REPUBLIC OF SOUTH AFRICA

IN THE HIGH COURT OF SOUTH AFRICA,
GAUTENG LOCAL DIVISION, JOHANNESBURG

CASE NO: 34461/14

(1) REPORTABLE: NO
(2) OF INTEREST TO OTHER JUDGES: NO
(3) REVISED. NO

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DATE SIGNATURE

In the matter between:

P.: G. N.O.

Plaintiff

and

MEMBER OF THE EXECUTIVE COUNCIL FOR HEALTH AND SOCIAL DEVELOPMENT (GAUTENG) Defendant

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J U D G M E N T

FISHER J:

[1] The plaintiff claims, on behalf of her child, N., now aged 6, damages arising out of injury to the child's brain which occurred some days after birth. The injury occurred as a result of the development of high levels of bilirubin in the blood that led to a condition called kernicterus – which caused cerebral palsy.

[2] The plaintiff also claimed an amount for her own damages in respect of past hospital and medical expenses and general damages for emotional pain and shock. This claim was not persisted with.

[3] The defendant denies liability and, in the alternative, seeks an apportionment of damages.

[4] This quantum and merits have been separated in terms of rule 33(4). This part of the case involves only the determination of the merits.

[5] The salient evidence before me reveals the following:

1. N. was born at Leratong Hospital, a State controlled hospital in Krugersdorp, on [….] at 17h25. The birth was full term and without any complications and N. appeared well at birth. Breastfeeding was established.
2. The plaintiff and N. were discharged at 13h25 on 02 October 2010 on day 1 of life (a 24 hr period *post partum* being considered medically as day 1 of life).
3. The hospital records show that on the day of discharge both baby

and mother presented as healthy.

[6] The plaintiff testified that, on day 2 of life, all was well. She brought the child to the home she shared with her mother (i.e. the baby's grandmother) she testified that the child's condition was not then noticed by herself or anyone else to be other than normal. Most importantly, the child did not, according to the plaintiff, exhibit any yellowing of the skin and/ or eyes.

[7] On days 3 and 4 of life the child's condition was, according to the plaintiff, unchanged. She states that the child was then breastfeeding in a way that she regarded as normal. It should be noted that the plaintiff gave birth to her first child approximately 12 years before the birth of N. and thus had some experience in this regard, albeit some time before N.'s birh.

[8] According to her evidence it was only on day 5 (05 October that she noticed that N. was not "sucking properly". She was concerned about this.

[9] The plaintiff thus took N. to a private general practitioner on the evening of day 5 (05 October 2010), Dr Moosa. Dr Moosa examined N. and, according to the plaintiff, found no cause for immediate concern. Importantly, he did not, according to the plaintiff, note any jaundice. Dr Moosa told the plaintiff to express her breastmilk and bottlefeed N. with this expressed milk.

[10] N. did not improve over the night of day 5 and into the next morning.

[11] On the morning of day 6 of life (06 October 2010) the plaintiff took N. to the Rietvlie Clinic in Krugersdorp, a State run institution, as she remained concerned about N.'s condition.

[12] The nurse who examined N. at the clinic was concerned because N. presented with jaundice and was reported by the plaintiff to have been sucking poorly.

[13] A report was written at the clinic in order to facilitate the admission of N. to Leratong Hospital. The plaintiff was told that she should take N. to the hospital in order to secure her treatment there and present the report to attending staff. This report from the clinic was placed in evidence. It recorded the nurse's concerns and specifically the jaundice, the lack of sucking, and that the umbilicus was infected.

[14] The plaintiff went directly to the hospital as advised and as instructed she presented the report from the clinic to the personnel at the hospital.

[15] The plaintiff arrived at the hospital before 12h00 on 06 October 2010 and N. was admitted at 12h20.

[16] It appears from the records that the child's condition was treated as an emergency on arrival in that the child's bilirubin count was found to be dangerously high shortly after her admission – a blood test revealing a count of 715 µmol/l which the experts all agreed is dangerously high (the normal count being approximately 274 µmol/l and below)

[17] It was agreed by all the expert witnesses that the definitve treatment

for the child, given the high billiruben count and her serious condition, was an exchange blood transfusion.

[18] It was accepted by all experts that the requirements for the transfusion required the ordering of the blood and that this could take some time as it could involve sourcing a donor and would require matching and transportation from the National Blood Services in Aukland Park to the hospital.

