IN THE HIGH COURT OF SOUTH AFRICA

(WESTERN CAPE DIVISION, CAPE TOWN)

REPORTABLE

CASE NO: 8734/2017

In the matter between:

N[...] Z[...] Plaintiff

And

THE MEMBER OF THE EXECUTIVE COUNCIL
FOR HEALTH – WESTERN CAPE Defendant

Coram: Parker, AJ

Matter heard on: 23, 25, 29, 30 April and 24 July 2024

Judgment delivered electronically on: **01 November 2024**

JUDGMENT

PARKER, AJ:

Introduction

[1] Plaintiff claims damages in her personal capacity and on behalf of her minor son arising out of the treatment administered to the Plaintiff during her pregnancy and the birth of S[...] ("baby") at the Mitchells Plain Midwife Obstetric Unit ("MOU") on 19 December 2010.

[2] Since merits and quantum have been separated I am to decide on liability only.

[3] The Plaintiff averred in her particulars of claim that the injury was caused by the substandard care and for the negligence of medical staff at the MOU, who failed to implement the appropriate procedures when it was evident that she presented with shoulder dystocia. Furthermore, that the administration of the appropriate procedures would have prevented the shoulder dystocia and the resultant brachial plexus injury and Erb's palsy to the baby.

Common cause

[4] It is common cause the delivery was complicated by shoulder dystocia[1].

[5] There was a time interval of eight minutes between the delivery of the baby and the baby's head, and, as a result of the delivery he suffered an injury to his brachial plexus in the form of Erb's palsy and was also diagnosed with hypoxic ischemic encephalopathy.

[1] meaning that one or both his shoulders got stuck inside the pelvis of the mother at birth.

[6] The baby's birth weight was recorded as 4530g. Therefore, the baby is considered as a large newborn and falls into the category of macrosomia. After the baby was born he required resuscitation.

[7] The baby was transferred to Mowbray Maternity Hospital for further management and upon arrival had seizures. Treatment administered included head cooling and medication for seizures.

The issues

[8] Whether the staff at the MOU were negligent in treating the Plaintiff during the Plaintiff's management and delivery; and

[9] Whether that negligence had caused the injury.

List of Witnesses

[10] For plaintiff:

10.1. Ms. L. Fletcher – nurse and midwife

10.2. Dr. CP. Davis – obstetrician and gynaecologist

10.3. Dr. A. Keshave – paediatric neurologist

10.4. Dr. H. Lewis – paediatrician

10.5. Professor S. Andronikou – professor of radiology

[11] For defendant:

11.1 Sister Faro – midwife

11.2 Dr. Wright – Specialist obstetrician and gynaecologist

Plaintiff's evidence

[12] She is a widow with three children. S[...] is her youngest child and currently 13 years old. She was 35 years old when she fell pregnant with him. When she was six months pregnant, she made her initial visit to the antenatal facility on 13 October 2010. Her HIV status was negative and her diabetes and blood pressure were assessed as normal. However, she was mildly anaemic. Ferrous sulphate and folic acid were initiated at 36 weeks of gestation.

[13] When she was about 41 weeks pregnant she attended the antenatal clinic (10 December 2010). A letter of referral was issued to her for an appointment at Mowbray Maternity hospital on 20 December 2010, if she had not delivered before then.

[14] On 19 December 2010 her waters broke at home, she experienced contractions and was admitted to the MOU, where she was placed on a hospital bed with the back of the bed raised. She described in court how she was positioned with her upper torso at an angle, legs apart with her knees bent. She recalls when the baby was on the way, the staff changed her position on the bed and her legs were brought closer to her abdomen.

[15] She remembered people in the room at the time, one of the staff members stood at the end of the bed to receive the baby. Another stood behind her, massaging her back, whilst, another stood next to her and placed both hands just below her breastbone and pushed her tummy down under her ribs.

[16] Despite pushing to the best of her ability, the baby did not emerge. One of the medical staff assisted her by pressing on the top part of her abdomen, while others

were holding her legs up. At the time, she was lying on her back on the hospital bed. She was unable to see what they were doing, however, recalls that the baby was born not long after the episiotomy. She did not see the baby until she went to the ambulance. She testified that "*I will never forget the day of the delivery of my baby because it was the day that I gave birth and I remember very well that the people were there more than two of them*".

