IN THE HIGH COURT OF SOUTH AFRICA
(GAUTENG DIVISION, PRETORIA)
REPUBLIC OF SOUTH AFRICA

CASE NO: 32412/2020

REPORTABLE: **NO**
OF INTEREST TO OTHER JUDGES: **NO**
REVISED: **YES**
DATE: **02 JUNE 2022**

In the matter between:

N[....] S[....] obo Plaintiff
A[....] S[....]

and

THE MEC FOR HEALTH
GAUTENG PROVINCIAL GOVERNMENT Defendant

JUDGMENT

JANSE VAN NIEUWENHUIZEN J:

1. This action emanates from the birth of A[....] S[....] on 18 December 2008 at the Far Rand East Hospital ("the hospital"), Gauteng. What should have been a joyful event for the plaintiff ended in tragedy for both A[....] and the plaintiff.

2. As a result, the plaintiff instituted action against the defendant based on the alleged negligence of the nursing staff who attended to the birth. A[....] suffered

severe brain damage during the birth.

3. At the inception of the trial, I was informed by the parties that they have agreed on the separation of the merits and quantum of the plaintiff's claim. I issued a separation order and the trial only proceeded in respect of the merits of the plaintiff's claim.

DISPUTE

4. The defendant accepted that its nursing staff had a duty of care towards the plaintiff and A[....]. Vicarious liability and wrongfulness are as a result not in dispute.

5. The defendant, however, denied that its nursing staff was negligent. As a result, the question of negligence and whether there is a casual connection between the alleged negligence and the damages suffered by A[....] remained in dispute.

FACTUAL MATRIX

6. The events preceding A[....]'s birth are common cause between the parties.

7. The plaintiff had a normal pregnancy and on all accounts, A[....] was a fit and healthy fetus. On 18 December 2015, the plaintiff experienced labour pains at approximately 11:00 and was admitted at the hospital at 13:30.

8. The progress of the plaintiff's labour was monitored and at 21:15 A[....] was delivered vaginally.

9. A[....] was, however, not a healthy baby and required active resuscitation (manual bag-mask breathing assistance) after birth because he exhibited delayed respiratory adaptation. His recorded Apgar scores were therefore 'assisted-by-resuscitation' scores. A[....] was admitted on oxygen after birth.

10. A[....]'s clinical presentation during the neonatal period was in keeping with a Sarnat Grading of Hypoxic Ischaemic Encephalopathy (HIE) Score of 2, evidenced

by the following clinical features: he had a depressed level of consciousness, seizures and poor primitive reflexes.

11. In addition to neonatal encephalopathy, A[....] exhibited transient kidney dysfunction, also in keeping with intrapartum sustained asphyxia.

12. His full blood count result was initially recorded as normal but was thereafter corrected for the presence of nucleated red blood cells. A[....]'s nucleated red blood cell count (NRBC) was 11/100 WBC, which was slightly raised (Normal is < 10 NRBs/100 WBCs).

13. The question then arises what caused a seemingly healthy fetus to be born with severe brain damage.

THE CAUSE

14. The cause for A[....]'s brain injury is also common cause between the parties, to wit:

14.1 A[....]'s intrapartum care during admission, the latent phase of labour and the active phase of labour, including during the second stage of labour, was of a substandard nature;

14.2 A[....]'s severe brain injury was caused by an intrapartum hypoxic-ischemic brain injury and possible postnatal (neonatal) hypoglycaemia;

14.3 the MRI brain scan demonstrates the injury pattern as a mixed pattern of prolonged partial hypoxic injury with features of a more profound terminal hypotensive insult.

15. Although the cause of A[....]'s brain injury is common cause between the parties, the question of negligence is not. The defendant alleges that there was nothing the nursing staff could do to prevent the brain injury from occurring.

NEGLIGENCE

16. In view of the common cause facts, the negligence of the nursing staff revolves around the question of when the nursing staff should have taken the first steps to prevent the eventual brain injury.

