liability in her plea.

9. Save for the closing arguments which were presented in open court, the trial was conducted on a virtual platform.

10. At the commencement of the trial the issues of liability and quantum was separated in terms of Rule 33(4) and the matter proceeded on the issue of liability only. The quantum of the plaintiff's claims was postponed *sine die*.

The pre-trial conference:

11. At the second pre-trial conference conducted on 20 July 2021, the parties recorded the following issues as being common cause:

    11.1. The factual allegations to which I have made reference in paragraphs 1, 2, 3 and 5 above;

    11.2. During the plaintiff's admission and the period she remained at the hospital, the employees of the defendant owed her and the child a duty of care. There was an implied and/or tacit contract between the plaintiff and the defendant's employees that the labour/birth will be conducted according to reasonable acceptable standards and the defendant's guidelines or protocols in order to give birth to the child without any avoidable health conditions or complications occurring;

11.3. On her birth, the child was resuscitated by way of suctioning and bagging, amongst other things;

11.4. At delivery, there was meconium stained liquor present;

11.5. The Apgar scores recorded after resuscitation were 7/10 and 8/10;

11.6. The child's neurological impairments were caused by an intrapartum or peripartum event;[1]

11.7. The correctness of the recordings and medical findings in the hospital record (bundle C) is a matter for evidence by the experts and hospital staff who completed the record.

12. The issues that were recorded as remaining in dispute were the following:

12.1. The cerebral palsy suffered by the child is as a result of the negligent conduct of the defendant's employees;

12.2. The Apgar scores recorded at birth were not re-assuring or were not congruent with the condition of the baby after birth;

12.3. There was a diagnosis of poor progress of labour and presence of foetal distress;

12.4. The labour of the plaintiff was prolonged;

[1] Intrapartum meaning *occurring during the act of birth*, and peripartum meaning *occurring shortly before, during or immediately after giving birth*

12.5. The child was diagnosed with birth asphyxia during/after labour;

12.6. Hypoxic Ischemic Encephalopathy ("*HIE*") developed after the delivery; and

12.7. The labour of the plaintiff was conducted sub standardly.

Agreements between the experts as per the evidence:

13. During the course of the trial it transpired that the parties' respective experts were in agreement that:

13.1. the second stage of the plaintiff's labour was prolonged;

13.2. poor progress in labour was diagnosed due to cephalopelvic disproportion

13.3. birth asphyxia was diagnosed shortly after the birth, as was foetal distress;

13.4. HIE was diagnosed after the delivery.

13.5. The experts who testified in relation to the Apgar scores were in agreement that the scores were not congruent with the condition of the baby immediately after birth.

14. The issues in dispute were further limited by the concession made in the closing argument of counsel for the defendant, Ms. Montsho-Moloisane SC,

that the only issue to be determined by the court is causation. Prior thereto, the negligence of the defendant's employees was in dispute. It was now conceded that the failure of the medical staff to monitor the plaintiff and child in accordance with the criteria in the Guidelines for Maternity Care in South Africa (2007) ("*the Guidelines"*), was substandard conduct and admittedly negligent and wrongful.

The particulars of claim:

15. The plaintiff's particulars of claim is 21 pages long. It is a blatant exercise of an unselective "*copy and paste*". A number of allegations are unnecessarily repeated for no good reason and it is replete of allegations which simply did not relate to the plaintiff's case. By way of example, it is pleaded that:

15.1. The employees of the defendant failed to properly monitor the foetal growth[2] and to refer the plaintiff to a hospital for anti-natal sonar tests;[3]

15.2. The nursing staff failed to "*rupture her membranes"* under septic conditions;[4]

15.3. The plaintiff's request (for a caesarean section) was turned down and she was told that the delivery would be by natural although her previous delivery had been caesarean;

[2] see paragraph 15, read with 14.5
[3] see paragraph 15, read with 14.8
[4] see paragraph 14.9, read with 14.12

15.4. The new-born was placed in a caesarean ward instead of neonatal ICU.[5]

16. This renders the particulars of claim not only unnecessarily long and complicated but made it difficult for the court to understand the plaintiff's case and for the defendant to identify the case it actually had to meet. It is therefore perhaps not surprising that the defendant responded with little more than a bald denial.

The amendment:

17. In the defendant's closing argument, reference was for the first time made to an amendment of the plea to include reliance on a so-called sentinel event of cephalopelvic disproportion as a defence.

