

SOUTH AFRICA / JUDGMENT

A.D obo L.D v Member of the Executive Council for Health Eastern Cape (505/2021) [2024] ZAECBHC 3 (19 March 2024)

[2024] ZAECBHC 3

COURT

Eastern Cape High Court, Bhisho

BEFORE

Gqamana

CASE / FILE NUMBER

505/2021

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IN

THE HIGH COURT OF SOUTH AFRICA

(EASTERN

CAPE DIVISION, BHISHO)

Case

no: 505/2021

In the matter between:

A

D obo L D

Plaintiff

and

THE MEMBER OF THE

EXECUTIVE

COUNCIL

FOR HEALTH EASTERN CAPE

Defendant

JUDGMENT

GQAMANA J

[1] On 24 January 2017, the plaintiff was admitted at Bisho hospital and was later transferred by an ambulance to Cecelia Makiwane hospital. The reasons for such transfer or referral will be dealt with below. She gave birth to a son, L, by vaginal delivery at 05h15 at Cecelia Makiwane hospital. The plaintiff was 32 years old at the time and she was gravida 2 para 1.[1] L was born in a compromised state, he did not cry at birth and immediately after birth he had to be resuscitated for 20 minutes.

L also had convulsions following resuscitation and required supportive ventilation.

[2] The plaintiff instituted action in her personal and representative capacity against the the defendant, the Member of the Executive Council for Health in the Eastern Cape Province Government (the MEC). In the particulars of claim she alleged that the defendant had a duty to ensure that public hospitals under her control render medical care, treatment and advice to the public with such skill, care and diligence as is reasonably expected of medical personnel, medical practitioners and nursing staff in ensuring that proper, efficient and reasonable health services are provided to the members of the public including the plaintiff and L.

[3] The plaintiff further alleged that, on 24 January 2017, she was admitted at Bisho hospital for maternity and obstetric care and was later transferred to Cecelia Makiwane hospital where she gave birth to L. Further it is alleged that by reasons of her admission, the defendant's medical staff in the aforementioned hospitals were under a legal duty of care to ensure that they render to the plaintiff and L medical care, treatment and advice with such skill, care and diligence reasonably expected of medical practitioners and nursing staff in similar circumstances. In addition she alleged that the defendant's medical staff were negligent and it was their negligence that caused L to suffer a permanent impairment to his brain. As a result thereof, the plaintiff claimed damages in the sum of R 57 million against the defendant.

[4] The defendant admitted that she owed the plaintiff and L duty of care while they were admitted in the aforementioned hospitals. The defendant denied liability and breach of such duty of care by the medical staff. In addition to that, the defendant denied that there was any undue delay in attending to the plaintiff. In amplification of such denial, the defendant pleaded that, the plaintiff and L were afforded proper medical care and treatment in accordance with the guidelines and protocols and that the services were rendered to the plaintiff and L within the available resources at the aforementioned hospitals.

[5] At the commencement of the trial, parties agreed to separate the determination of liability from quantum and I made an order to that effect. In addition, issues were further narrowed down and the only issue remaining is the question of negligence. The defendant denied that the medical staff were negligent and that L's condition was as a result such negligence.

[6] The basis of the test for negligence is that set out in *Kruger v Coetzee*[2]:

“For the purposes of liability culpa arises if:

(A) A diligens paterfamilias in the position of the defendant:

(I) Would foresee the reasonable possibility of his conduct injuring another in his personal property and causing him patrimonial loss;

And

(II). Would take reasonable steps to guard against such occurrence; and

(B). The defendant failed to take such steps.”

[7] As a point of departure, I will set out the common cause facts in order to give factual perspective underlying the issues in dispute. Most of those facts are derived from the plaintiff’s evidence as well as that of sister Mangesana considered together with the joint minutes filed by the pediatricians and radiologists experts and the maternity case record.