[19] The indications on the hospital record appear to be that the blood was ordered almost immediately after admission and that the child was put under phototherapy and hydrated whilst waiting to have the transfusion. This, all agreed, was the indicated treatment at the time and that no undue delay in treatment had occurred by this stage.

[20] It was accepted by the experts that the treatment of the child from admission at the hospital to the commencement of the transfusion was acceptable, if not optimal.

[21] The blood must have been received by 21h00 on 06 October 2010 as at that time the transfusion was first attempted.

[22] There are indications that there were numerous attempts on the part of the attending clinician to put up an arterial line. This is a line into an artery which allows for the exchange transfusion.

[23] The neonatologists were all in agreement that the setting up of an

arterial line in a neonate is notoriously difficult. It was agreed between them that the most elementary approach when conducting an exchange transfusion was to put up an umbilical line, which is a line that goes directly into the umbilical cord of the child.

[24] It was the evidence of the neonatologist experts it would have been substantially improbable for any doctor to have resorted to the arterial line, if the umbilical line was available to him/her.

[25] The likelihood is that the umbilicus was septic and thus was eschewed by the attending clinician. That there was an infection is suggested by the letter from the clinic.

[26] The evidence of Dr Mogashoa and Prof Christianson called on behalf of the plaintiff was that the attending doctor was, in all probability, in a serious dilemma: he could risk introducing infection into the childs blood by inserting the transfusion line into the septic umbilicus or continue the difficult task of putting up an arterial line.

[27] It emerges from the records that the latter course was tried by the attending clinician for some hours with no success. This resulted in a delay in administering the transfusion from 21h00 on day 6 to 11h30 on day 7 which included the delay involved in having to order new blood – as the blood obtained would have gone “stale” .

[28] The transfusion was eventually achieved *via* resort to the umbilical

line. It was started at 11h30 on 07 October 2010 and was completed by 13h45 on that date.

[29] A broad spectrum antibiotic, “Claforan” was administered before the transfusion. It seems probable that this was because of the infection in the umbilicus.

[30] After the transfusion, the child’s bilirubin count had reduced to within a normal range.

[31] The negligence contended for by the plaintiff can be distilled in to the following;

1. Failing to inform the plaintiff that the child must be seen for a check-up by a trained medical professional on day 3 of life and /or;

2. Failing to treat the child properly from the time that she was presented for treatment at the Rietvlie Clinic to the time that she was given the indicated exchange transfusion at the hospital, and more specifically that the transfusion was not given timeously.

[32] The Defendant’s defence is, in essence, a bare denial of negligence and liability. In the alternative, it contends for contributory negligence on the part of the plaintiff on the basis that she did not seek appropriate and timeous treatment for the child under the circumstances.

[33] I will dispose first with the second ground in that it appeared at the end of the case to be the least contentious. In relation to this ground, the enquiry is whether the standard of care that was given to N. when she was admitted at hospital on 06 October 2010 was adequate.

[34] The causation element must also be considered in this context. Even if it is proved that there was negligence in the manner that N. was treated at the hospital, the plaintiff would still have to establish that there was a causative link between such negligence and the harm that was suffered by the baby.

[35] The plaintiff testified herself and called 2 expert witnesses Dr Lefakane a paediatrician and Dr Diar a paediatrician and neonatologist. The Defendant called 3 witnesses, Dr. Cooper, a Neurologist, Dr. Mogashoa, a Paediatric Neurologist, and Professor Christianson, a Paediatrician and Geneticist.

[36] The experts were in agreement that the cause of the damage to N.'s brain was dyskinetic cerebral palsy secondary to bilirubin encephalopathy or kernicterus.

[37] There is no doubt that the disability suffered is of a very serious nature. It has resulted in a high level of gross motor function impairment and global delay in the development of the child.

[38] Dr Diar, on behalf of the plaintiff, agreed with Dr Mogashoa and Prof Cooper that there was in all probability significant irreversible damage

done to N.'s brain before she was taken to hospital by the plaintiff on day 6 of life.

[39] It was the consensus of the experts that it was impossible to determine how the damage had progressed from the date of admission and particularly during the delay in the administering of the transfusion or to what extent this delay would have exacerbated the disability. It was further the consensus that the level of the bilirubin was so high on admission, that the likelihood was that a major part of the damage to the brain had been suffered by the time of arrival at the hospital. It was also the general consensus that the damage done would have been substantially irreversible by treatment at this stage. Indeed, Dr Mogashoa, who was a most impressive witness, was of the view that the efforts of the clinicians treating the child would, by the stage of admission, have focused on saving the life of the child as the priority rather than alleviating any progression of the damage. It is accepted by the experts that by the stage of admission the child was critically ill and had already suffered significant brain damage.