18. It transpired that:

18.1. The defendant had delivered a notice of intention to amend its plea on 13 July 2021;

18.2. At the pre-trial on 20 July 2021, it was recorded in paragraph 3, under the heading "*Nature of Defendant's Defence/Special Plea*", that "(*t)he defendant's initial defence of a bare denial has since been amended in terms of rule 28(1) notice, subsequent to which the amended pages were to be filed upon the expiry of the dies stipulated."*

[5] see paragraph 19, read with 18.1.21

18.3. The *dies* expired on 27 July 2021, without any objection by the plaintiff;

18.4. The defendant, however, did not effect the amendment in accordance with Rule 28(5).

19. Counsel for the defendant submitted that the recordal in the pre-trial minute was sufficient; that the subrule is permissive in that a party wishing to amend "*may*" effect the amendment by delivering the amended pages as contemplated in Rule 28(7), but that such a party is not obliged to do so in order for the amendment to become effective.

20. While Mr. Kunju, counsel for the plaintiff, submitted that there was no amendment, that the plaintiff had been entitled to assume that the defendant did not have the evidence to support the allegation and decided not to proceed with the amendment, he conceded that the envisaged defence had been dealt with in the evidence.

21. Counsel were both unable to refer me to the evidence relating to this "*sentinel event*". I did not understand it to be the defendant's case that once CPD was diagnosed, nothing could be done to avoid the injury to the foetus.

22. I ruled that the notice of intention to amend had lapsed due to the defendant's failure to effect the amendment, and that the purported amendment did not form part of the pleadings.

23. A party who is entitled to amend by virtue of the other party's failure to object, must effect the amendment in a manner prescribed in Rule 28(7). On expiry of the time afforded for objection, the party seeking the amendment acquires *the right* to amend, but the actual amendment of the pleading only takes place when the amendment is effected within the time stipulated by Rule 28(7).[6] Furthermore, there was no application made from the bar for an amendment of the plea in terms of Rule 28(10).

Issues in dispute:

24. In view of the admission of negligence and wrongful conduct on the part of the employees of the defendant, it follows that the question to be decided is whether the plaintiff has proven on a balance of probabilities that the negligent and wrongful conduct of the defendant's employees is causally linked to the harm suffered by the baby, in other words, the cerebral palsy. Stated differently, has the plaintiff established that injury suffered by the child could have been avoided if the employees had properly monitored the plaintiff and the foetus and had acted appropriately in relation to the results of such monitoring, and/or had the said employees performed a caesarean section operation timeously, and in any event immediately after observing signs of foetal distress.

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[6] See **Van Heerden v Van Heerden**, 1977 (3) SA 455 (W) at 457G-458A; **Fiat SA (Pty) Ltd v Bill Troskie Motors**, 1985 (1) SA 355 (O) at 358C; **Erasmus Superior Court Practice**, 2nd Ed, Van Loggerenberg, Vol 2, page D1-342

Evidence before the court:

The radiologists - joint minute:

25. The radiologists filed a joint minute wherein they recorded that:

25.1. The features of the MRI brain scans conducted of the child are in keeping with prolonged partial hypoxic ischemic brain injury in a term baby. This means a brain that was at least 37 weeks gestation up to two months after birth;

25.2. There is no evidence of congenital brain malformation;

25.3. The cause and probable timing of the hypoxic ischemic injury are deferred to the experts in the fields of neonatology and obstetrics.

Dr. Kamolane, radiologist on behalf of the defendant:

26. The defendant called Dr. Kamolane to testify in respect of limited issues and he explained how an HIE insult occurs. Importantly, his evidence was that the images of a brain exposed to a hypoxic insult, differ depending on whether the insult was of a partial prolonged nature, or of an acute nature.

27. Where there is a shortage of blood to maintain the entire brain, the body redirects the available quantity to the central part of the brain, the basal ganglia. This results in the outer white matter being starved of blood and

oxygen. When the blood flow is restored, the basal ganglia has remained normal while the injury affects only the white matter.

28. Where the brain requires a certain quantity of blood to function normally, and there is a decrease in the flow, so that only a part of the required quantity of blood and oxygen reaches the brain, the term "*partial*" is used. "*Prolonged*" means that the decreased supply of blood/oxygen to the brain persisted for an hour or more.[7] By contrast, when the HI injury is referred to as "*acute profound*", this normally suggests a sudden catastrophic event and if the event persists for 20 minutes or longer, it will be fatal to the foetus.

The obstetricians - joint minute:

29. The revised joint minute of the obstetricians, concluded subsequent to their receipt of the maternal records (bundle C), formed the basis of their evidence. The following is a summary of the common cause material facts:

29.1. The plaintiff was a 26 year-old in her first pregnancy, HIV positive (CD4 count of 133) for which she was being treated.