Ms Fletcher – nurse and midwife

[17] Ms. Fletcher, testified that her expertise was primarily focused on nursing education and medico legal compliance. She also acknowledged that she had never encountered a shoulder dystocia occurrence.

[18] She testified on the Guidelines for Maternity Care in South Africa, and her view is that the Plaintiff ought to have been referred to a hospital for assessment on the grounds that she was over the age of 34. According to the records, her body mass index (BMI) - the Plaintiff was obese which is associated with an increased risk of delivery of a larger than normal baby. The Plaintiff's hemoglobin level was low (9.7), and in terms of the Guidelines the Plaintiff suffered from mild anaemia, which should have been investigated and treated. This was not done. She further described that a post term pregnancy is one that exceeds 41 weeks gestation. According to her, a number of problems including birth asphyxia, meconium aspiration, cephalo-pelvic disproportion and post-maturity syndrome are associated with a post term pregnancy.

[19] She describes the nursing records at the MOU as woefully inadequate and in some instances non-existent. Antenatal records were incomplete, omitting important information such as the Plaintiff's HIV status, steps to address anaemia etc. Apart from the partogram, there were no records that detailed the progression of Plaintiff's labour, particularly when the second stage of labour began. She described that the McRobert's manoeuvre is a specific intervention that is required for shoulder dystocia, used in an obstetric emergency. It was anticipated that nurses would generate a comprehensive

and exhaustive report subsequent to the delivery. In the available records, the only record of shoulder dystocia was found in a very brief report written after the delivery and before transfer to the Mowbray Maternity Hospital. Ms. Fletcher asserts that she would have anticipated comprehensive notes of information such as when the baby's head was delivered, why there was a delay between the delivery of the head and the body and, in particular, what manoeuvres were performed. This would have been a retrospective report because during the delivery it would not have been possible to compile a contemporaneous report.

[20] In her view, the nursing care was substandard in the antenatal period due to the fact that the Plaintiff was not referred for assessment by a medical practitioner or to the hospital, despite being a requirement in terms of her age. The Plaintiff and the infant were at risk of premature labour and postpartum haemorrhage due to the apparent lack of attention given to the anaemia the Plaintiff had experienced.

[21] At the last antenatal visit on 10 December 2010 the Plaintiff should have been referred to a hospital for assessment. When the appointment was made for the Plaintiff to attend at the Mowbray Maternity Hospital for induction of labour on 20 December 2010, she was not informed to go to the hospital when she went into labour.

[22] In examining the nursing care during labour she held the view that it was substandard, in that on admission to the MOU the Plaintiff was in labour and there was a concern that the baby was big. This together with her age, obesity and post-dates should have prompted immediate referral to hospital for delivery.

[23] The Plaintiff's evidence suggests that the nursing care during the delivery was also substandard. Although an attempt was made to conduct a manoeuvre, the technique used was not the correct application of the Mc Robert's manoeuvre. The Plaintiff was not positioned correctly on the bed, as she was not placed at the side or along the edge of the bed. The suprapubic pressure was not administered, and the fundal pressure was incorrectly employed.

[24] If the Plaintiff has been referred to a hospital during pregnancy but especially when she was admitted to the MOU in labour, the probability of medical assistance when the emergency occurred (shoulder dystocia) would have been high and the outcome would probably have been different.

Defendant's Witness: Sister Faro – Midwife

[25] Sister Faro is a speciality professional nurse. On 19 December 2010 she was on duty at the MOU. According to her, three midwives and two nurses would be on duty. She has encountered cases of shoulder dystocia quite a few times in her career and estimates that there would be two to three cases per month at the MOU.

[26] She has no independent recollection of this specific case, however was able to identify her handwriting in some of the notes. She read some of the recorded notes which were available that the Plaintiff gave birth to an *"alive male infant (very sick) by normal vaginal delivery (NVD)",* and *"Head out at 11h35 and shoulder dystocia, body following at 11h43, ONLY!!"*

[27] She explained the operations of the MOU, how it was run, and on average the MOU saw about 320 deliveries per month. None of the staff who were on duty on the date of the delivery of the baby were traceable. She could therefore only provide context on notes which were made, since she was not the scribe, save where it was recognisable as her own. Issues of admissibility of her evidence was raised by the Plaintiff. Nevertheless, she stated that the standard practice would be for a member of staff to record information on a piece of paper, which would be used by the midwife to write her summary later. She testified that fundal pressure would never have been used before the delivery of the baby.

