IN THE HIGH COURT OF SOUTH AFRICA

KWAZULU-NATAL DIVISION,

PIETERMARITZBURG

CASE NO: 14275/2014

In the matter between:

NOMPUMELELO POLITE MADIDA **APPLICANT**

(OBO [S…….] [S……..] [M……..])

And

THE MEC FOR HEALTH FOR THE

PROVINCE OF KWA-ZULU-NATAL **DEFENDANT**

ORDER

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[1] The defendant is liable to pay the plaintiff for such damages as she is able to prove in due course.

[2] The defendant is ordered to pay the plaintiff's costs to date (including the costs of the formal application for the adjournment of the trial) on the scale as between party and party; such costs to include, *inter alia*:

a. The costs of both senior and junior counsel, including their fees for preparation for the trial, the opposed application and for consulting with the expert witnesses Dr Kara and Dr McLynn.

b. The costs of the MRI scan including the costs of Dr Misser to prepare his report, the anaesthetist and hospital fees that were necessary to obtain the MRI scan.

c. The qualifying fees of the expert witnesses Dr Y Kara (specialist paediatrician) and Dr D McLynn (obstetrician and gynaecologist), including the costs of preparation of their medico-legal reports, the costs of qualifying themselves to testify at the trial, the costs of their attendance at consultations with the Plaintiff's attorney and counsel and their reservation fees as determined by the taxing master, namely:

[3] All costs shall be payable within fourteen days of the taxation by the Registrar and Taxing Master of this court or within fourteen days of agreeing them.

JUDGMENT

Date of hearing: 24-25 February 2016
Date of judgment: 14 March 2016

D. Pillay J

Introduction

[1] [S……..], born on 29 January 2009 has spastic quadriplegic cerebral palsy, epilepsy, scoliosis, chest deformity poor cognitive ability, feeding difficulty and no hand function. Her young mother the plaintiff instituted an action for her for damages arising allegedly from medical negligence of employees of the defendant, the Member of the Executive Council for the Province of KwaZulu-Natal (Health). On the morning of the trial the defendant applied formally to adjourn the trial set down for three days. The plaintiff opposed the application.

In Part A of my judgment I give reasons for refusing the adjournment. In Part B I determine negligence and liability for damages.

Part A: Application for adjournment

[2] The basis for the adjournment was that the defendant did not have the complete medical records of the plaintiff. It was submitted that the defendant was unable to respond in any way to the plaintiff's claim without its medical experts having expressed their opinions on the complete medical records.

[3] In support of the application the defendant relied on the affidavits of Ms Kim Donnelly and Stuart Clive Chambers who are officials from the Legal Services Unit in the Provincial Department of Health. Much of Mr Chambers' affidavit is devoted to setting out the plaintiff's case. He also acknowledged that it was the plaintiff who gave the state attorney a bundle of the defendant's records. He omitted to mention that they were given on 14 April 2014 and that they covered the relevant period of labour and birth of [S……..]. In October 2015 the defendant's representatives were furnished with another incomplete set of hospital and medical records at the consultation held at Eshowe Hospital the very institution whence this claim arises.

[4] Notwithstanding its acquiescence in securing preferential trial dates it occurred to the defendant's representatives on a date not disclosed in Mr Chambers affidavit that given the lateness of the defendant's own discovery the defendant's experts had not had an opportunity to examine its discovered hospital and medical records. Having seen the hospital records and the reports from the plaintiff's experts the defendant's experts recommended that [S……] be assessed to determine the nature of the disability, that a radiologists opinion be obtained as well as an MRI scan, despite the plaintiff having already supplied the defendant with an MRI and her expert's report. An obstetric opinion was also recommended on the standard of medical care and whether or not the defendant was negligent. Once these reports were available the defendant and its experts would have been in a better position to assess the merits of the plaintiff's claim. Otherwise the defendant was not able to make such an assessment.

[5] The defendant had inadequate time to investigate the merits of the plaintiff's claim. Crucially it needed experts to comment on the opinion of the plaintiff's

experts. Experts also had to attend to preparing joint minutes. Counsel for the defendant Adv J Singh was unable to inform the court as to what the basis of the defence was without the experts' reports.

[6] Ms Donnelly started emailing the Chief Executive Officer of Eshowe hospital and the uThungulu District manager from 12 November 2015 to obtain the complete hospital records. She received no response right up to 27 January 2016 when she instructed the state attorney to apply for the adjournment. They finally received the complete records on 9 February 2016.

[7] The plaintiff's attorneys contended that the original records have at all times been at Eshowe Hospital under the control and administration of the defendant. Hence the defendant had access to these records at all times and was free to uplift them from Eshowe Hospital.

[8] In reply Mr Chambers acknowledged on behalf of the defendant that the records were ordinarily in the possession of Eshowe Hospital but that the applicant was unable to obtain them timeously as was apparent from the numerous correspondence from Ms Donnelly to the hospital. Mr Chambers continued in reply to point out that the defendant is dealing with public health and public funds and that there are limited resources, which require responsible handling. Hence whenever the question of liability arises expert evidence is necessary to inform the defendant's decision as to whether to concede the question of liability.

[9] I refused the application for adjournment for the following reasons:

The defendant cannot be heard to say that it did not have medical and hospital records of which its employees were custodians. It is not as if the medical records were held by the plaintiff or some other person. They were the defendant's own records. The defendant weakened its own position by failing to avail the records on time to its own team.

