**IN THE HIGH COURT OF SOUTH AFRICA**
**WESTERN CAPE DIVISION, CAPE TOWN**

**REPORTABLE**

**CASE NO: 5088/2017**

In the matter between:

**K[....] X[....]** Plaintiff

and

**MEMBER OF THE EXECUTIVE COUNCIL**

**FOR HEALTH, WESTERN CAPE** Defendant

Bench: P.A.L. Gamble, J
Heard: 12, 13 & 14 October 2020; 9, 10 &11 February 2021; 17 & 18 March 2021.
Delivered: 13 October 2021

This judgment was handed down electronically by circulation to the parties' representatives via email and release to SAFLII. The date and time for hand-down is deemed to be 10h00 on Wednesday, 13 October 2021.

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**JUDGMENT**

**GAMBLE, J:**

INTRODUCTION

1. At 02h16 on 27 June 2006 the plaintiff gave birth to her second child, a baby daughter called S[....], ('the child") at the Mowbray Maternity Hospital in Cape Town. Subsequent to her birth, the child was diagnosed with cerebral palsy, which the plaintiff attributes to the substandard medical care rendered to her prior to the birth. The plaintiff now seeks damages from the defendant ("the Province"), in both her personal capacity and on behalf of her child, as a consequence of the alleged negligence of the Province's nursing staff who treated her in the perinatal phase of her pregnancy at an obstetric clinic run by the Province.

2. By agreement between the parties, the question of the quantum of the plaintiff's claims is to stand over and the Court was requested to determine only the merits of the matter. In a special plea delivered by the Province together with its plea on the merits and quantum, it is alleged that the plaintiff's personal claim has prescribed, the summons in this matter having been served on the Province on 22 March 2017 – almost 11 years after the event. The plaintiff did not replicate to the special plea, which falls to be determined together with the claim on the merits.

3. During the trial, the plaintiff was represented by Mr. A.D. Schoeman SC of the Grahamstown Bar and Ms. N. Mashava of the Cape Bar, while Ms. M. Adhikari of the Cape Bar represented the Province. After the completion of several days of evidence rendered in open court, the matter was argued virtually in March 2021. The Court is indebted to counsel for their comprehensive heads of argument which have assisted in the preparation of this judgment.

THE APPLICABLE LEGAL PRINCIPLES

4. The approach in our law to the plaintiff's claims is not controversial. It is trite that in order to succeed in her delictual claim for damages, the plaintiff must establish that the wrongful and negligent conduct of the Province's nursing staff, acting within the course and scope of their employment, caused her harm.[1]

5. In Oppelt Cameron J, (for the minority) provided the following useful summary of the approach to matters of this nature with reference to Kruger v Coetzee,[2]

"[106] In our law *Kruger* 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 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 defendant-specific ('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*[3] 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

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[1] Mtetwa v Minister of Health 1989 (3) SA 600 (D&CLD) at 606 B-F; Oppelt v Department of Health, Western Cape 2016 (1) SA 325 (CC) at [34].

[2] 1966 (2) SA 428 (A)

[3] 1914 AD 519 at 525

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

6. While in Oppelt the court was required to assess the expertise and conduct of an orthopaedic surgeon and a neurosurgeon employed in a state hospital, I consider that the approach advocated by Cameron J may be applied *pari passu* to midwives and nurses employed at a dedicated obstetric clinic run by the Province, where a degree of expertise in the handling of pregnancies and the delivery of children through natural child-birth was manifestly necessary.

7. In this regard, the Court was told that such units are staffed exclusively by midwives and nurses – there are no doctors present – who attend to the delivery of babies at the clinic day in and day out, 365 days a year. It is only when the case demands a higher level of care than that which can be provided at the obstetric clinic, that the mother is referred to a hospital for the intervention of a doctor. Mtetwa is authority for the liability of the Province for the negligence of its employees and I did not understand Ms. Adhikari to take issue with the manner in which the professional conduct of such staff (*qua* nurses and mid-wives) is to be assessed.

8. As to the level of care that the plaintiff was entitled to demand of the nursing staff at the MOU, Collins[4] provides a useful summary of the applicable test. The case involved the insertion by a nurse of a tracheostomy tube into a 16-week-old baby whose breathing was compromised and who required ventilation. The nursing staff in the unit where the baby was being treated were required to have training and experience in specialist care of paediatric tracheostomy patients. The learned Judge made the following observation.

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[4] Collins v Administrator, Cape 1995 (4) SA 73 (C) at 81I – 82B

"The question that arises is whether the failure on the part of the hospital staff promptly to replace the tracheostomy tube amounted to negligence in the circumstances. It is trite law that a patient in the hospital is entitled to be treated with due and proper care and skill. The degree of care and skill that is required is that which a reasonable practitioner would ordinarily have exercised in South Africa under similar circumstances (see *Dube v Administrator, Transvaal* 1963 (4) SA 260 (W)). The need for particular care and vigilance in the case of pediatric tracheostomy patients is obvious. Not only is the possibility of accidental decannulation readily foreseeable, but unless immediately remedied the consequences are fatal. Indeed, this need for care and vigilance is reflected in the staff allocated to the tracheostomy unit."

In my view, the plaintiff was thus entitled to demand that she and her unborn child be treated with the requisite degree of care and expertise expected of a duly qualified midwife.

9. As will appear later, there was a series of guidelines published in 2000, which set the standard of care expected in 2006 for maternity care in clinics, community health centres and district hospitals countrywide. It is not in dispute that the Province's nursing staff at the clinic were obliged to treat the plaintiff in accordance with those guidelines and that if they failed to do so their conduct might establish negligence. Whether there was in fact such negligence is ultimately for the Court to determine, having had regard to the expert opinion placed before it.[5]

AN OVERVIEW OF THE MEDICAL EVIDENCE

10. The plaintiff testified personally in regard to both the merits and the special plea. She further presented the evidence of two expert witnesses from Durban, Dr. Ashraf Ebrahim, a specialist gynaecologist and obstetrician, and Dr. Yatish Kara, a paediatrician. The Province presented the expert evidence of Dr. Michael Wright, a Cape Town specialist gynaecologist and obstetrician. There was no evidence from any of the Provincial staff who treated the plaintiff and the child and the

[5] Medi-Clinic Ltd v Vermeulen 2015 (1) SA 241 (SCA) at [25]

parties' experts relied heavily on contemporaneous nursing notes and reports, test results, tables and similar documentary evidence for their respective opinions.

11. It should be stated at the outset that the three medical specialists who testified are highly experienced practitioners who discharged their functions as expert witnesses in accordance with the time-honoured principle that they were there to assist the Court in understanding the medical concepts inherent in the evidence and were not called upon to determine whether there was negligence on the part of the Province's employees nor to support the version contended for by the party calling them[6]. The Court is indebted to the doctors for their assistance in determining a difficult case.

12. The plaintiff procured a report dated 26 April 2019 from an expert radiologist in Cape Town, Dr. Bates Alheit, who analysed an MRI scan of the child taken on 19 April 2017 for purposes of determining the cause of her cerebral palsy. The original MRI report was prepared by a certain Dr. Shalen Misser of Durban after Dr. Kara advised in a medico-legal report dated 22 January 2016 that such an investigation was advisable. At the trial the plaintiff preferred to call a local radiological expert to analyse the scan and Dr. Alheit was effectively substituted as an expert for Dr. Misser. Both parties accepted the opinion expressed in Dr. Alheit's report which was admitted into evidence without more.

13. The approach of the Court in evaluating the expert evidence of Drs. Ebrahim, Kara and Wright placed before it was usefully summarized in Medi-Clinic (with reference to Linksfield Park) as follows.

"[5] In para's 37 -39 [of Linksfield Park] the court held that what is required in the evaluation of the experts' evidence is to determine whether and to what extent their opinions are founded on logical reasoning. It is only on that basis that a court is able to determine whether one of two conflicting opinions should be preferred. An opinion expressed without logical foundation can be rejected. But it must be borne in mind that in the medical field it may not be possible to be definitive. Experts may legitimately hold diametrically opposed views and be able to

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[6] Michael and another v Linksfield Park Clinic (Pty) Ltd and another 2001 (3) SA 1188 (SCA) at [40].

support them by logical reasoning. In that event it is not open to a court simply to express a preference for the one rather than the other and on that basis to hold the medical practitioner to have been negligent. Provided a medical practitioner acts in accordance with a reasonable and respectable body of medical opinion, his conduct cannot be condemned as negligent merely because another equally reasonable and respectable body of medical opinion would have acted differently."

BACKGROUND TO THE TREATMENT OF THE PLAINTIFF

14. The evidence establishes that the plaintiff (born on 13 March 1985) was aged 21 years when she gave birth to her second child. The hospital notes record that there were no problems with her first confinement some 3 years earlier. During the course of her second pregnancy, the plaintiff visited her local antenatal clinic in Khayelitsha. At such a clinic, a pregnant mother is customarily seen and assessed by a midwife. If there are no complications, the mother will usually give birth to her child at the clinic – in this case the Khayelitsha Midwife and Obstetric Unit ("MOU") – assisted by a midwife. If the circumstances of a mother's condition are problematic and demand a higher level of medical care and intervention, she is usually referred (and if necessary transported) to the Mowbray Maternity Hospital ("MMH"). So, for instance, where a caesarean section delivery ("a C-section") is contemplated, a referral to MMH would be prescribed.

15. The plaintiff presented for the first time at the MOU on 20 April 2006 and was examined then and subsequent thereto on various occasions by the nursing staff. At approximately 08h00 on 26 June 2006 the plaintiff reported at the MOU in the early stages of labour. She remained at the MOU throughout the day where she was seen by nursing staff from time to time. Eventually at approximately 00h30 the plaintiff was rushed through to MMH by ambulance where an emergency C-section was commenced at 01h40 and the baby delivered at 02h16. It is common cause that the child's medical condition is not attributable to the negligence of any of the staff at MMH.

16. The focus of the case then is on the treatment of the plaintiff by the Province's nursing staff throughout her pregnancy at the MOU, commencing on 20

April 2006 and terminating at around midnight on 26 June 2006. Broadly speaking, the issues can be defined as –

(i) whether the Province's employees at the MOU wrongfully and negligently breached the legal duty they assumed towards the plaintiff and her unborn child to assess, manage and treat them with the degree of care, skill and diligence reasonably expected of reasonably competent nursing staff in their position; and if so,

(ii) whether the breach of that legal duty was causally connected to the injuries suffered by the child.

17. That enquiry will, in turn, focus, firstly, on the plaintiff's general treatment at the MOU during the period 20 April to 25 June 2006, and then, and more specifically, on her treatment there during the course of 26 June 2006.