29.2. The plaintiff booked at the clinic at 26 weeks, attended antenatal clinic twice and was well during the pregnancy.

29.3. She attended the hospital on 4 November 2012 at 10h00 with abdominal pains and was assessed by nursing staff. It is noted that

[7] He qualified this to state that some people had pushed the time back to as little as 45 or 50 minutes. Dr. Mbokota's evidence was that 45 minutes would be sufficient time.

she was in the early latent phase of labour and that the FHR was normal. She is seen regularly during the day and is transferred to ward 17 (the "*lying in*" ward) at 17h00. The FHR is normal throughout and the last entry is at 21h00.

29.4. The next entry is at 10h00 on 5 November 2012 when she is having strong contractions. Although the apparent failure to have monitored the plaintiff is substandard care, it is not likely that this was related to causation.

29.5. At an unknown time she is assessed as being 5-6 cm dilated and draining clear liquor[8], having ruptured membranes at 04h00. She is to be transferred to the labour ward.

29.6. At 14h00 she is assessed to be 6cm dilated with a normal FHR of 142 beats per minute and still draining clear liquor.

29.7. She is assessed at 17h05 and has only progressed to 7cm. The FHR is between 134 and 137 bpm on the CTG.

29.8. At 19h30 she is fully dilated with a FHR 136 bpm and clear liquor.

29.9. The intrapartum care appears to be standard and there was no evidence of foetal distress during this period. She then starts to bear down.

[8] Amniotic fluid

29.10. At 20h40 she has made no progress and the doctor is called. The FHR is now 116 bpm

29.11. At 20h50 she is assessed by the doctor who diagnoses cephalopelvic disproportion ("*CPD*") and orders an emergency caesarean section. There is no record of the FHR or the nature of the liquor. Although the doctor gave instructions that CTG monitoring be commenced at 21h00, there are no CTG records.

29.12. The next entry is at 22h55 when she has now been moved to theatre. The FHR is recorded as "*132-90 b/m*".

29.13. The caesarean section is done at 00h00.

29.14. Apgar scores of 7 and 8 at 1 and 5 minutes are recorded. The liquor is thickly stained with meconium.

29.15. The indications given for the caesarean section are CPD and failure to progress in the second stage of labour.

29.16. The partogram has a single entry at 14h00 showing the 6cm dilation. There are a few CTG tracings, but the only ones of value are for the period 16h10 until about 17h00.

Dr. Wright, specialist obstetrician and gynaecologist on behalf of the plaintiff:

30. Dr. Wright testified as follows regarding the phases of labour:

30.1. the latent phase is the phase during which the dilation of the cervix is less than 4cm;

30.2. the active phase is when the cervix has dilated to more than 4cm, up until full dilation;

30.3. the active phase is, in turn, divided into a first and second stage. The first stage can take up to 8 hours, although it could be stretched to 12 hours, whereas the second stage should not take much longer than 45 minutes and at most 2 hours, provided that the FHR is continually monitored.

31. The purpose of the Maternity Guidelines for South Africa was highlighted as "…*it is significant to note the purpose of the Maternity Guidelines, which is inter alia to promote patient safety and better outcomes for mother and child in childbirth. They comprise 'the basic minimum that needs to be known by all professional nurses and doctors'. The aim by their use is to lower high maternal and perinatal morbidity and mortality rates and to improve the quality of care for women, their babies, and their families*."[9]

32. The Guidelines prescribe the degree of monitoring of the mother and foetus during labour:

32.1. During the latent phase, the FHR ought to be monitored every 2 hours and the mother examined every 4 hours.

[9] **AT on behalf of ST v MEC for the Department of Health, Eastern Cape Province**, (305/2018) [2021] ZAECBHC 37 (18 October 2021)

32.2. During the active phase, if the mother is considered to be low risk, she is to be examined every 2 hours and the FHR measured every half an hour. The liquor is also examined every two hours, if the membranes have ruptured. During the second stage of the active phase, the FHR is measured with every second contraction. The measurement is to be taken before, during and after contractions.

32.3. Should the mother become high risk, the monitoring must be continuous.

33. A prolonged labour puts the mother at high risk.

34. Common indicators of foetal distress are an abnormal FHR and meconium present in the liquor.

The partogram:

35. The partogram is a graphic representation of the mother's well-being during labour which is designed so that one can see what is happening from a single page. The partogram was not completed according to the Maternity Guidelines.

Foetal heart rate monitoring:

36. An abnormal FHR is detected by monitoring, either using a hand-held trumpet-like Doppler device, or by utilising a CTG that measures both the

uterine contractions and the FHR, and transfers the information electronically onto an external graph or tracing.

