

IN THE HIGH COURT OF SOUTH AFRICA
GAUTENG DIVISION, JOHANNESBURG

CASE NO: 37432/2013

DATE: 17TH JANUARY 2023

REPORTABLE: NO

OF INTEREST TO OTHER JUDGES: NO

REVISED:

In the matter between:

E[...]: P[....] N[....] NO, for and on behalf of:

E[...]: L[....]

Plaintiff

and

**THE MEMBER OF THE EXECUTIVE COUNCIL
FOR HEALTH OF THE GAUTENG PROVINCE**

Defendant

Coram: Adams J

Heard: 7, 8, 10, 13, 14, 15 and 17 August 2018, 17, 18, 19 and 20 September 2018, 23 January 2019, 6, 7 and 8 July 2021, 28, 29 and 30 March 2022, and 15 September 2022.

Delivered: 17 January 2023 – This judgment was handed down electronically by circulation to the parties' representatives by email, by being uploaded to *CaseLines* and by release to SAFLII. The date and time for hand-down is deemed to be 10:00 on 17 January 2023.

Summary: Trial – Delict – medical negligence – damages – liability in respect of a minor born with brain damage who now suffers from cerebral palsy – whether hospital staff negligent – if so, whether such negligence caused the damage – negligence and causation established – MEC liable.

ORDER

(1) The defendant's special plea of prescription is dismissed with costs, including the costs consequent upon the employment of two Counsel (where so employed).

(2) It is declared that the defendant is liable for 100% of the damages that are proven or agreed to be due to the plaintiff in her capacity as parent and natural guardian of her minor child arising from her brain injury.

(3) The defendant shall pay the plaintiff's costs of the determination of this issue relating to his liability, including the costs consequent upon the employment of two Counsel (where so employed).

JUDGMENT

Adams J:

[1]. The central issue in this defended action is whether the defendant ('the MEC') is liable, in his official capacity as the person responsible for the actions of

employees of Gauteng Provincial hospitals, for the brain injury sustained by the plaintiff's minor child ('the minor child') before or during her birth at the Charlotte Maxeke Academic Hospital ('CMAH' or simply 'the hospital') on 04 March 2005. The minor child, who is at present just short of eighteen years old, suffers from spastic quadriplegic cerebral palsy (SQCP) or dyskinetic cerebral palsy. The questions to be answered in this matter is whether that condition resulted from negligence on the part of the hospital and the nursing staff at the CMAH and whether such negligence can be causally connected to the aforesaid developmental outcome in relation to the minor child.

[2]. Those questions are to be decided against the factual backdrop of the matter as set out in the paragraphs which follow. The common cause facts are gleaned from the objective documentary evidence presented during the trial, which endured for approximately nineteen days over an extended period of about four years, as well as from the *viva voce* evidence led during the trial on behalf of the parties. In that regard, the plaintiff led the expert testimony of the following experts: Dr Langenegger (Obstetrician & Gynaecologist); Professor Van Toorn (Paediatric Neurologist); Professor Smith (Paediatrician and Neonatologist); Professor Nolte (Nursing Specialist) and Dr Alheit (Radiologist). The defendant led the evidence of the following experts: Dr Malebane (Obstetrician & Gynaecologist); Dr Mogashoa (Paediatric Neurologist); Professor Bolton (Paediatrician) and Dr Weinstein (Radiologist). All of the expert witnesses had regard to the hospital records and the clinical notes on which their opinions were based. As always, the hospital records and the clinical notes played an integral part in establishing the common cause facts in the matter and those documents are referenced by me during the discussion of the common cause facts.

[3]. As already indicated, on 04 March 2005, at about 05:30, a baby girl, weighing 2704 grams, was born by normal vaginal delivery to the plaintiff at the CMAH. This had been her second pregnancy and prior to giving birth she had presented herself at the CMAH antenatal clinic for the first time on 10 February 2005 and thereafter again on 17 February 2005, on which date she was seemingly examined for the first time during her pregnancy. At that date, the gestational age was estimated at eight months and one week. On 3 March 2005 – the day before the birth of the child –

there was another visit by the plaintiff to the antenatal clinic, which, according to the records, appears to have been uneventful. At 00:05 on 04 March 2005, the plaintiff presented herself at the maternity ward of the hospital and complained of lower abdominal pains. At 05:30 – about five and a half hours after admission to the labour ward – her child was born by normal vaginal delivery assisted by a vacuum extraction. The post-delivery clinical notes recorded *inter alia* that the baby had suffered birth asphyxia.

[4]. In this action, the plaintiff – in her capacity as the mother and natural guardian of her minor daughter, who is presently seventeen years old – sues the MEC for damages. The CMAH falls under the auspices of the defendant MEC, who is responsible in law for any injury caused by the negligence of staff employed there. That much is common cause between the parties. The plaintiff alleges that the hospital staff had been negligent during the birth of her child and that this negligence caused the hypoxic ischemic injury ('HIE') and its sequelae. As a result, she claims damages on behalf of her minor daughter.