17. To answer this question, the parties engaged the services of various experts. Joint minutes of the experts of the same discipline were introduced into evidence and certain of the expert witnesses testified in the trial. In view of the fact that the nursing staff attended to the plaintiff during labour, I propose to first of all deal with the contents of the joint minute between the registered nurses and midwives, to wit Ms Fletcher on behalf of the plaintiff and Ms Muthelo on behalf of the defendant.

Joint minutes between registered nurses and midwives

18. Ms Fletcher and Ms Muthelo agreed, *inter alia*, as follows:

> 18.1 Monitoring during the latent phase of labour was substandard according to the Guidelines for Maternity Care in South Africa (2007) ("the Guidelines") as follows:
>
> > 18.1.1 the first vital signs were monitored during admission at 13:50, however, the readings were not recorded. The second monitoring was only done at 19:00 which is 5 hours apart instead of 4 hours as required;
> >
> > 18.1.2 a vaginal examination was not performed 4-hourly as required (it was done at 13:50 when the cervix was 2cm dilated and then again at 19:00 when the cervix was 9cm dilated). This resulted in missing the onset of the active phase of labour and therefore the omission to monitor the foetal heart rate half-hourly as is required during the active phase of labour;

18.1.3 the foetal heart rate was not monitored as required. While the foetal heart rate was within normal parameters at 13:50 (150 – 160 bpm) and 14:00 (156 bpm), it was close to the upper border of being normal (150-160 bpm) and in the circumstances required either continued monitoring (it was monitored for only 10 minutes) or follow-up regular monitoring thereafter. In this case, the second Cardiotocography (CTG) monitoring was only done at 19:00, 5 hours late. Additionally, there is no evidence that the foetal heart rate was monitored before and immediately after contractions as required.

18.1.4 by the time the foetal heart rate was monitored on CTG at 19:00 (during the active phase of labour), variability was minimal and there were no accelerations, in other words it was non-reactive.

18.2 Monitoring and care during the active phase of labour (from 4cm to full dilation of the cervix) was substandard according to the Guidelines as follows:

18.2.1 the foetal heart rate was not monitored half-hourly (or before and immediately after contractions) as required. The foetal heart rate was only assessed at 19:00 and 20:00;

18.2.2 the CTG Tracing at 19:00 was recorded as 120-150 bpm. The available tracing itself demonstrates minimal variability and was non-reactive. This should have prompted the nurses to request an assessment by a medical practitioner. The nurses, however, failed to do so.

18.2.3 the CTG tracing at 20:00 (160-170bpm) was pathological and immediate medical assistance should have been summoned. There is no evidence in the records that a medical practitioner was notified of the foetal distress or of any other interventions (such as intrapartum resuscitation) done by the midwife to respond to the abnormality, as required.

18.3 The Partogram should be started when active labour (4cm dilation) commence and all findings should be plotted on the Partogram. In this case the Partogram only commenced at 19:00 when the cervix was already 9cm dilated. Because a vaginal examination was done at 13:30 and not again at 19:00 (5 hours 30 minutes later), the beginning of the active phase of labour was missed and the Partogram was started late.

18.4 Assessment and intervention during the second stage of labour (from full dilation until the completion of delivery of the fetus) was substandard according to the Guidelines as follows:

18.4.1 there was no evidence of monitoring of the foetal heart rate after every second contraction once the mother started bearing down;

18.4.2 according to the Partogram, the cervix was fully dilated at 20:00 and the baby was delivered at 21:15;

18.4.3 although the record does not state when bearing down started, records indicate that the mother was a "bad pusher";

18.4.4 despite the prolonged second stage and the foetal distress that was present, there is no evidence that assistance from a medical practitioner was requested.

Dr Sevenster

19. Dr Sevenster, an obstetrician and gynaecologist testified on behalf of the plaintiff.

20. In his evidence read with the summary of his evidence, Dr Sevenster confirmed that the medical records indicate that the plaintiff was in the latent phase of the first stage of labour when she was admitted to hospital.

21. Dr Sevenster explained that foetal heart rate monitoring is important to establish the wellbeing of the foetus. More importantly, foetal heart rate monitoring should be done prior to and immediately after contradictions to determine the effect of the reduced oxygen flow during contractions to the foetus.

