IN THE HIGH COURT OF SOUTH AFRICA

KWAZULU-NATAL LOCAL DIVISION, DURBAN

Case No. 6375/2017

In the matter between:

Thembi Nomusa Mpanza Plaintiff

(obo M[….] E[….] D[….])

and

MEC for Health for the Province of KwaZulu-Natal Defendant

Judgment

Lopes J:

[1] The plaintiff is Thembi Nomusa Mpanza who sues for damages on behalf of her minor son M[….] E[….] D[….], a boy born on the 19th of February 2014 at the Stanger Hospital. The plaintiff's cause of action arises out of the alleged negligence of the medical staff at Stanger Hospital in attending to the birth of M[….]. It is alleged that as a result of their negligence M[….] has been left in what was described as the 'worst case' of cerebral palsy. The plaintiff sues for R15 500 000.

[2] At the outset of the hearing Mr *Pillemer* who appeared for Ms Mpanza together with Ms *Beket*, recorded that by way of an order of Vahed J on the 4th of May 2018 the issues were separated. I am accordingly required to decide only the

issue of liability at this stage. The quantum of damages is to stand over. Mr *Pillemer* also informed me that the special plea of prescription has been settled. The defendant, the MEC for Health for the Province of KwaZulu-Natal, was represented by Mr *Mthethwa.* He confirmed that settlement.

[3] The following facts emerged from the hospital records. It was agreed that those records contained notes made by various members of the hospital staff and could be used without further proof. Whilst the truth of the contents was not admitted, the parties accepted that what appeared in the writing of the various staff members had been written by them. The facts are as follows:

(a) Ms Mpanza was 27 years of age when she was brought to the Stanger Hospital by ambulance at 4:54am on the 19th February 2014.

(b) Ms Mpanza was complaining of labour pains. She was 38 weeks' pregnant.

(c) Ms Mpanza had had a previous pregnancy, and the child of that pregnancy was born by caesarean section.

(d) Two and a half hours after her arrival, at 7:30am, Ms Mpanza was seen by a member of the nursing staff. She told the nurse that she wished to have a caesarean section because she could not bear the pain of a natural birth. The nurse recorded no abnormalities. Ms Mpanza was in an early stage of labour and her cervix had dilated between one and two centimetres. The first active phase of labour had not yet begun.

(e) One hour and 45 minutes later at 9:15am, Ms Mpanza was seen by a Doctor Sullivan. He examined her and recorded that she was four centimetres dilated. She had therefore entered the active part of the first stage of labour.

(f) At 11:50am, despite having agreed that Ms Mpanza would undergo birth by way of a caesarean section, an artificial rupture of membranes (an AROM) was performed, the effect of which was to rupture her membranes so that her waters were breached, and the process of a

vaginal birth accelerated. A CTG tracing was started at about the same time. This showed an abnormal heart-rate.

(g) At 12:20pm Ms Mpanza began to bleed heavily and she was admitted for an emergency caesarean section which was performed at 1:15pm when M[….] was delivered. It was apparent from the outset, (although this was contradicted in some of the hospital notes), that he was already severely injured when he was born.

[4] Mr *Pillemer* called two witnesses, the first of whom was Doctor Yatish Dhirajal Jath Kara, a paediatrician in private practice. Dr Kara handed in his curriculum vitae evidencing that he is competent to speak to the nature and time that Mhlengi sustained his injuries. As a preliminary to compiling his expert report, Dr Kara spoke to Ms Mpanza and examined M[….]. He obtained from Ms Mpanza a medical family history and her own maternity history. He also discussed with her the events which occurred during her labour and thereafter. In addition Dr Kara examined the hospital medical records. At the time when Dr Kara compiled his medical report, he did not have the assistance of a Magnetic Resonance Imaging (MRI) report, which was only produced later.

[5] Dr Kara described M [….] as being cerebral palsied with quadriplegia. He was stiff and weak in all four limbs. There was also the possibility of dystonia where the limbs of a person suffering cerebral palsy may be stiffer at certain times than at other times. His view was that the cerebral palsy was caused in this matter by hypoxia-ischemic encephalopathy (HIE). M[….] is completely paralysed, blind and possibly deaf, and there is nothing which medical science can do at this stage to repair the damage. With intensive rehabilitation and occupational therapy it may be possible that he could improve by one level (he is currently at level 5). Dr Kara's view is that M[….] will never be able to walk or even crawl. He is in the category of the 'worst case' of cerebral palsied persons and would never recover.