[10] In terms of ss 13 and 17 of the National Health Act 61 of 2003 the defendant's employees have a statutory duty to preserve and protect such hospital and medical records. Failure to do so opens the defendant's employees to criminal prosecution and liable on conviction to a fine or to imprisonment for a period not exceeding one year or to both such fine and imprisonment.

[11] The Health Professions Council's Guidelines on the keeping of patient records dated May 2008 applies to health care practitioners in both the private and

public service. It identifies what constitutes health records, why documents or materials should be retained and what information is compulsory for recording.[1][2] It prohibits alteration of records and requires reasons for any amendments to be specified on the record.[3] Errors may be corrected but the date of the change must be entered and the correction signed in full. The original record must remain intact and fully legible.[4] Additional entries at a later date must be dated and signed in full. The guidelines also provide for the retention of health records, which must be stored in a safe place and if stored electronically then safeguarded by passwords. In the case of minors their records must be kept until the minor's twenty-first birthday. For mentally incompetent patients the records must be kept for the duration of the patient's life. Health records kept in a provincial hospital or clinic including the records of minors and mentally incompetent patients may only be destroyed with the authority of the Deputy Director General concerned.[5]

[12] I have detailed the National Health Act and Guidelines to emphasise their importance and the rationale and seriousness with which the health professions view the keeping of patients' records. So when they are not available when they should be there is potentially a breach of a rule of law and codes of good practice. Non-compliance with statutory requirements and codes of good practice that impact directly on the health of members of the public is cause on its own to refuse the adjournment. To do otherwise would lead to the mistaken inference that the court is prepared to condone or tolerate the illegality. The lack of a bona fide explanation for the unavailability of the records fortifies my opinion.

[13] No affidavit by the custodian(s) accompanies the application. Neither Mr Chambers nor Ms Donnelly was a custodian of the medical and hospital records of Eshowe Hospital. They cannot explain why the custodians of the records at Eshowe Hospital were unable or unwilling to hand over the records to them. Were they lost? Were they misfiled? Did anyone even attempt to look for them? These are questions for which the defendant's managers must find

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[1] Clause 4 of the guidelines
[2] Clause 2 of the guidelines
[3] Clause 8 of the guidelines
[4] Clause 3 of the guidelines
[5] Clause 9 of the guidelines

answers in order to not only succeed in the application for an adjournment but also to hold public officials accountable to do the job they are meant to do. How else does one begin to fix the recurring and costly problem of missing records if one cannot unravel why they are missing or unavailable?

[14] The custodians are the persons who should have knowledge of the records. They must explain what happened to them, why they were not made available to the defendant's Legal Services Unit as soon as possible after the plaintiff instituted proceedings and at the latest when the defendant requested them, and why they failed to respond to the numerous correspondence from the Legal Services Unit. It could not be that the records were not available because the defendant had given the bulk of the reports to the plaintiff. The plaintiff relied on them to issue summons. The lack of an explanation from the custodians was another ground sufficient on its own to dismiss the application. But there is more.

[15] Ironically it is the plaintiff who gave the defendant's representatives copies of defendant's own records. She did so on no less than on two occasions: once on 14 April 2015 and again on 7 October 2015. Therefore the defendant had the bulk of the records upon which the plaintiff's claim was founded as early as April 2015. Albeit they were incomplete they were sufficient for the plaintiff's purpose of formulating her action. The subsequently produced records included the CTG during labour (which, as will be seen, supported the plaintiff) and the treatment of [S……] after birth which was not particularly material.

[16] In her letter of demand dated 25 September 2014 the plaintiff pinned her case to the negligence of the defendant's employees for the medical services they rendered from the time she was admitted to the delivery of [S……] between 28 and 29 January 2009. The defendant had the most relevant records on the basis of which its experts could have formulated a view as to whether the defendant was negligent during that period. In fact its experts had to formulate a view on the same records that the plaintiff relied on in order to participate meaningfully in any debate to determine the merits of the plaintiff's claim. Quite literally, without a view on the same records the defendant would not, to use a cliché, 'be on the same page' as the plaintiff and the court hearing her claim. That is not to say that additional records would not be relevant. It simply means that the defendant must formulate a view as to whether the plaintiff is able to

discharge her onus based on the records she relied on. If she did not that would be the end of the matter. If she did then the search for additional information becomes essential.

[17] It surprised me therefore that the defendant's representatives were able to deliver a plea without its medical records. To my repeated questions to Adv Singh as to what her client's defence was I received no coherent answer other than that the plea was a bare denial because the defendant had not obtained opinions from its experts.

[18] Experts express opinions after the fact once all the evidence is gathered. The starting point to establish the facts as to what transpired during the crucial hours between labour and delivery of [S……] had to be the medical personnel directly involved in rendering the services at that time. The crux of the case is whether a doctor was called. This was an elementary enquiry that should easily have been established by the hospital personnel who attended to the plaintiff. It implicated a material fact that the plaintiff had to prove if the defendant disputed her version that no doctor attended to her at crucial times during labour and delivery.