[8] On or about June/July 2016, plaintiff attended a local clinic because she was not feeling well and it is then that she became aware that she was pregnant. She was also tested her for viral infections and her results were positive. She was immediately placed on appropriate medication. Thereafter she attended antenatal clinic regularly. The estimated date of delivery according to the pregnancy scan was 28 January 2017. Her antenatal care was uneventful.

[9] On 24 January 2017, she was admitted at Bisho hospital at 00h30 complaining of labour pains. On admission and on the history obtained from her, she reported that her contractions started around 21h00, the previous night[3] and her membranes ruptured at 22h30.

[10] Upon vaginal examination by sister Mangesana[4] at labour ward, it was found that the plaintiff was in the active phase of labour. She was 6cm dilated and her cervix was thick. The presenting part was stationed at -3. The liquor was clear[5] and her pelvic was adequate. The contractions were lasting 40 seconds. The plaintiff was advised not to push because she was still far from delivery. The plaintiff testified that she complied with the nurses’ instructions not to push although she was in extreme pains and was experiencing contractions. However, according to sister Mangesana’s evidence, plaintiff continued bearing down prematurely despite her advise and was uncooperative.[6] Plaintiff then said she was in pains and she felt the urge to push. I will deal with this later below.

[11] On general examination, plaintiff’s pulse was 123 beats per minute (bpm) and her blood pressure level was elevated, it was 143/94.[7] She also had blood spots in her urine. Her body temperature was 36.8 degrees celsius.

[12] The fetal status[8] was also checked by sister Mangesana on admission. The foetus lie was longitudinal. The foetus was in the cephalic presentation.[9] Generally this position allows for smoothest delivery. The liquor was normal. The foetal head was at 4fifths above the pelvic brim. The foetal heart rate was 159 bpm. It was checked by use of a transducer. The cardiotocography (CTG)[10] was not be done because plaintiff was uncooperative. Having

assessed and examined the plaintiff, sister Mangesana recorded the following maternal, fetal and labour risk factors: ‘mother bearing down continuously? Big baby[11], and possible obstructed Labour” respectively. The plan was to place plaintiff on the CTG and for the doctor to assess her. All the information was also recorded in the partogram.[12] The doctor on duty was notified of the plaintiff’s condition but was unable to attend to her immediately as the doctor was busy resuscitating another baby that had meconium aspiration syndrome. [13]

- [13] It is common cause that the combination of the continuous bearing down and a thick cervix in active phase of labour is called “Khanula syndrome”.
- [14] Upon plaintiff’s examination on admission it was known by the nursing staff that there was a possible macrosomia with a possibility of an obstructed labour. It was also known that there was no theatre sister on duty.
- [15] It is common cause that from admission at 00h30 until 03h30, the foetal heart rate was monitored half hourly in accordance with the maternity guidelines. Sister Mangesana however, conceded that the record does not show that the foetal heart rate was monitored before and after the contractions.[14] At 01h00 the foetal heart rate was 160bpm meaning the foetus was still in good condition. The maternal condition was also assessed hourly.
- [16] At 01h30, the plaintiff was assessed by Dr Beets. The foetal heart rate was 127 bpm. However, labour had not progressed because cervix dilatation was still 6cm and the head position was still at 4fifths above the pelvic brim.
- [17] Normal progress of labour requires dilatation at a rate of at least 1cm per hour in primigravidae and 1.5 cm per hour in multigravidae. Because plaintiff was a multigravidae it would have been expected of her to have delivered at 03h30 if one moves on the basis that, she was 6cm dilated on admission.
- [18] If the rate of dilatation is slower, the medical staff attending to the patient must search for the cause of poor progress.[15] Subject to the diagnosis of the cause of poor progress and the condition of both the mother and the foetus, the medical staff may allow 2 hours of observation during which the uterine contractions have to be normal.
- [19] Plaintiff’s labour was allowed to progress with a possibility of vaginal delivery. However, from 00h30 to 02h30 there was neither progress on cervical dilatation nor head descent because plaintiff remained at 6cm dilated and the foetus head at 4 fifths above the pelvic brim.