22. A non-reactive result is an indication of a distressed fetus and the cause of the distress should immediately be determined and addressed. Foetal distress is routinely observed and with the necessary intervention damage to the fetus is minimised or in most cases rectified with a positive outcome.

23. Dr Sevenster explained that according to the Guidelines for Maternity Care in South Africa 2007 ("the Guidelines"), the following monitoring should be done during the latent phase of the first stage of labour:

23.1 maternal blood pressure, pulse rate and temperature must be monitored 4 hourly;

23.2 uterine contractions and foetal heart rate must be monitored 2 hourly;

23.3 vaginal examination for cervical dilation must be performed 4 hourly.

24. The CTG for 14:00 with a tracing from around 13:50 to 14:15, revealed, *inter alia*, the following:

24.1 the paper speed was 1cm/minute;

24.2 the baseline heart rate was approximately 150 beats per minute ("bpm");

24.3 there are two episodes of accelerations where the heart rate was just above 160 bpm for just over 30 seconds;

24.4 there is one acceleration where the foetal heart rate ("FHR") was just above 160bpm for just under 30 seconds;

24.5 variability acceptable; and

24.6 two decelerations occurred to 110 – 120 bpm, but Dr Sevenster could not comment on it as no contractions were registered.

25. Having regard to the aforesaid, Dr Sevenster stated that the tracing was normal, but with the mentioned accelerations and no context regarding the decelerations and uterine contractions, it would in his opinion, have been reasonable to continue with CTG monitoring for a longer period or the FHR should have been followed up with another CTG within 30 minutes. If the accelerations (above 160 bpm) continued, action should have been taken.

26. According to the Guidelines, the uterine contractions and FHR should have been monitored at 16:00. This did, however, not occur.

27. The next recording was only done at 18:00 and reflected mild contractions with a FHR of 150 bpm.

28. At 19:00 the Partogram was commenced and the first examination and monitoring during the active phase of labour was performed. At the time the plaintiff was already 9 cm dilated.

29. The CTG tracing at 19:00 revealed the following:

29.1 the paper speed was 3cm/minute, which Dr Sevenster considered not to be the usual speed, but still acceptable;

29.2 FHR is 120-150 bpm;

29.3 minimal variability is present. Variability in the FHR is important because it indicates the variation in the foetal heart rate from one beat to another and the result between the interaction of the central nervous system, barro- receptors, chemo-receptors and cardiac responsiveness;

29.4 no accelerations or decelerations;

29.5 the FHR was recorded as reactive which is incorrect as the FHR pattern was non-reactive with reduced variability and a significant change in the baseline.

30. In respect of the variability of the FHR at 19:00, Dr Sevenster opined that the tracing should have been a cause for concern. Variability is a fluctuation in FHR of more than two cycles per minute. Minimal variability, as in A[....]'s case, is variability of less than five cycles per minute.

31. The minimum variability was a significant sign of intrapartum foetal compromise (probably hypoxia) and was an indication that intra-uterine resuscitation (IUR) should be performed and that a doctor should be notified to assess the labour for expedited delivery.

32. The minimal variability was not recognised by the nursing staff and nothing was done.

33. Things sadly did not improve for A[....]. Dr Sevenster remarked as follows in respect of the CTG tracing that was done from 20:00 to 20:20:

33.1 paper speed not visible;

33.2 FHR 170 – 180 bpm which indicates foetal tachycardia;

33.3 minimum variability.

34. Dr Sevenster opined that foetal tachycardia when associated with loss of or poor viability is a sign of intrapartum foetal distress. The most probable cause for foetal tachycardia in the prevailing circumstances is foetal hypoxia.

35. The result of the above findings is that the FHR was pathological at 20:00 and

delivery should have been expedited as a matter of urgency. Due to the substandard care, the plaintiff was in labour for another hour and 15 minutes, which, according to Dr Sevenster, probably resulted in the final insult and injury to the perirolandic, basal ganglia-thalamus.

Professor Lotz

36. Professor Lotz, a radiologist testified next. Professor Lotz was referred to the joint minutes he compiled with Dr Kamolane, the defendant's radiologist. Professor Lotz confirmed that they had regard to a MRI scan of A[....] which was done on 10 March 2020 and stated that their joint opinion is one of a mixed pattern of prolonged partial hypoxic-ischemic injury with, in addition features of a more profound terminal hypotensive insult.

