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

CASE NO: 2018/44268

REPORTABLE: YES / NO

OF INTEREST TO OTHER JUDGES: YES / NO

REVISED: YES/ NO

26 JANUARY 2023

In the matter between:

M[....]: R[....] obo

Plaintiff

M[....]: A[....]

And

The MEC For Health:

Gauteng Provincial Government

Defendant

Judgment

Thupatlase AJ

Introduction

[1] The plaintiff who is an adult female has issued summons against the Member of Executive Council (MEC) for Health in Gauteng Province. She is acting in both her personal capacity as well as on a representative capacity on behalf of her minor child. The plaintiff is the biological mother of the child in question.

[2] The defendant is the MEC for Health in Gauteng Province. The MEC is sued as a nominal defendant and the executive authority responsible for the affairs of the Provincial Department of Health in Gauteng in terms of Section 2(1) of the State Liability Act¹. The defendant is alleged to be vicariously liable for damages caused by the negligent conduct of the medical staff at the clinic as well at the maternity hospital.

[3] The claim against the defendant is based on alleged medical negligence on the part of the employees of the defendant during the scope and course of their work as health professionals. These include nursing and medical staff at Dobsonville Itereleng Community Health Clinic and Chris Hani Baragwanath Maternal Hospital (CHBMH). It is alleged that this emanated from the treatment and care that the plaintiff received after she was admitted for the parturition of the baby.

[4] The trial of this matter was for a duration of eight days. I am thankful to all the parties and in particular the experts witnesses who testified in this matter. The use of technology was quite useful and facilitated the conclusion of this trial. The medical experts testified via medium of MS Teams.

[5] It is common cause that the plaintiff gave birth to a child who is presently suffering from cerebral palsy. The plaintiff alleges that this was as a result of the substandard monitoring and care that she and the baby received during birth. This was on the early hours of 08 July 2008.

[6] The court is required to determine two elements of delict, these being causation and negligence or put differently whether there was failure by staff at CHBMH to

¹ Section 2 (1) provides that: 'In any action or proceedings instituted by virtue of the provisions of section 1, the executive authority of the department concerned must be cited as nominal defendant or respondent'.

properly monitor the mother and the foetus during delivery that resulted in the injury to the brain. The central issue for determination is the management of labour of Ms M (plaintiff) from the time she was attended Dobsonville clinic and CHBMH until the baby was delivered.

[7] The *lis* between the parties is whether there was sub-standard care during the intrapartum period while the plaintiff was under the care of the hospital staff and further whether this resulted in the child suffering a hypoxic ischaemic brain injury which resulted in cerebral palsy.

Plaintiff's Evidence

[8] Ms M[...] testified that she had an unplanned pregnancy which she discovered after five months of gestation. She immediately informed her parents and also booked at the antenatal clinic. She only attended the clinic twice, being on the 03rd of June 2008 and on 07th June 2008. She testified further that she did not use any recreational drugs during her pregnancy or at all. She was also healthy during her pregnancy and the only medication prescribed to her was supplements in the form vitamins.

[9] During the two visits to the pre-natal clinic, she was never informed of a possibility that the child may be delivered pre-maturely. She was never alerted to any abnormalities regarding her pregnancy.

[10] She attended the clinic on the 06 July 2008. This was after observing blood stains when wiping her vagina with a tissue paper. After her admission the midwives observed that progress of her labour was slow and decided to transfer her to the hospital. She was transported by ambulance and was accompanied by a nurse who checked and monitored her during the journey to the hospital. At the hospital further treatment and monitoring took place. This was on 07 July 2008.

[11] The plaintiff testified that she was regularly assessed, and a machine was used to check the foetus and that the machine was generating paper-based reports.

During the monitoring the nurses mentioned that dilation of the cervix was fluctuating between 6cm and 8cm.

[12] The plaintiff testified that she was experiencing severe and unbearable pain that made her to screamed for help. She was advised to push hard as there was a risk to the foetus and the midwife also assisted by pushing her abdomen. She described the push as gentle. The push was for about 10-15 minutes. She ultimately gave birth to a baby.

[13] After the baby was delivered it did not cry and was taken to the Intensive Care Unit (ICU). She later went to check the baby and observed that it was incubated and had drips inserted in the head. She was informed that these steps were taken as the baby was suffering epileptic fits.

[14] The plaintiff further testified that the baby was unable to breastfeed and had to be fed intravenously. Subsequent to their discharge from hospital she was able to breastfeed the baby. After about six months she observed that the baby was crying incessantly, vomiting, and not eating properly and the baby was subsequently diagnosed with cerebral palsy.

[15] Under cross-examination the plaintiff confirmed that she was monitored throughout labour and that the nursing staff checked on her from time to time.

[16] The second witness for the plaintiff was Prof Lotz. He is a radiologist with vast experience in the field of radiology. He gave a detailed account of his qualifications. He testified that after he had studied the Magnetic Resonance Image (MRI) scan, he concluded the baby suffered a mixed pattern of basal ganglia-thalamus (BGT) and anterior prolonged partial hypoxic ischemic injury. In addition, to his testimony he also commented on the joint minute that was prepared jointly with fellow radiologist, Dr. Kamolane.

[17] The essence of his testimony was to justify his conclusion that the baby suffered BGT as opposed to Dr. Kamolane who concluded that the MRI pattern demonstrates

a pattern consistent with an acute profound hypoxic ischemic brain injury in a term infant.

[18] According to Dr. Lotz in the absence of a catastrophic/sentinel event one cannot talk of acute profound injury. He indicated that from a radiological point of view he was unable to determine the presence or otherwise of such sentinel event. According to Dr. Lotz contemporary radiological literature refers to BGT² in preference to acute profound injury. According to him the use of the term BGT is neutral and accords with modern scientific knowledge on the subject.

[19] He however, conceded that in 2018 when he wrote his initial report, he concluded that the child suffered a mixed pattern of 'acute profound (central) event and prolonged partial (peripheral) hypoxic ischemic injury of both cerebral hemispheres. He suggested that the conclusion and the use of the phrase could still be correct if existence of a sentinel event can be shown have been present.