[6] Dr Kara pointed to the contradiction in the medical records which indicate that Ms Mpanza told the medical staff that she wished to give birth by caesarean section. The doctor who recorded this, however, also recorded that she should undergo an

AROM. This was contra-indicated because any medical intervention to disrupt the condition of the membrane in which M[….] was at that stage encased, would accelerate the process of a vaginal birth. This is because the AROM triggers the birth reaction in the body of a mother. Dr Kara pointed out the note at page 25 of the maternity records from Stanger Hospital which indicated both that:

(a) Ms Mpanza would be booked for a caesarean section after the emergency caesarean sections were completed; and

(b) Ms Mpanza would go the labour ward and an AROM would be performed.

Dr Kara records that there is no explanation for this very odd sequence of treatment proposed by the doctor.

[7] Dr Kara also testified that Ms Mpanza started bleeding heavily and the medical staff assumed that this was because of a ruptured uterus. They decided to perform a caesarean section under a general anaesthetic. Dr Kara drew attention to the fact that the course of the pregnancy had been uneventful, and there was no concern on the part of the hospital staff upon her arrival at hospital. However, several hours later, M[….] was born with signs of brain damage. It transpired that Ms Mpanza had suffered a placental abruption, which had caused the heavy bleeding which occurred.

[8] There was also confusion in the ‘Apgar’ schedule which is a nursing tool designed to indicate whether a child requires resuscitation at birth. It records the subjective observations of the nurses. The scores recorded on M[….]’s Apgar chart indicate a child in a reasonable condition, but this was not consistent with the compromised state in which M[….] was delivered, as referred to by the doctors in the medical records. It is also contradicted by the fact that it was necessary to resuscitate M[….], and that oxygen was also administered to him, which was also a contradiction if the Apgar scores were accurate.

[9] Blood tests were carried out on M[….] at birth, and they indicated high acid levels in his blood. This is also evident from other indications in the blood analysis. The acid levels in M[….]’s blood establish beyond doubt that he underwent an HIE.

[10] Dr Kara was of the view that his clinical examination and the hospital records clearly show that M[….] was highly compromised at the time of delivery and that he is confidently able to state:

(a) The injury occurred during the labour process;

(b) The Apgar's scores are clearly wrong; and

(c) That M[….] had suffered an interference with his brain function, which was indicated by his inability to suck or cry and the fact that his body did not have a normal colour. The presence of a brain injury makes it highly unlikely that the HIE occurred during pregnancy and prior to the birth process. In this regard Dr Kara pointed out that the defendant's expert agreed with his view on this aspect.

[11] Dr Kara stated that when he eventually saw the MRI report it confirmed his conclusions. Other possibilities of the cause of the brain injury had been excluded and the circumstances made it all the more likely that an HIE occurred at birth.

[12] Dr Kara testified that the MRI is a highly accurate tool for identifying when the injury occurred, which in this case could only have occurred between 36 and 44 weeks. Had it otherwise being the case, the MRI would have been different. Dr Kara referred to the work of Professor Volpe (of Harvard University), a paediatric neurologist who wrote the definitive textbook on neonatal injuries. He opines that three factors are necessary in order to establish the injury at birth:

(a) Evidence of foetal distress at birth;

(b) Neurological depression at birth; and

(c) Evidence of encephalopathy at birth.

All three were present here.

[13] Dr Kara testified that foetal heart-rate was the first detectable event as a precursor to brain injury. This is because less oxygen and blood is supplied to the heart muscle. This could lead to a lowering or an elevation of blood pressure –eg. the heart attempts to compensate for the reduced oxygen and blood supply by increasing the heart rate. This can occur during birth when contractions take place and result in short periods of intermittent hypoxia.

[14] A critical point is reached where the heart is unable to pump enough blood to the brain, and the body diverts blood which would have gone to other vital organs to the brain in order to enable survival. The next step is that the brain would shut-off the blood supply to various parts of the brain which are not essential for life. It is hoped that the body recovers in time to re-stimulate the shutdown brain functions. If this does not happen and the insult is prolonged, what is referred to as a watershed pattern of injury occurs. In most cases the injury is detectable and preventable, and the cardiotocograph, which records foetal heartbeat and uterine contractions, would have alerted the staff in time for steps to be taken. Monitoring and careful attention to the patient will detect the problems in the vast majority of cases.