37. Professor Lotz with reference to the MRI scan pointed to the peripheral white matter loss in the brain. Professor Lotz explained that when a lack of oxygen occurs during labour, the foetus will first of all shut down oxygen to the non-vital organs such as the kidney, liver and lungs.

38. The brain is the last organ that will be deprived of oxygen and the peripheral white matter loss on the MRI confirms a prolonged period of oxygen loss.

Professor Smith

39. Lastly Professor Smith, a specialist neonatologist testified on behalf of the plaintiff. The relevance of Professor Smith's evidence read with the joint minute between Professor Smith and Dr Kganane, a paediatrician/intensivist, is the probable duration of the hypoxia prior to A[....]'s birth.

40. The experts agreed that A[....] suffered probable birth asphyxia, required resuscitation and then developed an early onset neonatal encephalopathy of a moderate degree. In addition to the neonatal encephalopathy, A[....] exhibited transient kidney dysfunction, which is collectively in keeping with intrapartam sustained asphyxia.

41. Furthermore, A[....]'s slightly raised nucleated red blood cell and platelet count (NRBC) of 11 NCRBs/100WBCs, normal being < 10/NRBCs /100 WBCs indicates acute hypoxia that lasted between 4 – 6 hours.

42. This concluded the evidence on behalf of the plaintiff.

Dr Mbokota

43. The defendant's first witness was Dr Mbokota, a specialist obstetrician and gynaecologist. Dr Mbokota's evidence differed substantially from that of Dr Sevenster and the registered nurses and midwives.

44. Dr Mbokota's evidence accorded with his medico-legal report. In paragraph 8 of the report Dr Mbokota came to the following conclusion:

> *"8.10 Except for assessing the progress of labour after 5-hours instead of 4-hours and fetal condition 2-hourly, there is no other identifiable area of substandard care in the latent phase of labour.*
>
> *8.10.1. Despite this, the fetal condition was normal when it was assessed in the active phase of labour.*
>
> *8.11 In the active phase of labour, the fetal condition was not documented every ½ hour but the last assessed fetal condition 15 minutes prior to delivery was normal with clear liquid and no fetal heart abnormalities were detected.*
>
> *8.12 The outcome of the fetus is unlikely to have been due to activities in the first stage of labour and the absence of fetal compromise or meconium-stained liquor confirms this; but most likely in the second stage of labour during the bearing down period which necessitated expediting delivery by fundal pressure.*
>
> *8.13 It is also highly probable that ANC* [Ante-natal care] *factors played a*

huge role in this case could have been ante-natal as she booked late, was HIV positive and was probably on ARV's prior to being pregnant.

8.14 This outcome could not have been prevented by the staff at the hospital as brain injury occurred prior to labour or late in the second stage of labour."

45. It became apparent during cross-examination that Dr Mbokota was unaware of the findings of the other expert witnesses.

46. Firstly and based on the opinions of the other expert witnesses, it is common cause between the parties that A[....]'s brain injury is not attributable to his ante- natal care. In other words the brain injury did not occur prior to labour.

47. Secondly, the fact that the specialist neonatologist and the pediatrician/intensivist agreed that the acute hypoxia lasted between 4 – 6 hours, does not accord with Dr Mbokota's opinion that foetal distress only commenced in the second stage of labour during the bearing down period.

48. Faced with the aforesaid medical opinions, Dr Mbokota conceded the possibility that A[....]'s brain injury could have been caused by intrapartum sustained asphyxia.

Dr Kamolane

49. Dr Kamolane, the radiologist on behalf of the defendant testified next. Dr Kamolane stated that it is extremely difficult for a radiologist, who has only studied the MRI scan of a 12 year old, to estimate the duration of the lack of oxygen to the brain of the child during birth.