[20] There was a huge debate with counsel for the defendant around the use of the nomenclature with Prof Lotz conceding that the use of the neutral phrase of BGT has caused an impasse amongst radiologists. He insisted that he was merely quoting the eminent scholars in the subject of radiologist.

[21] According to the evidence of Dr. Lotz he observed the following abnormalities to the brain. The brainstem was found to have atrophied mildly and the basal cisterns were widened. The same was with the folia of the cerebral vermis. There were no signs of any congenital anomalies or genetic disorders. According to him there was a definitive feature of sub-perirolandic white matter insult which was evident bilaterally and almost symmetrically.

[22] He also observed a marked loss of volume of both hippocampal formations which according to him is associated with atrophy of the fornices and mamillary bodies. He observed generalized reduced white matter throughout both hemispheres

²Jessica L. Wisnowski et al 'Seminars in Fetal and Neonatal Medicine' Published: October 26, 2021 DOI:<https://doi.org/10.1016/j.siny.2021.101304> states that 'Central/basal ganglia – thalamus (BGT) injury pattern. This pattern is characterized by injury to the BGT and may extend to the cerebral cortex, usually localized to the perirolandic region. On neuropathology, it is often referred to as the "cerebrocortical-deep nuclear pattern". The BGT pattern is typically bilateral and symmetric

of the brain. According to Dr. Lotz prolonged partial insults that developed over a period allowing compensatory redistribution of blood flow to occur result in a different pattern of injury. The process is referred to as autoregulation.

[23] According to Dr. Lotz in case of neonates moderate insults of short duration can cause little or no injury to the brain and that more prolonged insults result in injury to the intervascular boundary or watershed zones. He further testified that in severe hypoxic ischemic damage may extend even beyond boundary zones to involve true anterior and middle cerebral arterial territory.

[24] Dr Lotz confirmed under cross-examination that the main point of difference between him and the other radiologist, Dr Kamolane was whether there was prolong partial injury to the brain. According to the doctor the radiologist cannot assist the court to determine the time when the injury occurred by looking at the MRI scan. Prof Lotz opined that prolonged partial asphyxia of the maternal event resulted in more slowly evolving hypoxia and acidosis followed by late deceleration of the foetal heart rate, diminished cardiac output, hypotension and that evidence for cerebral ischemic brain injury becomes apparent after several hours.

[25] Prof Lotz testified that prolong partial hypoxic ischemic injury is according to Volpe³ a prolonged process of redistribution of blood by way of autoregulation. The brain is taking blood from other parts of the body in order to safe and protect what he refers to as the reptilian brain. He confirmed that during this stage the baby is in distress.

[26] The third witness who was called on behalf of the plaintiff was Prof. Theron. He is an obstetrician, and his qualifications were not disputed. He has a long history in the field of obstetrics. He studied the hospital records in order determine the type of treatment that the plaintiff received from the medical staff at the clinic and hospital. He also referred to the joint expert minute he prepared with Dr Mbokota.

³ Joseph J Volpe "Hypoxic-Ischemic Injury in the Term Infant: Pathophysiology" Chapter 19 states as follows: 'Severe and prolonged insults result in diffuse and marked neuronal necrosis, involving the many levels of the neuraxis described earlier as the diffuse pattern of injury. The cerebral-deep nuclear pattern of neuronal injury appears to be related to insults that are less severe and prolonged, often termed partial, prolonged asphyxia. The deep nuclear-brain stem pattern of injury to basal ganglia-thalamus-brain stem has been described in human infants with a severe, abrupt event, often termed total asphyxia'.

[27] There are significant differences on important aspects of their respective evidence. Dr Mbokota also testified, and his evidence will be dealt later in the course of this judgment. Each of the obstetricians made efforts to justify their conclusions. Prof Theron commented with specific reference to the partogram that formed part of the hospital records. He also commented on the application of fundal pressure referred in medical literature as Kristellar manoeuvre.

[28] Prof Theron emphasised the importance of pre-natal clinic records in order to get all the information regarding the progress of pregnancy. He concluded that the prolonged labour was the cause of the injury the baby subsequently suffered. He contended that earlier intervention should have been taken to artificially rupture the membrane and to decide whether Caesarean section was necessary. He concluded that there was insufficient monitoring done and that where it was done was not done according to Guidelines issued by the Department of Health.

[29] Prof Theron referred to the partogram that was plotted to monitor labour progress and concluded that there was a failure to take an appropriate action after the action line was crossed. He indicated that labour by its very nature is stressful to the foetus particularly during contractions. He indicated that if it is realized that labour would be prolonged then a definite action must be taken after action line on the partogram has been crossed.

[30] Prof Theron explained that the reason why contractions during labour are stressful to the foetus is because during time of such contractions blood flow from the maternal side to the placenta is reduced resulting in the oxygenated blood supply to the foetus being compromised. This poses risk to the foetus in cases of prolonged labour. The result of foetal distress may result in brain injury or even death.

[31] Prof Theron further explained that if labour is progressing poorly then artificial rupture of the membrane must be considered. According to the partogram there was no progress of labour after 5 hours and after another 2 hours the patient had crossed the alert line. He noted that there was no regular monitoring of the labour. According to him it is vital to monitor the foetal heart rate and for such heart rate to be recorded after every 30 minutes during active phase of labour. In addition, presence or

absence of deceleration must be identified and recorded after every 30 minutes. In this case the recording was recorded hourly which according to him was sub-standard care.

[32] The evidence of Prof Theron is further to the effect that the action line on the partogram was crossed at 18h30 and that artificial rupture of the membrane (AROM) should have been done otherwise Caesarean section should have been considered earlier. This will have accelerated delivery. The only exception would have been in the case of cephalopelvic disproportion. There is no indication that this was the case. This was because no moulding was reported and therefore ruling out cephalopelvic disproportion as cause for slow progress. This action should have been taken at 20h00. Instead, there was no record of monitoring until at 22h55.