COMMON CAUSE ISSUES

18. Before traversing the evidence adduced by the parties, it will be useful to set out the issues which are not in dispute. I will revert to the opinion of Dr. Alheit shortly but first I shall refer to the joint minute prepared by Drs. Ebrahim and Wright on 6 June 2018. In accordance with the customary practice, the two experts recorded their points of agreement and disagreement.

19. The specialists agreed that –

(i) the plaintiff's probable due date was not known during her pregnancy in 2006;

(ii) it was unlikely that the child's cerebral palsy was due to an antenatal cause;

(iii) the plaintiff was admitted to the MOU in early labour on 26 June 2006;

(iv) the plaintiff was found to be in active labour at about 20h50 with clear liquor;

(v) there was no progress in labour from about 20h50 until about midnight;

(vi) the plaintiff was transferred to MMH for fetal distress;

(vii) meconium staining of the liquor was noted at birth;

(viii) the child had significant hypoxic ischaemic encephalopathy in the neonatal period and now has cerebral palsy;

(ix) the management at MMH was standard and the delay in delivery was attributable to technical problems.

20. In relation to the last-mentioned point of agreement, it bears mention that before the medical staff at MMH decided to perform a C-section on the plaintiff they first attempted a forceps delivery[7] but were unsuccessful. Thereafter, three attempts were made at a vacuum delivery[8] but this too failed because the machine malfunctioned. The C-section was thus the only other option to effect delivery and it was performed without any problems.

21. The specialists expressed a difference of opinion regarding -

(i) the plaintiff's probable gestational age during labour;

(ii) the quality of fetal heart rate monitoring in labour; and

(iii) whether the plaintiff's intrapartum care was causally related to the child's cerebral palsy and, given the radiological features, whether anything could have been done to avoid the final outcome.

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[7] A procedure whereby the fetus is prised out of the vagina using a forceps tool – similar to a large pair of tongs.

[8] A procedure whereby a vacuum machine is applied to the fetus's head and extraction from the vagina by way of suction is procured.

In relation to the last-mentioned point of disagreement, I understand the term "intrapartum care" to refer to the medical treatment and related activity surrounding the actual delivery of the child.

22. In relation to points (ii) and (viii) of their areas of agreement Drs. Ebrahim and Wright touch on two important aspects. In the first instance, they agree that the child's cerebral palsy was not attributable to any pre-existing condition on the part of the mother or of the fetus itself. This is confirmed by Dr. Kara who states as follows in his report of 22 January 2016.

"8.1 There are no known preconceptual factors (e.g. maternal mental retardation, thyroid disease, epilepsy) or antenatal factors (e.g. maternal infection including HIV, congenital infections, proteinuric hypertension, diabetes, prematurity etc.) that could lead to cerebral palsy."

This view was repeated by the doctor in the witness box.

23. Secondly, Drs. Ebrahim and Wright are in agreement that the child presented with clear signs of hypoxic ischaemic encephalopathy ("HIE") in the neonatal period and that she now has cerebral palsy as a consequence thereof. I understand the neonatal period to refer to the period immediately following the birth of the child and lasting for the first few weeks of life. Encephalopathy, generally, refers to any disease of the brain and it is necessary, in this case, to consider HIE, in particular, as it is accepted that it caused the child's condition of cerebral palsy.

UNDERSTANDING HIE

24. HIE is dealt with by Dr. Kara in his report of 22 January 2016 and is described therein as a "subgroup of neonatal encephalopathy". This opinion was also traversed extensively in Dr. Kara's evidence and is uncontentious. For the sake of accuracy, I shall therefore quote directly from the report.

"**9. Neonatal Encephalopathy**

9.1 Neonatal Encephalopathy is a clinically defined syndrome of disturbed neurological function in the earliest days of life in the term infant, manifested by difficulty with initiating and maintaining respiration, depression of tone and reflexes, sub normal level of consciousness and often seizures, usually affecting the full term infant. This term is preferred to [HIE] as it is not always possible to document a significant hypoxic-ischemic insult and there are potentially several other causes like metabolic disease, infection, drug exposure, nervous system malformation etc. Investigation depends on the clinical presentation.

9.2 HIE is a subgroup of neonatal encephalopathy. To consider hypoxic ischaemic encephalopathy to have occurred in the intrapartum period, there has to be evidence of neonatal encephalopathy. Before attributing the cause of neonatal encephalopathy, one has to consider the probability of other conditions that may cause an encephalopathy.

9.3 It is most likely that the neonatal encephalopathy [in this case] was due to hypoxic ischaemic injury as other causes are mentioned below and reasonably excluded."

25. The finding in para 9.3 of the report was arrived at by Dr. Kara after discounting the causes of the child's encephalopathy as including meningitis, maternal infection or intrauterine infection, metabolic or chromosomal disorders, maternal drug use and obstetric causes that affect blood flow to the fetal brain. However, he did recommend that an MRI[9] examination be performed on the child.

26. This radiological examination conducted by Dr. Misser revealed the following features which are referred to in the report of Dr. Alheit.

"The MRI features, in the appropriate clinical context, are considered as diagnostic of an **acute profound (central) hypoxic ischemic injury** (APHII) of the brain, as seen from 35 – 36 weeks' gestation onwards, now visualized in the chronic stage of evolution on the MR scan done at the age of 10 years and 10 months."

[9] Magnetic resonance imaging – a type of scan that produces detailed images of the inside of the body through the use of magnetic fields and radio waves – www.radiologyinfo.org .

The report by Dr. Alheit is of a technical nature as he explains the etiology of the diagnosis and the basis for his findings, but there is no debate on his finding of the features of an "acute profound" event.

27. In considering the nature and extent of such an event, it suffices to refer to the explanation given by Dr. Ebrahim in his evidence-in-chief regarding HIE:

"That is abnormal neurological function in the baby at birth as a result of a reduction in oxygen and adequate perfusion by blood in the brain."[10]

Later in his evidence-in-chief Dr. Ebrahim, when commenting on the MRI report, spoke also of

"a sudden massive reduction in oxygen supply that gives that kind of injury on the MRI".

He opined that such an "acute decompensation" was likely to have occurred over a period of 20 – 40 minutes based on the manner in which the injury presented on the MRI.[11]

28. In Maggeya[12] Majiet JA, noting that "(h)ypoxia is a prolonged reduction in oxygen supply to the brain" and that "(i)schaemia is a restriction in blood supply which leads to a shortage of oxygen" gave the following judicial explanation of HIE which will provide some further understanding of the issues at play in this matter.

"[8] It was common cause that Kwanga suffered an acute profound hypoxic event during labour. The experts were agreed that all indications point to a global hypoxic ischaemic injury of a catastrophic nature which resulted in spastic dystonic quadriplegic cerebral palsy. A hypoxic ischaemic event can be described as lack of oxygen and inadequate perfusion of oxygen through the blood to the brain which causes damage to the brain. Despite initial

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[10] Record p96.4

[11] Record pp 148-9

[12] Maggeya v MEC for Health, Eastern Cape [2018] ZASCA 141 (1 October 2018). In the minority judgment Majiet JA (Tshiqi JA concurring) dissented on the facts but his judgment is uncontroversial on the issue of the cause and effect of HIE

vigorous contestation on behalf of the MEC, it became common cause by the end of the trial that the cerebral palsy was caused by an acute, profound hypoxic ischaemic injury (the injury). The consensus was brought about by the conclusions contained in the admitted expert report of Professor Van Toorn, a paediatric neurologist. His conclusions were supported by the findings of Professor Savvas Andronikou, a radiologist who performed a magnetic resonance imaging (MRI) scan on Kangwa. His radiology report was admitted as evidence by agreement. In that report, Professor Andronikou concluded as follows:

'*Features are those of a chronic evolution of a global insult to the brain due to hypoxic ischaemic injury, of the acute profound type, most likely occurring at term'*.

Professor Van Toorn concurred with the radiology report that 'Kwanga's MRI changes are consistent with a global hypoxic ischaemic injury, of a catastrophic nature, at or around term'.

[9] A brief explanation of the cause and development of hypoxic ischaemia which injures the brain is necessary. The fetus is completely dependent upon the mother for nutrition and oxygen, transmitted through the umbilical cord from the mother's placenta. During the onset of labour, the contractions of the uterus (commonly known as 'labour pains') affect the placenta. As the contractions increase in strength, the blood vessels in the placenta become constricted and the blood supply to the fetus via the umbilical cord contains increasing levels of carbon dioxide and less oxygen. Monitoring of the fetal heart rate occurs by means of a cardiotocograph (CTG), which also measures the uterine contractions. CTG readings will convey to nursing staff monitoring the patient three important facets of heart normality: (a) the average (baseline) heart rate which, as stated, should be between 110 – 160 beats per minute; (b) the baseline variability of the heartbeat which normally should be between 5 – 10 beats per minute; and (c) accelerations in the heartbeat. Early and late decelerations of the heartbeat are related to contractions of the uterus. Late decelerations occur after the commencement of uterine contractions and recover some time after the contractions had ceased. A fetal heart rate below 90 bpm and a series of late decelerations of the heartbeat are cause for concern, as they may suggest that the fetus is in distress. They are referred to in medical parlance as a 'non-reassuring fetal heart rate'. Depending on the severity of the fetal distress, it may be necessary to expedite the delivery by performing an urgent caesarean section. Absent timeous intervention, the increasing levels of reduced oxygen supply to the fetus (hypoxia) will result in brain damage."

29. There was some debate before this Court (between the obstetricians in particular) about the nature of the event which caused the damage to the child's brain but ultimately there was agreement that there was no "single sentinel event" (for example, a prolapse of the umbilical cord or a placental abruption) which caused the acute profound hypoxia in this matter. Both doctors accepted that there were late decelerations[13] in the fetal heart rate and that, in association with the plaintiff's contractions in active labour, these were the most likely cause of the hypoxia.

30. In his evidence-in-chief, Dr. Wright gave the following useful explanation of such a deceleration[14].

"M 'Lord, decelerations mean that slowing of the fetal heart rate by more than 15 beats per minute. Under normal circumstances with a normal healthy baby everything like that, the slight drop in the oxygen levels during a contraction, causes the fetus to slow its heart a bit and then the normal fetus with normal uterine contractions as soon as a contraction stops, it recovers. So, it would be analogous again to you or I holding our breath. If we hold our breath, we may find our heart rate changes but as soon as we start breathing, it will go back to normal. And that's the same in the fetus. If the heart rate does not recover almost inversely related to the contraction, in other words the deceleration is at its highest when the uterine contraction is at its strongest and the uterine contraction wears off, so the fetal heart rate starts to recover. So you have a deceleration that is coincidental with the uterine contraction and that's known as an early deceleration and it's usually a very benign event. The late deceleration is when that recovery does not take place immediately after the contraction so you will see the contraction, which would be recorded on the graph or palpated by the nurse, the contraction stops but the fetal heart rate still remains slow and may take 15 to 30 seconds to come back to normal after the contraction has stopped. That is called a late deceleration and that is certainly a far more ominous sign than an early deceleration…"

31. The central question, then, in this case is when this sudden deprivation of oxygen to the fetal brain is likely to have occurred. Dr. Ebrahim believed that the

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[13] Also referred to as "Type II decelerations".

