

SOUTH AFRICA / JUDGMENT

H.N v MEC for Health, KZN (1287/2014) [2018] ZAKZPHC 8 (4 April 2018)

[2018] ZAKZPHC 8**COURT**

Kwazulu-Natal High Court, Pietermaritzburg

BEFORE

Koen

CASE / FILE NUMBER

1287/2014

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IN THE HIGH COURT OF SOUTH AFRICA

KWAZULU-NATAL DIVISION, PIETERMARITZBURG

Case no: 1287/2014

In the matter between:-

H N Plaintiff

and

MEC FOR HEALTH, KZN Defendant

-

Coram: Koen J

Heard: 26 March 2018

Delivered: 4 April 2018

O R D E R

-Judgment is granted in the following terms:

1 It is declared that the Defendant is liable for 100% of the Plaintiff's damages, as proved or agreed, arising from the

birth with disability of M N, a boy, born on [...] August 2012.

2 The Defendant will pay the Plaintiff's reasonable and necessary costs of the action to date on the party and party scale in the High Court, as taxed or agreed, which shall include:-

- (a) the costs of the reports of the Plaintiff's experts:-
 - (i) Dr DM McLynn, obstetrician, including qualifying, reservation and attendance fees (not necessarily limited to R1500.00, subject to the discretion of the Taxing Master) and the costs of his supplementary report and the costs of the joint minute;
 - (ii) Prof S Andronikou, radiologist, and the costs of the joint minute;
 - (iii) Dr Y Kara, paediatrician, including qualifying, reservation and attendance fees (not necessarily limited to R1500.00, subject to the discretion of the Taxing Master) and the costs of the joint minute;
- (b) the costs of the MRI scan performed by Lake, Smit and Partners Inc. together with the costs of the anaesthetist, hospital and paediatrician involved in obtaining the said scan;
- (c) the costs of the rule 37 proceedings and case flow hearings;
- (d) the costs of preparation for trial;
- (e) the cost of preparation of heads of argument;
- (f) the fees of two counsel, where employed;

No order is made in respect of the wasted costs occasioned by the adjournment on 10 October 2017.

3 The matter is adjourned sine die for the determination of quantum.

J U D G M E N T

Koen J:

Introduction

- [1] This is an action in which the Plaintiff in her personal capacity and on behalf of her minor child, M N ('M'), to whom she gave birth in the Greytown Hospital on 6 August 2012, claim damages from the Defendant. M was subsequently found to suffer from spastic quadriplegic cerebral palsy. The Greytown Hospital is administered, managed and controlled by the Defendant. The Plaintiff alleges that M's condition was caused by the negligence of the Defendant's employees.
- [2] At the commencement of the trial the issue of liability was separated for determination before all other issues. This judgment deals with that issue only.[1]

Background

- [3] It is common cause that:

- (a) M suffers from spastic quadriplegic cerebral palsy, a permanent condition;
- (b) The MRI scan of his brain revealed damage compatible with a hypoxic ischaemic injury in a term infant with the possibility that it was prolonged.[2]
- (c) The cause of his condition cannot be ascertained conclusively from the scan. The specialist radiologists of both the Plaintiff and of the Defendant, per their joint minute agreed that regard had to be had to the clinical picture to determine the probable cause;
- (d) The applicable operating guidelines require that the foetal heart rate of M had to be monitored every half-hour during the active phase of labour;
- (e) There was no monitoring of the foetal heart rate for a period of 2 hours between 6pm to 8pm in the active phase of labour;
- (g) A Caesarean section operation should occur under the operative guidelines within one hour of the decision to do one;
- (h) One and a half hours passed between the decision to perform a Caesarean section and the delivery of M.

The Legal Test

[4] The test in medical negligence cases is succinctly summarised inter alia by Corbett JA in *Blyth v Van der Heever*.^[3] The two questions mentioned in *Blyth* arising in this matter are:

- (i) what factually was the cause of the ultimate condition of [M];
- (ii) did negligence on the part of [the Defendant] cause or materially contribute to this condition in the sense that [the Defendant] by the exercise of reasonable professional care and skill could have prevented it from developing.'

[5] Before considering whether these questions are to be answered in favour of the Plaintiff or Defendant it is necessary to deal briefly with the evidentiary value of the hospital records of the Defendant.

The Evidentiary Value of the Hospital Records

[6] Both parties made extensive reference during the leading of the evidence to the hospital records,^[4] which the Defendant had kept, relating to the Plaintiff's confinement at the Greytown Hospital and the birth of M. At the

commencement of the trial it had been agreed that the status to be assigned to these documents inter alia was that they are what they purport to be without being proof of the truth thereof.

[7] To the extent that there are records, the Defendant has inter alia relied on a favourable Apgar score which the nursing staff of the Defendant had determined at one minute and five minutes after M's birth as indicative of him having been born as a healthy baby. The Plaintiff, on the other hand, has relied on references in the official hospital records that

there was 'foetal distress' and 'cephalo-pelvic disproportion' present to support her case. The questions arising relate to the admissibility and the evidentiary value to be given to these entries appearing in these records.