[33] After the performance of AROM a period of 2 hours should be allowed to assess any further progress. During that period CTG monitoring should be continued to assess foetal condition. According to his observation and reading of the partogram there was no action taken until at 22h55. According to his testimony the AROM was delayed.

[34] According to the evidence of Prof Theron there is clear proof that the foetus was in distress. There is shown by the presence of the meconium grade 1, which was grey stools. According to the professor the labour was so prolonged that the recordings went beyond the partogram. He concluded that because there was no CTG readings the doctor was unsure of the foetal condition and that the decision to defer further action until 22h55 was ill-advised. The decision should have been taken much earlier around 20h30.

[35] The professor also commented on the condition of the baby and specifically about APGAR⁴. He commented that the APGAR score was low. The baby had a low

⁴ APGAR stands for Appearance, Pulse, Grimace, Activity and Respiration. In the Apgar test, five factors are used to check a newborn baby's health. Each is scored on a scale of 0 to 2, with 2 being the best score. For Appearance the skin colour is checked; for Pulse, heart rate; for Grimace, reflexes; for Activity, muscle tone; and for Respiration, breathing rate and effort. The individual scores for the five factors are added up to obtain a score out of ten. The highest score to be achieved is 10 and scores of 7, 8 or 9 out of 10 are normal or good scores. Source: kidshealth.org.

score 5/10 at 1 minute and appeared to have been floppy. He commented that the APGAR was subjective.

[36] Prof Theron further testified that according to the clinical records the gestational period was correctly estimated using the fundal height measurement and also correctly plotted on the fundal height graph for women whose menstrual dates are unknown. This is provided by the Guidelines for Maternity Care in South Africa.

[37] The professor also dealt with the subject raised by his colleague Dr Mbokota regarding the possibility of constitutionally small baby. He argued that the baby could be constitutionally small but still be a perfectly normal baby. This could also be on account of the size of the mother of the baby. He excluded that possibility based on the fact that the plaintiff's weight was 57.3kg and her weight of 154cm and with Body Mass Index (BMI) of 20. These he concluded were measurements of a normal sized mother.

[38] Prof Theron was also asked to comment on the evidence of the plaintiff that fundal pressure was applied. He indicated that whilst the practice is not necessarily dangerous, but it is not recommended by World Health Organisation (WHO). The other difficulty regarding the fundal pressure application is that it is not taught to medical students and midwives.

[39] Prof Theron insisted that monitoring of the foetal condition was inadequate especially subsequent to reactive CTG that was done at 18h30. The baby was born asphyxiated at 00h25 which was 5 hours and 55 minutes later.

[40] Under cross-examination Prof Theron insisted that the monitoring of the foetus was sub-standard as such monitoring was done beyond the 30 minutes period as stipulated in the Guidelines.

[41] The fourth witness called by the plaintiff neonatologist. He is Prof Kirsten. He also prepared a joint minute with Dr Kganane for the defendant. Dr Kganane was not called to testify. The expertise of Prof Kirsten was not disputed. He confirmed that

the child in question is microcephalic and dystonic and suffers spastic cerebral palsy complicated by the developmental delay and intellectual disability.

[42] Prof Kirsten did not take issue with conclusions of the two radiologist who studied the MRI scan that Prof Lotz and Dr Kamolane. He did not venture a view on the conclusion regarding BGT and interior watershed (prolonged partial) hypoxic ischaemic injury and the conclusion that MRI scan are in keeping with an acute profound hypoxic ischaemic in a term infant. It was however the common cause between Prof Kirsten and Dr. Kganane who unfortunately did not testify, that the plaintiff did not suffer a catastrophic/sentinel event during labour.

[43] Prof Kirsten testified that there was no evidence that the plaintiff suffered catastrophic/sentinel event during labour. He studied the nurse's notes and concluded that the infant was severely depressed at birth and lacked oxygen. He indicated that the fact that the baby did not breathe spontaneously at birth suggests that it was not breathing intra-utero. He also indicated that the heart rate of less 100ml is very low and further suggests that the baby was exposed to less oxygen intra-utero.

[44] Prof Kirsten dealt with the low APGAR score and testified that this is a clear sign that the baby was severely hypoxic at birth and an indication that the baby was already severely hypoxic before it was delivered. He also questioned the APGAR score of 5/10 at 1 minutes. He thought that given the depressed nature of the baby the score was low. He was of the view that a score of 3/10 would be an accurate reflection of the state of the baby immediately upon birth. This he based on the recordings of the doctor who observed the condition of the baby after it was delivered.

[45] Prof Kirsten further dealt with the process of labour in more detail. He indicated that during uterine contractions the blood to the foetus gets reduced and this is accompanied by less supply of oxygen. He indicated that a normal baby will be able to tolerate such less supply of oxygen. He indicated that with a prolonged labour where the foetus is exposed to uterine contraction for about 16 hrs (during latent and active labour) over time the baby will be hypoxic. He explained that this so because

there will no metabolism and the foetus will develop metabolic acid and would be acidotic.

[46] He continued to illustrate his conclusion by pointing out that the first blood gas of the bay was recorded at 6.8ph which he regarded is a very low reading. The carbon monoxide and caused acidosis. He emphasised the importance of monitoring the heart rate half hourly during labour. He indicated if the monitoring is only of the heart rate and not decelerations then all what the medical professional can determine with such monitoring is that the foetus was alive but not the state of health of such a foetus.

[47] Prof Kirsten likened labour to a journey and that the second phase of labour is the most dangerous and that the baby should ideally arrived at that stage strong. He indicated that this is so because during the second phase of labour the contractions are stronger, and the relaxation period is very short. He concluded that in our case the foetus arrived at this second phase of labour severely stressed. The baby was already acidotic. He concluded that that is what led to the midwives applying fundal pressure as they realized that the baby was in trouble. According to him at that stage the midwives should have called an obstetrician to expedite delivery.