[5]. It is the case of the plaintiff that the nursing and medical staff at the hospital were negligent in that they allowed her to endure several hours of labour in circumstances when a Caesarean Section was indicated and reasonably required as a safer alternative to natural vaginal delivery. She also alleges in her particulars of claim that she was negligently left unmonitored and unattended for lengthy periods of time. As a result of the prolonged labour and the hospital staff's failure to perform a Caesarean Section to deliver her child, so the plaintiff avers, the child suffered a hypoxic ischaemic incident / birth asphyxia due to perinatal asphyxia. This, in turn, caused the child to sustain severe brain damage, as a result of which she suffers from cerebral palsy, mental retardation and epilepsy.

[6]. The material grounds of negligence relied upon by the plaintiff is that the hospital staff and the doctors at the hospital failed to properly, sufficiently or adequately assess the plaintiff's stage of labour when she was admitted to the hospital and that they failed to monitor the plaintiff's labour and foetal well-being appropriately or with sufficient regularity. Importantly, the plaintiff claims that the attending doctors and nurses negligently failed to appreciate that plaintiff's labour

was not progressing appropriately or as required in the circumstances. In that regard, the allegation by the plaintiff is that the staff and the doctors did not properly monitor the foetal heart rate, which resulted in them failing to detect that the foetus was in distress. There was a failure by the staff, so the plaintiff avers, to monitor the foetus by the use and the running of accurate Cardiotocography ('CTG') tracings. A CTG is a continuous recording of the foetal heart rate obtained via an ultrasound transducer placed on a pregnant mother's abdomen, which, if it had been used properly, so the plaintiff submits, would have indicated to the nursing staff and the doctors a foetal heart rate pattern which was completely unsatisfactory. Lastly, the allegation is made by the plaintiff that the hospital staff failed to perform a Caesarean Section on the plaintiff in circumstances where it was necessary to do so.

[7]. In sum, the case of the plaintiff is that, during the birth process, the foetus was deprived of oxygen for prolonged periods of time as a result of negligence on the part of the hospital staff, which resulted in the new-born baby suffering a hypoxic ischaemic incident / birth asphyxia, causing severe brain damage, cerebral palsy, mental retardation and epilepsy. But for the foregoing negligence, so the case of the plaintiff goes, the foetal distress and consequent birth asphyxia suffered by the foetus would have been timeously diagnosed and immediate, appropriate and proper therapeutic measures would have been implemented and the complications of foetal distress and birth asphyxia, such as damage to the brain and cerebral palsy, would have been prevented.

[8]. The MEC denies liability. The medical and nursing staff of the hospital, so the MEC alleges, did not act negligently, and even if they were negligent, such negligence was not a cause of the adverse developmental outcome of the neonate. It is the case of the MEC *inter alia* that the child's condition possibly resulted and probably did result from the relatively short umbilical cord (40 cm), which probably would have played an important role in the causal pathway leading to cerebral palsy. According to the literature, so the case on behalf of the MEC goes, the normal mean length for a 36 to 37 weeks' gestation is about 42 cm to 55 cm. So, for example, Prof Bolton (the MEC's Paediatrician and Neonatologist) referred to a 2017 article by *Yamamoto et al*, who concluded that a short umbilical cord (approximately shorter

than 45 cm) was a clinically useful indicator of adverse pregnancy outcomes and that a shorter cord is associated with higher risk of adverse pregnancy outcomes.

[9]. It was also the evidence on behalf of the MEC's Paediatric Neurologist (Dr Mogashoa) that the plaintiff's daughter's neurological impairments were caused by 'peripartum hypoxic distal risk factors' such as the late antenatal clinic booking and the last minute visit to the clinic, and 'proximal risk factors', namely a short umbilical cord, opioid analgesia and poor maternal effort during labour and birth. Dr Mogashoa therefore concluded that the child's condition was caused by peripartum hypoxia of an acute profound nature, which conclusion, so the MEC contends, is supported by the predominance of dyskinesia and the radiological findings.

[10]. I interpose here to mention that, during the course of the hearing of the matter (on 15 August 2018), the parties agreed that it would be convenient to separate the issues of liability from that of the quantum of the plaintiff's claim. An order to that effect was granted in terms of Uniform Rule of Court 33(4) and the matter proceeded to trial only on the issues of negligence and liability. The quantum of the plaintiff's claim was postponed *sine die*.

[11]. The available documentation, which assist in the factual findings, are the following: Plaintiff's Antenatal Card; Obstetrical clinical / maternity records; Neonatal records, including the *Road to Health Chart* for the child.

[12]. From the Antenatal Card, it could be established that the plaintiff had her first antenatal check-up on 17 February 2005. It appears from the records that she had, for the first time, visited the antenatal clinic a week earlier, on 10 February 2005. There are no records indicating that she was examined on that date, although it appears from the Antenatal Card that the routine blood tests were done on that day.

[13]. It was recorded that the plaintiff, at the time of her first visit to the Antenatal Clinic, was 23 years old and in her second pregnancy. Her previous delivery was in 2003 by caesarean section. The indication (medical reason) for the caesarean section was not recorded. Her normal menstrual period ('LNMP'), preceding the pregnancy was 21 June 2004, which meant that her estimated date of delivery

(‘EDD’) was 30 March 2005. The only past medical history of note was the caesarean section and her family and social history was non-contributory.