The experts

Drs CP. Davis – obstetrician and gynaecologist and D. Wright – Specialist obstetrician and gynaecologist

[28] There was little dispute between both Drs Davis and Wright. Both described what the Mc Robert's manoeuvre is and when it is employed in a delivery.

[29] Their agreed findings are that the Plaintiff was obese, she was most probably post term, there was an entry on the partogram that this might be a big baby and are all warning signs that this might be a big baby. The attending staff should always be alert to the possibility of shoulder dystocia. The prediction of shoulder dystocia is largely inaccurate. All birth attendants should be familiar with the techniques to facilitate delivery in cases of shoulder dystocia. The Mc Robert's manoeuvre should be performed immediately when shoulder impaction is encountered. Due to substandard record keeping no evidence could be found that any of the accepted manoeuvres were performed to deliver the baby.

[30] Dr Davis was of the opinion that the bruising and swelling of the baby's right arm, as well as the fact that the delivery was a standard vertex delivery, indicate that an alternative delivery method was employed to deliver the posterior arm and the McRobert's manoeuvre was not performed. Dr Wright was of the opinion that the Mc Robert's manoeuvre was probably attempted but failed and therefore some other manoeuvre, such as delivery of the posterior arm was also performed. This would account for the trauma to the baby. Not all instances of brachial plexus injury are due to substandard care. Dr Davis was of the opinion that there is no evidence that the Mc Robert's manoeuvre was performed and therefore the delivery was conducted in a substandard manner. Dr Wright was of the opinion that in the absence of adequate documentation in this case, it was impossible to judge the standard of care administered to manage this complication.

Dr Keshave – paediatric neurologist

[31] Defendant admitted his medico legal report. Dr. Keshave posits that S[...]'s cognitive function and language are further compromised by the hypoxic injury she sustained at delivery, as evidenced by the following: low Apgar scores; delay from delivery of the head to the body; the need for intubation and resuscitation after delivery; oxygen saturation noted to be 48% despite intubation at 5 minutes after delivery; seizures documented at Day 1 of life; and the maximum hypoxic-ischemic encephalopathy (HIE) score of 15 (grade 3 HIE).

Dr. Humphrey Lewis – paediatrician

[32] Dr Humphrey Lewis, perused the relevant hospital records and testified: that Neonatal encephalopathy is a clinical syndrome that presents with abnormal neurological function and is characterized by difficulty in maintaining respiration, decreased activity in level of consciousness, reduced motor tone, persistence of primitive reflexes and seizures in term and late preterm newborns. Hypoxic ischemic encephalopathy (HIE), which is defined as disturbed cerebral function due to lack of oxygen to the brain following antenatal/perinatal adverse events, is the most common cause of neonatal encephalopathy.[2]

33.1 The seizures which were noted on admission to the Mowbray Maternity Hospital were signs of abnormal neurological status due to the baby having been exposed to hypoxia at birth.

33.2 S[...] received hypothermia therapy at Mowbray Maternity Hospital which is cooling of the whole body for a period of time. The effect of the hypothermia therapy did a lot to improve this child’s outcome with a heart rate of 34 he may have died.

[2] Transcript: p17(5-18); Cognitive Outcomes in Late Childhood and Adolescence of Neonatal Hypoxic-ischemic Encephalopathy, Bundle B p107.

33.3 Regardless of motor impairments in late childhood and adolescence, children with a history of HIE are at risk for cognitive and executive function difficulties.

Dr. Lewis – paediatrician

[34] Dr Lewis concluded that there is no doubt that the baby had a significant period of intrapartum asphyxia as a result of obstructed labour due to shoulder dystocia. The infant required resuscitation as there was a severe bradycardia (low heart rate) and the Apgar scores were 1/10 at 1 and 5 minutes respectively.

Prof Andronikou – professor of radiology

[35] Professor Andronikou, gave evidence concerning a MRI brain scan performed on the baby on 24th February 2017 at the age of 6 years and two months. He found no abnormalities on the scan and there were no features of hypoxic ischemic injury. More advanced radiological studies such as diffusion tensor imaging could be performed. Professor Andronikou referred to an academic article dealing with MRI imaging done on South African children in the diagnosis of the causes of cerebral palsy.[3] The authors retrospectively reviewed brain MRI reports from 1600 medical legal data bases, comprising cerebral palsy cases referred for medical legal evaluations long after an alleged perinatal hypoxic ischemic event occurred. Of these cases, 8.2% were categorized as normal based on the MRI scan, although all the children suffered from cerebral palsy.