[14] Record p728.4

brain injury was sustained in approximately the last hour of pregnancy – perhaps somewhere between 01h15 and 02h16 - and gave the following explanation.[15]

"M'Lord, when the decompensation takes place there is no chance for the fetus to recover *in utero* and if delivery doesn't take place, then the fetus will die *in utero.* So the only reason that this child survived is because the child was delivered and received resuscitation in the neonatal unit so this injury would have happened in the last hour at the most."

32. That explanation by Dr. Ebrahim leads directly to the primary factual question in this case *viz.* whether the staff at the MOU should have referred the plaintiff to MMH at an earlier stage during the evening of 26 June 2006 so that the HIE might have been avoided by the performance of an earlier C-section. I shall revert to Dr. Ebrahim's evidence on that score after I have dealt with Dr. Kara's testimony regarding the HIE.

33. Dr. Kara is a paediatrician with vast experience in the assessment of newborn babies. He took the Court through his report to demonstrate the symptoms in the child's condition immediately after birth, which he said, were indicative of an intrapartum hypoxic ischaemic injury which caused the cerebral palsy. Given that it is common cause that the child experienced such an insult in the intrapartum phase (i.e. during the active phase of the plaintiff's labour), it is not necessary to go into Dr. Kara's evidence on that aspect any further.

34. What is of importance in Dr. Kara's evidence, however, is the question as to when, in the stage of active labour, the injury was likely to have occurred. Dr. Kara's unchallenged evidence on this point is to the following effect.[16]

"…Now if the fetal heart was, if the brain injury had occurred prior to 01:30, it is possible, nothing is possible (sic), but it is possible that the injury occurred prior to 01:30 – but then there would have been a very high probability of this baby being dead at the time of birth.

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[15] Record p150.11

[16] Record pp 532.13 to 533.4

So because we say that in this type of injury, and the comment was that you have a 45-minute period to deliver the baby – yes, that's to prevent injury. But you can still have a live baby up to 90 minutes after this type of injury. And there are studies that show after certain events where there's uterine rupture, etc, they did manage to deliver a live baby severely brain damaged at 90 minutes. But beyond that there's very little data of babies surviving beyond 90 minutes.

So I can safely say that it is probable that this baby was injured in the last 90 minutes, and that's giving some leeway, in the last 90 minutes of labour."

35. When the Court suggested to the witness that this would have put the injury at around 00h45 (when the plaintiff was probably in the ambulance en route from the MOU to MMH), Dr. Kara replied –

"But having said that, it could have occurred a little later, I don't know."

Dr. Kara's opinion is consistent with that of Dr. Ebrahim who suggested that the injury occurred 60 minutes rather than 90 minutes before birth, the point being that the plaintiff's experts believed that the radiological evidence sustained their contention that an injury of this sort occurred very late in the pregnancy, during the active phase of labour and shortly before delivery of the infant.

36. During cross-examination, Ms. Adhikari did not take issue with Dr. Kara's estimate of an insult some 90 minutes before birth but suggested to the witness that the plaintiff may already have arrived at the hospital by then. He replied as follows.[17]

"It is possible, but the issue is, were appropriate steps taken prior to the injury to minimise the risk of that injury."

37. That last mentioned remark by Dr. Kara identifies the focus of this case already referred to - was the plaintiff cared for at the MOU with the requisite degree of

[17] Record p 543.21

skill and care, were reasonable steps taken by the staff there to minimise the risk of injury to the child *in utero* and, importantly, were there warning signs of an impending medical catastrophe which warranted earlier referral to MMH and which were not appreciated or adhered to by the MOU staff.

THE ASSESSMENT AND ANTENATAL TREATMENT OF THE PLAINTIFF

38. As stated earlier, the Province adduced no evidence from any of its staff employed at the MOU and, consequently, the obstetric experts on both sides were obliged to rely on a variety of nurses' notes and records (and their respective interpretations thereof) for their opinions of the antenatal obstetric care afforded to the plaintiff. The admissibility of these records into evidence was not disputed but one must nevertheless proceed with caution in assessing the contents thereof precisely because of the absence of *viva voce* evidence from the nursing staff. That having been said, the areas of disagreement were fortunately not extensive and might be summarized as follows.

39. Firstly, there is the issue as to just when during the active phase of labour the acute HIE occurred. While the plaintiff's experts were in agreement that this happened at most 90 minutes before the birth and were not challenged in regard thereto, Dr. Wright subsequently testified that it was probably much earlier than that. Secondly, there was a dispute as to when fetal distress began to manifest in the unborn child and, allied to that, whether the response of the staff at the MOU was appropriate thereto. Thirdly, there was an issue around the extent of the plaintiff's pregnancy at the time she reported to the MOU on 26 June 2006.

40. There are really only three documents which are important to consideration of the issues in this matter. The first is the record of the plaintiff's antenatal attendances at the MOU in relation to her pregnancy. For the sake of convenience, I shall call this document the "MOU Record". The MOU Record is a fairly elementary document drawn up for use by staff employed at the "Peninsula

Maternal and Neonatal Services" as a record of a mother's attendances at an antenatal clinic (such as the MOU) prior to her going into labour. The contents of the MOU Record will appear from the discussion of the evidence.

41. The second document is the Record of Admission form ("the Admission Form") which was filled in when the plaintiff presented at the MOU on the morning of 26 June 2006 and was first examined by the staff on duty. The document records the observation of certain relevant facts and the plaintiff's medical condition, as well as that of the fetus.

42. The third is a large A3 document known as a "Partogram". It is a standard *pro forma* document used to record the progress of a patient's labour at the MOU through both the latent and active phases. The Partogram is well known to any nurse or midwife working in an obstetric unit throughout the country and has standard columns and graphs for the recordal of vital information regarding the mother's condition during labour.

43. The use of the Partogram is extensively referred to in the document already referred to and issued by the National Department of Health in Pretoria entitled "Guidelines for Maternity Care in South Africa: A Manual for Clinics, Community Health Centres and District Hospitals" ("the Guidelines"). The document has been revised from time to time and it was agreed between the parties that the 2000 edition was in operation at the time of the birth of the child. While the MOU Record and the Partogram cover two distinct phases of a mother's pregnancy, the latter has to be considered against the background of the former and is informed thereby.

44. The MOU Record shows that the plaintiff visited the clinic for the first time on 20 April 2006. Her personal details reflected that she was then 22 years of age and had had one previous pregnancy when she had delivered a 2,9kg son at 40 weeks' gestation, without any complications. The plaintiff was in good health and was screened for the presence of special conditions such as HIV and TB, none of which was found to exist.

THE EXPECTED DATE OF DELIVERY

45. No recordal was made in the allocated space of the observations of any vaginal examination conducted on 20 April 2006 but the "SF-measurement" was noted as "34 cm". This, said Dr. Ebrahim, refers to the "Symphysis Fundal Measurement" which is an external measurement taken by the examining nurse of the mother's pregnant abdomen. Using an ordinary tape measure, the length of the fetus is calculated by placing the tape on the pubic bone and measuring up towards the top of the fetus. The SF measurement is said to provide a useful, non-invasive calculation of the age of the fetus.

46. In the plaintiff's case, the 34cm measurement on 20 April 2006 suggested a fetus aged about 34 weeks. Given that an average pregnancy lasts around 40 weeks, Dr. Ebrahim said that this measurement suggested that the child would then have been expected to have been born in about 6 weeks' time – around 2 June 2005.

47. Dr. Ebrahim testified further that the calculation of the age of a fetus (and therefore the expected date of delivery – "EDD") could also be arrived at with reference to the mother's last menstrual cycle. Provision is thus made on the MOU Record for jotting down the patient's "LMP" - in the plaintiff's case this was recorded as 13 November 2005. This translates into a pregnancy of approximately 23 weeks at the time of her first visit (or "booking" as the doctor termed it). There was thus a significant difference of 11 weeks between the two calculations, with the LMP calculation taking the EDD into early August 2006. Yet, the nursing staff did not record anything whatsoever in the place on the form reserved for the EDD and manifestly did not appreciate the potential difference in dates.

48. As part of the MOU Record, there is a graph on which the nursing staff can plot the estimated gestational age. The graph has three pre-determined parallel lines which respectfully represent the 40$^{th}$, 50$^{th}$ and 90$^{th}$ percentiles of the gestational age. This is then calculated by entering the SF measurement on the graph by placing a dot on the line which corresponds with the date of the measurement.

49. In the plaintiff's case, the graph shows that SF measurements were taken on 20 April, 8 and 25 May and 15 June 2006. All of the dots correspond with the 50th percentile of measurement and record that the plaintiff had reached 40 weeks of gestation by 15 June 2006 when the SF measurement was of the order of 37cms. In the result, the MOU staff should have known that on that day the plaintiff had already reached the term of her pregnancy (or in medical parlance that she was "at term"). Furthermore, when the plaintiff arrived at the MOU on 26 June 2006, the nursing staff should have been alive to the fact that she was at a later stage of her pregnancy and needed to be treated accordingly.

50. As will be seen later, the plaintiff arrived at the MOU on the morning of 26 June 2006 in the early stages of labour and was treated as she then presented – "at term".[18] However, the failure of the nursing staff to record the EDD at the earliest possible opportunity and to provide some indication as to when she was expected to give birth would have left the MOU staff in the dark as to whether the mother was overdue at that stage or not.

51. According to Dr. Ebrahim, the plaintiff might have been as far advanced as 43,5 weeks in her pregnancy, which presented a potentially dangerous situation for the fetus. Such a situation could have indirectly impacted on the development of HIE through fetal distress as Dr. Ebrahim explained[19] -

"…. instead the antenatal nurse's failure to recognize the importance of determining her EDD and to be aware that she was overdue indirectly resulted in a delay in the diagnosis of fetal distress and the neonatal complications that ensued. In other words, they failed to realise that they were dealing with a possibly overdue pregnancy at the time that she presented in labour because that date was several weeks after her due date as calculated from the first visit – from her first appearance at the clinic. The reality, M'Lord, is that nobody ever knew what her correct due date was."

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[18] The phrase suggests that the pregnancy had reached 40 weeks and that the mother was ready to deliver.