[19] Instead in its plea the defendant noted the facts that the plaintiff pleaded in paragraph 8 of her particulars of claim, which were extracted from the defendant's records from the plaintiff's admission to the hospital at 11h00 on 28 January 2009. It also noted that [S…….] was diagnosed with hypoxic ischaemic encephalopathy (HIE) grade 2/3 and neonatal convulsions probably as a result of birth asphyxia. But it denied any knowledge as to the cause of these consequences. It also had no knowledge as to whether its hospital personnel were negligent in any of the ways contended for by the plaintiff. Disconcertingly the defendant had no knowledge as to whether nursing staff reported foetal compromise to a doctor and whether a doctor was ever called to attend to the plaintiff during what the plaintiff contended was a difficult delivery. It pleaded no facts about what protocols if any the staff did implement.

[20] To plead 'no knowledge' and to put the plaintiff to the proof of facts that should be easily ascertainable was not a plea in good faith. It is hardly the response of a caring health service. Proof as to whether a medical doctor had attended to the plaintiff had to come from the hospital staff on duty at the time and from

their records. As far as the plaintiff was concerned no doctor attended to her at the crucial stages of labour.

[21] The defendant had indicated its intention to engage its experts on several occasions. It offered no explanation as to why it did not do so timeously. At the rule 37 conference on 28 July 2015 the defendant represented by Adv Singh undertook to revert about whether the defendant would engage its own experts. The defendant neither reverted nor signed the conference minutes, which the plaintiff eventually filed in court unsigned. On both occasions when the defendant's representatives received the records from the plaintiff the defendant did not say that the records were inadequate or that it was unable to proceed without complete records. On the contrary the state attorney responded on 8 October 2015 that he was consulting with witnesses on 13 October 2015 and would revert by the end of October to the plaintiff's attorneys. When the plaintiff's attorney received no response she enquired on 23 November 2015 whether the defendant had intended instructing experts as the trial dates were close. She also requested proper compliance with rule 36(2) relating to possible examinations of [S…….] and rule 36(9)(a) in respect of experts. Still the defendant failed to comply. To date the court has no explanation as to why the defendant failed to engage its experts timeously or at all.

[22] The defendant cannot be heard to say that it did not have sufficient time to prepare for trial. Mr Chambers had agreed with the plaintiff that the matter was ripe for trial. The plaintiff applied for and secured preferential trial dates without opposition because the claimant is a child.

[23] The following chronology is a self-explanatory basis for refusing the adjournment. The plaintiff delivered a letter of demand on the defendant on 30 September 2014. On 15 October 2014 the plaintiff served summons on the defendant. On 26 November 2014 Ms Donnelly instructed the state attorney Mr Kunene. Notwithstanding the plea falling due twenty days later, four months after the summons was delivered the state attorney requested on 17 February 2015 a three-week indulgence to deliver its plea. Despite a further four-week indulgence the state attorney had not delivered the plea by 16 March 2015. The defendant had to be compelled to plead by a notice of bar. The defendant delivered its plea without having sight of its own medical records.

[24] On 14 April 2015 the plaintiff delivered a bundle of the defendant's hospital records on which it relied to allege negligence on the part of the defendant's employees. At a rule 37 conference held on 20 July 2015 the defendant indicated that it would revert as to whether it intended to engage its own experts.

[25] On 1 September 2015 the plaintiff invited the defendant to concede negligence and liability as [S…..] was in immediate need of physiotherapy, occupational therapy and speech therapy and such costs had already been incurred. Furthermore [S……] also needed to consult with an orthopaedic surgeon to investigate a possible dislocation of her hip.

[26] At a rule 37 (8) conference convened on 11 September 2015 the court by consent certified the matter ready for trial on the issue of negligence and liability with quantum being held over for determination at a later date. Three days were allocated for trial by consent.

[27] On 1 October 2015 Mr Kunene and Ms Donnelly were advised of the trial dates. On 2 October 2015 they asked the plaintiff's representatives for medical records of the plaintiff to enable them to consult experts with a view to determining whether liability should be conceded. Seemingly Ms Donnelly had not received the records and reports previously delivered on 14 April 2015. Furthermore, a copy of the compact disc of the MRI scan had been sent to the state attorney's offices on 2 September 2015. Nevertheless the plaintiff's attorneys emailed the hospital records to Ms Donnelly again on 7 October 2015.

[28] On the same day the plaintiff's attorneys advised Mr Kunene and Ms Donnelly that they had not responded to the rule 37 minute; they had undertaken to do so within two months from 28 July 2015. On 8 October 2015 the state attorney enclosed the signed minutes and advised that it was consulting with its witnesses on 13 October 2015 and would revert by the end of October.

[29] On 23 November 2015 the plaintiff's attorneys reminded the state attorney Ms Naidoo and Ms Donnelly that the defendant had not responded about its intensions to instruct experts. The plaintiff's attorney also enquired whether they had received the CD of the MRI scan.

[30] On 4 December 2015 the defendant abandoned its special plea and indicated its intention to engage the services of a gynaecologist, a neonatal paediatrician and a specialist radiologist as experts. Mr Kunene undertook to provide their reports within the time limits prescribed by the rules.