[14]. On examination at the Antenatal Clinic on 17 February 2005, her height, weight and blood pressure were 153 cm, 60.7 kg and 120/70 respectively. Examination of the heart, lungs, neck and breasts revealed no abnormalities. The size of the pregnancy (fundal height) was 33 cm (equivalent to 8 months and 1-week gestational age). Results of the blood tests Ph, Positive (blood group) and RPR negative (test for Syphilis) were normal. Her blood level, HB 10, is considered low (less than 11) during pregnancy. According to an entry on page 2 of the maternity book, the plaintiff refused to be tested for HIV. The problems listed were previous caesarean section (c/s XI) and late booker (presented for antenatal care in advanced pregnancy). She had two uneventful antenatal visits (17 February and 3 March 2005).

[15]. On 3 March 2005, she was reported to have complained of occasional lower abdominal pains (LAP) but with good foetal movements felt (FMF). It was recorded that she wanted to attempt VBAC (vaginal birth after caesarean section), meaning that her wish was to attempt a vaginal delivery even though her last delivery was by caesarean section. Her subsequent consultation was scheduled for 17 March 2005.

[16]. According to the maternity book, under the heading ‘Antenatal Admissions only (Doctor's and Midwife's notes)’, the date and time of assessment were 4 March 2005 at 00h05 and the plaintiff was assessed as a P1, G2 (P, Parity = number of deliveries and G, Gravidity = number of pregnancies). This therefore indicated that she had previously delivered one child and was in her second pregnancy (P1, G2 respectively). The pregnancy was estimated to have been 36/40 (9 months) by dates. LNMP and EDD were recorded to have been on 21 June 2004 and 25 March 2005 respectively. Her medical and surgical history was unremarkable (‘nil of note’).

[17]. It requires emphasising that, according to the hospital records and the clinical notes, when the plaintiff and her unborn baby were admitted to the CMAH, both their conditions were within normal limits. That much is apparent from the plaintiff's blood pressure reading and other vital signs readings, as well as the subsequent NST

tracings relating to the foetus. There was no indication whatsoever that there were any problems with either the plaintiff or her foetus. There was, for example, no indication of any maternal infection. What is more is that until about 02:40 that morning, no problems were experienced by the foetus and no difficulties were noted on the record as far as the foetus is concerned.

[18]. On admission, the plaintiff was reported to have complained of lower abdominal pains ('c/o LAP'), with no history of 'SHOW' (blood stained mucoid discharge expelled vaginally at the onset of labour) or SROM (spontaneous rupture of membranes). On clinical examination, her blood pressure was 150/68 and pulse was 86 bpm. The clinical size of the pregnancy ('HOF' or 'height of fundus') was 37 weeks (9 months and 1 week). The foetal position was reported as being within normal limits. The foetal heart rate was recorded as 142 beats per minute (bpm) and foetal movements were reported to have been felt by the mother. The Non Stress Test ('NST') machine – used for electronic measurement of the foetal heart rate – was reported to have been in progress ('recording').

[19]. The maternity book recorded 'the Plan' as 'the patient to be assessed by the doctor'. Another entry was made that the doctor had called and indicated that they would come to review the patient. It was further noted that the plaintiff had been seen by a doctor at 01:20 and was assessed to have been in active phase of labour (APL), whereafter she was transferred to labour ward for further management.

[20]. Spontaneous rupture of membranes was recorded to have occurred at 01:30. At 01:45, the plaintiff, who was assessed as a 22-year-old P1, G2 at 37 weeks (9 months and 1 week), with the cervix dilated at 3 cm and the foetal heart rate of 132 beats per minute, was described as being distressed. A note was also made that she had just been started on the NST (Non Stress Test). The plan was for her to receive sedative medication, if the NST was reactive (optimum foetal condition). At 01:50, she was given sedative medication (*Pethidine* and *Aterax*) for pain relief. At 02:40, 'early decelerations on CTG' were noted. A CTG refers to monitoring of maternal contractions and foetal heart rate in a patient who is in labour. On the other hand, it is referred to as an NST when the patient is not in labour (without sustained uterine contractions), wherein only the foetal heart rate is being monitored. Decelerations

are sustained drops in the baseline foetal heart rate in relation to the occurrence of the uterine contractions. They are termed 'early' if the decrease and recovery of the foetal heart rate corresponds to that of the uterine contraction. Late decelerations are characterised by delayed recovery of the foetal heart rate after the resolution of the uterine contraction.

[21]. With the observation of early decelerations, the patient was given oxygen (3 litres per face mask), turned on her left lateral side and given intravenous fluids (1/2 DS, Dextrose Saline infusion).

[22]. Again, it bears emphasising that at 02:40 there was a reference to 'early decelerations' on the foetal heart rate monitor and that the hospital staff, at that time, was of the view that the foetus was in distress. Intra-uterine resuscitation was accordingly done at that stage by the medical personnel by supplying oxygen to the plaintiff. It can therefore safely be inferred that the hospital personnel, at that time, thought that it was necessary to give the mother oxygen in order to address the foetal distress, that they thought was present at the time.