37. A heartrate of not less than 110 and not more than 160 beats per minute (*"bpm"*), falls within the parameters of the Guidelines. Variability is to be expected, however, a deceleration (a drop of more than 15 bpm) in the absence of a contraction, or a FHR that remains low or takes long to recover after a contraction, are both indicative of a problem.

38. When contractions occur, due to the increased pressure in the uterus the oxygen flow to the foetus via the placenta is inhibited. The foetus has a number of ways of coping with the deoxygenation, but due to the drop in the blood oxygen levels, there is a risk of hypoxia.

Poor progress in the second stage of labour:

39. The Guidelines provide in relation to poor progress in the active phase of labour, meaning that delivery has not occurred after 45 minutes of pushing, that where there is CPD, a caesarean section should be performed, and if foetal distress is found, a caesarean section should also be performed. Finally, the Guidelines direct that when foetal distress is suspected the mother is to be placed on her left side, administered oxygen and hydrated, and if she is fully dilated, the baby must be delivered immediately.

40. The main thrust of Dr. Wright's evidence was that the insult to the foetus occurred during the period between 20h50 and midnight, i.e after taking the decision to perform a caesarean section until delivery.

41. The decision to perform a caesarean section was taken at 20h50, but the baby was only delivered at 00h00, 3 hours and 10 minutes later.

42. The evidence was that the delay in performing the caesarean section, after having made the decision that it must be done on the grounds of a prolonged second stage and CPD, was unacceptable and substandard care and the foetus would probably have suffered hypoxia during this period, which would be reflected on an MRI as prolonged partial hypoxic insult, as was the case in this instance.

43. The Maternity Guidelines direct that a caesarean section should be performed within one hour of the decision to perform surgery.

44. Despite the diagnosis of CPD rendering the plaintiff and foetus high-risk and in need of continuous monitoring, in the course of that three hour period she was monitored only once.

45. Dr. Wright testified that the entry of "*132-90bpm"* indicates a highly significant drop in the FHR and indicates that the foetus was getting into trouble, in other words, foetal distress was developing.

46. Had the plaintiff been monitored as she should have been, the developing foetal distress would have been noted and action may have been taken,

either in a more rapid delivery of the baby or by providing intra-uterine resuscitation.

47. There is no indication that any IUR was initiated on the records. These steps are taken to assist the mother and the foetus and to improve the outcome of a foetus that is in trouble prior to delivery. These steps include turning the mother on her side, administering oxygen to the mother, re-hydrate the mother and stop the contractions as the foetus is exposed to hypoxia with each contraction.

48. At the delivery the foetal head was locked between the pelvic bones, and the delivery was described as "*difficult*" on the Summary of Labour record.

Dr. Mbokota, specialist obstetrician and gynaecologist on behalf of the defendant:

49. Dr. Mbokota did not consider the delay in performing the caesarean section to be causative of the hypoxic ischemic injury. His evidence was that:

49.1. the foetal condition with a FHR of 132 – 90 bpm was normal;

49.2. suppressing uterine activity in the second stage usually does not achieve anything except the side-effects of the tocolytic agents.

50. Dr. Mbokota was of the view that the difficulty in delivering the baby by way of caesarean section was the actual cause of the hypoxic ischemia.

51. Dr. Mbokota accepted that the foetal condition was normal at 22h55 because the FHR taken at that time (132bpm) was normal. During his evidence in chief it was clear that he had assumed that the FHR had been measured by CTG. Under cross examination, this assumption was shown to be ill-founded for two reasons. There is no reference made to a CTG in the clinical notes relating to this heartrate, and neither were there notes signed off, whether by the attending doctor who had interpreted the CTG or by anyone else. Even if the FHR had been ascertained manually, there is no indication whether the HR had been measured before, during or after a contraction, as stipulated by the Guidelines. His explanation for the reading of 90 bpm in cross-examination was that it is the baseline that must be within the accepted parameters and not the range (i.e. 132 and 90), is contradictory of his evidence in chief that the reading of 90bpm could refer to the mother's pulse.

52. In the final analysis, the experts' contradictory views of the meaning of the recording of 132 - 90 bpm, demonstrates that it not reliable to establish what the foetal condition was at 22h55. I can therefore not accept that as at 22h55, the condition of the foetus was normal, especially as there is no indication of how this heart rate was observed.

53. I also have difficulty in accepting Dr. Mbokota's proposition that the injury occurred due to the difficulty in delivering the baby by caesarean section. This proposition is supported solely by a note in the clinical records to the effect that the birth was "*difficult*" (as opposed to easy) and a further

comment that "*the head was descended and locked between the pelvic bone*".

54. Drs Wright and Mbokota further differed on the difficulty in delivering a baby whose head is stuck between the pelvic bones, and whether this process will cause hypoxic damage to such a baby.