[48] The fact that the baby was acidotic made it hypersensitive to fundal pressure. He concluded that the fact that there was severe acidosis is an indication of poor observation and monitoring during labour. He indicated there was no correct resuscitation method by the doctor in order to initiate and maintain respiration. This led to neonatal encephalopathy. According to Prof Kirsten the baby suffered intrapartum hypoxic-ischaemic insult to the brain, and this occurred over a prolonged period.

[49] The fifth witness called on behalf of the plaintiff was Prof Nolte who is a nursing specialist. She also confirmed that she produced a joint minute with Dr. Candice Harris on behalf of the defendant. The agreement between them was that the plaintiff's pregnancy progressed normally. There were no maternal problems or illnesses recorded during pregnancy. The foetus seemed to grow normally during pregnancy. This was according to the symphysis-fundal height measurements.

[50] Prof Nolte confirmed the conclusion of the joint minute with Dr Harris that the midwives who cared for the plaintiff at CHBMH during labour delivered a sub-standard care in that they did not record maternal and foetal observations according to the Maternity Guidelines during active phase of labour, as well as the second stage of labour, and especially in the case of a mother with prolonged active labour where the foetal heart rate should be continuously monitored with CTG.

[51] And further that according to the agreed joint minutes the midwives failed to report an extremely prolonged labour to the doctor and failed to diagnose in time foetal compromise and as a result the baby with an APGAR of 5/10. In addition, the midwives failed to keep complete records of the case.

[52] In respect of the application of fundal pressure Prof Nolte testified that such a manoeuvre is not taught to nurses, as it carries huge risks. This is because such pressure reduces flow of blood to the placenta and therefore to the foetus.

[53] In respect of the standard of monitoring during labour, Prof Nolte testified that during active phase of labour maternal observation must be done hourly and that the foetal heart rate must be checked half hourly and be recorded after each contraction.

[54] The importance of such recording of contraction is because of heart deceleration. It should be done before and after deceleration. This is to be able to monitor the heart rate correctly. The importance and use of the partograph was also discussed by Prof Nolte.

[55] Prof Nolte concluded that the baby was born by normal vaginal vertex delivery at 00h20 on the 08 July 2008 with a birth weight of 2295kg at 36 weeks of gestation and with APGAR score of 5/10 at 1 minute and 6/10 at 5 minutes. She indicated that records were not available for her in order to provide a fair comment on midwifery management of the plaintiff during the course of her pregnancy, labour, and delivery. According to her the neonatal records provide evidence that the plaintiff had prolonged labour and that there was a delay before the admission to the labour ward. There was also inadequate monitoring.

[56] Prof Nolte also commented on the partograph as a tool to monitor labour and much of what she said confirmed the earlier evidence of Prof. Theron.

[57] The sixth and last witness called on behalf of the plaintiff was Dr. Pearce who is a paediatric neurologist. She confirmed that she compiled a joint minute of their opinions with Dr. Mogashoa. Both experts made their findings based on clinical records that were made available to them and in addition both did the neurological examination of the baby at different times. Dr Pearce on 25 October 2018 and Dr Mogashoa on 11 September 2020.

[58] She placed on record their points of agreement. These were that the baby suffers from a mixed cerebral palsy which was predominantly dystonic and gross motor functional classification scale V, indicative that the baby has severely impaired movement.

[59] She further placed on record that there was agreement between the paediatric neurologists that the baby is incapable of independent mobility and that his co-morbidities include profound intellectual disability, scoliosis, previous epilepsy, nutritional wasting, strabismus and possible cortical impairment, microcephaly, bilateral hip dislocation, contractures, behavioural concerns, and severe developmental delay.

[60] Dr. Pearce also confirmed that there was agreement that the baby fulfils the criteria for the diagnosis of Grade II neonatal encephalopathy. It was also agreed that in determining the aetiology or cause of the baby's neonatal encephalopathy congenital brain abnormalities, intra uterine growth restriction, intra cranial haemorrhage, in-born errors of metabolism, neonatal infection, acquired metabolic conditions and genetic disorders were excluded as possible causes. Dr. Pearce specifically mentioned in cross-examination that intra uterine growth restriction could not be determined as there was no recording of the head circumference of the baby at birth.

[61] In dealing with her own report Dr. Pearce concluded that the baby has a severe mixed type of cerebral palsy, predominantly dystonic and that based on the history

obtained and the clinical records available, this condition was most likely the result of intrapartum hypoxia. She described the intrapartum period as being the period between onset of labour until delivery.

[62] It is also important to note that there was agreement that the timing of the insult was determined to be most likely intrapartum.

Defendant's Evidence

[63] The first witness for the defendant was Dr. Mbokota. He is obstetrician with vast experience in both public and private health care sectors. He confirmed that he compiled a report and in addition also confirmed the joint minute he prepared with Prof Theron. There are points of agreement in the joint minute, but also significant differences and these differences will be dealt with during analysis of the admitted evidence. At this stage it suffices to deal with the evidence of Dr. Mbokota as he gave it.

[64] He confirmed that in preparing his report he relied on the neonatal record card, neonatal admission notes, four pictures of ultrasound scans. He was not provided with any maternity records. Importantly he also confirmed that he interviewed the plaintiff. This was on the 27/08/2020. This is some 12 years after the event. He also referred to the literature materials which were also made available to the court and also National Department of Health 2007 Guidelines for Maternity Care in South Africa.

[65] He confirmed that the plaintiff was 21-year-old and was pregnant for the first time. He testified on the interview he had with the plaintiff regarding her pregnancy in particular that she discovered at 5 months that she was pregnant. At the pre-natal clinic, the pregnancy was estimated at 37 weeks gestational age. He confirmed that a baby can be delivered between 37 and 42 weeks. The abdominal estimation during labour was found to be 21 weeks in gestation.