Gestation

[36] Dr Wright testified that normal pregnancy in humans are between 37 completed weeks and 42 completed weeks. Once you get beyond 42 weeks the morbidity and

[3] Magnetic Resonance Imaging Diagnosis of Causes of Cerebral Palsy in a developing country: a database of South African children. SAMJ September 2021, Vol III no 9 M.M. Elsingergy et al.

mortality of mother and baby increases. Hence the selection of 42 weeks as being the cutoff point where a normal pregnancy should probably end. Dr Davis, on the other hand, opined that a normal pregnancy are from 38 to 41 weeks and agreed that the gestation of a baby is an estimate.

Hospital Records

[37] This brings me to the Hospital records. The purpose of hospital and medical notes made for a patient speaks for itself. It is to provide reliable evidence of, and information about, *'who, what, when, and why'* something happened. Accurate medical record keeping is vital for doctors, medical staff, medical establishments and the health sector, facilitating effective patient management and providing evidence of proper care. The absence of such records or gaps in the record keeping can result in serious circumstances, especially where events take a serious turn during a medical emergency.

> *"It is very important for the treating doctor to properly document the management of a patient under his care. Medical record keeping has evolved into a science of itself. This will be the only way for the doctor to prove that the treatment was carried out properly."* [4]

[38] The Defendant was unable to account for the absence of medical records in this matter, particularly during the critical eight-minute period of delivery. Whilst I can understand that the health sector operates under highly stressful environments and that the MOU where the delivery occurred is a busy unit, seeing at least 5-7 shoulder dystocia cases per month, the keeping of records therefor is imperative to avoid attracting lawsuits such as this, where the available records offer little explanation of the events that transpired at a critical time of the delivery.

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[4] Source Medical records and issues in negligence - PMC Indian J Urol. 2009 Jul-Sep; 25(3): 384–388. doi: 10.4103/0970-1591.56208
PMCID: PMC2779965PMID: 19881136
Medical records and issues in negligence
Joseph Thomas

[39] It is also unclear how the baby sustained an injury to the right arm in the absence of such recordings to clarify the manoeuvres that were executed and whether the McRobert's manoeuvre was executed. The right arm injury is an objective indicator that the shoulder dystocia was not appropriately managed, as indicated by Dr Davis.

The Plaintiff's submissions

[40] It is argued that defendant's staff were negligent in the management of the Plaintiff's pregnancy and the delivery of the baby in the following respects:

40.1 The failure to pay sufficient regard to the Plaintiff's obesity and excessive weight which pointed to macrosomia which could lead to birth complications;

40.2 The failure to take cognizance of the date of the Plaintiff's last menstrual period;

40.3 The failure to adequately examine the Plaintiff and take note of indications of the possibility of macrosomia during the antenatal phase;

40.4 The failure to refer the Plaintiff for an antenatal ultrasound to establish the gestational age and size;

40.5 The failure to complete the maternal syphilis treatment antenatally;

40.6 The failure to identity that the pregnancy was post-dates and thus timeously refer the Plaintiff to a secondary hospital for induction of labour;

40.7 The failure to ensure that suitably qualified medical staff were present to identify any risk factors, together with the possibility of a macrocosmic infant;

40.8 The failure to intervene at an earlier stage thereby allowing the second stage of labour to be unduly prolonged by failing to apply the McRobert's Manoeuvre;

40.9 The failure to conclude that it would be appropriate to transfer the Plaintiff to the Mowbray Maternity Hospital for delivery;

40.10 The failure to properly examine the Plaintiff in circumstances where it would have been established that the foetus was suffering from foetal distress;

40.11 The failure to properly evaluate and examine the Plaintiff in circumstance where it would have been established that S[...] was a large baby and that a caesarean section should be performed.

40.12 The failure to properly examine the Plaintiff in circumstances where there was lack of progress of birth and that a caesarean section was necessary;

40.13 The failure to provide the Plaintiff with the correct and necessary medical treatment and services;

40.14 The failure to perform the delivery of S[...] with such skill as would reasonably be expected; and

40.15 The failure to exercise the proper degree of skill, care, competence and diligence in treating the Plaintiff.

The Defendant's submissions

[41] The Defendant argues that the views and opinions of Ms. Fletcher were of lesser significance, as they were unable to aid the court in reaching a suitable decision. This is due to the fact that Ms. Fletcher's career was characterised by a lack of hands-on experience, with the exception of a brief period. Consequently, she is less qualified to provide commentary than the Defendant's midwife, Ms. Faro. The Defendant argued that Faro's testimony provided the court with insight and context onto the practices in the unit at the time where she was a senior nurse and Plaintiff's objections to her evidence regarding notes which she, Faro, did not scribe even if it amounted to opinion evidence, is still admissible.