55. There was no evidence of any traumatic injury to the baby as a result of the actual delivery, or how long it took to release the baby's head. This is accordingly speculative evidence without any substantial evidence to support such speculation. Furthermore, if the hypoxic damage was caused during the process to release the baby's head during the actual delivery, it would not be in keeping with the MRI reflecting a partial prolonged hypoxic injury which requires an extended period of hypoxia, but would probably reflect an acute hypoxic insult.

56. Dr. Mbokota was constrained to agree with the opinion of Dr. Wright that if the caesarean section had been performed within an hour (of the decision to perform such an operation), as per the Guidelines, it is probable that the injury would have been avoided and the outcome for the baby would have been different.

The paediatric neurologists, Drs. Keshave and Pierce:

57. Two paediatric neurologists testified, Dr. Keshave for the plaintiff and Dr. Pierce for the defendant. The purpose of their assessment of the child and

consequent reports was in the first place to determine her physical, neurological and developmental deficits. The experts were in agreement with the minor suffering from spastic quadriplegic cerebral palsy, which is supported by the MRI imaging. Furthermore, that there were no congenital disorders, genetic disorders, neurometabolic disorders or vasculopathies present, nor was there any intra-uterine infection.

58. Based on the child's medical records, the history obtained by the experts and their clinical examination, the child's condition is most likely the result of perinatal hypoxia, in other words, the lack of oxygen during labour and at the time of birth.

59. Dr. Pierce and Dr. Keshave disagreed on whether the birth anthropometry of the baby was within normal limits for gestational age, as Dr Pierce was of the opinion that it demonstrated asymmetrical intra-uterine growth restriction. This and the antenatal exposure of the unborn foetus to HIV, may have played a role in the resilience of the foetus with exposure to an insult, but deferred to the obstetricians in this regard.

60. Dr. Keshave opined that the condition of the child complied with JJ Volpe's criteria for neonatal encephalopathy:

60.1. Evidence of foetal distress or risk of hypoxic/ischaemia.

60.2. A need for resuscitation and low Apgar scores. Although the scores were normal, the presence of cyanosis an hour after birth*, inter alia*, indicated the Apgar scores were not documented correctly.

60.3. An overt neurological syndrome in the first 24 hours of life. The presence of seizures, hypotonia and decreased movements place the child in the mild to moderate category.

61. Her condition fulfilled most though not all the criteria set by the American Academy of Obstetrics and Gynaecology to determine HIE in a new born.

62. Dr. Pierce accepted that the child's history and clinical records are in keeping with grade 2 encephalopathy.

63. To determine what caused that neonatal encephalopathy, Dr. Pierce considered the hypoxic ischemic encephalopathy to be the most likely cause, based on the information given to her and the MRI.

64. Dr. Keshave concluded that the most likely cause for the child's clinical presentation is perinatal asphyxia (a lack of oxygen at birth), which accords with MRI scan and the clinical diagnosis of cerebral palsy.

The paediatric neonatologists/paediatricians:

Dr. Mathiva, paediatric neonatologist on behalf of the defendant:

65. Dr. Mathiva testified on behalf of the defendant. She testified regarding the care of the baby from her admission to the neonatal ward after birth, until her discharge 10 days later.

66. According to the medical records, the reason for the admission to the neonatal ward was foetal distress. She was slightly cyanosed on her admission at 01h25. She was given nasal cannular oxygen. There were further reports of mild/slight respiratory distress. Fits were observed for the first time at 09h10 on 7 November 2012. She was treated appropriately for this. Her vital signs were normal, blood sugar and blood gas tests showed normal results.

67. In her evidence she agreed that while the Apgar scores indicated a healthy, normal baby, these scores were not consistent with the condition of the baby at birth. Dr. Mathiva noted that the tests for blood gasses were conducted on the second day only, and should have been done an hour after the birth in order to best manage the baby. However, whatever steps had been taken, seemed to have improved the condition and normalised the blood acidity. Amongst other reasons, a hypoxic insult can cause a baby to have seizures.

68. In her opinion, the history and clinical presentation in the immediate post-delivery period suggest that a hypoxic ischemic event occurred, but she is unable to determine when. The child showed early signs of neonatal encephalopathy post-delivery and thus her neurological developmental problems are likely or possibly related to a hypoxic ischemic insult.

Dr. Kara, paediatrician on behalf of the plaintiff:

69. Dr. Kara concluded that the cerebral palsy as seen in the minor child was probably caused by a prolonged partial hypoxic ischaemic injury noted on the MRI scan.

70. There is adequate evidence to confirm that the baby suffered from an encephalopathy at birth, including convulsions within the first 24 hours.