- [20] At 02h30, the plaintiff was again assessed by Dr Beets and it was recorded on the maternity case record that, the dilatation curve had crossed the action line on the partogram. It is then that Dr Beets took the decision to refer plaintiff for caesarian section because of obstructed labour with poor progress and gave instructions that she be tocolysed.[16] Plaintiff was given 30mg of Adalat to suppress contractions. She was also catheterised. Plaintiff refused CTG saying that she was still in pains. The fetal condition at this stage was still good.[17]
- [21] Again at 03h00, plaintiff was given tocolytic drug, i.e 20mg of Nifedipine. Although there are three regiments for tocolysis, but the first line regiment was the most suitable for the plaintiff. There was no stock for the second line regiment which would have been a suppository. And the third line of regiment is the Salbutamol and it is unsuitable to a patient with a heart rate above 120 bpm. The fetal heart rate was 129 bpm. Sister Mangesana recorded in the maternity case record at 03h10 that she was unable to sedate the plaintiff due to CTG not being traceable. Sedation is given to a patient to reduce labour pains. But before a patient is given sedation the fetal condition has to be known.
- [22] At 03h30, again Nifedipine (20mg) was administered to plaintiff. The fetal heart rate was 137bpm. No information recorded in the partogram at 03h30 of the cervical dilatation and head position.
- [23] The information recorded in the clinical notes at 03h40 is that plaintiff was handed over to the Emergency medical services (EMS) “in a stable condition” and the fetal heart rate at that time was 127bpm.
- [24] The next entry is at 04h45 by the medical staff at Cecelia Makiwane hospital. The plaintiff was fully dilated and the foetus head was on the perineum. The foetal heart rate was recorded as 105 bpm. It was also recorded that the patient was pushing all the way from Bisho hospital and even on admission at Cecelia Makiwane hospital, she was still pushing. None of the medical staff from Cecelia Makiwane hospital testified during trial.
- [25] The plaintiff delivered vaginally at 05h15 and her newborn baby was in a compromised state. She testified that her baby, L did not cry at birth, and he was immediately removed from her by the nurses. She saw him later in the day at the Intensive Care Unit.
- [26] The maternity records shows that L was assigned Apgar scores of 2/10 at one minute, 2/10 at five minutes and 4/10 at ten minutes after birth. The Apgar score is the test given to newborns soon after birth and this test checks an infant’ heart rate, muscle tone and other signs to see if extra medical care or emergency care is required.
- [27] The parties also submitted joint minutes of the paediatric experts,[18] the radiologists[19] and obstetricians.[20] In the joint minutes, the aforementioned experts agreed that the brain injury to L occurred intrapartum.[21]
- [28] The paediatrician experts agreed that L was not breathing at 10 minutes after birth and had convulsions following resuscitation and required supportive ventilation. They

further agreed that L's head size at birth was normal with no signs of intrauterine growth restriction (IUGR). In addition they excluded the antenatal

injury as the probable cause of L's brain injury, despite the plaintiff's HIV status.[22] Further they are in agreement that L has spastic and dyskinetic cerebral palsy (GMFCS 5).[23] They also agreed that L suffered hypoxic ischaemic injury.[24]

[29] Insofar as the cause of the brain injury that L suffered, radiologists are in agreement that the MRI scan excludes the genetic disorders as a cause. They further agreed that the MR study displays chronic features related to a peripartum[25] hypoxic ischaemic injury of the brain. Further they agreed that the imaging features are in keeping with Peripheral Watershed (partial prolonged) hypoxic ischaemic injury.