[31] On 7 January 2016 the plaintiff applied to compel the defendant to respond to outstanding pre-trial issues. The court ordered the defendant to pay the costs of that application. On 30 November 2015 Mr Kunene had asked to have [S……] assessed on 13 January 2016. The plaintiff acquiesced but requested a notice in terms of rule 36(2). The plaintiff received no response. By 20 January 2016 the plaintiff's attorneys reminded Mr Kunene, Ms Naidoo and Ms Donnelly that they had not received the rule 36(2) notice to have [S……] examined on 13 January 2016. The plaintiff was emphatic that no adjournment would be entertained as a consequence.

[32] On 3 February 2016 the defendant's representatives were again reminded that they had the CD of the MRI, that no arrangements had been made for [S……] to be examined on 13 January and of its undertaking to deliver its reports within prescribed time limits. Again the plaintiff emphasised that no adjournment would be granted.

[33] On 3 February 2016 Mr Kunene informed the plaintiff's attorneys that the defendant had additional hospital records. As at 4 February 2016 despite several requests Mr Kunene had not delivered these to the plaintiff's attorneys. About 8 February 2016 the defendant's representatives arranged to have the medical records from Eshowe hospital that were given to defendant's counsel during her consultation there to be delivered to the plaintiff's attorneys. Eventually the plaintiff's attorneys arranged to have them collected from the defendant's counsel on 9 February 2016. Mr Kunene advised that because he had now found further records he required an adjournment for an opportunity to assess [S……] on 17 February 2016 barely a week before the trial. The plaintiff refused to adjourn the matter.

[34] The plaintiff's attorneys arranged for Dr Y Kara the paediatrician and Dr D.M McLynn the obstetrician gynaecologist to report on the additional hospital records. They were able to do so in good time to avoid an adjournment.

[35] The defendant applied formally for a postponement of the trial on 16 February 2016.

[36] The defendant is entitled to seek whatever advice or opinions it needs to arrive at its decision. However it is unreasonable to seek expert evidence only at the time of trial and not when the demand is made or even by the time a plea has to be delivered. Manifestly the earliest assessment of liability will avoid the escalating costs of litigation involving two counsel, four experts, huge bundles of pleadings, several pre-trial conferences at the end of which the defendant still remains unprepared for trial as in this case.

[37] The application for a postponement might well have been for a short duration. The plaintiff might well have taken five years to launch the action as submitted for the defendant. Although her reasons for doing so are not before me it is not hard to fathom why an indigent single mother with a child with severe disabilities would delay litigation. In contrast the defendant is not similarly disadvantaged. It has not demonstrated any reasons why the hospital records could not be found, why it could not have proceeded with the copies of its own records furnished by the plaintiff and be ready for trial within two years from receiving the letter of demand.

[38] It is also not open to the defendant to object as it does to the delivery of further expert reports based on the supplementary hospital records it supplied because they are late when it is in fact the defendant who delivered them late. That would be the plaintiff's call. But she is prepared to press on with the trial.

[39] A postponement is an indulgence granted or refused in the exercise of judicial discretion. Also weighing heavily against the defendant is the overriding consideration that at issue is the rights of a child which, constitutionally speaking, are paramount. The defendant has not shown any good cause for the adjournment.

[40] The defendant tendered to pay the plaintiff's costs occasioned by the adjournment on a party and party basis and the costs of reserving six experts. The plaintiff claimed:

a. costs of two counsel including their fees for preparation for trial and consulting three experts and their fees for the first day of the trial,
b. the costs of the plaintiff's attorney attending consultations with the expert witnesses,
c. the trial reservation fees in the amount of R15 000.00 each for three expert witnesses,

d. the costs of counsels' fees to be assessed by the society of advocates and to be payable within fourteen days,
e. the attorney's costs to be paid within fourteen days,
f. and all remaining costs to be paid on taxation.

[41] If the court had granted the postponement it would have had to award most of these costs to the plaintiff. Otherwise as a student in her third year of study she would have had to bear them personally if she did not recover them from the defendant.

[42] The tender was for payment of costs from public coffers. It was not accompanied by any explanation as to whether the custodian of the records had been identified, held accountable for the wastage of public funds, and whether the defendant was implementing remedial measures institutionally to hold those responsible for delays and transgressions accountable. The defendant already had an order for costs for non-compliance with pre-trial procedures. In these circumstances to award another huge amount again as wasted costs arising from an adjournment would have been an unconscionable imposition on the fiscus.

[43] For these reasons I dismissed the application for the adjournment but reserved costs.

Part B: The Trial

[44] The trial commenced after I dismissed the application for an adjournment and continued the following morning. The following morning the defendant instructed senior counsel from Durban to travel to Pietermaritzburg to inform the court that it intended to note an appeal when the court gives its reasons for refusing the application for the adjournment on some future date. It was incomprehensible to me as to why such costs at the expense of the fiscus had to be incurred when Ms Singh who was still on record could have communicated this information to the court. Besides, without reasons being furnished the defendant could not properly note an appeal. Furthermore, the defendant had yet to formulate its view on liability, which if conceded, would dispense with any appeal against my refusal of the adjournment. After informing the court of the defendant's intention its legal team withdrew from the

proceedings. The trial proceeded and was concluded in the absence of representation for the defendant