71. The only apparent cause of the encephalopathy was the prolonged partial hypoxic ischaemia seen on the MRI. This is supported by the records that reflect a prolonged second stage of labour, CPD, an emergency caesarean section and foetal distress and meconium liquor.

72. The baby was not growth restricted, excluding placental insufficiency, no reason to suspect intra-uterine infection, no evidence of congenital brain or vascular abnormality or metabolic disease. It was highly unlikely that the cause preceded labour as there was no concern over the foetal condition when the mother presented in labour and the probability of an antenatal injury giving rise to HIE is extremely low. Dr. Kara excluded a post-natal injury, unrelated to birth events, because the baby was already not born well. The baby did not cry, had to be ventilated after birth by suctioning and bagging, which indicates that the Apgar scores were not correct.

73. Dr. Kara's view that the HIE-injury occurred intrapartum was based on the records and the various literature referred to in his report, according to which

HIE is predominantly caused during the labour, when contractions can impair oxygen and blood supply to the foetal brain.

74. The combination of the factors already referred to as well as the admission and discharge diagnosis of HIE / birth asphyxia, make it probable that the cerebral injury occurred during the labour. The nature of the cerebral palsy suffered by the child, does not make an intrapartum HIE injury unlikely.

Dr. Kganane, paediatric intensivist on behalf of the defendant:

75. Dr. Kganane's evidence did not assist the court in view of the following:

75.1 Dr. Kganane obtained the minor child's history from the plaintiff and had examined the child, but she testified that the medical records she had received were incomplete. Dr. Kganane never received the additional documents that became available in 2020, upon which the other experts had either supplemented or completed their reports. It is evident from the joint minute that most of her disagreements with the propositions posed by Dr. Kara, were based on her not having been in possession of the same facts.

75.2 The proposition put forward by Dr Kganane – namely that the more likely cause of the cerebral palsy was congenital infection, is excluded by the agreement reached in paragraph 2.9 of the second pre-trial minute that the child's *"neurological impairments were caused by the intrapartum or peri-partum event"*.

The plaintiff's evidence:

76. The plaintiff's evidence lacked detail and was not really aligned to the clinical records. She maintained that the baby was born on the third night that she was in the hospital; that seven hours elapsed from her being sent from the labour ward to theatre; that she was given a general anaesthetic and was unconscious when the child was born, while the records reflected that she had been administered an epidural. She however steadfastly maintained that she was not monitored by way of CTG or otherwise.

77. The plaintiff's evidence of an absence of monitoring, is supported by the hospital records, which likewise indicate an absence of adequate monitoring of either the plaintiff or the foetus.

78. The proper test for evaluating a witness' testimony is not whether a witness is truthful or indeed reliable in all that she says, but whether on a balance of probabilities, the essential features of the story which she tells are true.[10] When her evidence is tested against the common cause facts and the inherent probabilities, it cannot be rejected.

79. The plaintiff's evidence regarding the pain she endured in the course of her hospitalisation, and the emotional pain and anguish that raising the child causes her, were not disputed. She has had to stop working to devote all her time to care for the child.

[10] **Santam Bpk v Biddulph,** 2004 (5) SA 586 (SCA) paras 10 and 13

Discussion:

80. Three possible causes of the brain damage in issue are:

80.1. unmonitored and uncontrolled contractions and the effect thereof on the foetus;

80.2. the failure to stop such contractions at the time the decision was taken to perform a caesarean section until it was done; and

80.3. the failure to perform the emergency caesarean section within an hour from the time that decision was taken, without any explanation as to why it was not done.

81. It is trite that in order to succeed in her claim for damages, the plaintiff must establish that the wrongful and negligent conduct of the defendant's employees, acting within the course and scope of their employment, caused her harm.

82. The following useful summary of the approach to such matters was provided by Cameron J, albeit writing for the minority, in **Oppelt v Department of Health, Western Cape**:[11]

"[*106] In our law Kruger (v Coetzee*[12]*) embodies the classic test. There are two steps. The first is foreseeability - would a reasonable person in the position of the defendant foresee the reasonable possibility of injuring*

[11] 2016 (1) SA 325 (CC)
[12] 1966 (2) SA 428(A) at 430

another and causing loss? The second is preventability - would that person take reasonable steps to guard against the injury happening?