[23]. In the records, there is also an unnumbered page with incomplete records of assessment by the doctor. Her blood pressure was 150/68. The gestational age was 37 weeks and foetal position was within normal limits. The cervix was 3 cm dilated. The baseline foetal heart rate was 140 beats per minute. An additional note was made in relation to the foetal heart rate monitoring as follows: 'Loss of contact due to patient bearing down in [last word illegible]'. This means that there were periods of discontinuity (loss of contact) in the CTG tracing due to the fact that the patient had been bearing down (contraction of abdominal muscles in an effort to effect vaginal delivery).

[24]. The problem list included the fact that the patient was in the active phase of labour and that she had had a previous caesarean section. The plan was for her to be transferred to labour ward.

[25]. The next review was by a doctor at 03:30. Again, the clinical note records that the plaintiff was assessed as a 22 years old G2, P1 with a previous caesarean

section at 36 weeks in active phase of labour. She was reported to have been distressed. On the CTG the baseline foetal heart rate was about 130 beats per minute with early decelerations, small accelerations (indicator of foetal wellbeing). The variability (gradual decreases and increases in the amplitude of the successive heart beats, from the baseline foetal heart rate) was reported to have been fair. The estimated foetal weight was 2,8 kg. The cervix was 8 cm dilated. There was evidence of mild (1+) caput (swelling of the foetal scalp) and no evidence of moulding (overlapping of the foetal skull bones). Liquor was described to have been clear. And 'the plan' was for the patient to be reviewed after 2 hours.

[26]. Another entry at 03:30 was made by the midwife, who described the findings made by the doctor at the 03:30 review. At 04:30, the patient was reviewed by the midwife again. She was assessed to have been distressed significantly (++). The cervix was fully dilated and the foetal head had descended into the pelvis. There was 2 degrees of caput and 1 of moulding. The plaintiff was taken to the 'second stage' room for delivery. The second stage of labour is from the time that the cervix is fully dilated and vaginal delivery is imminent.

[27]. The next review was at 05:20 by the doctor, who indicated that they had been 'called to see a patient, apparently fully dilated (the cervix) and bearing down for 1 hour'. The plaintiff was reported to have been 'very uncooperative'. A note about the NST, commented that the 'NST not running (no tracing) at the moment, last tracing +/- 04:00, loss of contact but looked acceptable'. On abdominal examination the foetal head was assessed to have significantly descended into the maternal pelvis. According to the assessment, the foetal head was not felt above the pelvis (0/5 above the pelvis). The estimated foetal weight ('EFW') was recorded as 3 kg. The cervix was fully dilated and the foetal head had descended into the pelvis as assessed during the vaginal examination. The degrees of caput and moulding were 2 and 1 respectively, and, according to a further clinical note, there was 'very poor maternal effort'. This is to be interpreted as an observation that the plaintiff, during this period, was not making sufficient attempts in bearing down (pushing to effect vaginal delivery). Thereafter, it was recorded that an episiotomy was made, which is an artificial incision on the perineum made in an attempt to release the tension of the

perineal muscles in order to expedite the delivery of the foetal head (and consequently of the foetus).

[28]. It was further recorded that a Vacuum had been applied and that the foetus was delivered with the first attempt at 05:30. A vacuum is a suction based instrument applied on the foetal scalp to expedite vaginal delivery.

[29]. The post-delivery note records a 'Poor Apgar [score]' of +/- 3/10, and that a Paediatrician was summoned to assist with the management of the unwell neonate, with a poor Apgar score, whereafter the new-born baby was intubated and bagged. The 'Apgar Score' is a general and qualitative determination of the general wellbeing of the new-born within the first five to ten minutes of life. Its primary use is to assess the need for and response to resuscitation of the new-born. The score is usually determined at 1 and 5 minutes after delivery. Another assessment may be done at 10 minutes, particularly when resuscitation was instituted.

[30]. The delivery of the placenta and the repair of the episiotomy were done by the midwife. An entry by the midwife at 06:55 reported that the plaintiff had been very uncooperative. She reportedly did not follow instructions and that a (nursing) sister was asked to convince her to cooperate but had failed. She was reported to have had prolonged second stage of labour for one hour. It was further noted that the delivery had been by vacuum extraction and that an alive female infant with the following Apgar Scores: 2/10 at one minute; 4/10 at five minutes and 5/10 at ten minutes. The birthweight was recorded as 2704 grams and the baby was observed to have been 'born flat +++ and floppy', with severely decreased muscle tone. The interventions included 'bagging', which is a term denoting artificial ventilation by the administration of oxygen via compression and decompression of a specialised bag. Oxygen was also supplied to the neonate through a face mask. It was also indicated that the Paediatrician had taken over the management of the new-born and that she was taken to Transitional Unit (intensive care unit).

[31]. According to the Partogram, which is a schematic representation on which the observations during labour, relating to the mother and her foetus, are recorded, the cervix was 6 and 8 cm dilated at 00:30 and 02:30 respectively. The foetal heart rate

at 00:30 was recorded as 140 and as 133 at 02:30. The main use of a Partogram is to document the monitoring of the progress of labour. The uterine contractions were recorded to have been strong, the plaintiff's blood pressure and pulse were observed to have been normal between 03:30 and 05:00.