[30] Regarding plaintiff's management of labour the obstetrician experts are at loggerhead. Dr Swan who was called on behalf of the plaintiff is of the opinion that the medical staff at Bisho hospital failed to offer appropriate care to plaintiff and the management of her labour was not according to the guidelines for maternal care in South Africa. His view was that the failure to timeously deliver L is the cause of him to be born in extremely poor condition with signs of hypoxic ischemic encephalopathy (HIE).[26]

[31] The manner in which the foetal condition was monitored and the completion of the partogram by the medical staff is not an issue. The plaintiff's case is that the defendant's medical staff at Bisho hospital were negligent in that, they failed to offer her appropriate care during her labour and also failed to deliver L timeously. As a result of such negligence, L was born in poor condition and suffered brain damages.

[32] On the other hand, the defendant denied that her medical staff were negligent and pleaded that plaintiff and L received reasonable maternity and obstetric care, there was no undue delay in attending to her and that the treatment given to them was in accordance with the maternity guidelines and protocols of her department. The defendant in support of its case presented the expert evidence of Dr Mbokota.

[33] Dr Swan was very critical on the manner in which the medical staff at Bisho hospital managed the plaintiff's labour pains. He testified that nitrous oxide should have been administered and that would have reduced the pains and in turn reduced her non-cooperation. This is neither here nor there because such omission was not the probable cause of L's brain injury.

[34] To me the crux of this case lies on whether the management of the plaintiff's labour at Bisho hospital was in accordance with the maternity guidelines and protocols. As indicated above the obstetrician experts expressed conflicting opinions in this regard.

[35] Where there are conflicting expert opinions, this Court[27] recently articulated the approach therein as follow:

“49. The correct approach to the evaluation of the conflicting experts opinions offered to the court to assist it in determining an issue does not involve considerations of their credibility but rather entails an examination of the opinions presented and the analysis of their reasoning, preparatory to the court in reaching its own conclusion on the issues at hand”[28] .

[36] The point of departure is that an expert witness must base his opinion on facts and the court must be satisfied that such opinion has a logical basis. There are plethora of authorities that have stressed the need for clarity as to the facts upon which an expert’s opinion is based.[29]

[37] The factual evidence herein is the plaintiff on admission was 6cm dilated and the foetus head was stationed at 4 fifths above the pelvic brim. Despite her non-cooperation and her continuously bearing down, the medical staff were able to assess her condition and the foetal condition. From the common cause facts there were no signs of fetal distress. The existing risk factors as identified at the initial assessment, namely the possible macrosomia, the continuous bearing down and the possible obstructed labour were known by the medical staff at Bisho hospital as early at 00h30. Coupled thereto it was known that the intervention measures for an obstructed labour was a caesarean section. When the night shift started at 19h00 it was known that the scrub nurse was not on duty. Despite the existing protocol, no arrangements were made to ensure that the hospital is able to perform caesarean section delivery 24 hours a day.

[38] In terms of the guidelines on maternity care,[30] Bisho hospital as a district hospital is required to have staff and facilities for performance of caesarean section delivery 24 hours a day. Firstly, Dr Mbokoto’s evidence that because there was no scrub nurse and as such the theatre facilities to perform caesarean sections on the night in

question changed the status of the Bisho hospital to that of a community health centre has no logical basis.

[39] Secondly, his view that even if there was a scrub sister it would have been inappropriate to perform the caesarean section at Bisho hospital because of the fact that plaintiff was morbidly obese and the possibility of an obstructed labour is neither sound nor supported by the factual evidence.

[40] On the defendant’s own evidence, the reason why the caesarean section could not be performed at Bisho hospital was because of the unavailability of the theatre sister on duty. [31] Dr Beets’ decision to transfer the plaintiff to Cecelia Makiwane hospital was not influenced by expectation of difficulties with the surgery due to morbid obesity of the plaintiff and serious co- existing medical conditions. The so-called possible problems of anaesthesia that underlie Dr Mbokota’s opinion were as matter of fact not a concern to the medical officer that was managing the plaintiff’s labour.