[19] Record p 46.11

52. One of the important reasons for determining the EDD accurately relates to placental function. Dr. Ebrahim stressed that once the mother is beyond 42 weeks in her pregnancy, the placenta is liable to be less effective and that this in turn can impact on the blood flow to the fetus and a consequent reduction in oxygen supply thereto.

"Now just as pregnancies that are too premature have certain risks if delivery occurs too early, there is a different spectrum of risks that are present when the pregnancy is overdue and undelivered. And this is related largely to the fact that the placenta, the afterbirth, ages as the pregnancy advances and at the same time the demands of the fetus are increasing… (f)or oxygen, glucose and other nutrients. Principally, in this case we are worried about oxygen in labour so as the pregnancy goes overdue the placenta sometimes, not always, sometimes is incapable of meeting the requirements of the fetus…

So the placenta is designed generally to function optimally up to about 42 weeks although most babies will deliver by about 40 weeks. And this obviously applies to healthy women because the placenta can fail if there are problems in pregnancy so in a healthy person this is what we would expect in terms of placental function."

53. In his evidence, Dr. Wright said that he considered that the LMP date was misleading. He held the view that the bleeding experienced by the plaintiff on 13 November 2005 (which she probably mistook as menstruation) might have been occasioned by the type of contraception (an injection) the plaintiff had been using before she fell pregnant and that the LMP was then earlier than actually recorded. Dr. Wright, however, held the view that because the staff at the MOU treated the plaintiff on 26 June 2006 as being "at term", she was not likely to have been beyond 42 weeks, which is the outer parameter of that phrase as it is understood in the obstetric setting. This is the phrase that the staff at MMH also used in their notes.

<u>THE TREATMENT OF LABOUR AT THE MOU – THE PLAINTIFF'S EVIDENCE</u>

54. The plaintiff testified that she attended the Nolungile Clinic in Khayelitsha on 19 April 2006 for purposes of a consultation regarding birth control. She was told that she might in fact be pregnant and was referred to the MOU (which

is at Nonqubela) which she attended for the first time on 20 April 2006. After describing how the SF measurement was taken at that first visit, the plaintiff said that she returned to the MOU for the three further visits already referred to – on 8 and 25 May and 15 June 2006. At the last visit, the plaintiff said that the staff informed her that the child was "all right." She confirmed that she did not suffer from any illnesses or infections during her pregnancy and that she did not smoke either during that time.

55. At about 07h00 on the morning of Tuesday 26 June 2006, said the plaintiff, she experienced abdominal pain and went to the MOU where she arrived at about 08h00. The plaintiff went on to say that she sat around in the reception area until she was first examined at around 10h00, when she was told to lie on a bed. During that examination, the nurse inserted two fingers into her vagina and also listened to her stomach with a "stethoscope". This was the phrase used in court by the interpreter but it seems that the parties accepted that the plaintiff was describing a "fetus scope" which is a manual listening device, conical in shape, which is placed on the mother's abdomen and through which the nurse can listen to, and monitor, the FHR. Apparently, the MOU was not equipped with a cardiotachograph ("CTG") which is a more sophisticated electronic device used to measure the fetal heart rate "FHR"). However, MMH was equipped with a CTG.

56. I pause to mention that, as para 9 of the judgment in Maggeya makes clear, monitoring of the FHR before birth is critical in establishing whether or not there is fetal distress. As the learned Judge of Appeal pointed out, of particular importance in that regard is whether there are any signs of late decelerations in the FHR after a contraction. A rate of 90 beats per minute ("bpm") would be indicative of such a deceleration. I shall revert to this later.

57. The plaintiff said that after the first examination at 10h10, she was told the fetus was "all right" whereafter she told to sit on a chair again. The plaintiff said she was similarly examined again at about 15h00 on a bed and then told again to sit on a chair. The plaintiff said her next examination was at around 21h00 when she started feeling strong abdominal contractions. Initially the plaintiff said that there was only one examination by the night staff (around 21h00) before she was taken through

to MMH, but under cross-examination she accepted that there may have been subsequent examinations at the MOU that she could no longer recall. Importantly, though, the plaintiff testified that the only times that she was told by the nursing staff at the MOU to lie on a bed was when she was examined by them. For the rest, she said, she was told to sit on a chair. This is indicative of a failure by the staff to adhere to the Guidelines.

58. The plaintiff said that an intravenous drip was inserted into her arm while she was in the ambulance en route to MMH and that she was conscious during the C-Section operation, describing what appears to have been an epidural anaesthetic. She noted that upon delivery the child did not cry and that she did not suckle either. According to the obstetricians and the paediatrician, these are the early signs suggestive of cerebral palsy at birth. The plaintiff's further evidence related to the special plea of prescription, which I will discuss under a separate head later.

DR. EBRAHIM'S ASSESSMENT OF THE TREATMENT AT THE MOU

59. For his expert opinion, Dr. Ebrahim relied on the Admission Form completed at the MOU at 10h10 on 26 June 2006, the Partogram contemporaneously filled in later that day and the various doctors' and nursing notes from MMH. Dr. Wright was content to do likewise, both specialists being of the view that there was no better recordal of events than these documents.

60. It is important, in deciphering the Admission Form and the Partogram, to understand the phases of labour – both latent and active – each of which is characterised by physiological changes to the woman's body. Dr. Ebrahim explained that during the latent phase, the mother's uterus and cervix start to undergo physiological changes which result in the cervix dilating (i.e. enlarging) and flattening out so as to become part of the uterus. As I understand it, the patient's cervix dilates to approximately 3cms during this phase as her body prepares itself for the passage of the fetus through the "birth canal", as Dr. Ebrahim called it. The latent phase is established by the midwife by having regard to both the initial dilation of the cervix and, importantly, the presence of contractions.

61. Later, during the active phase of labour, the contractions will be more pronounced and, importantly, the cervix dilates up to 10 cm (ordinarily the full extent of its dilation) in order that the fetus can be expelled from the uterus via the birth canal through the vagina. The dilation of the cervix is usually monitored by the midwife inserting her fingers into the patient's vagina and estimating the extent of the opening of the cervix. Obviously, if there is insufficient dilation of the cervix, the fetus will be obstructed and unable to freely pass through the birth canal. When that occurs the health of the fetus may be compromised resulting in injury thereto. It follows that proper monitoring of the cervix during labour is important.

62. The Admission Form reflects that upon her first examination at 10h10 on 26 June 2006 the plaintiff's membranes were intact, the cervix was dilated at 2-3cm, that she was thus regarded as being in the latent phase and that she was to be re-assessed four hours later. Her temperature, pulse rate and blood pressure were within normal limits and the FHR was "regular" at 138 bpm.

63. The only other entry of relevance on the Admission Form is a note of an examination at 15h15 that day when the FHR was recorded as 140 bpm and "regular", the membranes were still intact and the cervix was "still the same". Contractions were recorded as "2 x moderate 1 mild".

THE PARTOGRAM

64. The first entry on the Partogram is at 20h50. This signifies that at that stage the MOU staff regarded the plaintiff as being in active labour. Dr. Ebrahim expressed concern at the fact that, firstly, the follow up examination occurred 5 hours after the initial examination at 10h10 and that the third examination took place some 5,5 hours after the second. He pointed out that this was not in accordance with the accepted protocol contained in the Guidelines.

65. Accordingly, during the latent phase of labour there should have been 4 hourly vaginal examinations (at 14h15 and 18h15, assuming the plaintiff was still in the latent phase at the latter time) and every 2 hours thereafter once she was in the

active phase. Such examinations would have established the extent of the cervical dilation. Further, during the latent phase, the FHR should have been monitored every 2 hours (at 12h00, 14h00, 16h00 and 18h00) and in the active phase, every half an hour, “before, during and after contractions.”

66. Because these protocols were not adhered to by the MOU staff, the Court does not know just when the plaintiff entered the active phase of labour. However, Dr. Ebrahim suggested that active labour probably commenced at around 18h00 to 19h00 given that at 20h50 her cervical dilation was recorded on the Partogram as 7cm. The doctor’s conclusion in this regard was predicated on the accepted assumption that in active labour cervical dilation generally occurs at the rate of around 1cm per hour and that active labour commences when the dilation is at 4cm. I did not understand Dr. Wright to take issue with these assumptions.

67. While the Partogram makes provision for the recordal of relevant medical information during both the latent and active phases of labour, there are no annotations whatsoever thereon during the latent phase, while the first note during the active phase only commenced at 20h50. This reflected that there was an “AROM” (artificial rupture of membranes), which is a procedure where the nursing staff would have pricked the membranes through the cervix to allow the plaintiff’s waters to break. When this occurred, the staff noted that the liquor, which was discharged, was “clear”.

68. The Partogram has a column under the active phase for the recordal of the FHR, with provision for a measurement both before and after contractions. The first such entry was at 20h50 and recorded as 120-130 bpm before a contraction and approximately 110 bpm after a contraction. Between 21h50 and 22h50 it was measured at 100-110 bpm after a contraction and between 23h00 and 24h00 at between 90-100 bpm after a contraction. These were regarded by Dr. Ebrahim as a clear manifestation of late decelerations in the FHR, a situation which he said warranted urgent medical intervention.

69. However, the notes suggest that it was only at around midnight (after the measurement below 100 bpm) that the decision was made to transfer the plaintiff

to MMH. When the plaintiff arrived at the hospital by ambulance at 01h30, the receiving doctor's notes show that her cervix was fully dilated and the FHR ranged between 60 and 182 bpm. The obstetricians both agreed that the fetus was manifestly in distress at that stage and urgent action was thus warranted. As already indicated, the hospital staff responded by attempting a vaginal delivery by the vacuum method and when this failed, and they were unable to effect a forceps delivery, the plaintiff was taken to theatre at 01h55 for an emergency C Section.

MONITORING THE FHR

70. I have already referred to Maggiya at [9], where the learned Judge of Appeal discusses the importance of monitoring the FHR and any decelerations therein. Nevertheless, for the sake of completeness, I shall recite the full extent of Dr. Ebrahim's explanation in his evidence-in-chief regarding the necessity for careful monitoring of the FHR.[20] I did not understand Dr. Wright to take issue with this view.