[32]. According to the 'Summary of Labour' document, which is a record of the date, times and duration of the various stages of labour, the first and second stages of labour endured for four hours, thirty minutes and for one hour respectively. The total duration of labour was five hours and forty minutes.

[33]. The 'Summary of Delivery', which was completed by the Midwife, recorded the date and time of delivery as 4 March 2005 at 05:30 by vacuum extraction. The birthweight was noted as 2704 grams and gender of the neonate as female. The weight of the placenta and the length of the umbilical cord were recorded to have been 550 grams and 40 cm respectively. The placental membranes were noted to have been complete and there were no knots on the umbilical cord. The date and time of discharge from the hospital was recorded as 4 March 2005 at 16:00.

[34]. The 'Road to Health Chart' is a document which documents and records the progress made by the new-born baby from date of birth and contains particulars relating to the date of delivery, place of birth, weight, height and Apgar Scores of the child. Under the subsection with the heading 'Problems during pregnancy / birth / neonatally', the following is noted: 'Birth Asphyxia and TAGA ('Term Appropriate for Gestational Age').

[35]. An MRI report was compiled by Dr AB Weinstein, an expert Radiologist instructed by the defendant, in relation to MRI distribution of changes when the plaintiff's child was nine years and eight months old. Those changes were recorded as Bilateral Putamen and Thalamic Hyper Intensity, which Dr Weinstein viewed as features which are in keeping with a hypoxic-ischemic event/s predominantly of an acute profound type.

[36]. From the review of the antenatal records the plaintiff was a high risk patient, due to the fact that her previous delivery was by caesarean section. The other

concerns and possible risk indicators were that she started her antenatal care in the third trimester of pregnancy (three weeks before she delivered), she was not tested for HIV. As a consequence of the above, there was limited opportunity for the healthcare providers to screen her and the foetus for others conditions such as HIV for the mother and genetic and chromosomal abnormalities for the foetus amongst others. In all other respects (medical, family and social history) she had no other indicators of a high risk pregnancy.

[37]. Importantly, there are no records of the foetal heart rate monitoring between 04:00 and 05:30 and the only reference (at 05:20) to the foetal condition was a reference to a CTG done around 04:00 by the doctor. The only reasonable inference to be drawn is that there was no monitoring of the foetal heart rate from 04:00 to when the child was delivered at 05:30.

[38]. By all accounts, the new-born baby was diagnosed with neonatal encephalopathy and that the requirements for such diagnosis were met. Neonatal encephalopathy is considered to be 'a clinically defined syndrome of disturbed neurologic function in the earliest days of life in an infant born at or beyond 35 weeks of gestation, manifested by a subnormal level of consciousness or seizures, and often accompanied by difficulty with initiating and maintaining respiration and depression of tone and reflexes'. The aforesaid diagnosis was based on the description of the child at birth. The Apgar scores were low, the baby was described as hypotonic (flat and floppy) with delayed onset of spontaneous respiration as indicated in Prof Bolton's report (the defendant's specialist Paediatrician) which are some of the criteria in the case definition.

Discussion and Analysis

[39]. The starting point of the discussion should, in my view, be the fact that, based on the foetal heart rate on admission and the subsequent reviews, the foetal condition was optimum at the time when the plaintiff was admitted to the CMAH shortly after midnight on 04 March 2005. It is therefore possible that the poor foetal condition at birth may be a reflection of the deterioration in the foetal condition (foetal distress / hypoxia) between 04:00 and 05:30, during which period there was no

monitoring of the foetal hear rate, despite the fact that there were signs of foetal distress at about 02:40. By 03:30 the condition of the foetus had evidently not improved despite the interventions, such as the supply of oxygen to the plaintiff, by the hospital personnel before then.

[40]. This then means that, because there were times when the foetal heart rate was abnormal (repeated early decelerations), it is possible that hypoxia (as marked by deterioration in the foetal heart rate) may have occurred during labour or during the delivery.

[41]. Professor Smith, the neonatologist retained by the plaintiff, in explaining the foregoing reasoning and conclusions, emphasized the presence of the warning signs that should have raised the alarm with the hospital and medical staff in relation to the plaintiff's labour and the delivery of the child. Those include the non-reassuring CTG tracings at about 02:40, which compelled the nursing staff to place the plaintiff into the foetal resuscitation position. This, so Professor Smith testified, is a clear indication that the foetus was in distress and required to be monitored constantly until the delivery. He rejected the MEC's reliance on a short cord as a possible causative mechanism for the cerebral palsy, which, so his evidence went, would have manifested problems sooner than the intrapartum stage of the birth. He emphasised, rightly so, in my view, the clear lack of monitoring after 04:00, especially in circumstances where the plaintiff should have received continuous monitoring. He comprehensively explained the causal pathway of hypoxic ischaemic encephalopathy and identified the presentation of such encephalopathy in the child. He explained that during the birth the child was exposed to recurrent hypoxic events and found himself in a recurring hypoxic pattern resulting in eventual hypoxic and ischaemic collapse.