[42] None of the so-called risk factors alleged by the Plaintiff could be attributed to the complication that occurred and the manner in which it occurred. The complication of shoulder dystocia and the injury which resulted was not foreseeable, as the Plaintiff was reasonably regarded at the MOU as a low-risk patient. Both experts agreed that the Mc Robert's manoeuvre was attempted. Dr. Wright further said that the fact that it did not work does not imply that it was incorrectly done.

[43] The evidence shows and the Plaintiff's expert Dr. Davis agreed that up until the time that the baby's shoulder got stuck, Plaintiff's labour had progressed normally and there would have been no reason to refer the Plaintiff to hospital.

[44] Despite being referred to MMH, the Plaintiff presented herself at the MOU in active labour. She was duly admitted and when the complication occurred the staff's training kicked in, and ultimately, they saved S[...]'s life. The Plaintiff's expert obstetrician, Dr. Davis, agreed that that in these circumstances they baby could have died.

The legal principles

[45] I am mindful that the evidence of the Plaintiff (as a single witness) should be treated with caution, as she is the only party before the Court testifying on her pregnancy and delivery and as such her evidence, is credible to the extent that her uncorroborated evidence must satisfy the court that on the probabilities it is the truth. In this regard, Plaintiff testified that she recalls the birth as if it was yesterday, despite the fact that she claimed that her waters had broken at home when she arrived at the MOU or that she was perplexed about the dates of her most recent antenatal clinic visit. Her testimony regarding the birth was unequivocal.

[46] A medical practitioner is required to exercise the degree of skill and care to be expected from the skilled practitioner in his or her field. A Supreme Court of Appeal authority established the test when a reasonable practitioner in such circumstances would have foreseen the likelihood of harm, would have taken the necessary steps to guard against its occurrence and that the concerned practitioner concerned failed to take such steps.[5]

> *"We cannot determine in the abstract whether a surgeon has to has not exhibited the reasonable skill and care. We must place ourselves as nearly as possible in the exact position in which the surgeon found himself when he conducted the particular operation and we must then determine from all the circumstances whether he acted with reasonable care or negligently. Did he act as an average surgeon placed in circumstances would have acted, or did he manifestly fall short of the skill, care and judgment of the average surgeon in similar circumstances? If he falls short he is negligent"*[6]

[47] Flowing from this, the Plaintiff must establish that the wrongful and negligent conduct of the nursing staff acting within the course and scope of their employment,

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[5] *Mukheiber v Raath* 1999 (3) SA 1065 (SCA) at 1077.
[6] *Van Wyk v Lewis* 1924 AD 438 at p 461-462

caused the harm.[7] In this regard the Constitutional Court following the approach to matters of this nature in Kruger v Scouts, in Upper v Department of Health Western Cape[8] sets out:

> *"[106] In our law Kruger embodies the classic test. There are two steps. The first is foreseeably – 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 the then appellate division noted that this standard does not expect the impossible of medical personnel:*
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> > *- a medical practitioner is not expected to bring to bear upon a 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 is he does not.*
>
> *[108] This means that we must ask, what would exceptionally competent and exceptionally knowledgeable doctors have done? We must ask: what can be expected of the ordinary or average doctor in view of the general level of knowledge, ability, experience, skill and diligent possessed and exercised by the profession, bearing in mind that the doctor is a human and not a machine and that no human being is infallible. Practically, we must ask, was the medical*

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[7] *Mtetwa v Minister of Health* 1989 (3) SA 600 (D&CLD) at 606B-F
[8] *Kruger v Scouts, in Upper v Department of Health Western Cape*

professional's approach consistent with a reasonable and responsible body of medical opinion? The test always depends on the facts. With a medical specialist, the standard is that of a reasonable specialist."