"(W)ith each contraction there is a natural constriction of the blood vessels that are traversing the uterine muscle to get to the placenta. So, the uterine vessels are on the surface of the uterus, the placenta is on the other side of the muscle inside the womb and the branches of the uterine artery have to get across this muscle barrier before it gets to the placenta, and, in contracting there is a natural narrowing of these vessels that are traversing the musculature. So, there is a transient reduction in oxygen supply to the fetus for the duration of the contraction and that reduction can be 25% in normal labour when each contraction…the amount that gets to the fetus when the uterus is not contracting is reduced by 25% during a contraction and that supply is restored at the end of a contraction and generally contractions are in strong labour about 40 to 60 seconds long so that's the duration of the oxygen deficit with each contraction, three or four contractions in a 10–minute interval. But during the resting phase the fetus regains its supply and is able to cope with that reduction, a healthy fetus is able to cope with that reduction. But if we are to take a healthy fetus and the labour is prolonged then at the latter stages of labour the baby may show signs of not being able to cope because its reserves have been used up by the hours of labour before that so that distress may occur in the latter stages of labour - in the second stage of labour. On the other hand, it may occur early in labour if a fetus looks apparently well but has got some diminished

[20] Record p122.15 – 124.11

reserve for a reason that can't be measured. It just is not able to tolerate the early contractions of labour or the contractions in the middle of labour. **So it's for that reason that the heart rate must be monitored closely during labour because one never knows when the fetus is not going to compensate for the effects of the contractions and the only way we have of knowing this is by checking the fetal heart rate** and the time when the fetus' inability to cope is best displayed is after a contraction because the contraction is the insult, the transient insult, and that is the reason for checking it before and after a contraction. When the baby is very sick then the heart rate is obviously abnormal even in between contractions but by that time it is too late. So, in general, babies are able to withstand this reduction throughout labour and if there is a sign from the baby's side that it is not, the doctor is not in a position to know whether that - whether the baby has already reached the end of its tolerance. That only time tells one…" (Emphasis added)

71. In the result, Dr. Ebrahim was critical of the overall monitoring of the plaintiff. In addition to the fact that she had not had the prescribed 2-hourly vaginal examinations prior to the onset of active labour, he was concerned that with effect from 20h50 the monitoring of the FHR was not in accordance with the Guidelines. In this regard he testified that the first FHR recordal at 20h50 was

"a doubtful reading and the second [at 21h50] was definitely a deceleration so there were things that needed to be done at that time rather than just continue the monitoring after that. I think that's the issue that I have with the monitoring."[21]

72. The doctor's concerns about the lack of monitoring of the FHR in the active phase must also be viewed in light of the fact that the MOU staff had no inkling whatsoever of the plaintiff's EDD. Dr. Ebrahim said that it was possible that she may well have been post-term when she reported there on the morning of 26th June 2006, a situation which would have warranted a higher degree of urgency and care in the treatment of the plaintiff and her unborn child.

"I think, M'Lord that the possibility of baby being a post term fetus ought to have been at the back of the minds of the staff looking after her because there was great uncertainty about the due date and, with the information at hand, this computed to a due date of well over 42

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[21] Record p129.5

weeks. So it would have been prudent to have exercised vigilance in monitoring this fetus right from the start. In fact, the recommendations are that if the pregnancy is post term that mother should deliver in a hospital rather than a clinic. So this mother should have been discussed with the doctor at the base hospital [i.e. MMH] on admission for a decision to be made as to where was the safest place for this mother to labour (sic) right from the very start."[22]

There is no evidence from the Province that this took place and certainly no note to that effect in the MOU records.

73. In relation to the FHR monitoring only having commenced at 20h50, Dr. Ebrahim was critical of the fact that the plaintiff was not sent to MMH earlier than 00h30.

"So you know, given that she was managed at the clinic she ought to have had her fetal heart rate checked more frequently, both in the latent and the active phase of labour and obviously now with hindsight and knowing what the outcome of the baby is and looking at the labour graph which shows that the fetal heart rate was abnormal from probably - well certainly from 21h50 onwards and probably from 20h50 – there's a strong possibility that it was abnormal even before that. **So all in all this patient ought to have been sent to the hospital much earlier than was done in the event**."[23] (Emphasis added)

74. When asked to speculate at what time the plaintiff ought to have been referred to MMH, Dr. Ebrahim suggested that this would have been shortly after 21h50. He motivated his opinion as follows.

"(Y)ou know the observation at 21h50 (sic - 20h50) is probably a deceleration. I think it's a deceleration but it's open to interpretation – but the observation at 21h50 is clearly a deceleration and at that stage given the possibility of her being postdates (sic), knowing that

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[22] Record p140.23-141.10

[23] Record p145.6-15

one has to refer the patient, which is going to take an hour, it is safer to pre-empt problems rather than wait for a crisis to appear before referring."[24]

75. A further cause for concern in the treatment of plaintiff's labour related to the dilation of the cervix. Dr. Ebrahim observed that the dilation at 15h15 was measured as 3cm and at 20h50 as 7cm. The Guidelines indicate that when the dilatation is of the order of 4cm, the mother is to be regarded as having moved from the latent to the active phase of labour and, as I have noted, generally there is a 1cm dilatation per hour thereafter in the active phase. For that reason, said Dr. Ebrahim, he assumed that the plaintiff went into active labour around 18h00. It is axiomatic that because no 2-hourly measurement was taken in terms of the Guidelines, the staff were unaware as to when the plaintiff actually went into active labour and, most importantly, when the half-hourly monitoring of the FHR ought to have commenced.

76. As I have already noted, the Partogram contains three transverse parallel lines, designated respectively as "Base", "Alert" and "Action", on which the nursing staff are required to record the extent of the cervical dilation when measured from time to time. The level of each recordal is intended to indicate to staff what degree of activity is required of them at that stage. The recordal on this part of the Partogram reflects that the plaintiff's cervical dilation remained constant at 7cm for around 3 hours - between 20h50 and 24h00. Manifestly, the anticipated hourly increase in dilation of 1cm was not occurring and the birth canal remained constricted rather than opening up to allow the fetus to pass through freely as the contractions increased. With the dilation remaining fixed at 7cm for that three-hour period, the labour crossed the "Alert Line" without the staff taking appropriate action: it seems that this only happened when it crossed the "Action Line" hence the calling of the ambulance around midnight.

DR. WRIGHT'S EVALUATION OF THE MOU TREATMENT

77. In his evidence, Dr. Wright agreed that the Guidelines were not adhered to by the MOU staff in a number of respects. Firstly, the doctor acknowledged that

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[24] Record p145.19-25

there was a failure to record the EDD and that this omission had an adverse effect on the management of the pregnancy.

78. At p20 of the Guidelines the following is stipulated in relation to the EDD.

"It should be indicated on the antenatal card how the gestational age was estimated. The first estimation of gestational age, **with the expected date of delivery**, will be used for the remainder of the pregnancy and must not be changed unless some important new information becomes available." (Emphasis added)

Dr. Wright agreed that, had the MOU staff done what was required of them in terms of the Guidelines, they would have arrived at an EDD of "early June."[25] In light of the fact that generally accepted practice is to deliver a fetus by 41 (and at most 42) weeks[26], when the mother is beyond 41 weeks, under the Guidelines, she should be referred to hospital for further investigation.[27] Given the estimate by Dr. Wright of the EDD of "early June", by 22 June 2006 onwards the gestational age of the fetus exceeded 41 weeks and the plaintiff should accordingly have been referred to MMH upon arrival at the MOU on the 25th.[28]

79. Secondly, Dr. Wright agreed that the monitoring of the plaintiff by the staff at the MOU was not according to the Guidelines in various respects. He acknowledged that there was a failure to conduct four-hourly vaginal examinations with effect from 10h10, resulting in insufficient monitoring of the cervical dilation and, importantly, to establish when the dilation went beyond 4cm thus placing the plaintiff in active labour. [29]

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[25] Record 655.18

[26] Record 653.8

[27] Record 696.17

[28] Record p783.5

[29] Record p778.20 – 779.4; 783.1 – 21

80. The doctor confirmed that there was a further failure to conduct two-hourly FHR examinations with effect from 10h10 and half-hourly FHR examinations after the plaintiff went into active labour which he also accepted was probably around 18h00.[30]

81. Dr. Wright accepted that there was also a failure to observe the Guidelines at around 18h00 when it was evident that the plaintiff had been in the latent phase of labour for 8 hours. He further agreed that the Guidelines expressly provide that "(t)he latent phase is prolonged when it exceeds 8 hours" and that there were specific steps which should then have been undertaken by the staff at around 18h00, being -

- Consideration, and the exclusion, of other causes of abdominal pain;
- The exclusion of false labour; and
- "After excluding fetal distress and cephalopelvic disproportion, rupture the membranes and/or start an oxytocin[31] infusion as for the active phase of labour." [32]

None of these steps was undertaken at 18h00 and, as demonstrated earlier, the membranes were only ruptured almost 3 hours later. Furthermore, there is no indication on the Partogram that fetal distress was considered by the MOU staff for the purposes of exclusion, nor that oxytocin was administered at any stage. In short, nothing was done to enhance the progression of labour when this was required under the Guidelines.

82. But there is more. Once the staff established that the plaintiff was in active labour, the Guidelines obliged them to monitor the FHR more frequently - every half-hour. Dr. Wright acknowledged the importance of monitoring the FHR in ensuring

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[30] Record 803.5

[31] Dr. Wright testified that this is a drug that causes increased contractions during, and is used to induce, labour.

[32] Record 795.1 – 798.15

the health of the fetus and agreed that at least from 20h50 onwards the staff failed to follow the Guidelines in this regard too.[33]Under cross-examination, Dr. Wright agreed that there had been no monitoring whatsoever of the plaintiff for more than five and a half hours (15h15 to 20h50) and, given the importance of regular FHR monitoring to assess fetal well-being, that this had left a huge void in the matter and precluded the MOU staff from having a "holistic view of how this baby had progressed."[34]

83. Dr. Wright disagreed with Dr. Ebrahim's view that there had been a late (or so-called "Type II") deceleration during the 20h50 monitoring of the FHR but agreed that this was certainly the case at 21h50 and also an hour later at 23h00.[35] While agreeing with Dr. Ebrahim that such an injury would usually take place over a period of anything between 10 and 40 minutes, Dr. Wright held the view that the "damage causing event" (as Mr. Schoeman SC rather aptly termed it in argument) was more likely around 23h00 or thereafter. As already noted, both Drs. Ebrahim and Kara were of the view that this event rather occurred between an hour and an hour and a half before the birth, probably at a time when the plaintiff was at the hospital, or on her way there. There is thus a significant difference of medical opinion on this aspect to which I shall revert later.

84. When asked by Ms Adhikari in his evidence-in-chief whether he confirmed that the event was around 23h30, Dr. Wright explained as follows.

"Ja I think that's where it started then because, M'Lord, if one looks at all of the evidence that we have that after that – at, hang on, 22h50 the fetal heart rate appears to be normal….(t)hen by 23h00 it is severely abnormal and there is never another normal fetal heart rate recorded because the other heart rate which she had done – that are (sic) entered on the partogram and the heart rate when she got to Mowbray are all abnormal. So we don't have a period where there was, as there was previously, a period of normality after the abnormal fetal heart rate. We have a severe deceleration and the fetal heart rate is never again recorded as being

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[33] Record 700.25

[34] Record 805.22

[35] Record 721.2 – 723.12

normal….And therefore I cannot see how you can ignore that as being the time when this event occurred."