[66] Dr Mbokota continued to testify that during the interview with the plaintiff she indicated that she attended pre-natal clinic many times. This was despite the clinic

reports recording only two visits before onset of labour. This was on the 03/06/2008 and 13/06/2008. Dr. Mbokota emphasised the importance of regular attendance of the pre-natal clinic. This to ensure that any risk that is discovered can where possible be eliminated in time.

[67] Dr Mbokota dealt at length with the sequence of events as observed from the records regarding the journey from the onset of labour through to delivery. The delivery was planned to take place at Dobsonville clinic. He indicated that according to him there was appropriate management of the plaintiff until delivery. He testified that both the maternal and foetal conditions were adequately monitored. This included monitoring the heart rate using CTG.

[68] He confirmed that contractions is a hypoxic event as the foetus is deprived of oxygen. The normal grown foetus is able to withstand the pressure. The doctor dealt at length with the partogram that was completed.

[69] He admitted that the active phase of labour lasted for 16 hours which was prolonged. He disputed evidence that there was inaction on the part of the medical staff by not rupturing the membrane at around 18h45.

[70] Dr. Mbokota dealt extensively with the aspect of intra uterine foetal growth restriction (IUGR). This was a point of major disagreement with Prof. Theron. He testified that the birth weight of 2295kg at 36 weeks of gestation with grade 1 MSL is diagnostic of IUGR. He described the IUGR refers to failure of a foetus to achieve its full genetic growth potential.

[71] He concluded that in this case this was a symmetric IUGR. This is where the insult/injury occurs in early pregnancy and the likely are generic or chromosomal defects, intrauterine infection, or exposure to teratogenic substances and very severe placental insufficiency of incredibly early onset.

[72] Dr. Mbokota concluded that IUGR developed most likely symmetrically before 20 weeks of gestation. He testified that this phenomenon could not be excluded given the fact that the plaintiff attended pre-natal clinic twice whilst she was already

29 weeks pregnant. As foetus with IUGR has poor reserves and could not tolerate labour. He concluded the staff at the clinic and hospital could not have foreseen or prevented that as it happened before the plaintiff pre-natal clinic.

[73] In respect of the aspect of meconium that was found in the amniotic fluid, Dr Mbokota contended that the presence of the meconium grade 1 was an indication that the insult to the foetus happened much earlier. He indicated that there is no evidence of fresh meconium. He further referred to the Guidelines to the effect that no special measures need to be taken when grade 1 meconium is found. He contended that the medical staff were correct in not taking any action despite the presence of meconium as this was old meconium.

[74] Dr Mbokota also dealt with application of fundal pressure during labour. This was postulated by Prof Theron as a possible cause of the injury to a foetus during the intrapartum period. Dr. Mbokota admitted fundal pressure was not taught to medical professionals but that it has been applied throughout the world by the midwives to assist in the delivery of babies. He indicated he didn't believe that fundal pressure had any effect on the outcome of the condition of the foetus. He further indicated that fundal pressure was found to rather cause damage to the mother. The advice by WHO to discourage the use of the fundal pressure was only issued in 2017 and the baby was born in 2008.

[75] In terms of the joint minute Dr Mbokota confirmed that the fundal height measurement was correctly plotted but it is an estimation. He however, argued that this measure was specific to a certain community in the Western Cape. He testified that the fundal height measurement was merely a guide and was not something absolute.

[76] Dr Mbokota commented on the radiological findings and indicated that he agreed with Dr. Kamolane that there was no anterior watershed insult. He argued that the injury could have happened prior to the plaintiff attending pre-natal clinic or in the last 30 minutes of labour and therefore an acute profound injury could result. He indicated that if the foetus had been subjected to total occlusion for 30 minutes during labour, then the baby would have died for lack of oxygen.

[77] The second witness called for the defendant was Dr. Kamolane. He is a radiologist. He confirmed his report and further that he also that had prepared a joint minute with Prof Lotz. In respect of his own report, he indicated that he found that the brain insult was as a result of acute profound hypoxic ischaemic brain injury.

[78] He explain how such insult occurs and indicated that this comes about because of sudden catastrophic cut of blood occlusion to the area of the brain. This suggests that the insult as acute means the insult was severe profound and the suddenness refers to acute profound. He indicated that in terms of nomenclature he uses the term BGT and acute profound interchangeably.

[79] He confirmed that from a radiological point of view he was unable to determine when the process of occlusion took place or what the cause of the injury could have been. He testified that the causes and what precipitates hypoxic ischaemia are complex and often multifactorial. These could be placental or maternal. He indicated that it is the obstetricians who are best suited to determine the probable timing of the brain injury.

[80] Dr Kamolane further dealt with the joint minute he prepared with Prof Lotz and in particular with the differing views they had regarding the injury. As already indicated Prof Lotz concluded that there was a mixed pattern of BGT and anterior watershed prolonged hypoxic ischaemic injury. He confirmed his conclusion that he saw an acute profound injury. He agreed that there was injury to the central brain injury but disagrees that there was additional anterior watershed injury. This he said was injury to the frontal part of the brain.

[81] Dr. Kamolane indicated that he uses BGT and acute profound injury interchangeably and that the debate of the sentinel event is for obstetricians and not for radiologists. According to Dr. Kamolane the injury he observed could occur between 36 weeks to 2 months after the child has been born. The insult he observed can occur during what he referred to as perinatal period. This he explained does not occur only during the intrapartum period as it also could happen during the post-natal period.

Common Facts

[82] Whilst it is clear that this was a long trial and there are divergent opinions of what happened from the onset of labour until the Baby AM was delivered, there is on the other hand issues where there is complete agreement.

[83] It is common cause that Baby AM suffers from cerebral palsy. The paediatric neurologist referred to the condition as grade ii neonatal encephalopathy. It is common plaintiff had prolonged labour of about 16 hours.

[84] The plaintiff only attended pre-natal clinic twice before labour. There is also agreement that the report keeping in this case was sub-standard. It is also common cause that there was no monitoring for about 4 hour 55 minutes before delivery.