[15] The second witness for the plaintiff was Professor Eckhart Johannes Buchmann. He is a Specialist Obstetrician and Gynaecologist, with a sub-specialisation in maternal and foetal medicine. He is competent to speak to the nature and effects of oxygen deprivation in foetuses and foetal brain injury. From 2005 – 2012 he was the Head of Obstetrics and Gynaecology at the Chris Hani Baragwanath Hospital in Johannesburg – the largest maternity unit in Southern Africa. He has also been the Professor of Obstetrics and Gynaecology at the University of the Witwatersrand since 2003.

[16] On the 28th of August 2018 he prepared a report dealing with the treatment of Ms Mpanza and the injuries suffered by M[….]. He investigated the pregnancy history of Ms Mpanza, including the ante-natal history of her visits to the KwaDukuza clinic during her pregnancy, as well as the hospital records of her delivery.

[17] Professor Buchmann regarded Ms Mpanza as being a patient at risk because she had previously undergone a caesarean section, which meant that she had a scar on her uterus when she was pregnant with M[….]. This created a weakness. Her right to undergo a further caesarean section should have been given serious

consideration. The decision by the hospital staff to administer an AROM was contra-indicated because it would accelerate the process of vaginal birth, in circumstances where the doctor had said that she would undergo a further caesarean section.

[18] Professor Buchmann opined that Ms Mpanza should not have been allowed to wait so long (an hour and three-quarters) before seeing a doctor – this after she had already waited two and a half hours' before being seen and assessed by a labour ward professional. The delay was unwarranted because she was already in the first phase of labour. By the time she saw the doctor she was in the active part of the first stage, being four centimetres dilated. From that time on, she should have been properly monitored, involving a nurse at her side so that the nurse could check the heart-rate of the foetus from time to time. This did not happen. Had it been done, the problems which did occur would have been detected in time for remedial action to have been taken.

[19] Although the doctors thought that the heavy bleeding of Ms Mpanza was caused by a ruptured uterus (when in fact it was a placental abruption), the action of performing an AROM was the worst thing they could have done in the circumstances. This would have exacerbated the effect of the placental abruption, making strengthened contractions and hypoxia more likely. One can only assume that when the CTG detected a low heart-rate at 11:50am, the foetus was already in distress.

[20] Professor Buchmann agreed that the MRI is a very good diagnostic tool for determining the duration and severity of a foetal brain injury in the event of oxygen deprivation. The picture in the current MRI showed a mixture of an acute profound and partial prolonged hypoxic-ischaemic brain injury. The failure of the hospital staff to monitor the foetal heart-rate once the active stage of labour was detected delayed the caesarean operation with the increased risk of hypoxic brain damage.

[21] The plaintiff's case was then closed. The defendant led no evidence, and Mr *Mthethwa* closed its case.

[22] In the circumstances the plaintiff has clearly established on a balance of probabilities that:

(a) Ms Mpanza arrived at Stanger Hospital in the very early stages of labour.

(b) She told the nursing staff that she wanted to give birth by way of a caesarean section.

(c) The attending doctor, for reasons not explained, decided that an AROM was indicated. This was done, and had the effect of accelerating the process of a vaginal delivery.

(d) Ms Mpanza then starting bleeding heavily at approximately 12:20pm, because of a placental abruption. This occurred after the AROM (performed at 11:50am), and is evidenced by the heart-rate recordings, and would have had the effect of strengthening the contractions and increasing the likelihood of hypoxia.

(e) Because the CTG started abnormally, it is safe to assume that the foetal heart-rate was already abnormal.

(f) A combination of prolonged profound hypoxic-ischemic injury and an acute hypoxic-ischemic event could have been avoided if the medical staff had properly monitored Ms Mpanza, as they were bound to do in terms of the internationally accepted procedures and as the Department of Health Guidelines for Maternity Care provide.

(g) The failure to properly monitor Ms Mpanza is evident from the outset of her arrival at hospital. She only saw a nurse at 7:30am, having arrived at 5:00am. She was already in the early stages of labour, and was a patient at risk because of her previous caesarean section. She was then kept waiting for a hour and three-quarters before she was attended upon by a doctor. At this stage, at the latest (9:15am), she should have been monitored. Had she been monitored, the foetal distress would have been detected at an early stage, and an intervention could have been made.