DISCUSSION

50. In view of the aforesaid evidence it is apposite to have regard to the test applicable to medical negligence.

51. In *Oppelt v Department of Health, Western Cape* 2016 (1) SA 325 CC, the Constitutional Court restated the test at para [71] and [72], to wit:

> "*[71] In simple terms, negligence refers to the blameworthy conduct of a person who has acted unlawfully. In respect of medical negligence, the question is how a reasonable medical practitioner in the position of the defendant would have acted in the particular circumstances.*
>
> *[72] In Pitzer the court stated:*
>
> > *'What is or is not reasonably foreseeable in any case* is a fact boundenquiry*…..Where questions that fall to be answered are fact bound there is seldom any assistance from other cases that do not share all the same facts [Emphasis added].'*

52. In casu it is the actions of a reasonable registered nurse and midwife ("registered nurse") that should set the standard of the conduct of the medical staff that attended to the plaintiff and A[....].

53. In their joint minute the registered nurses described the care that the plaintiff and A[....] received as sub-standard. The mere fact that the care was sub-standard does not itself establish negligence.

54. The instances in which the care was sub-standard are, however, crucial to the eventual outcome of the matter. The fact that the plaintiff and A[....] were not correctly monitored led to a situation where the timeous detection of foetal distress was missed.

55. Even more disconcerting is the lack of action when early warning signs were apparent. Both registered nurses and Dr Sevenster stated that, although the FHR was within normal parameters at 14:00, it was close to the upper border of being normal and required either continued monitoring or follow-up regular monitoring.

56. The next CTG was, however, only done at 19:00, some 5 hours later. Dr

Sevenster explained that the monitoring of the FHR is vital in determining whether the foetus experiences any distress.

57. In monitoring the FHR regularly, foetal distress is easily identifiable and treatable. Should the situation become more serious the timeous intervention of a medical doctor is crucial.

58. Dr Sevenster testified that timeous intervention prevents or at least limits the possibility of brain injury due to hypoxia.

59. The fact that the hypoxia occurred over a prolonged period of time is supported by the evidence of the specialist neonatologist, the paediatrician/intensivist and the radiologists. The diagnosis of neonatal encephalopathy, transient kidney dysfunction, which is collectively in keeping with intrapartam sustained asphyxia and A[....]'s slightly raised nucleated red blood cell and platelet count, are well documented clinical observations and I have no hesitation in accepting the evidence of the various experts in this regard.

60. Similarly, the diagnosis of Professor Lotz and Dr Kamolane of a mixed pattern of prolonged partial hypoxic-ischemic injury, in addition to features of a more profound terminal hypotensive insult, fits in with the clinical picture of prolonged hypoxia.

61. The evidence of the registered nurses and that of Dr Sevenster conclusively establishes that:

61.1 the medical staff dismally failed to monitor the FHR regularly and correctly (i.e, before and after a contraction);

61.2 that the FHR at 19:00 was non-responsive and required urgent intervention; and

61.3 that early detection and intervention could have limited or prevented the severe brain injury A[....] suffered.

62. Dr Mbokota is the only dissenting voice in the body of medical opinions. Dr Mbokota's evidence that the foetal distress only commenced at 20:00 does not accord with the observations, opinions and clinical findings of the other experts. Dr Mbokota's concession during cross-examination that the foetal distress could have been for a longer period and thus could have commenced prior to 20:00, was well made and in keeping with the remainder of the evidence.

63. In the result, I am satisfied that the plaintiff has, on a balance of probabilities, established that the medical staff was negligent in the instances discussed *supra*.

64. I am similarly satisfied that their negligence caused A[....]'s severe brain injury.

ORDER

In the premises, the following order is made:

1. The defendant is liable for the plaintiff's proven or agreed damages.

2. The defendant is ordered to pay the costs of suit.

N. JANSE VAN NIEUWENHUIZEN
JUDGE OF THE HIGH COURT OF SOUTH AFRICA
GAUTENG DIVISION, PRETORIA

DATE APPLICATION HEARD PER COVID19 DIRECTIVES:
19 April 2022

DATE JUDGMENT DELIVERED PER COVID19 DIRECTIVES:
2 June 2022

APPEARANCES

Counsel for the applicant	Advocate F Pauer
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Instructed by:	State Attorney, Pretoria