[85] It is also common cause that the Baby AM was born in a seriously compromised state of health. The baby had a AGPAR of 5/10 after 1 minute and 6/10 after 5 minutes. The baby struggled to initiate and maintain respiration and suffered fits and had to be incubated and fed intravenously.

Analysis

[86] The defendant pleaded that the State is obliged to provide healthcare services, subject to availability of resources and that the mere failure to assess or monitor does not introduce a new source of danger that would not have existed.

[87] The defendant further pleaded that research shows that despite monitoring even in developed countries, the cerebral palsy still occurs. It contended that failure caused by unavailability of resources cannot bring about liability as that would be contrary to the Constitution.

[88] The expert witnesses who testified formulated their opinions based on the plaintiff's medical records as obtained and made available by the defendant, including her antenatal card, the partogram, the neonatal records, as well as the magnetic resonance imaging (MRI) scan performed on the baby. Dr. Mbokota did

consult with the mother of the baby in 2020. The paediatric neurologists also consulted with the baby at different times as indicated above.

[89] The MRI features were considered as diagnostic of an acute profound (central) hypoxic ischaemic injury by the expert of the defendant, Dr Kamolane and Prof Lotz though Prof Lotz later changed diagnosis to central basal ganglia and thalamic hypoxic ischaemic injury (BGT). Dr. Kamolane maintained that the use of the nomenclature didn't affect finding of profound acute profound and that he uses the nomenclature of BGT and acute profound interchangeably.

[90] The issue for determination was defined as being whether the standard of care during the intrapartum period and while under the care of the hospital staff at the hospital resulted in the child suffering a hypoxic ischaemic brain injury which caused the child's current cerebral palsy. The only elements of delictual liability for determination are negligence and causation. The court will proceed to deal with these two elements.

Approach of Expert Evidence

[91] As is apparent reliance by both parties was based exclusively on expert evidence to prove or disprove the case for either party. The correct approach in dealing with expert evidence is to be mindful of what was stated in the case of ***Michael Linksfield Park Clinic*** 2001 (3) SA 1118 (SCA) namely that there is difference between scientific and judicial measures of proof and that an expert's testimony must show logical reasons based on something more than professional intuition. It is perhaps apt that I quote the judgement in order to vividly illustrate the point 'Finally, it must be borne in mind that expert scientific witnesses do tend to assess likelihood in terms of scientific certainty. Some of the witnesses in this case had to be diverted from doing so and were invited to express the prospects of an event's occurrence, as far as they possibly could, in terms of more practical assistance to the forensic assessment of probability, for example, as a greater or lesser than fifty per cent chance and so on. This essential difference between the

scientific and judicial measure of proof was aptly highlighted by the House of Lords in the Scottish case of *Dingley v The Chief Constable, Strathclyde Police* 2000SC (HL) 77 and the warning given at 89D-E that ‘one cannot entirely discount the risk that by immersing himself in every detail and by looking deeply into the minds of the experts, a Judge may be seduced into a position where he applies to the expert evidence the standard which the expert himself will apply to the question whether a particular thesis has been proved or disproved – instead of assessing, as a Judge must do, where the balance of probabilities lies on a review of the whole of the evidence’. See para [40]

[92] The court in *Linksfeld* further cautioned ‘that a court is not bound to absolve a defendant from liability for negligent medical treatment or diagnosis simply because expert opinion evidence is that the treatment or diagnosis was in accordance with sound medical practice. It laid down that what is required in that evaluation is to determine whether the opinions advanced by the experts are founded on logical reasoning’. See para [37]

[93] The duty of an expert to the court was explained as follows in the case in *AM and another v MEC Health, Western Cape* [2020] ZASCA 89; 2021 (3) SA 337 (SCA) *para*17: ‘. . . The functions of an expert witness are threefold. First, where they have themselves observed relevant facts that evidence will be evidence of fact and [be] admissible as such. Second, they provide the court with abstract or general knowledge concerning their discipline that is necessary to enable the court to understand the issues arising in the litigation. This includes evidence of the current state of knowledge and generally accepted practice in the field in question. Although such evidence can only be given by an expert qualified in the relevant field, it remains, at the end of the day, essentially evidence of fact on which the court will have to make factual findings. It is necessary to enable the court to assess the validity of opinions that they express. Third, they give evidence concerning their own inferences and opinions on the issues in the case and the grounds for drawing those inferences and expressing those conclusions.’

Causation

[94] In regard to causation it is trite law as stated in the case of ***Minister of Safety and Security v Van Duivenboden*** 2002 (6) SA 431 (SCA) ([2002] 3 All SA 741; [2002] ZASCA 79) para [25] that : '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'.

[95] In addition, the 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 damage or injury.

Negligence

[96] It is trite that the negligent conduct of a medical professional is to be assessed against the standards prevailing in the medical profession at a particular time period, in order to determine whether reasonable steps were taken or not. The oft quoted leading case on negligence is ***Kruger v Coetzee*** 1966 (2) SA 428 (A) at 430E- where the court stated that what is required to be established is whether the reasonable person in the shoes of the wrongdoer would, firstly have reasonably foreseen the possibility of harm, secondly would have taken reasonable steps to prevent the harm; and thirdly, did not take those preventative steps.

[97] In the case of ***Oppelt v Head: Health, Department of Health Provincial Administration Western Cape*** [2015] ZACC 33; 2016 (1) SA 325 (CC) at para [71] the court held that: 'In simple terms, negligence refers to the blameworthy conduct of a person who has acted unlawfully. In respect of medical negligence, the question is how a reasonable medical practitioner in the position of the defendant would have acted in the particular circumstances.'

[98] It is trite that the negligent conduct of a medical practitioner is to be assessed against the standards prevailing in the medical profession at a particular time period, in order to determine whether reasonable steps were taken or not. This is so

because of the rapid developments in medical field influenced by innovative technologies. In this case the applicable standards were those contained in the Department of Health Guidelines for Maternity Care in South Africa 3 edition 2007 (Guidelines).