85. The central thesis in Dr. Wright's evidence then was, accepting that the MOU staff had fallen short in adhering to the Guidelines in a number of crucial respects, whether the damage-causing event could have been avoided through earlier intervention by the MOU staff. Both obstetricians agreed that at any efficient state hospital it would take staff between 45 minutes and an hour to assess a pregnant patient, decide on a C-section and take her to theatre. Added to that is the fact that before the plaintiff could be taken to MMH, a specially equipped obstetric ambulance (colloquially called "The Flying Squad") would have to have been called to the MOU to collect the patient and undertake a journey lasting at least 20 minutes along Cape Town's N2 highway through to Mowbray. One might thus fairly allow 45 minutes to an hour for the calling of the Flying Squad and its journey through to MMH. Thus, an allowance must be made for a time lapse of between one and a half and two hours between the decision being made at the MOU to transfer the plaintiff to MMH and the delivery of the child. The MOU staff would have been aware of these time constraints.

86. If one has regard to the Partogram, it would seem that the MOU staff only started making preparations to send the plaintiff through to MMH at around midnight: the notes state that she was evidently given an oxygen mask, an intravenous drip was put up and her bladder was emptied. There is also reference on the Partogram to a certain "Dr. Chiporo" at "MMH" while the operation notes for the C-Section reflect that s/he was the surgeon who performed the procedure. Clearly, the MOU staff were in contact with the surgical staff at MMH at that time. Further, there is a manuscript note at the end of the document that reads "FSQUAD ON WAY 00h30 Ref 103". It is not clear whether this refers to the fact that the ambulance left the MOU at 00h30 or was called out to the MOU at that time.

87. The first indication in the MMH notes establishing a timeframe is an entry noting that the FHR was measured with a CTG at 01h15. It is recorded that there were then Type II decelerations with the FHR at 60 bpm before, and 182 bpm

after, contraction. The MMH notes also reflect that the surgeon was called to review the patient at 01h30.

88. In the circumstances, the delay from around midnight (when the decision to refer the plaintiff to MMH appears to have been taken) to 02h16 (when the child was delivered) cannot, in my view, be described as unreasonable in the circumstances. In any event, I did not understand either of the obstetricians to complain about any unnecessary delay or tardiness on the part of the MOU staff, the ambulance service or the MMH staff once the decision to transfer the patient had been made. What really is at issue is whether that decision should have been made earlier than midnight.

SHOULD THE PLAINTIFF HAVE BEEN TRANSFERRED TO MMH EARLIER?

89. The answer to this question is influenced by various considerations. Firstly, there are the late decelerations in the FHR which, it is common cause, had clearly manifested by 21h50 at the latest. Both obstetricians agreed that this was indicative of fetal distress and warranted urgent steps being taken to ensure the well-being of the fetus at that time.

90. Secondly, there is the common cause fact that the Partogram records that the plaintiff's cervical dilation had remained constant at 7 cm from 20h50 to 24h00. While the absence of dilation for 4 hours is, in and of itself, cause for concern, the real problem with the evaluation of this observation is that there was, as already mentioned, no recordal as to when the dilation increased from 3 to 4cm and beyond. In other words, the MOU staff were in the dark as to the danger inherent in the plaintiff's failure to dilate according to the normal pattern, and they seemed oblivious to the fact that the failure to dilate probably occasioned an obstruction to the fetus moving from the uterus through the birth canal.

91. The 2000 Guidelines contained a section specifically devoted to the management of "**EMERGENCIES DURING LABOUR**". Firstly, they deal with the evaluation of fetal distress as follows.

"**Fetal distress**

This is suspected when the following signs are observed:

- Baseline fetal heart rate > 160 beats per minute
- Baseline fetal heart rate < 100 beats per minute
- Baseline variability persistently < beats per minute on a CTG (in the absence of sedating drugs)
- Late decelerations of the fetal heart rate."

92. Then the Guidelines prescribe the management of fetal distress as follows:

"**Management of fetal distress**

1. Explain the problem to the mother;
2. Lie the mother in a left lateral position;
3. Give oxygen by face mask at 6L/minute;
4. Start an intravenous infusion of Ringers-Lactate to run at 240ml/hour;
5. Perform vaginal examination for cervical dilatation and to exclude cord prolapse.

   - If vaginal delivery is imminent (cervix fully dilated) deliver immediately by vacuum extraction if necessary;

   - If vaginal delivery is not imminent, give hexoprenaline 10 micrograms IV stat and prepare for immediate caesarean section. Transfer urgently from a community health center to hospital."

93. The MOU staff, through their failure to adhere to the Guidelines, had no way of knowing that the plaintiff was in a prolonged latent phase of labour by 18h00 at the latest. Such knowledge, in and of itself, would have alerted the MOU staff to the necessity (under the Guidelines) for a referral to hospital at that stage.

94. A further factor to be borne in mind is that, because the EDD had not been fixed or recorded, the MOU staff had no marker by which to assess the age of

the fetus and they therefore failed to appreciate that the plaintiff was probably beyond the usual term of a pregnancy when she presented at the MOU on 26 June 2006. In this regard, there is, in my view, no particular significance in the fact that there are various recordals on both 26 and 27 June 2006 that the plaintiff and/or the fetus were "at term." This description has relevance only to the extent that it distinguishes the fetus as having fully developed at birth rather than being premature.

95. To be sure, the use of word "term" cannot be employed to establish the age of the fetus with any degree of accuracy at birth. The point here simply is that the Guidelines are clear at p28 where they list a series of risk factors that warrant "non-urgent referral to hospital". One such factor is "Pregnancy beyond 41 weeks". Accordingly, whether the plaintiff presented at the MOU at 41, 42 or 43 weeks, she was required to be taken through to MMH without more. Had this happened, it is reasonable to infer that her pregnancy would have been managed by medical staff with a higher degree of competence using more advanced machines such as a CTG.

96. Lastly, it is apparent from the Partogram that the response of the MOU staff at around midnight was, generally speaking, in accordance with the Guidelines, and, as I have observed, they cannot be faulted for their treatment of the plaintiff at that stage. But that is not the issue.

97. It is suggested by Dr. Ebrahim that the FHR at 20h50 was a late deceleration, which would have triggered the emergency response from staff approximately 3 hours earlier. Dr. Ebrahim's view of the fetal condition at this time is, however, not shared by Dr. Wright. But both doctors agree that by 22h00 there was undoubtedly fetal distress. In such event, the plaintiff should have been taken through to MMH two hours earlier than she actually was. And, given the time frames already referred to, had this happened, the child would have been delivered about 2 hours earlier – shortly after midnight.

98. I have demonstrated that the Province's staff at the MOU were in breach of the Guidelines in a number of material respects. Some fall outside of the phase of active labour but are nevertheless cause for concern. At p34 of the Guidelines there is

a warning to staff in bold which is highlighted with the image of a ringing bell and which reads –

"**All findings of maternal condition, fetal condition and progress in (sic – labour?) must be recorded on a partogram. Failure to use a partogram during labour constitutes substandard care.**"

99. I have shown how the Partogram fails to record any observations made during the latent phase and during the active phase there are only partial recordings which are not in compliance with the Guidelines. Chief among these is the failure to check the FHR every half hour from around 18h00 onwards. This was a grave shortcoming as this recordal was critical to knowledge of the well-being of the fetus. Had that been done properly, it may have resulted in the staff being alerted to decelerations even before 20h50. To be sure, they would certainly have had a sound basis to evaluate the gravity of the 22h00 reading and the need to take immediate action under the protocols established under the Guidelines.

100. In the result, I am driven to conclude that there was ample evidence available to the MOU staff to merit a decision to refer the plaintiff to MMH by 22h00 at the latest and that the failure to do so constitutes substandard care of the plaintiff and a failure to observe the reasonable level of conduct to be expected of a midwife employed at the MOU. However, such substandard care does, of itself, not constitute negligence: it must be shown that the failure to adhere to the Guidelines was causally connected to the injury suffered by the plaintiff, and, further, that the employees' inactivity was wrongful.

CAUSATION

101. The test for causation (and with particular reference to cases involving an omission) was dealt with by the Constitutional Court in Lee[36]. The case involved a claim by a sentenced prisoner that the negligence of the Department of Correctional Services had resulted in him contracting tuberculosis ("TB") whilst incarcerated, the

[36] Lee v Minister of Correctional Services 2013 (4) SA 144 (CC)

case being based on an alleged negligent omission by the department. Nkabinde J explained the approach as follows.

"[37] The Supreme Court of Appeal dealt with the elements of a delictual claim and confirmed the High Court's finding regarding wrongfulness in relation to the responsible authorities' failure "to have reasonably adequate precautions against contagion, which was the foundation of the claim." I agree with the Supreme Court of Appeal that there was a negligent breach on the part of the responsible authorities for failing to maintain an adequate system for management of TB. The next prong of the inquiry is, however, whether the negligent omission caused the applicant harm – in becoming infected with TB. This is so because it is only causal negligence that can give rise to legal responsibility.

[38] The point of departure is to have clarity on what causation is. This element of liability gives rise to two distinct enquiries. The first is a factual enquiry into whether the negligent act or omission caused the harm giving rise to the claim. If it did not, then that is the end of the matter. If it did, the second enquiry, a juridical problem, arises. The question is then whether the negligent act or omission is linked to the harm sufficiently closely or directly for legal liability to ensue or whether the harm is too remote. This is termed legal causation.

[39] This element of liability is complex and is surrounded by much controversy. There can be no liability if it is not proved, on a balance of probabilities, that the conduct of the defendant caused the harm. This is so because the net of liability will be cast too wide. A means of limiting liability, in cases where factual causation has been established, must therefore be applied. Whether an act can be identified as a cause depends on a conclusion drawn from available facts or evidence and relevant probabilities. Factual causation, unlike legal causation where the question of the remoteness of the consequences is considered, is not in itself a policy matter but rather a question of fact which constitutes issues connected with decisions on constitutional matters as contemplated by section 167(3)(b) of the Constitution.