[42]. Professor van Toorn, the Paediatric Neurologist retained by the plaintiff, supported the conclusions relating to the causal pathway to neonatal encephalopathy. He accepted that it is difficult to assess with certainty the timing of the insult to the brain of the unborn child, but indicated that when the intrapartum resuscitation started, the insults had probably already begun.

[43]. It is also instructive that Professor van Toorn agreed with his counterpart, Dr Mogashoa, the Paediatric Neurologist retained by the MEC, that the plaintiff's child has a mixed (predominantly dystonic) type of cerebral palsy, with severe global developmental delay, which paints a clinical picture of a predominantly basal ganglia affectation, the signs of which are dystonia, chorea and athetosis. These features, so these experts agreed, can look different at different times and are affected by the mood of the patient, pain, level of excitement, level of arousal etc, dystonia and dyskinesia is the same spectrum of movement disorder. The clinical picture of predominance of dystonia / dyskinesia is in keeping with an acute profound insult, which is also confirmed by the MRI findings, which indicate that the child's MRI changes are consistent with an acute profound hypoxic ischemic event ('HIE'). The Paediatric Neurologists also agreed that the MRI features are not in keeping with meningitis, structural brain malformations or stroke.

[44]. Professor Bolton, the Paediatrician retained by the MEC, gave evidence to the effect that the alleged short umbilical cord should be considered as distal cause of the brain damage. However, on his own version under examination-in-chief, he conceded that there is no consensus on what would constitute a short umbilicus and the science on this issue is at best unclear. He further conceded that, in the absence of a short cord, infection and genetic factors which he conceded were absent, an intrapartum hypoxic ischemic event was the most probable cause of the child's cerebral palsy. Professor Bolton was also constrained to concede that the mere fact that the foetus was in distress and that there was a lack of monitoring, justify a finding of negligence on the part of the medical and nursing staff at the CMAH.

[45]. I now turn to consider whether, on the facts before me, the plaintiff's claim has been established, the central issues in that inquiry being those of negligence and causation.

[46]. In *Minister of Safety and Security v Van Duivenboden*¹, the SCA held as follows at para 25:

¹ *Minister of Safety and Security v Van Duivenboden* 2002 (6) SA 431 (SCA), [2002] ZASCA 79;

‘A plaintiff is not required to establish the causal link with certainty but only 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.’

[47]. Furthermore, in *Minister of Finance and Others v Gore NO*², the SCA commented as follows at para 33:

‘Application of the “but for” test is not based on mathematics, pure science or philosophy. It is a matter of common sense, based on the practical way in which the ordinary person’s mind works against the background of everyday life experiences.’

[48]. As regards the issue of negligence, *Vallaro obo Barnard v MEC*³, in my view, finds application. In that matter it was held, with reference to *McIntosh v Premier, Kwazulu-Natal and Another*⁴, that:

‘The second inquiry is whether there was fault, in this case negligence. As is apparent from the much-quoted dictum of Holmes JA in *Kruger v Coetzee* 1966 (2) SA 428 (A) at 430E-F, the issue of negligence itself involves a twofold inquiry. The first is: was the harm reasonably foreseeable? The second is: would the *diligens paterfamilias* take reasonable steps to guard against such occurrence and did the defendant fail to take those steps? The answer to the second inquiry is frequently expressed in terms of a duty. The foreseeability requirement is more often than not assumed, and the inquiry is said to be simply whether the defendant had a duty to take one or other step, such as drive in a particular way or perform some or other positive act, and, if so, whether the failure on the part of the defendant to do so amounted to a breach of that duty. But the word “duty”, and sometimes even the expression “legal duty”, in this context, must not be confused with the concept of “legal duty” in the context of wrongfulness which, as has been indicated, is distinct from the issue of negligence.

² *Minister of Finance and Others v Gore NO* 2007 (1) SA 111 (SCA), [2006] ZASCA 98;

³ *Vallaro obo Barnard v MEC* Appeal Case No A 5009/16, Gauteng Local Division (Full Court);

⁴ *McIntosh v Premier, Kwazulu-Natal and Another* 2006 (6) SA 1 (SCA);

The crucial question, therefore, is the reasonableness or otherwise of the respondents' conduct. This is the second leg of the negligence inquiry. Generally speaking, the answer to the inquiry depends on a consideration of all the relevant circumstances and involves a value judgment which is to be made by balancing various competing considerations including such factors as the degree or extent of the risk created by the actor's conduct, the gravity of the possible consequences and the burden of eliminating the risk of harm. ...'

[49]. Plaintiff's labour was high-risk from the outset. She was *gravidity 2*, having previously (in 2003) given birth by caesarean section and having opted for a BVAC. Shortly after she went into labour, CTG readings showed early decelerations in the foetal heart rate, and intra-uterine resuscitation was done to address the distress the foetus was experiencing. An hour later, and despite the remedial action taken by the nursing and other hospital staff to alleviate the foetal distress, the foetus was still not stable. The experts agreed that the plaintiff's condition required continuous monitoring, at the very least by further CTGs on a continuous basis. A reasonable medical practitioner would accordingly have been alert to the possibility of harm to the foetus caused by an abnormal or distressed foetal heart rate. The questions in this case are really what steps would reasonably have been taken to prevent that harm, when those steps would reasonably have been taken, and whether those steps were in fact taken.