[41] A court is not bound to absolve a defendant from liability for negligent medical treatment just because evidence of expert witness, albeit genuinely held is that the treatment in issue accorded with sound medical practice.[32]

[42] Further in terms of the maternal care guidelines, all hospitals should be able to perform an emergency caesarean section within one hour of the decision to operate. In the instant matter, the decision for caesarean section was taken at 02h30. The plaintiff should have been operated by no later than 03h30. Plaintiff only delivered at 05h15 and her baby was in extremely compromised state. The medical staff at Bisho hospital failed to deliver the plaintiff's baby timeously. There are two reasons for saying that. Firstly, the possibility of an obstructed labour was diagnosed on admission. The appropriate intervention measure for that is a caesarean section. There was no scrub sister and as such it would not have been possible to perform caesarean delivery at Bisho hospital. That information was known by the night supervisor and also sister Mangesana. However plaintiff's labour was allowed to progress at Bisho hospital and was not timeously transferred to Cecelia Makiwane. Again at 01h30 there was no progress with the plaintiff's labour. It is not disputed that for a multigravidae the expected dilatation is 1.5cm per hour. At 01h30 even though there was no progress with her labour, plaintiff was not transferred to another hospital with theatre facilities. Secondly, even when the decision was taken at 02h30 for a caesarean section, same was not performed within one hour of the decision to operate medical when the labour progression crossed the action line, a decision was taken to transfer the plaintiff to Cecilia Makhiwane hospital for delivery by cesarean section. Dr Swan testified that in terms of the maternity case guidelines, all hospitals should be able to perform an emergency caesarean section within one hour of the decision to operate. There is no exception to this 'one hour rule' and I reject the opinion expressed by Dr Mbokota that the one hour applies only if the cesarean section would be performed in the same hospital. There is simply no logical basis for his opinion.

[43] For all the above reasons, I'm satisfied that on the balance of probabilities the issue of negligence has been established by the plaintiff. The defendant's medical staff at Bisho hospital failed to provide plaintiff and L with proper medical care and that they failed to deliver L timeously.

[44] It is trite that there has to be a causal link between the defendant's actions or omissions and the harm suffered by the plaintiff for a successful delictual claim to succeed.[33] The existence of a nexus depends on the facts of a particular case. On the facts herein, the brain injury to L was caused by the negligence of the defendant's medical staff at Bisho hospital. The failed to provide plaintiff and L with proper medical care and treatment and they failed to deliver L by caesarean section within a hour of the decision to operate, the failure to comply with the maternity care guidelines and protocol

which required Bisho hospital to be able to perform caesarean delivery 24 hours a day and within an hour of the decision to operate. But for the above actions and omissions by the defendant and her medical staff at Bisho hospital, L would not have suffered cerebral palsy.

[45] In the results, the following order shall be issued:

1. The separated issues relating to the merits are determined in favour of the plaintiff and accordingly, the defendant is held liable in respect of the cerebral palsy suffered by L and the damages suffered thereto, in both her personal and representative capacity on behalf of L.
2. The defendant is ordered to pay the plaintiff's taxed or agreed party and party costs of the plaintiff's action on the merits, on the High Court scale, together with interest thereon calculated at the prescribed legal rate per annum and from 14 (fourteen) days after date of taxation or agreement, as the case may be, to date of final payment, and with such costs to include:

2.1 costs up to and including 10 November 2023,

2.2 counsel's costs for drafting heads of argument,

2.3 the reasonable costs of consultations, travelling and subsistence

of plaintiff's experts and legal representatives for purposes of consultations and trial; and

2.4 the costs of report, supplementary reports, qualifying expenses, joint minutes and reasonable day reservation

fees in respect of plaintiffs' merit expert witnesses, in respect of Dr Swan and any other experts who have filed Rule 36(9)

(a) and (b) notice in relation to the determination of the issue of liability.