[40] Mr Brown, who represented the plaintiff, rightly conceded that, after the hearing of all the evidence, and with regard to the substantial level of agreement between them as to the cause of the damage or put differently the steps that could have been taken to avoid the condition suffered by the child that the likely cause of the cerebral palsy was the fact that the child was not seen by a medically trained person before it was too late to avoid

the devastating brain damage sustained by the child. The experts were in substantial agreement that had the child been seen by a qualified medical practitioner on or before day 3 of life the damage to N.'s brain would, in all likelihood, have been prevented.

[41] In light of the evidence that has been presented and with reference to the hospital records I cannot find that there was any negligence in the treatment administered to the child from the time she was presented at the Rietvlei Clinic to her discharge from hospital. The evidence of the plaintiff's expert paediatrician was to the effect that bilirubin tests were done in the private hospital in which he was employed, on day 1 and day 3 of birth, and sometimes even on day 2, in order to attempt observe a trend. It was conceded by him that this was an optimal situation and that State facilities would, most likely, not extend themselves to this kind of monitoring.

[42] Accordingly, the second ground of negligence is rejected. I might add that I was impressed and heartened by the manner in which the child and the plaintiff were managed from the time that the child was taken to the Rietvlie clinic to her discharge from the Leratong hospital. The nurse who saw her at the clinic, immediately diagnosed her condition, was astute to the danger of the symptoms presented, and took steps to get the child treated as a matter of urgency. The staff and doctors at the hospital did the best that they could, under trying, circumstances to treat N. in the best way possible.

[43] This case then turns on the obligations of the State medical facilities

who attend upon the delivery of babies and the immediate care of mothers and babies *post partum* to provide information and direction to mothers to the effect that the babies should be examined on or before day 3 of life by a qualified health care practitioner.

[44] The plaintiff's evidence was to the effect that she was not told that the child should be seen by a medically trained person on day 3 of the child's life.

[45] The defendant's case does not, as I understand it, go as far as to suggest was not that it was not necessary for the plaintiff to have been told this. Instead it contends that there are indications on the hospital records that she had indeed been educated, at least, as to breast feeding and hygiene and that the likelihood was that this would have included her being told that she present the child for a check-up on day 3 of life. Reliance was also placed by the defendant on the clinic report which indicted that the child was presented there "*for the 3 day follow up*".

[46] There is currently in place a routine management and information system which applies nationally and which caters to the presentation of infants for inoculation and development charting after birth. In this matter, a chart known as "*The Road to Health*" was introduced into evidence in relation to N.'s monitoring, vaccinations, and development. I am told that charts such as these are commonly in use in all State hospitals and clinics. They appear to be part of the national health care protocol but apply, at least, in the State facilities concerned in this action. The chart contains the

emblem of the Department of Health and thus appears to have an official status. The chart is to be kept by the parent or caregiver of the child and the following prominent admonishment is to be found thereon "*IMPORTANT: always bring this chart when you visit any health clinic, doctor or hospital and present the chart on school entry*". The chart is, on the face of it, designed to be used as a way of creating and signifying a programme for the management of infant health and development. The chart is constructed in such a way that it allows for information to be filled in by the attending clinician or relevant member of the hospital/clinic staff as a general and accessible record of the child's developmental and relevant features of health. It also records the child's vaccinations. Most importantly, it provides a direction to the parent or caregiver of the child to bring the child in for examination and vaccination at certain determined intervals. In this regard there is provision made on the chart for the attending medical practitioner to note thereon in manuscript when the child should next be seen at the clinic or other medical facility. This is obviously vital to preserve continuity in relation the monitoring of the child.

[47] It was accepted by the experts that the first 3 days of life are regarded generally as being crucial in monitoring an infant with reference to the condition that occurred in this case and generally. Optimally, the mother and child would remain in hospital for this period or would be visited at home within this period. However, it is accepted that over-crowding and limited resources in State run facilities makes this impossible from a general perspective. For the most part, when mothers and infants

present as healthy at birth they are swiftly discharged. In this instance, discharge took place within 24 hours of birth.