[99] As it was stated in **Castell v De Greeff** 1993 (3) SA at 512A-B: '[t]he test remains always whether the practitioner exercised reasonable skill and care or, in other words, whether or not his conduct fell below the standard of reasonably competent practitioner in his field.' The general rule is that he/she who asserts must prove. In this case the Plaintiff had to proof the damages sustained were caused by the defendant's negligence.

[100] In the case of **Premier of Western Cape v Loots** NO [2011] JOL 27067 (SCA) 2011 JDR 0250 (SCA) at para [13] the court stated as follows: 'for its legal basis the argument rested on the so-called concrete or relative approach to negligence. According to this approach it cannot be said that someone acted negligently because harm to others in general was reasonably foreseeable. A person's conduct can only be described as negligent with reference to specific consequences. Yet, the relative approach does not require that the precise nature and extent of the actual harm which occurred was reasonably foreseeable. Nor does it require reasonable foreseeability of the exact manner in which the harm actually occurred. What it requires is that the general nature of the harm that occurred and the general manner in which it occurred was reasonably foreseeable. At some earlier stage there was a debate as to whether our courts should follow the relative approach as opposed to the so-called abstract or absolute approach to negligence. But it now appears to be widely accepted that our courts have adopted the relative approach to negligence as a broad guideline, without applying the approach in all its *ramifications*.'

[101] See also **Sea Harvest Corporation (Pty) Ltd and Another v Duncan Dock Cold Storage (Pty) Ltd** 2007 (1) SA 827 (SCA) at para [22] where the court stated as follows: 'It is probably so that there can be no universally applicable formula which will prove to be appropriate in every case. As Lord Oliver observed in *Caparo Industries plc v Dickman and Others* [1990] 2 AC 605 (HL) at 633F-G [1990] All ER 568 at 585 *in fine* -586a), 'the attempt to state some general principle which will

determine liability in an infinite variety of circumstances serves not to clarify the law but merely to bedevil its development in a way which corresponds with practicality and common sense.’ I agree. A rigid adherence to what is in reality no more a formula for determining negligence must inevitably open the way to injustice in unusual cases. Whether one adopts a formula which is said to reflect the abstract theory of negligence or some other formula there must always be I think, a measure of flexibility to accommodate the ‘grey area case.’

[102] It follows that the conclusion that the Defendant’s conduct was negligent should be based on proven facts and not on abstract considerations as was stated in **Van Wyk v Lewis** 1924 AD 438 at 461 -462 that: ‘we can’t determine in the abstract whether a surgeon has or has not exhibited 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 similar circumstances would have acted, or did he manifestly fall short of skill, care, and judgment of the average surgeon in similar circumstances? If he falls short, he is negligent.’

[103] The court was referred to the case of **Meyers v MEC, Department of Health, Eastern Cape** [2020] ZASCA 3; [2020] 2 All SA 377; 2020 (3) SA 337 (SCA). In this case the majority found that the Plaintiff discharged the onus establishing negligence on the part of the surgeon who caused two small injuries to plaintiff’s bile duct during surgery to remove gall bladder. There was no evidence to establish how it came about that the injuries occurred. At para [82] the court stated as follows: ‘In my view at the close of Ms Meyer’s case after both she and Dr. Pienaar had testified, there was sufficient evidence which gave rise to an inference of negligence on the part of Dr. Vogel. In that regard it is important to bear in mind that in a civil case it is not necessary for plaintiff to prove that the inference that she asks the court to draw is the only reasonable inference; from a possible inference suffices for her to convince the court that the inference she advocates is the most readily apparent and acceptable inference. That inference remained undisturbed by the evidence of a Dr. Vogel. And, as I have attempted to show, Prof. Bornman’s evidence did not tip scales against Meyer’s. in short, when Prof. Bornman’s evidence is read together

with the evidence of Dr. Pienaar (as, to my mind it should be), no reasonable suggestion has been offered as how the injury could have occurred, save for negligence on the part of Dr. Vogel.'

[104] It is trite that 'there can be no inferences unless there are objective facts which to infer the other facts which it is sought to establish. In some cases, the other facts can be inferred with as much practical certainty as if they had been actually observed. In other cases, the inference does not go beyond reasonable probability. But if there are no positive proved facts from which the inference can be made, the method of inference fails and what is left is mere speculation or conjecture', See ***Bates & Lloyd Aviation Pty Ltd v Aviation Insurance* 1985 (3) SA 916 (A) at 939 F-C.**

Conclusion

[105] I agree with the plaintiff's submissions that there had been inadequate monitoring during the birth process when there were danger signs such as a prolonged labour process and other signs of distress of the foetus. It is common cause that labour was prolonged. I accept that the decision to artificially rupture the membrane was delayed. This possibility was considered at 18h30 and 5 more hours lapsed before action was taken.

[106] The child was born in a compromised state of health with low APGAR scores. The baby was floppy and did not cry after delivery and had to be taken to ICU for treatment. This supports the evidence of Prof Theron that the baby entered the second phase of labour already in a compromised state. The insult must have taken place during the intrapartum period. It can safely be concluded that given the prolonged labour period and the fact that during this period the baby was deprived of oxygen during contractions the insult to the brain took place.

[107] Upon delivery it was noted that the baby was blue and not breathing, pale and a low-rate APGAR, tone was reduced, and oxygen saturation was low and had no reflexes. These are clear signs that the baby was delivered in compromised state.

[108] On the totality of the evidence I reject the testimony of Dr Mbokota that adequate monitoring was done as per the Guidelines. I am satisfied that maternal monitoring was not done hourly as per the Guidelines and there was no half hourly monitoring of the foetus and where it was done, it was not according to standard as no deceleration to monitor heart rate was done or recorded.

[109] The National Guidelines for Maternity Care published in 2007 (maternity guidelines) list 'poor progress in the active phase of labour (crossing partogram action line)' and 'thick meconium staining of the liquor' among the list of labour related problems. If these factors are observed during monitoring, then appropriate steps must be taken to accelerate labour. This must be done by enlisting the assistance of an obstetric doctor.