[107] The key point is that negligence must be evaluated in light of all the circumstances. And, because the test is defendantspecific ('in the position of the defendant'), the standard is upgraded for medical professionals. The question, for them, is whether a reasonable medical professional would have foreseen the damage and taken steps to avoid it. In Mitchell v Dixon[13] the then Appellate Division noted that this standard does not expect the impossible of medical personnel: 'A medical practitioner is not expected to bring to bear upon the case entrusted to him the highest *possible degree of professional skill, but he is bound to employ reasonable skill and care; and he is liable for the consequences if he does not'.*

[108] This means that we must not ask: what would exceptionally competent and exceptionally knowledgeable doctors have done? We must ask: 'what can be expected of the ordinary or average doctor in view of the general level of knowledge, ability, experience, skill and diligence possessed and exercised by the profession, bearing in mind that the doctor is a human being and not a machine and that no human being is infallible. Practically, we must also ask: was the medical professional's approach consistent with a reasonable and responsible body of medical

[13] 1924 AD 519

opinion? This test always depends on the facts. With a medical specialist, the standard is that of the reasonable specialist."

83. Although the plaintiff's claim does not relate to a particular specialist, but to unidentified employees of the respondent including nurses, midwives and doctors, the degree of expertise to be expected from them will in each instance depend on the role of each one. See **Member of the Executive Council for Health, Eastern Cape v DL obo AL:**[14]

"… *Health professionals such as doctors and nurses are required to dispense reasonable care by adhering to the level of skill and diligence exercised by members of their profession, failing which they would be negligent. In the circumstances of this case, the hospital staff who attended to the respondent will be found to have been negligent if, in dispensing medical care to the respondent, they failed to foresee the possibility of harm occurring in circumstances where similarly qualified health professionals in the same position would have reasonably foreseen this possibility and would have taken steps to prevent it*."

84. The negligence and the wrongfulness of the conduct of the employees of the defendant in failing to monitor the plaintiff and the child is no longer in issue.

85. The Guidelines clearly and unequivocally prescribe that a caesarean section is to be performed where there is CPD and if foetal distress is found. The Guidelines also provide that the health care providers must ensure that the

[14] 117/2020 (2021) ZASCA 68 (3 June 2021) at para. [8]

caesarean section can be performed within one hour of the decision to operate.

86. The reason for this is obvious. As explained by Dr. Mbokota, "*Because cephalopelvic disproportion means that there is a misfit between the baby's presenting part and the mother's pelvis and therefore the baby will not come out and the only way to get the baby out is by caesarean section to avoid a few things. One, damage to the mother and also continuing with the labour that would then, may result in hypoxia to the baby*."

87. A caesarean section was ordered when a prolonged second stage of labour was diagnosed. The prolonged second stage was due to CPD. The delay in delivering the child required closer monitoring of the plaintiff and the foetus, which the defendant has admitted was not done, and further that such failure was both negligent and wrongful.

88. It is clear from the evidence of the experts, as well as the Guidelines, that foetal distress can be detected by monitoring the foetal heart rate. Once there are indications of foetal distress, the nurses and midwives must expedite the baby's delivery to eliminate the eventuation of harm. It follows that if neither the mother nor the foetal heartrate are monitored, the distress will not be noticed.

89. As stated in **AT obo ST v MEC for the Department of Health, Eastern Cape Province**,[15] "*the effect of inadequate monitoring is that there is an increased probability of adverse outcome in relation to undiagnosed fetal hypoxia which without intervention will result in fetal injury."*

90. The defendant led no evidence to explain the reason for the delay in performing the caesarean section, let alone the failure to take any steps to reduce the plaintiff's contractions accompanying her state of full dilation, or the resuscitation of the foetus as provided for in the Guidelines.

91. The delay in expediting the delivery of the baby at the time having regard to the evidence before me, was both negligent and wrongful.

92. The question is whether there was a causal link between the failure of the defendant's employees to monitor the plaintiff and the foetus, and to manage her labour and the caesarean section, in accordance with the Guidelines, on the one hand, and the child's brain damage which led to the cerebral palsy, on the other.

93. "*It is trite that where the defendant has negligently breached a legal duty and the plaintiff has suffered harm, it must still be proved that the said negligence caused the harm suffered. It is well-established that causation has two elements, namely: (i) the factual issue, the answer to which can be determined by applying the 'but for' test; and (ii) legal causation, which*

[15] (305/2018) [2021] ZAECBHC 37 (18 October 2021)

answers the question whether the wrongful act is linked sufficiently closely to the harm suffered; if the harm is too remote, then there is no liability."[16]

94. It is apposite to refer to **AN obo EN**,[17] upon which the defendant relied, in relation to causality:

> *"In Minister of Safety and Security v Van Duivenboden, this court 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, which 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. In Minister of Finance & others v Gore NO this court aptly held that the application of the 'but-for' test is not based on mathematics, pure science or philosophy. Rather, it is a matter of common sense, based on the practical way in which the ordinary person's mind works against the background of everyday life experiences. The flexible approach reflected in the above judgments was adopted by the Constitutional Court in Lee."*[18]

95. Ms. Montsho-Moloisane seemed to rely on the finding in **AN obo EN** *supra*, that the substandard foetal monitoring was not the cause of the brain damage suffered by the appellant's child, as support for the defendant's defence of *this* claim. It was held therein that even if there had been adequate foetal monitoring, the harm would still have ensued.