Dr D.M McLynn

[45] The first witness for the plaintiff Dr D.M McLynn a specialist obstetrician and gynaecologist took the court through his report based on the hospital records and interview with the plaintiff. He outlined generally how maternity units operate before delving into the specifics of the plaintiff's case. Generally a hospital's maternity unit has a senior midwife in charge, a senior doctor, specialist or experienced obstetrician and a number of midwives. On admission the patient's antenatal card would inform the midwife of the patient's complaints and obstetric history. The midwife would conduct a basic obstetric examination of the patient's abdomen to ascertain the presentation of the baby, the level of the baby's head above the pelvic brim and whether the patient is having labour contractions. Depending on the clinical status of the patient the midwife would execute a plan of action. If there are complications she would request an obstetric and medical assessment. Observing these protocols, which enable abnormal labour to be sifted out from normal labour are 'extremely important'.[6]

[46] Once in the labour ward a partogram system of observation enables regular examination and charts the progress of labour. If the labour is not progressing normally then the obstetrician on duty has to supervise the management of the patient and intervene at his or her discretion. If the labour is progressing normally then the attending midwife supervises the management of the patient. These are standard protocols that generally are observed.

[47] Dr McLynn had regard to a bundle of the Eshowe Hospital records relating to the pregnancy and postpartum care of the plaintiff, some paediatric documentation relating to [S…….], the medico-legal report of Professor Nolte, the nursing expert and a statement by the plaintiff. He found the entries from the midwives to be adequate but the medical obstetric patient records were minimal and incomplete. For the first stage of labour he drew on the following entries made by the nursing and the midwifery staff:

[6] Page 14 of Exhibit D Doctor McLynns report

[48] On 28 January 2009 the plaintiff was admitted at 11h20 complaining of labour pains, which had started at 08h00. A midwife assessed her and authorised her admission to a ward for a cardiotocography (CTG). A CTG is equipment used to monitor both the foetal heart and the contractions of the uterus for early detection of foetal distress. Dr McLynn had no copies of the CTG when he prepared his initial report.

[49] The plaintiff was at the time of her confinement a primagravida, that is a first pregnancy; she was also a teenager of short stature. He measured her height as 1,44 m. Each of these three features on their own increase the risk of complications and the presence of all three significantly increase the risk. Thus the plaintiff presented as a high risk labour which could lead to complications. The possibility of complications became clearer as her labour progressed over twenty hours and ten minutes before she delivered her baby. The midwifery and obstetrical staff at the hospital should have been aware of these risks and paid specific attention to the probability of positional labour complications that did arise in this case. But they failed to observe these standard protocols.

[50] At 14h30 the plaintiff complained of labour pains again. Her mild contractions were palpable. The nursing plan was to review the plaintiff in four hours; in the meantime she was urged to walk up and down the ward to encourage the foetus to position itself for birth.

[51] The nursing staff did not call for a doctor. Eshowe Hospital is large enough to have a dedicated medical officer on call. Usually doctors on call go on rounds about every four hours. In the management of the plaintiff between 11h10 and 14h30 Dr McLynn's only criticism of the medical services rendered to the plaintiff was that the midwife had failed to call the medical officer to assess the plaintiff, who was a high risk pregnancy, to decide how the labour would be managed going forward.

[52] At 20h00 labour was progressing well and the clinical notes indicated that the plan was to reassess the plaintiff in two hours. Two hours later the plaintiff experienced strong contractions and she was transferred to the labour ward for further management of active labour.

[53] At 22h00 the medical records show that both the maternal and foetal conditions were good and the labour progressed well. The enduring concern for Dr McLynn remained the initial observation of the high risk factors. She was

diagnosed as a right occipito-posterior position, meaning that the back of baby's head was against the plaintiff's back. From this position the top of the head would enter or try to enter the pelvis first instead of the circle of the crown, which molds more easily. Furthermore a posterior head circumference is larger than the anterior head circumference. Typically a right occipito-posterior position causes long delays in the first and the second stages of labour, as happened in this instance. As a foetal malposition that could lead to adverse maternal and neonatal consequences standard protocols required medical intervention, more so on account of the plaintiff's pre-existing condition as a primagravida teenager of short stature. Instead, the plaintiff was left to allow labour to take its natural course between 22h00 and 03h00.

[54] At 23h00 on examination in the labour ward a nurse recorded 'monitor foetal maternal condition half hourly' and 'report abnormalities to MO'. If such a report was made, there is no record of it.

[55] At 2h00 the plaintiff was 9cms fully dilated with a posterior occipital lie resulting in excessive caput (that is swelling due to injury to the brain hitting against the pelvic tissue), moulding and foetal distress. At this point, if not before, the baby should have been delivered.

[56] At 3h00 an hour and ten minutes prior to delivery she was given intrapartum resuscitation or oxygen. From this Dr McLynn inferred that the staff were 'well aware' that the foetus was distressed. Some damage might already have occurred. Still nursing staff failed to call the obstetrician on duty as standard operating procedures required them to do. The doctor would then have had to decide on the best mode of delivery of the baby either through caesarean section or assistance via suction or forceps. This was not a decision for the nursing staff.

[57] An occipito-posterior foetal position is a normal occurrence. Usually midwifes would wait for the foetal head to rotate and descend into the perineum before the patient starts pushing. In this instance the baby's head did not rotate anteriorly. The plaintiff testified that the midwife applied fundal pressure in the second stage of labour. Applying fundal pressure when the foetal head had not descended into the perineum ran the risk of (further) injury to the foetus as the baby's soft head pressed against the mother's bony pelvis. This was dangerous for both the plaintiff and her baby.