[48] Accordingly, to determine whether the Defendant's staff were negligent following the approach as in *Vermeulen*[9], the court will be guided by the determination with regard to the view of the experts. A court decides whether the *"failure to act in accordance with a practice accepted as proper in the relevant field is necessary*" A court weighing up the views of the parties' experts has to be satisfied that" their opinions have a logical basis" and whether in their views the experts had directed their minds to the question of comparative risks and benefits and reached a defensible conclusion on the matter.

Onus of Proof

[49] It is trite, the general *onus* of proof lies with the Plaintiff. "*He who asserts must prove*"[10].In so far as medical negligence is concerned in *Meyers v MEC, Department of Health, Eastern Cape*[11] found that once a plaintiff had given explanation for a claim, it was sufficient to place an evidential burden upon the Defendant to shed some light upon the circumstances attending to the Plaintiff. Failure to do so meant that, on the evidence as it then stood, the defendant ran the risk of a finding of negligence against it. Whilst a plaintiff bore the overall *onus* in a case, the defendant nonetheless had a duty to adduce evidence to counter the *prima facie* case made by the plaintiff. It remained for the defendant to advance an explanatory (albeit not necessarily exculpatory) account that the injury must have been due to some unpreventable cause, even if the exact cause be unknown.[12]

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[9] *Medi-Clinic LTD v Vermeulen* 2015 (1) SA 241 (SCA) at 250B-D
[10] *Van Wyk v Lewis* (*Supra*) at 444
[11] 2020(3) SA 337 (SCA)
[12] At 356A-C

[50] The evidential burden stated in *NVM obo VKM v Tembisa Hospital*[13]:

> *[86] A Plaintiff is not required to show a causal connection between the conduct or permission and the eventual harm with certainty. All that is required is "to establish that the wrongful conduct was probably a cause of the loss, which calls for a sensible retrospective analysis of what would probably have occurred, based upon the evidence and what can be expected to occur in the ordinary course of human affairs rather than an exercise in metaphysics. And cerebral palsy cases whether the brain damage is caused by HIE, like the present one, fall into a particularly challenging field of medicine, "where medical certainty is virtually impossible". It is a form of harm that calls for a more flexible understanding of factual causation.*
>
> *[87] In this matter, the applicant adduced sufficient evidence to prove factual causation, in the context of a harm which is replete with uncertainties. Absent any countervailing evidence from the respondents, the unchallenged evidence of the applicant's medical experts, particularly that of Prof. Kirsten and Dr Pistorius, together with the admitted facts and the joint minutes of the obstetricians, prove the applicant's claim for damages. The negligent failure by the hospital staff to conduct adequate monitoring of the foetal heart rate during the critical period, denied them the opportunity to detect the warning signs of the onset of hypoxia. That, in turn, resulting in the failure to take emergency measures to afford V more time until a caesarean section could be arranged. On the probabilities, the brain injury would not have occurred had all of this been done, or the risk of this brain injury, would have significantly reduced. In the premises, had I commanded the majority, I would have upheld appeal with costs."*

What is the role of expert witnesses and how their evidence is to be approached?

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[13] [2022] ZACC11

[51] The Court in *JA obo DA v MEC for Health* with reference to the *Linksfield* matter,[14] expressed the following view in relation to expert opinion:

> *"[12] … The cogency of an expert opinion depends on its consistency with proven facts and on the reasoning by which the conclusion is reached. The source for the evaluation of this evidence for it's cogency and reliability are (i) the reasons that have been provided by the experts for the position adopted by him/her; (ii) whether that reasoning has a logical basis when measured against the established facts; and (iii) the probabilities raised and the facts of the matter. It means that the opinion must be logical in its own context, that is, it must accord with, and be consistent with, all the established facts, and must not postulate facts which have not been proved.*
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> *[13] The inferences drawn from the facts must be sound. The internal logic of the opinion must be consistent, and the reasoning adopted in arriving at the conclusion in question must accord with what the accepted standard methodology are in the relevant discipline. The reasoning will be illogical or irrational and consequently unreliable if (i) it is based on a misinterpretation of the facts; (ii) it is speculative, or internally contradictory or inconsistent as to be unreliable; (iii) if the opinion is based on a standard of conduct that is higher or lower than what has been found to be an acceptable standard; and (iv) if the methodology employed by the expert witness is flawed. What flows from this is that the mere fact that an expert opinion is unchallenged does not necessarily mean that it must be accepted. However, if that evidence is based on sound grounds and is supported by the facts, there exists no reason not to accept it."*[15]