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[16] **HAL v obo MML v MEC for Health, Free State,** 2021 JDR 2607 (SCA) at para. [147]
[17] **AN v MEC for Health, Eastern Cape**, (585/2018) [2019] ZASCA 102 (15 August 2019)
[18] At para. [48]

96. The facts in that case do not assist the defendant. In **AN obo EN**, the baby suffered an acute severe hypoxic ischaemic insult at the end of the appellant's labour. The appellant was unable to prove that there was warning of the sentinel event that caused the damage, or that there would have been sufficient time to deliver the baby so as to avoid the damage.

97. It was further submitted on behalf of the defendant, that even if the nursing staff and the medical practitioners had monitored the plaintiff in accordance with the Guidelines, the second stage of labour would still have been prolonged due to the presence of CPD. It is not the plaintiff's case that the injury was due to either the prolonged second stage of labour or the CPD, but due to the failure to manage the labour and act appropriately upon the diagnosis of CPD. Healthy babies are born where mothers have CPD, the difference is in the management.

98. Reliance is also placed on the facts in **Member of the Executive Council for Health, Eastern Cape v DL obo AL.**[19] In that matter, the defendant had failed to perform the caesarean section within an hour and the plaintiff still had to prove on a balance of probabilities that that caused the harm. The plaintiff failed to do so.

99. The facts in **DL obo AL** do not correspond to the facts *in casu*. The brain injury was found to be due to an acute profound hypoxic ischaemic insult. The Court found that the plaintiff did not prove that had the baby been delivered within 60 minutes, rather than 86 minutes, the injury would have

[19] (117/2020) [2021] ZASCA 68 (03 June 2021), paras. 29-30

been avoided. In any event, the defendant therein could account for the passage of time, which the defendant did not attempt to do here.

Conclusion:

100. Having considered the whole of the evidence of the experts referred to above, I find that the plaintiff has demonstrated that the delay in performing the caesarean section, linked to the lack of monitoring and absence of action to improve the condition of the baby, were causative of the partial prolonged hypoxic ischaemic insult suffered by the child. The medical evidence presented is sufficient to show on a balance of probabilities that the child presented with neonatal hypoxic ischaemic encephalopathy which was the gateway for the development of the cerebral palsy from which the minor child suffers.

The costs:

101. Both parties' counsel complained about the conduct of one another in causing unnecessary costs. While the defendant made important concessions at the eleventh hour, the plaintiff's case was not pleaded in a manner intended to limit the issues, as I have pointed out. The plaintiff's counsel was absent on the second day of the trial, due to a commitment in the Constitutional Court which had not been timeously disclosed to his opponent. When considered as a whole, I cannot find that the conduct of either litigant warrants a special costs order.

Order:

102. In the result, I make the following order:

102.1. The defendant is liable to the plaintiff for 100% of the damages suffered in her personal and representative capacities as a result of the treatment by the defendant's employees at the Thelle Mogoerane Regional (Natalspruit) Hospital, of the plaintiff and her minor child born on 6 November 2012.

102.2. The defendant shall pay the plaintiff's taxed or agreed costs of suit incurred to date on the High Court scale, such costs to include:

102.2.1. The costs of all reports, addendums, preparation of joint minutes and qualifying expenses (where incurred) of the plaintiff's expert witnesses of whom notices in terms of rule 36 have been filed.

102.2.2. The costs of two counsel where so employed, including their travelling and accommodation expenses.

102.2.3. The accommodation and transportation costs incurred by the plaintiff in this matter.

102.2.4. Costs incurred by the plaintiff in respect of consultation with experts, preparation for trial and the hearing of the matter.

102.2.5. Costs associated with the virtual hearing, incurred by the plaintiff.

102.2.6. The costs for the production of the transcription of the Court proceedings.

HR FOURIE, AJ
Acting Judge of the High Court
Gauteng Division, Pretoria

Dates of Hearing: 8, 10 - 12, 15 - 18 November 2021, 14 January 2022

Judgment delivered: 23 March 2022

APPEARANCES:

For the plaintiff: Adv. V. Kunju
Adv. C. Gqetywa (on 14 January 2022)
Instructed by:
Ndebele Msuthu Inc.

For the defendant: Adv. L. Montsho-Moloisane SC
Adv. K.B. Bokaba
Instructed by:
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