[48] In this case the chart indicated to the plaintiff that she should make her first a clinic visit only after "*6 weeks*". Had she been told clearly and had it been noted on the chart that she should visit a clinic or hospital on day 3 of life, I must assume that she would have followed this direction. The need for vaccination and adequate childcare is clear. It protects the individual child and the broader public interest. It seems that it would not be unduly onerous to the State for a parent/ caregiver of a child who is discharged before day 3 of life to be directed that she/he should have the child assessed at a clinic, hospital, or other equivalent service on day 3 of life. That a service to so monitor neonates should optimally be available was accepted by all experts in this matter. It seems that such a system is already, informally at least, accommodated within the system. The chart relied on by the parent of the child should denote a 3 day follow up for early discharge babies.

[49] On this point generally, in their paper, "*Kernicterus in Otherwise Healthy, Breastfed Term Newborns"* (Paediatrics 1995 ; 96 (4): 730-733) which was commended to me by Prof. Christianson, - M Jeffrey Maisels (MB,BCh) and Thomas B. Newman (MD,MPH) state the following (at p 733) with reference to the prevention of kernicterus in early discharge neonates:

"*To address this issue, the American Academy of Paediatrics*

recommends that 'follow-up should be provided to all neonates discharged less than 48 hours of birth by a health care professional in an office, clinic, or at home within 2 to 3 days of discharge"

The learned authors go on to state further (at p 773):

"*Experience suggests that asking mothers to observe infants for the development of jaundice is not satisfactory. Despite such instructions, it is difficult for many parents to recognize significant jaundice."*

[50] There was no direct evidence led to contradict the plaintiff's evidence that she was not told to seek the exmination of N. on or before day 3 of life. Her evidence that she was not given any education as to dangerous signs to look out for, such as jaundice, was also not contradicted by any direct evidence. I accept that she was not given this advice and education. South Africa is a progressive part of a global community which has the priviledge of contributing to and benefiting from global developments in medicine. It seems that monitoring of infants in the crucial days after birth is an important part of being in accord with these global developments and to my mind it is not disproportionately onerous for the State to be required put in place the mechanisms to achieve this.

[51] This brings me to the defendant's claim that I should find that there was contributory negligence on the part of the plaintiff in relation to her failure to

monitor the child for jaundice and other signs that something was wrong and take appropriate steps.

[52] It is clear that the plaintiff took steps to seek medical help soon after she realized the child was not sucking properly at the breast. The lack of ability to suck was accepted by all the experts as being a classic sign of early but significant brain damage. The plaintiff took the child to a general practitioner only to be told that there was nothing seriously wrong with the child and that she should resort to bottle feeding. That Dr Moosa did not recognize that the child was jaundiced was strange. All the experts agreed that, by that stage (day 5) the jaundice should have been appararent to a doctor. Dr Mogashoa testified however that she was told by the plaintiff that when she took the baby home people who saw the baby did comment on the child being "*yellow*". The plaintiff denies this. I must take into account on this score the evidence that Dr Moosa did not recognize the child as showing signs of being severly jaundiced.

[53] I must accept that the probabilities support the version that the plaintiff was not told that the child should be seen by an appropriate medical practitioner at or before 3 days of life or, at least, educated as to possible symptoms exhibited by the child which could be dangerous. I thus cannot find that she was culpable in missing the signs of jaundice in the child or failing to comprehend the seriousness of the condition of the child. I take into account also that, nothwithstanding being told by Dr Moosa that there was nothing seriously wrong with the child, she disregarded this patently incorrect advice, and took the child to the clinic early the following morning.

[54] I accordingly find that the defendant was negligent in the circumstances of this case in failing to put in place structures which would, as a matter of procedure, inform the plaintiff that she should have the child assesed by an appropriately qualified medical practitioner by day 3 of life and that this failure caused the damage in issue.

I thus make the following order:

1. The question of liability is determined in favour of the first plaintiff in respect of the claim made on behalf of her minor child, N. P..
2. The costs of this separated issue are awarded to the first plaintiff to the extent of her claim made on behalf of the minor child N. P..

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D FISHER

HIGH COURT JUDGE

GAUTENG LOCAL DIVISION

Date of Hearing: 27 February – 03 March 2017

Judgment Delivered: 30 March 2017

APPEARANCES:

For the Plaintiff: Adv Brown instructed by Sepamla Attorneys

For the Defendant : Adv Zulu instructed by the State Attorney