[58] For the last four hours of her labour she was on continuous CGT. The CTG records reflect accelerated contractions of the plaintiff and heightened foetal heart rate for a prolonged period until delivery at 04h10. As the plaintiff's contractions increased the foetal heart rate also increased. Normally over ten minutes there should have been three to four contractions; however the plaintiff was having eight to nine contractions. The uterus had been over stimulated from quiescent to active. From this Dr McLynn deduced that the plaintiff might have been given drugs to accelerate the contractions. There is no record of any drugs being given to the plaintiff. The accelerated contraction did not allow the child's heart rate to recover between contractions. As a result of the accelerated heart rate the foetus developed an oxygen deficit. Reduced oxygen supplied to the foetal brain over a prolonged period resulted in hypoxic ischemic encephalopathy or brain damage. The foetus was delivered without the assistance of the obstetrician.

[59] The Apgar ratings were overestimated. Apgar the acronym for appearance, pulse, grimace (or reflexes), activity (or muscle tone) and respiration, is an assessment of a new born baby's physical condition immediately after birth to determine whether any additional medical or emergency interventions are need. For respiration and muscle tone the readings should have been 0 instead of 1. On a scale of 0-10 the total of 6/10 was an over estimation considering that the baby started breathing on her own only after three minutes. Intubating the baby immediately would have resuscitated her instantly and prevented the damage that the three-minute delay would have caused. But intubation is a procedure performed by the medical officer. And none was in attendance. The ischemia or lack of blood supply to the brain had probably set in six hours earlier at around 22h00.

[60] Dr McLynn opined that apart from an early visit from a doctor the lack of obstetrical intervention at any time throughout the process was a failing of the medical staff to do their jobs properly. If they had been monitoring the situation they would have noticed the deficiencies of the midwifery staff in their handling of the situation. Obstetric intervention at the various critical stages would most probably have resulted in the decision to deliver immediately either by caesarian section or with assistance in order to minimize damage to the baby

and end the plaintiff's predicament of a prolonged and difficult labour. The failure to so intervene was negligent.

Dr Yatish Kara

[61] Dr Yatish Kara the specialist paediatrician who corroborated Dr McLynn in several respects testified as follows: Generally when the oxygen and blood supply to the brain is cut off over a prolonged period then the body resorts to autoregulatory action to adapt to or mitigate the adverse effects of an oxygen deficit to the brain. It enables the limited oxygenated blood to flow to the vital part of the brain that sustains life, the basal ganglii or the 'primitive centres' at the expense of the other areas in the brain which become starved of oxygen and are damaged. In contrast, an immediate interruption of supply does not allow the body to trigger this coping or mitigating mechanism.

[62] In this case the MRI scan and the reports of the radiologists indicate that the brain of the foetus was deprived of oxygen for a prolonged period resulting in the partial prolonged hypoxic ischaemic (oxygen deprivation) injury. This kind of injury occurs in a term infant at the time of childbirth.

[63] Dr Kara concluded that the foetal distress would have occurred at 2h00 when the plaintiff was 9cm dilated. The fundal pressure aggravated the hypoxic ischemic injury. The encephalopathy or brain damage at birth was sufficient to cause cerebral palsy. Pointers at the neonatal stage that is, immediately post birth, allowed him to conclude that the cerebral palsy was probably caused by the injury. For instance [S…….] had convulsions soon after delivery. She had a poor cry for two weeks, poor oral feeding for over a week all of which suggested stage two encephalopathy, which lasted longer than seven days. He excluded other possible causes of intrapartum hypoxic injury such as meningitis and pre-existing obstetric conditions. Nothing suggested a postnatal event that could have caused the hypoxic injury.

[64] Furthermore, [S……] was delivered with a low Apgar score and compromised respiration. The Apgar score at one minute recorded her heart rate as over 100, slow and irregular respiration, her muscle tone showed some flexion, poor cry and body pinkness. Like Dr McLynn, Dr Kara also disputed the correctness of the Apgar score of 6/10 at one minute and 8/10 at five minutes considering that

the child did not cry at delivery and breathing had been delayed for three minutes. Essential blood profiling was not done at this stage.

[65] The hospital records of 30 January 2009 show that [S…..'s] neck was hyperextended, poorly responsive, with her eyes flicking and she seemed to be fitting. The diagnosis of HIE with seizures appears on the hospital records. The following day the entry in the hospital records reads 'HIE grade 2/3, neonatal convulsions, likely birth asphyxia'.

[66] Dr Kara also criticised the fact that the first blood sugar test was done three hours after birth and not at birth. Neither oxygen saturation nor blood pressure of [S……] was recorded during neonatal care. Monitoring blood pressure and blood sugar was essential to minimise on-going injury in hypoxic ischemia. The fact that the doctor saw [S…….] eight hours after delivery according to the records also concerned him.

[67] Dr Kara bolstered his opinion by referring to the work by Volpe (Neurology of the Newborn) who had identified factors that were also present in this case and supported his finding of causation. He also referred to the criteria set by the American College of Obstetricians and Gynaecology, which supported his conclusion that there was sufficient evidence to link the cerebral palsy to a hypoxic insult at birth.