N GQAMANA

JUDGE OF THE HIGH COURT

APPEARANCES:

Counsel for the Plaintiff

: Adv Y Malunga

Instructed by

: Attorneys

East London

Counsel for the Defendant

: Adv Simoyi

Instructed by

: State Attorneys

Dates heard on

: 16, 17, 19 October 2023; 10

November 2023

Judgment Delivered on

: 19 March 2024

- [1] A G2P1 would describe a female who has been pregnant twice, had one miscarriage at 8 weeks, and one live at term.
- [2] 1966 (2) SA 428 (A) 430E.
- [3] On 23 January 2017.
- [4] The sister on duty at labour ward on the night in question.
- [5] Which is suggestive of a baby who was not in distress.
- [6] Ms Mangesana: I was trying to get her co-operation because I wanted her to understand that she must not push before she was fully dilated. I told her she must not push because that may even injure the baby. As she was pushing continuously without stop, she would possibly injure the baby
- [7] Normal blood pressure level is less than 120/60
- [8] The size, number, lie, position and presentation.
- [9] Meaning the baby is head down, chin tucked to chest, facing the mother's back.
- [10] The CTG is used during labour to measure the fetal heart rate at the same time it measures the contractions in the uterus to monitor the fetal for any signs of distress.
- [11] Fetal macrosomia
- [12] A partogram is a measure for evaluating the progress of labour graphically.
- [13] Meconium aspiration syndrome occurs when a newborn infant breathes a mixture of meconium and amniotic fluid into the lungs around the time of delivery.
- [14] Mr Malunga: Okay there is no entry before the contraction? Ms Mangesana: No sir. Mr Malunga: Why is that? Ms Masengana :
- Here I was using the transducer just to see the fetal heart rate . I was not oscillating. Mr Malunga: Is that in keeping with proper record keeping? Ms Masengana : No, sir.
- [15] The use of the Rule of Ps, meaning one has to check the condition of the Patient, Power i.e. uterine contractions, the Passenger (the fetus) condition, ones has to look for signs of fetal distress, fetal size, fetal lie, fetal presentation and position and the level of the presenting part and Passage - the pelvic size and shape, cervix .

- [16] Tocolysis is an obstetrical procedure carried out with the use of medications with the purpose of delaying the delivery of a fetus in women presenting preterm contractions.
- [17] Fetal heart rate was 133 bpm.
- [18] Dr Kara and Dr Kganane.
- [19] Dr Macdonald and Dr Kamolane
- [20] Dr Swan and Dr Mbokota.
- [21] This is the period from the onset of labour until the end of the third stage of labour.
- [22] She was HIV positive which is a risk factor
- [23] Gross Motor Function Classification System Level V meaning that all areas of motor function are limited.
- [24] Lack of oxygen to the brain.
- [25] That is the period shortly before, during and immediately after birth.
- [26] This is a type of brain damage caused by lack of oxygen to the brain before or shortly after birth.
- [27] *TY obo MY v MEC for Health, Gauteng Province* Case No: CA 18/2022 judgment delivered on 8 March 2024.
- [28] *Michael and another v Linksfield Park Clinic Pty Ltd and another* 2001 3 SA 1188 (SCA) and *Oppelt v Head, Department of Health Provincial Administration: Western Cape* 2016 1 SA 325 (CC) at 35.
- [29] *AM and another v MEC for Health, Western Cape* 2021 3 SA 337 (SCA), *PriceWaterhouseCoopers Inc and others v National Potato CO-Operative Ltd and another* [2015] 2 ALL SA 403 (SCA).
- [30] Fourth Edition 2016.
- [31] Yes madam, do you know why this patient was referred to Cecelia Makhiwane hospital?
Response: As we do not have at Bisho, a theatre sister that night. She was sick and the doctor decided at 02h30 [that] the patient will not deliver as we expected- that is why we started tocolysis so the patient was transferred or referred.
- [31] Yes madam, do you know why this patient was referred to Cecelia Makhiwane hospital?
Response: As we do not have at Bisho, a theatre sister that night. She was sick and the doctor decided at 02h30 [that] the patient will not deliver as we expected- that is why we started tocolysis so the patient was transferred or referred.
- [32] *Oppelt (supra)*.

[33] Lee v Minister of Correctional Services 2013 2 SA 144 (CC).

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