Comparable Case Law

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[14] *JA obo DA v MEC for Health, Eastern Cape* 2022 (3) SA 475 (ECB)
[15] *JA obo DA v MEC for Health (supra)* at 482A – 482E

[52] In the matter of *N.P. v MEC for Health, Eastern Cape*[16] the delivery of the Plaintiff's baby had been complicated by shoulder dystocia, as a result of which the baby's arm was injured. According to the evidence during the delivery fundal pressure had been applied, the McRobert's manoeuvre had not been performed and suprapubic pressure had not been applied. The Court held as follows on the issue of negligence:[17]

> *"in the determination whether the doctor and midwife did not act with reasonable care and without negligence to minimalize or failing to prevent the effects of shoulder dystocia, enumerated the risk indicators*:
>
> 1. *The failure to detect all the risk indicators and to assess their cumulative effect in diagnosing the likelihood of shoulder dystocia;*
>
> 2. *The failure to, accordingly, prepare and put in place a management regimen or plan for dealing with the potential of shoulder dystocia;*
>
> 3. *The failure to take into account the obvious and important information imparted to them by the Plaintiff to the effect that a medical doctor had ascertained that the foetus was a large one and the failure to palpitate the Plaintiff to confirm this;*
>
> 4. *The failure to arrange for an attendant or nurse to take exact notes of what was going on as matters unfolded;*
>
> 5. *The failure to have sufficient assistants on standby;*
>
> 6. *The failure to place the Plaintiff at the edge or end of the delivery bed so as to assist with the delivery;*

[16] (1196/2012) [2014] ZAECMHC 28 (24 July 2014)
[17] At paragraph [40]

7. *The failure to place the Plaintiff in the McRobert's position with the help of assistants, more especially as there were apparently at least two other nurses or assistants available in the labour ward who did not assist or who were not called upon to assist;*

8. *The failure to cut a wide episiotomy;*

9. *The failure to apply suprapubic pressure to force the anterior shoulder under the symphysis pubis;*

10. *The application of fundal pressure;"*

11.

[53] In *ZL obo AL v MEC for Health, Eastern Cape*[18] the Court dealt with a similar claim relating to a birth injury complicated by shoulder dystocia. The Court referred to the joint minutes of the expert witnesses, obstetricians and gynecologists, who agreed that.[19]

"(a) the plaintiff presented with risk factors for shoulder dystocia, which included macrosomia and prolonged second stage of labour;

(b) when managing the shoulder dystocia, the doctor positioned the plaintiff's leg incorrectly. This significantly hindered his ability to overcome the shoulder dystocia;

(c) this situation was further aggravated by the use of fundal pressure. If suprapubic pressure had been applied instead of fundal pressure, the

[18] (378/2019) [2022] ZAECBHC 43 (6 December 2022)
[19] At paragraph [17]

shoulders would probably have been delivered normally and the injury would probably not have occurred;

(d) the failure to place plaintiff in the McRobert's position and the use of fundal pressure rather than suprapubic pressure probably resulted in the use of greater traction to deliver the baby, thus causing brachial plexus injury in the new-born and significant loss of function to the right arm and;

(e) if these manoeuvres were carried out correctly the injury would have been averted and A[....] would have had normal function of his right arm."

Conclusion

[54] Time is of the essence in cases of shoulder dystocia. According to Dr Wright if the body of the baby is not delivered within 5 minutes or sooner after the head, the baby will suffer from hypoxia.

[55] The plaintiff was required to prove, on a balance of probabilities that the Defendant's employees failed to exercise reasonable skill and care, in other words, that their conduct fell below the standard of a reasonably competent practitioner in their field and that the aforesaid negligence caused injury. A medical practitioner is bound to employ reasonable skill and care, and is liable for the consequences if he or she does not.[20] I am mindful that we are dealing with the conduct of a reasonable nurse and midwife who attended the delivery.

[56] In my view I have to agree with Plaintiff that it is manifest that the evidence presented by the Plaintiff established on a balance of probabilities that:

56.1 The hospital staff were negligent in failing to assess whether the plaintiff, a multigravida, had risk factors for shoulder dystocia. Had that been done

[20] Goliath v Members of the Executive Council for Health, Eastern Cape 2015 (2) SA 97 (SCA)

timeously, a caesarean section could have been performed, which would have prevented the injuries from occurring.