[110] The hospital records reveals that at around 22h55 on the 08/08/2018 the mother complained of severe pains and that at that stage cervix dilation was 8cm and the artificial rupture of the membrane was performed, and the amniotic fluid was grade 1 meconium stained and the CTG did not make contact.

[111] The suggestion that the foetus may have suffered intrauterine growth restriction (IUGR) is not supported by objective facts. This is in fact speculative in the extreme. The fact that the mother of the child only visited the pre-natal clinic twice cannot be used to conclude brain injury may have occurred prior to her visit to the clinic. The two paediatric neurologist who examined the baby and also had access to the reports of radiologist also excluded IUGR as possible aetiology of the child's neonatal encephalopathy.

[112] The evidence of both Prof Lotz and Dr Kamolane can be reconciled. There is no dispute that a brain injury occurred. The two experts told the court that as radiologists they studied MRI scans and produced a report. As to when the injury or assault may have happened is not within their field of expertise. The difference in the use of the nomenclature was explained and I am satisfied that cerebral palsy was as a result of hypoxia ischemia during labour.

[113] Whilst the court accepts the sincerity of the evidence of Dr Kamolane, I am on the objective facts satisfied that the evidence of Prof Lotz is to be preferred. This is based on the fact that the evidence of Prof Lotz was largely corroborated by what Dr Pearce also observed when she examined Baby AM. Dr Pearce assessed Baby AM clinically and agreed with Dr Mogashoa for the defendant that the spasticity is indicative of a white matter injury to the watershed areas of the brain of the child. A cranial ultrasound also diagnosed periventricular echo densities and prominent ventricles.

[114] I am further fortified in my view by the fact that on the evidence placed before court it became common cause that for an acute profound hypoxic ischaemic insult to occur there has to be sentinel event. It is also common cause that no such sentinel event was found to have existed or occurred during labour.

[115] This is clearly consistent with the findings of Prof Lotz when he observed primed or scorched and injury to the white matter and that this clearly depicted that the injury to the anterior watershed and or basal ganglia thalamus (BGT) which is associated with the termination of perfusion of oxygenated blood to the brain.

[116] There was agreement between the two radiologists that there is no possibility that hypoxic ischemic brain injury could have been as result of any genetic or congenital abnormalities nor that the brain injury could been caused by any toxic inflammatory or metabolic conditions.

[117] The defendant through Dr Candice Harris who produced a joint minute with Prof Nolte also admitted that there was sub-standard care. The injury is consistent with the conduct of the defendant's medical staff and nurses, allowing a prolonged labour of the plaintiff to continue with no adequate monitoring, exposing the foetus to a risk of hypoxic type brain injury. This was also confirmed by the obstetrician joint minute that standard of care required that artificial rupture of the membrane should have been considered at around 20h00. In this case the mother was only assessed after 5 hours 55 minutes, and this is indicative of substandard care.

[118] I am satisfied that given the fact that the reason why the plaintiff was referred to the hospital due to slow progress of labour, it was negligent conduct on the part of the medical staff to still delay admission to the labour ward. There was a factor that was avoidable.

[119] A further factor which is indicative of negligence was the crucial period between 18h30 and 22h55 when no action was taken to expedite labour. A lapse of period of 4 hours 55 minutes is in my considered view substandard care.

[120] Further and in any event, the conspectus of the evidence has shown on a balance of probabilities that the harm suffered by Baby AM is closely connected to the omissions of the hospital staff in relation to their inadequate monitoring of the plaintiff's condition at critical stage of labour. Consequently, the causal link between the negligence and the harm that ensued is undeniable. I accept that the plaintiff booked late for prenatal clinic. I am however not satisfied that that factor contributed to the baby being born with cerebral palsy. As stated by the paediatric neurologist, the available information and evidence, neurological and radiological findings support an aetiological diagnosis of intrapartum hypoxia.

[121] The following order is made:

1. the defendant is liable to compensate the plaintiff in her personal and representative capacity for 100% of the plaintiff's agreed or proven damages arising from the brain injury suffered by A[...] K[...] M[...] (the Minor) at Chris Hani Baragwanath Maternity Hospital on 08 July 2008.

2. The defendant shall pay the plaintiff's taxed or agreed party and party costs of suit on the High court scale in respect of the determination of the issue of liability, which costs shall not be limited to:

- 2.1. The reasonable costs of obtaining all expert medico-legal reports any addendum thereto (where applicable), as well as joint minutes if any, from the Plaintiff's expert witnesses, which were furnished to the Defendant, including but not limited to:

2.1.1. Prof. GF Kirsten (Neonatologist).

2.1.2. Prof. GB Theron (Obstetrician).

2.1.3. Prof JW Lotz (Neurological Radiologist).

2.1.4. Dr D Pearce (Paediatric Neurologist).

2.1.5. Prof AGW Nolte (Nursing Expert).

2.2. The qualifying, preparation and (virtual) court attendance fees in respect of all experts for the Plaintiff mentioned in the preceding paragraph.

2.3. The costs of counsel.

2.4. The costs of the preparation and perusal of the bundles used for trial purposes and the uploading thereof on Caselines.

2.5. The reasonable costs of all consultations between the Plaintiff and her attorneys and/or counsel, and/or witnesses and/or experts in preparation for trial.

2.6. the reasonable, taxable accommodation and transport costs incurred by or on behalf of the Plaintiff in attending all medico-legal consultations with the parties' experts, all consultations with her legal representatives and court proceedings, subject to the discretion of the taxing master.

Thupaatlase AJ

Appearances:

For the Plaintiff: Adv. Piet Uys
Instructed by: Edeling van Niekerk Inc.

For the Defendant: Adv. Nalane SC
Instructed by: State Attorney: Johannesburg

Heard on: 08/08/2022, 10/08/2022, 11/08/2022, 12/08/2022
15/08/2022, 16/08/2022, 16/08/2022, 17/08/2022 and
19/08/2022

Judgment on: 26/01/2023