[50]. The answers to these questions are fairly obvious. The foetal heartrate should have been monitored continuously until the baby was delivered. This was not done. On the contrary, the records clearly indicate that from about 04:00 to 05:30, when the baby was delivered, the CTG had been disconnected for whatever reason and no tracings were done. Therefore, in my view, the standard of care given to the plaintiff fell below the standard required of a medical practitioner. Given that the CTG readings at 02:40 and again at 03:30 gave cause for concern, the plaintiff ought arguably to have been given even closer attention and monitored continuously.

[51]. Unfortunately, that did not happen. If it did, the medical staff would probably have realised that the foetus remained distressed and would immediately have taken steps to protect it. This could have been done by taking further remedial action by,

for example, administering more oxygen and, to the extent necessary, by ordering an emergency Caesarean section.

[52]. In my view, the probabilities are fairly clear. The plaintiff's labour required more careful monitoring than was performed. It is difficult to understand why, at 04:00, the CTG monitoring was stopped. Maternal and foetal heart rate monitoring are critically important. They indicate the condition of the foetus. If they are not reassuring, they prompt intervention to deliver the baby. Once the second CTG indicated the recurrence of a problem with the foetal heart rate that was first noted at 02:40, continuous monitoring should have continued and if the problems persisted, action could and should have been taken. But it was not.

[53]. On the probabilities, the management of the plaintiff's labour was negligent in that inadequate monitoring was carried out, and no action was taken because there was no way of establishing that there was foetal distress. The bare minimum that should have been done – continuous and uninterrupted CTG monitoring of the foetus after the non-assuring tracing between 02:40 and 03:30 – was not done. The reason for the stopping of the CTG at 04:00 is unexplained.

[54]. The next question is whether, on the probabilities, the child would not have been afflicted with her injury, but for the negligence attributable to the MEC's staff. There was no dispute that, at the point of plaintiff's admission, the foetal condition was optimum. However, at about 02:40 there were indications of foetal distress, whereupon intra-uterine resuscitation was done by the supply of oxygen to the mother and by having her lay on her left hand side. By 03:30 foetal distress was still indicated, but that notwithstanding, there was no monitoring of the foetal heart rate after 04:00. At 05:30 the child was born and assessed as neonatal encephalopathic.

[55]. The Neonatologists briefed by the parties agreed that the case under review reasonably fulfils several of the criteria of AGOG 2014 to determine the likelihood that an acute hypoxic-ischemic event that occurred within close temporal proximity to labour and delivery, contributed to the neonatal encephalopathy. These expert witnesses also agreed that, where information is known with regard to the present case, the ACOG criteria were fulfilled. So, for example, the Case Definition, being

neonatal encephalopathy, was present, as were neonatal signs consistent with an acute peripartum or intrapartum event. Also, the criteria of Apgar scores below 5 at 5 and 10 minutes, was fulfilled.

[56]. Importantly, these experts agree in sum that the following criteria, linking an intrapartum event to the development of cerebral palsy, were recorded: intrapartum abnormal CTG traces, in keeping with a non-reassuring foetal condition; birth of a compromised baby with very low Apgar scores; the development of a neonatal encephalopathy of at least a moderate or moderate-severe degree; the MRI (done years later) which revealed an acute profound hypoxic ischaemic brain injury; the outcome of spastic quadriplegic cerebral palsy

[57]. On the probabilities, had the foetal condition been adequately monitored, a 'intrapartum hypoxic insult' would have been detected. The failure to monitor the foetal heartrate continuously as reasonably required cannot be disputed.

[58]. All of the experts, including the Neonatologists, excluded a range of other causes for the child's brain injury, such as infection, congenital abnormality, a metabolic disorder, an inflammatory disorder or a haemorrhage. As regards the alleged short umbilical cord as a possible cause, this has already been discussed *supra* and should, in my view, be ruled out as a possible cause of the child's brain damage.

[59]. It is accordingly at least probable, in my view, that, had the foetal heart rate been monitored properly, foetal distress would have been detected and remedial and preventative measures could have been implemented. Such further indications of foetal distress could have been dealt with timeously. This would probably have ensured that the stable condition of the foetus was maintained, either for as long as it took for the child to be born naturally, or for a Caesarean section to be performed. I am therefore satisfied that, on a balance of probabilities, the failure to properly and continuously monitor the foetal heartrate, which in turn resulted in a failure to take the steps necessary to maintain a healthy foetal condition after 04:00 caused the hypoxic brain injury that was later identified.

Defendant's Special Plea of Prescription

[60]. There is one more issue which I need to deal with, which relates to a special plea raised by the defendant in his amended plea to the effect that the claims by the plaintiff under any and/or all of the different heads of damages, excepting only general damages for pain and suffering and loss of amenities of life, are in truth and in fact claims by the plaintiff in her personal capacity and not those of her minor child. The MEC therefore asks for a declaratory order to that effect. This also means, so the MEC contends, that those claims have become prescribed and should therefore be dismissed with costs, which is the further order prayed for by the MEC in his special plea. I now turn my attention to deal briefly with this issue.