The Plaintiff

[68] The plaintiff testified and confirmed that fundal pressure was applied to her. [S……] was discharged after two weeks. In the nursery she was on a drip and an oxygen mask. A hospital physiotherapist informed her that [S……'s] progress would be delayed but that the plaintiff had 'nothing to worry about'. [S…….] is unable to walk, talk, crawl or stand. She also cannot see. At 7 years she is still wearing napkins implying that she has no bowl or bladder control. She recognises the plaintiff by her voice. The plaintiff is currently in her third year of study for an NQF diploma in education and development.

[69] Findings

[70] The plaintiff has established a causal link between the medical and hospital services rendered by the employees of the defendant and the injuries sustained by [S……] during birth, the consequences of such injury being HIE. Accordingly I find that the defendant is liable for having negligently caused [S……] to suffer hypoxic ischemic encephalopathy.

Costs

[71] In awarding the plaintiff the costs of the application for the adjournment I decline her request that it be on the scale as between attorney and own client, such costs to include the costs of experts who did not eventually testify. I refused the application and so no trial costs were wasted. As unreasonable as the conduct of the defendant's employees was, any cost order drains the health budget at the expense of health services for all. It does not punish the wrong doers. Some proportionality has to be maintained in making cost awards in these cases.

[72] As for the experts who did not testify Prof Nolte and Prof Lotz were superfluous; their fees should not be for the defendant's account. Drs McLynn, Kara and Misser who obtained and reported on the MRI were sufficient to establish the plaintiff's claim.

Institutional Diagnosis, Possible Remedies

[73] This case is a microcosm of a greater social phenomenon. It is no secret that with RAF (Road Accident Fund) cases waning medical malpractice is the new source of revenue for enterprising practitioners. Medical malpractice cases now occupy the space on the court roll vacated by RAF claims. Whilst RAF cases generated much abuse by some claimants and the legal, medical and other professionals who assisted them, not all practitioners exploited the system. Many claimants would have been left destitute without professional assistance given the statutory regime that operated at the time. Foreseeably, a similar experience as in RAF matters could replicate itself in medical malpractice suits. And when commercial interests become entrenched change will be harder to implement, as the experience in RAF matters shows.

[74] In another matter against the defendant[7] set down for trial two days before this case a child had suffered brain damage, seizures and was mentally handicapped allegedly on account of the medical negligence of the defendant's employees. The defendant sought and obtained an adjournment with an order to pay huge wasted trial costs because its officials initially deposed to affidavits stating that they did not have medical reports only to discover days before the trial that they did. The defendant's counsel had no instructions to explain to the court how this catastrophe arose. Hence I directed that the person(s) responsible should depose to affidavits explaining how the records were initially unavailable and then available. The affidavits had to be submitted to the National Minister of Health and the defendant for further action, and copied to the registrar for the court's information. My reason for doing so was, in deference to the separation of powers principle, to alert the political heads of a chronic administrative deficit in health services that is also impacting on the efficiency of the courts as time is lost in trial matters being adjourned. The problem of medical and hospital records being unavailable timeously or at all is a recurring feature in medical malpractice cases that result in adjournments and extraordinary waste of legal and experts' costs at the expense of the public purse.

[75] A quick survey of claims against the defendant enrolled for hearing from August 2015 to February 2016 is attached as an appendix to my judgment to give some statistical support for why medical malpractice is a matter of public interest law and why we should all be concerned. The survey reveals the following:

a. Fifty-eight (58) matters were set down for pretrial, trial and/or applications to compel between August 2015 to February 2016.
b. Forty-three (43) set-downs were for applications to compel (discovery, pre-trial information) against the defendant.
c. In 10 matters the defendant was ordered to pay the costs.
d. Of the 15 set-downs for trial 4 were adjourned with the defendant paying the costs in all these matters; in 3 of the 4 the defendant agreed

[7] P T Seme v MEC Health KZN Case No 14197/14.

to or was ordered to pay the whole or a portion of the plaintiffs' claims plus costs.

e. Costs were reserved, not ordered or undecided in 35 matters.
f. The defendant was ordered to pay attorney client costs in 1 matter.
g. Costs ordered against the defendant included experts and 2 counsel in 11 matters.
h. In 10 cases the claimants were born severely handicapped mentally and physically. These claims range between R11m and R20m.
i. In only 1 matter the plaintiff withdrew the action and tendered the defendant's costs.

[76] A disturbingly large number of matters are postponed with the MEC having to pay costs. It has not been possible to assess the amount of costs awarded as the bills are not left in the court file for taxation. On average plaintiffs engage three experts and two counsel. When matters are adjourned with the defendant having to pay the wasted costs the disbursements alone are therefore huge.

[77] Medical malpractice cases against the defendant are escalating rapidly. A knee jerk dispute resolution response instead of a problem solving approach is unlikely to yield sustainable institutional reform. On the contrary it is likely to increasingly compromise the delivery of efficient health services as the health budget is drained to meet malpractice claims and costs.

[78] One approach to minimising legal costs and litigating more efficiently is for either party to initiate a conference between the parties and, if necessary, before a judge in chambers as soon as summons is delivered to identify the issues in dispute, what needs to be proved and how that might best be accomplished. Availability of medical and hospital records and the possibility of engaging experts jointly can be canvassed at an early stage. Unlike traditional commercial litigation medical malpractice suits is a matter of public interest law. The approach should as far as possible be investigative with a view to problem solving. However, if plaintiffs make fraudulent claims or the defendant does not plead in good faith as I have found in this case, the litigation will be adversarial.