[40] Although different theories have developed on causation, the one frequently employed by courts in determining factual causation, is the *conditio sine qua non* theory or but-for test. This test is not without problems, especially when determining whether a specific omission caused a certain consequence. According to this test the enquiry to determine a causal link, put in its simplest formulation, is whether "one fact follows from another." The test—

*"may involve the mental elimination of the wrongful conduct and the substitution of a hypothetical course of lawful conduct and the posing of the question as to whether upon such an hypothesis plaintiff's loss would have ensued or not. If it would in any event have ensued, then the wrongful conduct was not a cause of the plaintiff's loss; [otherwise] it would not so have ensued. If the wrongful act is shown in this way not to be a causa sine qua non of the loss suffered, then no legal liability can arise."*

[41] In the case of "positive" conduct or commission on the part of the defendant, the conduct is mentally removed to determine whether the relevant consequence would still have resulted. **However, in the case of an omission the but-for test requires that a hypothetical positive act be inserted in the particular set of facts, the so-called mental removal of the defendant's omission. This means that reasonable conduct of the defendant would be inserted into the set of facts**. However, as will be shown in detail later, the rule regarding the application of the test in positive acts and omission cases is not inflexible. There are cases in which the strict application of the rule would result in an injustice, hence a requirement for flexibility. The other reason is because it is not always easy to draw the line between a positive act and an omission. Indeed there is no magic formula by which one can generally establish a causal nexus. The existence of the nexus will be dependent on the facts of a particular case. "(Footnotes omitted; Emphasis added)

102. Applying that approach to the facts at hand, the Court must ask itself whether it is probable that the child would have suffered an HIE if the staff at the MOU had taken reasonable steps to refer the plaintiff to MMH at latest 22h00 rather than midnight.

103. Dr. Wright accepted that the FHR readings on the Partogram at 21h50 indicated unequivocally that late decelerations had occurred. This was indicative of fetal distress and the Guidelines required the immediate transfer of the plaintiff to MMH. Had this been initiated at around 22h00, it is probable that at around midnight the plaintiff would have been admitted to the hospital where the level of obstetric care was most likely to have been higher – for instance, there was a CTG machine available for more accurate monitoring of the FHR (as in fact took place between 01h30 and 02h00) and, further, there was a fully equipped operating theatre where an emergency C-section could have been performed at relatively short-notice.

104. Looking at the matter overall, then, it is fair to say that the additional two hours potentially available for the treatment and assessment of the plaintiff through an earlier referral to MMH would probably have led to an earlier delivery of the child through C–section and the avoidance of the damage-causing event. In this regard, I have no hesitation in accepting the uncontested evidence of Drs. Ebrahim and Kara that the event occurred about one to one and a half hours before the birth of the child – at around 00h45 to 01h15. They both explained that if the event occurred earlier, the child would not have survived and would in all likelihood have been stillborn. I cannot fault the logic behind this assertion.

105. Dr. Wright's evidence in this regard (based on an opinion that was never put to the plaintiff's experts, as the defendant was duty-bound to do[37]) does not make sense. He postulated that the damage occurred at around 23h00 when there were repeated late decelerations indicative of fetal distress, thereby suggesting that the earlier transfer of the plaintiff to MMH would have made no difference as the damage was already done.

106. But the uncontested view on behalf of the plaintiff is that if that were the case, the child would have been stillborn. The fact that the child was born alive but with severe cerebral palsy is, according to the plaintiff's experts, rather an indication that the damage occurred during a very late stage of the pregnancy.

107. Applying the "but-for" test advocated in Lee by considering the mental removal of the omissions on the part of the MOU staff, I am satisfied that the plaintiff has established the factual element of causation. What then remains is whether the plaintiff has established the legal basis for causation. On that score, the question that arises is whether it can be said that the omission by the MOU staff to transfer the plaintiff to MMH earlier is directly linked to the injury sustained by the child or whether the consequences of their omission are too remote.

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[37] President of the Republic of South Africa v South African Rugby Football Union and others 2000 (1) SA 1 (CC) at [61] – [65]

108. The answer to that question is, in my view, rather self-evident. In order to avoid the damage-causing event, the plaintiff's unduly protracted labour (responsibility wherefore lay at the door of the MOU staff) had to be brought to an end and the child delivered into the world – whether through natural childbirth with the administration of the necessary drugs to enhance labour and the use of specilaised equipment, or through an emergency C-section.

109. To borrow from the field of contract law, "time was of the essence" in the plaintiff's case and the sooner action was taken by the MOU staff in terms of the Guidelines, the greater the prospect of avoiding injury to the fetus. In such circumstances, I am satisfied that the omission by the MOU staff to act timeously when the proverbial alarm bells were ringing is not too remote for purposes of determining causation. After all, the Guidelines required an immediate referral to MMH when the late decelerations were noted and the MOU staff simply ignored the prescripts thereof.

WRONGFULNESS

110. In our law, a party's liability for an omission only constitutes negligence in circumstances where the law regards it as necessary to impose a duty on such person to avoid negligently causing harm to another, thus rendering the omission wrongful.[38] This approach is utilised by the courts as a measure to regulate the imposition of liability in cases involving an omission and is based on the duty not to cause harm: the focus being on the reasonableness of imposing liability in any given case.[39]

111. With reference to the Constitutional Court judgment in Loureiro[40], Molemela AJ (for the majority) had the following to say in Oppelt.

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[38] Minister of Safety and Security v Van Duivenboden 2002 (6) SA 431 (SCA) at [25]

[39] Oppelt at [51]

[40] Loureiro and others v Imvula Quality Protection (Pty) Ltd 2014 (3) SA 394 (CC)

"[51] The next inquiry is whether the 'negligent omission is unlawful only if it occurs in circumstances that the law regards as sufficient to give rise to a legal duty to avoid negligently causing harm.' In *Loureiro* Van der Westhuizen J explained that the wrongfulness enquiry is based on the duty not to cause harm and that, in the case of negligent omissions, the focus is on the reasonableness of imposing liability. An enquiry into wrongfulness is determined by weighing competing norms and interests. The criterion of wrongfulness ultimately depends on a judicial determination of whether, assuming all the other elements of delictual liability are present, it would be reasonable to impose liability on the defendant for the damages flowing from specific conduct. Whether conduct is wrongful is tested against the legal convictions of the community which are 'by necessity underpinned and informed by the norms and values of our society, embodied in the Constitution'. "

112. At the level of precedent, as already demonstrated above, there have been various cases in which the courts have held medical and/or hospital staff liable in delict for negligently omitting to treat pregnant mothers in circumstances where their conduct (or, strictly speaking, the absence thereof) has led to the child suffering from cerebral palsy at birth. This case, therefore, does not break new ground and I did not understand Ms Adhikari to suggest otherwise. That having been said, wrongfulness must still be assessed on a case-by-case basis.

113. In its plea on the merits the Province accepted that it was required to –

"[3.1] At all relevant times provide [the plaintiff] with appropriate obstetric and/or other related medical care having regard to the conditions and standards prevailing at the time, and having regard to the nature, extent and severity of her medical condition; and

[3.2] At all relevant times exercise reasonable skill and care in administering such obstetric and/or other related medical care to [the plaintiff], to the standard of reasonably competent practitioners in their respective fields."

Similar allegations are made by the Province in respect of the duties it owed to the child.

114. The plea further contains several general denials of any breach of the duties owed to the plaintiff and the child. There are positive assertions that its staff at

both the MOU and the MMH provided the plaintiff and the child with appropriate obstetric and/or related medical care and, further, that they duly exercised reasonable skill and care in the treatment of the plaintiff and the child. In addition, the Province has pleaded the absence of causation[41] and the foreseeability of harm[42] to the child. There is no plea expressly placing wrongfulness in issue.

115. Adopting the view of Cameron J (who agreed with the aforementioned view of the majority in respect of the mandated approach to the determination of wrongfulness in Oppelt[43]), wrongfulness in this case is "incontestable". It is trite that if the Province breached any of the duties of care that it admittedly owed the plaintiff and the child, that such breach(es) would have been wrongful. Molemela AJ put the position thus in Oppelt in which the point in issue was whether the transfer of an orthopaedic patient should have been undertaken within a four-hour limit.

"[53] In its plea the respondent admitted the existence of 'a legal duty to dispense reasonable medical care'. However, the respondent disputed the duty to do so within the four-hour cut-off time and to transfer the applicant within that time to Conradie. In the face of an admitted legal duty of care, the applicant needed to show only that the legal duty was breached.

[54] The respondent's admission of a legal duty to dispense reasonable medical care is properly made. The law requires hospitals to provide urgent and appropriate emergency medical treatment to a person in the position of the applicant. There is no doubt that the legal convictions of the community demand that hospitals and healthcare practitioners must provide proficient healthcare services to members of the public. These convictions also demand that those who fail to do so must incur liability."

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[41] "[9.1] There was no causal connection between the injuries suffered by [the child], in particular any brain injury which is alleged to have resulted in her developing cerebral palsy, and any act or omission on the part of the doctors and/or the medical staff who attended on [the child] and [the plaintiff] at any time."

[42] "[9.2] The injuries suffered by [the child], in particular any brain injury that is alleged to have resulted in her developing cerebral palsy were not reasonably foreseeable."

[43] At [97]

116. Had the staff at the MOU observed the Guidelines as they were duty bound to do in terms of the requisite standard of care owed to the plaintiff and the child, they would have appreciated that the plaintiff should have been referred to MMH about two hours earlier than she actually was. And, as I have found, had they so acted, the injury to the fetus would, on a balance of probabilities, have been avoided. They did not do so and the plaintiff is now saddled with the onerous task of rasing a severely disabled child who will require constant care and supervision throughout her life, both as a child and later as an adult. The legal convictions of the community manifestly demand that the Province should shoulder this burden, to the extent that it can be ameliorated by an award of damages.

CONCLUDING REMARKS REGARDING THE MERITS

117. Having regard to the aforegoing, I am satisfied that the treatment of the plaintiff by the staff of the Province throughout the duration of her pregnancy, from the first clinic visit on 20 April 2006 to the last attendance at the MOU on 26 June 2006, did not comply with the Guidelines and fell significantly short of the standard of care to which she was entitled.

118. It follows therefore that the plaintiff has established that the staff of the Province were negligent in their treatment of her and her unborn child and that such negligence caused the injuries sustained by the child. The plaintiff is thus entitled to recover from the Province, in due course, such damages as flow from the injuries.

PRESCRIPTION OF THE PLAINTIFF'S PERSONAL CLAIM?

119. The summons issued on the plaintiff's behalf was served on the Province way out of time – on 22 March 2017. In terms of s12 of the Prescription Act, 68 of 1969 ("the Act") she had three years to do so – hence during June 2009 – whereas the summons was served almost 8 years later. In the result, the Province filed a special plea of prescription in May 2017. It is common cause that the prescription point is raised only in respect of the plaintiff's personal claim; the claim lodged in her representative capacity on behalf of the child has not yet prescribed.

120. In view of the provisions of s 12(3) of the Act read with s 12(1), the onus is on the Province to establish its plea of prescription[44].Those subsections read as follows.