[61]. In this action the plaintiff claims on behalf of her minor child *inter alia*: (1) future hospital, medical and related expenses; (2) future loss of earning / loss of income earning capacity / loss of employability. In his special plea, the MEC contends that, now that the plaintiff's minor child is so severely incapacitated, she owes the minor child a duty of support, which would include the duty to pay in his personal capacity all medical and hospital expenses reasonably incurred in respect of her, as well as ensure that the child is supported and maintained for the remainder of her life. This then means, so the MEC contends, that the plaintiff in her capacity as mother and natural guardian has suffered no damages in respect of such expenses: she should accordingly have sued in her personal and not in her representative capacity. The issue raised in the MEC's special plea was thus whether or not the minor was in law entitled to claim compensation for future medical and hospital expenses and future loss of earnings, as prospective patrimonial loss in respect of her bodily injuries.

[62]. This issue and the principles relating thereto have been dealt with extensively by the Supreme Court of Appeal in *Guardian National Insurance Co Ltd v Van Gool NO*⁵. The SCA rejected the self-same contentions raised by the MEC *in casu* mainly on the basis that a minor child, in addition to having available to him or her a right to claim from his or her parents to pay, according to their means, her prospective medical and hospital expenses, also had the right, as the victim of a delict

⁵ *Guardian National Insurance Co Ltd v Van Gool NO* 1992 (4) SA 61 (A);

perpetrated against him or her, to claim compensation from the wrongdoer for general damages relating to non-patrimonial loss (such as pain and suffering, loss of amenities, disfigurement and loss of expectation of life) as well as prospective patrimonial loss such as future medical and hospital expenses. These two rights are co-existent: the minor child's right to personal support did not deprive her of her delictual right against the wrongdoer.

[63]. That, in my view, spells the end of defendant's special plea. Moreover, as correctly pointed out by Mr Du Plessis SC, who appeared on behalf of the plaintiff with Mr Cremen, when the special plea was argued on 17 August 2018, the judgment in *Van Gool* and its *ratio decidendi* were endorsed by this Court (per Van der Linde J) in *Zondo v MEC for Health of the Gauteng Provincial Government*⁶, in which it was held as follows: -

'[14] So *Van Gool* made it plain that a minor has a claim for prospective patrimonial loss such as future medical and hospital expenses and future loss of earnings. *Van Gool* has not been overruled by the Constitutional Court, nor departed from by the Supreme Court of Appeal. It is thus binding on this court. In my view the present case is indistinguishable, and the contentious claims preferred here are, as in *Van Gool*, at least also claims of the minor.'

[64]. *Van Gool* is therefore the law in relation to the legal point raised by the MEC. That much appears to be accepted by Ms Mansingh, who appeared on behalf of the MEC. However, she also submitted that the common law on that point should be developed as provided for in the Constitution. I am not persuaded. It follows that the defendant's special plea falls to be dismissed and the costs of the special plea must follow the result.

⁶ *Zondo v MEC for Health of the Gauteng Provincial Government* (25644/2014) [2016] ZAGPJHC 243 (2 September 2016);

Conclusion and Costs

[65]. For all these reasons, it is my view that, on an evaluation of the evidence in its totality, it was established, on a balance of probabilities, that the cerebral palsy of the plaintiff's child was caused by the negligent and wrongful failure of the MEC's staff charged with the management of the plaintiff's labour, to take steps that would have prevented the hypoxic brain injury.

[66]. In these circumstances, I intend issuing an order declaring that the MEC is liable for 100% of the child's proven or agreed damages arising from her brain injury.

[67]. As regards costs, the general rule is that the successful party should be given his costs, and this rule should not be departed from except where there are good grounds for doing so, such as misconduct on the part of the successful party or other exceptional circumstances. I can think of no reason why I should deviate from this general rule and costs should therefore be awarded against the defendant in favour of the plaintiff.

Order

[68]. Accordingly, I make the following order: -

- (1) The defendant's special plea of prescription is dismissed with costs, including the costs consequent upon the employment of two Counsel (where so employed).
- (2) It is declared that the defendant is liable for 100% of the damages that are proven or agreed to be due to the plaintiff in her capacity as parent and natural guardian of her minor child arising from her brain injury.
- (3) The defendant shall pay the plaintiff's costs of the determination of this issue relating to his liability, including the costs consequent upon the employment of two Counsel (where so employed).

L R ADAMS

Judge of the High Court of South Africa

Gauteng Division, Johannesburg

HEARD ON: 7, 8, 10, 13, 14, 15 and 17 August 2018, 17, 18, 19
and 20 September 2018, 23 January 2019, 6, 7 and 8 July 2021, 28, 29 and 30
March 2022, and 2 September 2022.

CLOSING ARGUMENT ON: 15 September 2022

JUDGMENT DATE: 17th January 2023

FOR THE PLAINTIFF: Advocate Desmond Brown

INSTRUCTED BY: Du Plessis Attorneys, Johannesburg

FOR THE DEFENDANT: Adv Roshnee Mansingh

INSTRUCTED BY: The State Attorney, Johannesburg