[79] Although they present as a bipolar dispute between a plaintiff and a defendant with the remedy being findings on liability, compensation and costs the problem of malpractice remains institutional. Malpractice suits are retroactive in the sense that they seek to remedy past wrongs. The litigation resolves the dispute

but not the institutional problems. Remedies that are forward-looking, that seek to resolve problems for the future should be considered for long-term sustainable solutions. The court cannot initiate such remedies without the co-operation of the litigants.

[80] Most plaintiffs have no capacity or inclination to solve institutional problems their main aim being limited to resolving their dispute with an award of compensation and costs. Practitioners who have vested commercial interests in malpractice suits have even less incentive to participate in fixing the problems. For reasons best known to the defendant it has not taken the court into its confidence to disclose what obstacles it has to overcome to deliver health services efficiently to avoid malpractice claims. Nor does it proactively elicit the court's intervention by way of say, meaningful engagement with early court intervention as suggested above, structural reform, experimental remedies or similar supervisory or interventionist remedies to address its problems institutionally. Structural reform and some suggest even experimental remedies[8] have been issued by the Constitutional Court in the housing cases. [9] Defendants who struggle to get their institutions to comply tend to support experimental remedies.[10] In this case the defendant's Legal Services Unit who struggle to get the hospital records can benefit from experimentalist interventions.

[81] The growth of malpractice suits has been sudden. It might have caught the defendant unprepared. With the escalation of claims over the past five years the problems may seem overwhelming and insurmountable. These bespoke remedies could assist in fixing the problems. But this case shows that they are fixable if the law is simply obeyed. The challenge then is to implement measures to ensure that the law is obeyed.

[82] In this case the defendant was in a weak position not because of anything that the plaintiff or her lawyers did or did not do. It must be remembered that the plaintiff's case was based entirely on the medical facts produced by the

[8] Woolman, Stu 'The Selfless Constitution- Experimentalism and Flourishing as Foundations of South Africa's Basic Law' (2013) Juta.

[9] *Government of the Republic of South Africa & others v Grootboom & others* 2001 (1) SA 46 (CC); *Port Elizabeth Municipality v Various Occupiers* 2005 (1) SA 217 (CC); and *Occupiers of 51 Olivia Road, Berea Township and 197 Main Street, Johannesburg v City of Johannesburg & others* 2008 (3) SA 208 (CC).

[10] Sabel and Simon 'Destabilization Rights: How Public Law Litigation Succeeds' at 1065.

hospital. The defendant's case was weak for two reasons both of which are violations of the rule of law. As sector specific rules these rules enjoy the support of the health professions. In the first instance the duty to keep medical records is a statutory obligation. The second rule is the professional protocols that required a medical officer to attend and manage high risk labour. Both rules and especially the rule relating to the keeping of the records are non-discretionary requiring strict compliance. If management of a risky labour is open to the exercise of discretion that discretion has to be exercised reasonably by the medical officer not the nursing staff who are unskilled to manage the kind of life threatening complications that can and did arise in this case.

[83] The institutional remedies in this case as in every case in which medical records are not supplied to persons authorised to receive them is obvious: Efficient systems must be in place for preparing and preserving hospital and medical records in order to comply with the National Health Act and the Guidelines. This is a non-negotiable absolute requirement non-compliance with which will continue to escalate the claims and costs against the defendant. Given the instrumentality of this institutional deficit to malpractice costs, and for no better reason than that it is the law, the defendant must look to holding the custodians of the records personally accountable, if necessary on pain of discipline, criminal prosecution or both. Similarly the doctor on duty on the night that [S…….] was born has to account for his non-attendance on the plaintiff at crucial times of her labour.

[84] Without compliance with these rules the defendant would not be able to defend itself effectively against escalating malpractice claims. Compliance with both rules is unrelated to either the volume of patients or the number of claims being lodged. They are about having efficient systems in place and law abiding, accountable employees responsive to patient needs.

Order

a. The defendant is liable to pay the plaintiff for such damages as she is able to prove in due course.

b. The defendant is ordered to pay the plaintiff's costs to date (including the costs of the formal application for the adjournment of the trial) on the scale as between party and party; such costs to include, *inter alia*:

    i. The costs of both senior and junior counsel, including their fees for preparation for the trial, the opposed application and for consulting with the expert witnesses Dr Kara and Dr McLynn.

    ii. The costs of the MRI scan including the costs of Dr Misser to prepare his report, the anaesthetist and hospital fees that were necessary to obtain the MRI scan.

    iii. The qualifying fees of the expert witnesses Dr Y Kara (specialist paediatrician) and Dr D McLynn (obstetrician and gynaecologist), including the costs of preparation of their medico-legal reports, the costs of qualifying themselves to testify at the trial, the costs of their attendance at consultations with the Plaintiff's attorney and counsel and their reservation fees as determined by the taxing master, namely:

c. All costs shall be payable within fourteen days of the taxation by the Registrar and Taxing Master of this court or within fourteen days of agreeing them.

_____

D. Pillay J

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