"12. **When prescription begins to run -**

(1) Subject to the provisions of sub-section (2), (3) and (4) prescription shall commence to run as soon as the debt is due.

(2)…

(3) A debt shall not be deemed to be due until a creditor has knowledge of the identity of the debtor and of the facts from which the debt arises: provided that a creditor shall be deemed to have such knowledge if he could have acquired it by exercising reasonable care."

121. Accordingly, in this case the Province must establish the date upon which the plaintiff obtained either actual (or constructive knowledge) that the debt was due to her by the Province[45]. Actual knowledge is established if it can be shown that the plaintiff actually knew the facts and the identity of the debtor, while constructive knowledge is established if the Province can demonstrate that the plaintiff could reasonably have acquired knowledge of the identity of the debtor and the facts on which the debt arose through the exercise of reasonable care, the test being what a reasonable person in her position would have done.

122. In Macleod the Supreme Court of Appeal stressed that –

"[13] It is the negligent and not an innocent inaction that s 12(3) of the Prescription Act seeks to prevent and courts must consider what is reasonable with reference to the particular circumstances in which the plaintiff found himself or herself."

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[44] Gericke v Sack 1978 (1) SA 821 (A) at 827D-G.

[45] Macleod v Kweyiya 2013 (6) SA 1 (SCA) at [9]; Links v Department of Health 2016 (4) SA 414 (CC) at [24].

The learned Judge of Appeal went on to demonstrate the correct approach with reference to Shange[46] at [11].

"In…Shange…this court had to consider whether a 15-year-old learner who had been hit with a belt on the side of his eye by his teacher acted reasonably in waiting more than five years to institute action against the teacher's employer. As in the present matter, the plaintiff became aware of the possibility of a claim by chance. He had initially accepted the teacher's explanation that it was an accident. A family friend noted that he was wearing an eye patch and suggested that he should approach the Public Protector. An advocate in that office advised him of the possibility of a claim against the teacher. Snyders JA held that the delay was innocent, not negligent. She stated:

> '*He was a rural learner of whom it could not be expected to reasonably have had the knowledge that not only the teacher was his debtor, but more importantly, that the appellant* [i.e. the MEC as the employer of the teacher] *was a joint debtor. Only when he was informed of this fact did he know the identity of the appellant as his debtor for the purposes of the provisions of s 12(3) of the Prescription Act.'"*

123. The plaintiff and her attorney gave evidence on the question of prescription. When dealing with the facts relative to the plea of prescription, the plaintiff testified that upon her discharge from MMH she was not told anything regarding the fact that her child might be disabled. She later suspected that the child's developmental milestones were limited but, importantly, because of her work-related circumstances, she testified that she did not see the child regularly.

124. The plaintiff, who has a Grade 7 education, was in fixed employment as a farm-worker in Cape Town at the time of the birth of the child. When she was about 10 months old, said the plaintiff, she took the child to stay with her mother at Cofimvaba in the Eastern Cape. This was clearly for the sake of convenience because the plaintiff said she could not cope with two toddlers in Cape Town and do a

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[46] MEC for Education, KwaZulu-Natal v Shange 2012 (5) SA 313 (SCA)

full day's work. The plaintiff said that she thereafter saw the child once a year for three weeks during June when she took her annual leave and travelled to the Eastern Cape. It follows that the plaintiff was thus deprived of the opportunity of experiencing her child's handicap and lack of development on a day-by-day basis as many other mothers might have enjoyed.

125. The plaintiff testified that she noted over time during these annual visits that the child was not developing normally like her other children: she had difficulty swallowing due to a constricted throat and she could not use an ordinary spoon to eat. There were also problems with the child's mobility and she could not walk, only crawl.

126. The plaintiff testified that during April 2014 her mother told her that she had consulted an attorney, Mr. Mjulelwa, because "(T)he child wasn't right". The plaintiff said that she first spoke to her attorney in 2016. Mr. Mjulelwa practices at Mthatha in the Eastern Cape and he confirmed in evidence the circumstances under which he received his instructions. The attorney said that he then set about the onerous task of procuring the necessary hospital records and, when these were to hand, he arranged for the child to be assessed by Dr. Kara in Durban.

127. In June 2016, Dr. Kara furnished Mr. Mjulelwa with a medico-legal report in which he advised the plaintiff of the possibility that the child might enjoy a claim. In his report, Dr. Kara confirmed the diagnosis of HIE and advised that an obstetrician needed to be consulted to assess whether there was any negligence on the part of the Province arising from the treatment of the plaintiff in labour. On 18 October 2016, the plaintiff's attorney gave the requisite statutory notice to the Province and thereafter issued summons in March 2017.

128. In the result, it cannot be disputed that the plaintiff acquired actual knowledge of the debt and the identity of the debtor in respect of a delictual claim on behalf of the child in mid-2016, being 10 years after she had been treated at the MOU. The question that then arises is whether the Province has established that, through the exercise of reasonable care, the plaintiff could have acquired knowledge of her own claim (and, I stress, not that of the child) prior to mid-2016.

129. In the amended particulars of claim, that claim is formulated as “general damages for severe shock and the attenuation of the amenities of life in the sum of R500 000.00”. There is no further particularity explaining the nature, extent and cause of the plaintiff’s shock and attenuation of amenities but this will no doubt be explored should the trial proceed on the quantum. On the assumption that the personal claim is primarily founded upon the child’s cerebral palsy and the consequences thereof for the health of the child and her development, it would follow that the plaintiff would only have known that she enjoyed a claim for her own injury, and, importantly, against whom such claim lay, when Dr. Kara filed his report. It is reasonable to infer therefore that the plaintiff acquired actual knowledge of her alleged claim in June 2016.

130. Has the Province established on a balance of probabilities that the plaintiff, through the exercise of reasonable care, could have acquired knowledge of her claim before June 2016, such reasonableness being assessed with due regard for the plaintiff’s personal circumstances? I think not.

131. In the first place, the proposition was never put to the plaintiff under cross-examination and we cannot speculate what her answer in that regard would have been. Secondly, it is significant that the person who initiated the process of consulting a lawyer was the child’s grandmother, with whom she habitually resided for the first ten years or more of her life. The particular circumstances in which the plaintiff found herself meant that she did not have daily contact with her second-born and her knowledge of her developmental phases was limited thereby.

132. But even if one assumes that such reasonable knowledge could have been acquired by the plaintiff through the agency of her mother as the day-to-day carer of the child, the question that then arises is whether there was an appreciation on the part of either the plaintiff or her mother that the child’s condition was caused by the negligence of the MOU staff during the plaintiff’s labour.

133. The facts of the case demonstrate that the medical specialists who testified before this Court were divided as to whether there was negligence or not. And, that difference of opinion was based on complex issues of medical science. As

Zondo J put it in Links (a claim for medical negligence in which the plaintiff suffered personal physical injuries and only received advice regarding liability for the injury long after the event) –

"[47]…. That opinion was given years after the events in issue. Without advice at the time from a professional or expert in the medical profession, the applicant could not have known what had caused his condition. It seems to me that it would be unrealistic for the law to expect a litigant who has no knowledge of medicine to have knowledge of what caused his condition without having first had an opportunity of consulting a relevant medical professional or specialist for advice. That in turn requires that the litigant is in possession of sufficient facts to cause a reasonable person to suspect that something has gone wrong and to seek advice."

134. Earlier in that judgment, the learned Justice noted that it was for the party seeking to rely on prescription to adduce sufficient evidence to show that the claimant had reasonable grounds to suspect that the injuries forming the basis of her claim were as a consequence of medical negligence.

"[42] There is a further problem with the submission in that it presupposes that any explanation given to the applicant by the medical staff would have identified medical error was the actual or even a potential cause of his injuries. It is not necessary for a party relying on prescription to accept liability. To require knowledge of causative negligence for the test in s 12(3) to be satisfied would set the bar too high. However, in cases of this type, involving professional negligence, the party relying on prescription must at least show that the plaintiff was in possession of sufficient facts to cause them on reasonable grounds to think that the injuries were due to the fault of the medical staff. Until there are reasonable grounds for suspecting fault so as to cause the plaintiff to seek further advice, the claimant cannot be said to have knowledge of the facts from which the date arises."

135. We know from the evidence of the specialists that cerebral palsy does not only arise from HIE. As Dr. Kara's testimony demonstrated, there were a number of pre-existing conditions such as substance abuse on the part of the mother, maternal infection, intrauterine infection, metabolic or chromosomal disorder and meningitis or congenital brain abnormality on the part of the child that could have led to cerebral palsy. In such circumstances, it is not difficult to conclude that the child's

mother and/or grandmother did not realise that her impacted developmental phases were due to some cause extraneous to the birth of the child. This is all the more so in circumstances where they were women with limited levels of education and where the grandmother had limited access to medical care. The plaintiff testified in this regard that the child was taken by her mother to the local clinic at Cofimvaba where there no doctors on duty.

136. In any event, there was no onus on the plaintiff to adduce evidence that demonstrated her lack of knowledge of the child's condition. That duty rested with the Province and it took no steps to either put up any evidence on that score or, at the very least, to cross-examine the plaintiff in an endeavour to discharge its onus.

137. If follows, in my view, that the defendant has failed to establish that the plaintiff's personal claim has prescribed.

CONCLUSION

138. I am thus satisfied that the plaintiff has established that the child's medical condition was caused by the negligent treatment of the plaintiff by the defendant's employees at the MOU and that the defendant is liable to the plaintiff for such damages as she may yet prove in respect of her personal claim, as well as her claim on behalf of the child. I should point out, for the assistance of the parties that I would consider it appropriate for a *curator bonis* to be appointed to manage the award ultimately made in this matter, as it is likely to be considerable and the plaintiff's ability to manage such a sum of money might be limited. Costs will follow the result, as set forth hereunder.

**ORDER OF COURT**

A. The defendant's special plea of prescription is dismissed.

B. The defendant is liable to the plaintiff for damages in her personal and representative capacities as a result of the negligent treatment by the defendant's employees of the plaintiff and her minor child, S[....], (born on 27 June 2006).

C. The damages as aforesaid are to be established in further proceedings.

D. The defendant is liable for the plaintiff's costs of suit, which costs are to include –

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

2. All reserved costs;

3. The costs of all reports, preparation of joint minutes, qualifying expenses (including travel and accommodation) of the plaintiff's expert witnesses in respect of whom notices in terms of Rule 36 have been filed.

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**GAMBLE, J**

Appearances:

For the plaintiff: Adv. A.D. Schoeman S.C
Adv. N. Mashava

Instructed by Mjulelwa Attorneys,
Mthatha,
C/o Nonoza Potelwa Attorneys,
Cape Town.

For the defendant: Adv. M. Adhikari

Instructed by State Attorney,
Cape Town.