56.2 Once the plaintiff had presented with shoulder dystocia, the hospital staff ought to have applied the procedures prescribed in the protocol. Failure to apply those procedures, and in particular the application of fundal pressure as opposed to suprapubic pressure, has served to worsen the situation and had probably caused the injury.

[57] Based on the joint findings of the obstetricians, Ms. Fletcher, coupled with Defendant's failure to generate a comprehensive and detailed report following the delivery, particularly in terms of the manoeuvres that were implemented, is a matter of concern. The Defendant could not procure any witnesses regarding the events that transpired during the critical eight minutes, with the exception of the Plaintiff's Midwife Faro who had, had no recall of the birth. This leaves the only version before the court is that of Plaintiff herself.

[58] Both gyneacologists confirmed that the injury resulted from the shoulder dystocia. The reasonable inference guided by the opinions of the experts and plaintiff's own testimony that can be drawn is that the injury was caused by the failure of the hospital staff to apply the correct procedure or an attempted Mc Robert's manoeuvre. Unfortunately this could not be backed up by hospital records. Furthermore, I am of the view that drawing from the above, the application of fundal pressure as expressed by the plaintiff when she described the delivery that Fundal pressure was applied which according to Dr wright was a common practice "…*say 40, 50 years ago. But it has been severely criticised for its negative effects. And that I think that again today certainly I know from my experience when I was at Mowbray Maternity Hospital it was taboo, you did not see fundal pressure"*

[59] Accordingly based on the evidence before me, the Defendant's nursing staff were causally negligent in the following respects:

59.1 In failing to refer the Plaintiff to a hospital for the management of her pregnancy and the delivery of S[...];

59.2 In failing to perform the Mc Robert's manoeuvre at all, alternatively in failing to perform the Mc Robert's manoeuvre correctly;

59.3 In applying fundal pressure;

59.4 In failing to apply suprapubic pressure; and

59.5 Failing to keep detailed hospital notes.

Costs

[60] I see no reason to depart from the usual costs order that costs follow the result, and I have a discretion whether to allow the fees of two counsel.[21] In deciding whether or not the fees of a second advocate should be allowed, the court has regard to whether it was a wise and reasonable precaution to employ such advocate. The court will also have regard to the complexity of the matter, the importance of this case for the Plaintiff, the nature of the issues in dispute between the parties, the length of the hearing and the arguments, the importance of questions of principle or of law involved and the number of legal authorities quoted.[22]

[61] I see no reason to prejudice the plaintiff's counsel' employed and find that a basis that Senior Counsel's fees should be allowed on scale C, and Junior Counsel's fees on scale B.

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[21] *AD v MEC for Health & Social Development, Western Cape* 2017 (5) SA 134 (WCC) at 139J – 140A.
[22] *City of Johannesburg v Chairman, Valuation Appeal Board* 2014 (4) SA 10 (SCA) at [34]; *Henry v AA Mutual Insurance Association Limited* 1979 (1) SA 105 (C) at 107A; *Barlow v Motors Investments Limited v Smart* 1993 (1) SA 347 (W) at 352G.

Order

[62] In the circumstances, the following order is made.

62.1 The Defendant is liable for such damages as the Plaintiff may prove to have arisen as a result of the injuries sustained by S[...] during his birth on 19 December 2010 at the Mitchells Plain Maternity and Obstetric Unit.

62.2 The Defendant is liable for the Plaintiff's costs of suit on a party and party scale, including, but not limited to:

62.2.1 Senior Counsel's fees at scale C;

62.2.2 Junior Counsel's fees at scale B;

62.3 The consultation, preparation of medico-legal reports, appearances, engagement in preparation of joint minutes and the reasonable and necessary qualifying expenses (including travel and accommodation and drafting the expert reports) of the following expert witnesses:

62.3.1 Dr. CP Davis, obstetrician and gynaecologist;

62.3.2 Dr. H. Lewis, paediatrician;

62.3.3 Professor S. Andronikou, professor of radiology;

62.3.4 Dr. A. Keshave, paediatric neurologist;

62.3.5 Ms. L. Fletcher, nurse and midwife.

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R K PARKER

ACTING JUDGE OF THE HIGH COURT

Counsel for Plaintiff	**:**	Adv. P Corbett SC and Adv. E Benade
Instructing Attorney	:	Rob Menzies Attorneys – Ms Ingrid Essl
Counsel for Defendant	**:**	Adv. E Fitz-Patrick
Instructing Attorney	:	State Attorney – Ms Natalie Hendricks