(h) The AROM was unnecessary and exacerbated the situation. It was contradictory and flew in the face of her treatment plan, particularly because the vaginal birth was abandoned at 9:15am.

(i) The monitoring of the foetal heart-rate would have detected the placental abruption, and steps to avoid M[….] suffering brain damage could have been taken at an earlier stage. They were not, and the blame must lie at the feet of the hospital staff. They failed in both their contractual and common law duty of care to both Ms Mpanza and M[….] to provide

medical services and treatment with reasonable skill and care, and without negligence. They were negligent for the reasons set out above. Their negligence was causally linked to the devastating injuries sustained by M[….].

(j) The defendant is accordingly liable for 100% of the damages sustained by M[….] as a result of the hospital staff's negligence.

[23] With regard to costs, it is difficult to understand why this case came to trial. The defendant was provided with the plaintiff's expert witnesses' reports, and I understand, consulted experts. Nevertheless, the trial went ahead in circumstances where the plaintiff's experts were not in any way challenged, with only one question being asked of the two of them. That related to whether a previous urinary tract infection could have caused the brain injury. Dr Kara said it could not have done so. I fail to understand why it was necessary to waste the time of the experts and this court, all at considerable expense, when it so easily could and should have been avoided. It has been suggested that it is difficult to obtain instructions from the defendant to settle cases of this nature. That may be, but it is no excuse for the defendant to cause the holding of wholly unnecessary judicial proceedings simply because its employees are reluctant to make decisions. The courts are not here to do the administrative functions of the defendant. If the decision was a difficult one to make, there may be an argument for having the experts testify. This was not such a case. I accordingly deem it appropriate, as a measure of this court's displeasure at the conduct of the defendant's officials to order that the costs to be paid, should be paid on the attorney and client scale. The matter was clearly serious and warranted the employment of two counsel, and senior counsel. Given the hoops through which the plaintiff has been made to jump, it would have been unwise for the plaintiff to have done otherwise.

[24] I make the following order:

1. The Defendant is directed to pay to the Plaintiff, in her capacity as mother and natural guardian of M[….] E[….] D[….], a boy born on the 19th of February 2014, 100 % (One hundred percent) of the damages that she may prove that M[….] E[….] D[….] has suffered or will in the future suffer as a

consequence of the actions of the Defendant and/or its medical or nursing personnel in their treatment of the Plaintiff and M[….] E[….] D[….] at Stanger Hospital at the time of his birth, on the grounds set out in the Particulars of Claim.

2. The Defendant is ordered to pay the Plaintiff's costs to date on the scale as between attorney and client, including the costs of senior and junior counsel, such to include (but not limited to):

   (a) the reasonable and necessary costs of the plaintiff's attorney attending upon consultations with the under mentioned expert witnesses and the Plaintiff;

   b) the costs of senior and junior counsel, including their reasonable and necessary costs of preparation for the trial and the costs for the attendance of senior and junior counsel upon consultations with the under mentioned expert witnesses and with the Plaintiff as determined by the taxing master;

   (c) the costs of obtaining and the production of an MRI scan of the brain, in respect of which Dr S. Misser has reported, including the costs of the anaesthetist and hospital fees that were necessary to obtain the said MRI scan;

   (d) the reasonable and necessary fees of the under mentioned expert witnesses including the costs of their preparation to qualify themselves to testify at the trial, the costs of their reports, and for consultations with the Plaintiff's attorney and counsel namely:

      (i) Dr C Harris, Nursing Expert ;

      (ii) Professor E Buchmann, Obstetrician & Gynaecologist);

      (iii) Dr Y Kara, Paediatrician;

      (iv) Dr Bates Alheit , Specialist Radiologist ;

   (e) Reservation fees of :

      (i) Professor E Buchmann, Obstetrician & Gynaecologist);

(ii) Dr Y Kara, Paediatrician;

(iii) Dr Bates Alheit , Specialist Radiologist ;

(f) All reserved costs, including the costs of counsel incurred on the 4th of May 2018 in having the matter certified ready for trial at the Case Flow Conference hearings;

_____

Lopes J

Date of hearing:	6th of May 2019.
Date of judgment:	7th of May 2019.
For the Plaintiff:	Mr *Pillemer SC,* with Ms *Beket* (instructed by Friedman & Associates).
For the Defendant:	Mr *Mthethwa* (instructed by The State Attorney – KwaZulu-Natal).