- [8] Statements in the medical records that are favourable to the Defendant are hearsay where the author thereof was not called to

testify, and hence not admissible.[5] Accordingly, the apparent high Apgar scores[6] relied on by Dr Wildenboer, namely scores of 7 and 8 out of 10, determined at 1 and 5 minutes respectively, remain hearsay as the

author determining and recording those scores was not called to testify thereto. No application was made for the admission thereof

in evidence in terms of section 3 of the Evidence Law Amendment Act 1998, but even if there was, it would be unlikely to have succeeded

as there was no evidence that the author thereof was no longer available to give that evidence. These scores are in any event, in the opinion of all four the medical experts who testified, subjective and to that extent open to debate and unreliable. This was particularly, as Dr Kara testified, that the five minute score would be inflated by M's resuscitation with oxygen. Dr Wildenboer agreed. Thus, even if admissible evidence, no valid conclusion can be drawn from these scores.

- [9] Recordings favourable to the Plaintiff's case in establishing negligence and liability generally, and accordingly damaging to the Defendant's case, made as part of the records kept by the Defendant's servants, are however on a different footing. They constitute admissions by the servants of the Defendant made in the ordinary course of discharging their duties, which are binding against the Defendant.[7] The Defendant's staff are obliged to make these statements by recording the medical position as it unfolds in the records. They have an obligation to speak on behalf of the Defendant and dispute what is recorded, if indeed incorrect.

- [10] Mr Chetty who appeared for the Defendant did not dispute this interpretation.

The Cause of M's Cerebral Palsy

- [11] In determining what factually was the cause of, or what materially contributed to the condition of M, the standard of proof as in all civil matters is one on a preponderance of probability.

- [12] Dr Wildenboer, the Defendant's expert paediatrician, candidly conceded that a Hypoxic Ischaemic Event (HIE) is the most common cause of cerebral palsy.[8] In M's case that statement is also consistent with the expert radiological evidence. Taking that as the general point of departure, the question then arising is what caused or materially contributed to the HIE. The common cause radiological evidence is that it was possibly a prolonged hypoxic ischaemic injury. One possible cause of such an injury would be if the foetus was distressed.

The foetus could be distressed during prolonged labour during the active phase.

[13] Other possible causes mooted in the evidence included:

- (a) That the brain damage may have been the result of a syphilis infection to the child in utero.
- (b) That because the Plaintiff was HIV positive, it may also cause her child to be born with cerebral palsy.
- (c) That the Plaintiff could have rolled on to M when he was placed in the bed with her shortly after his birth and where he remained until the next morning, thus suffocating him or at least seriously restricting his breathing.

[14] AS regards the possibility of syphilis being the cause Dr Batchelder, the Defendant's specialist obstetrician, testified that the brain damage may have been the result of a syphilis infection to the child in utero. He made this observation because of an observation in the records that the Plaintiff was WR positive an indicator for syphilis, suggesting she had syphilis, and was not on treatment for it. Dr Kara explained clearly and convincingly that the Plaintiff did not suffer from syphilis.[9] Although not conclusive, the Plaintiff's evidence was also that she does not suffer from and was never diagnosed with syphilis. What however put the matter beyond doubt is that in the Plaintiff's discharge summary it was recorded that the child was RPR negative. Dr Batchelder consequently fairly accepted that syphilis was not a contributory factor and could be disregarded.

[15] As regards the suggestion that the Plaintiff was HIV positive and that this may have caused M to be born with cerebral palsy, it was not disputed that the Plaintiff was HIV positive. Dr Wildenboer however testified that HIV is not a direct cause of cerebral palsy, but merely raises the risk of HIE or makes the child of an infected mother more susceptible to possible HIE. Dr Kara testified, and this was not challenged, that a baby unexposed to HIV has a 0.2% risk of neonatal encephalopathy, whereas the same child would have double the risk, namely 0.4% if his mother was HIV positive. The presence of HIV therefore would not constitute a defence open to the Defendant, but can in any event be discounted since:

- (a) it falls naturally into the weak heart and thin skull rule type of case where a defendant takes his victim as he finds him;[10]
- (b) the presence of HIV which was known to the Defendant after admission of the Plaintiff raised the risk of HIE, which would necessitate more careful monitoring during the labour and birth processes.

[16] Dr Batchelder had also suggested that M's brain damage may have occurred if the Plaintiff rolled on to him during the night of his birth when very shortly after he was born he was placed in the bed with her until the next morning, thus suffocating him or at least seriously restricting his breathing. This suggestion was however never put to the Plaintiff and there is no evidence that it indeed happened. Indeed Dr Batchelder agreed that this was mere speculation.

[17] The other possible causes referred to in paragraphs [13] to [16] above being discounted, foetal distress and the sequelae following therefrom appears to be the most probable cause of M's condition. It is not necessary to determine conclusively as a matter of medical causation that foetal distress was actually the cause. It is sufficient if it is the most probable cause that presents itself.[11] Dr Batchelder agreed under cross-examination that since HIE is the main cause of cerebral palsy, and that the possibility that there was some unknown less probable cause which could have intervened to cause M's brain damage, was less likely.

[18] That foetal distress during the active stage of labour was the most probable cause, is also consistent with the evidence. There was evidence on a later CTG scan performed that there was foetal distress.[12] That scan has however apparently disappeared. Unfortunately poor monitoring as testified to by both obstetricians during the final

stage of labour also means that there is no primary evidence either in confirmation of or in contradiction of the finding of foetal

distress. It would not however have been revealed and recorded if M had not presented with signs of foetal distress.

[19] That this was an instance where foetal distress would be likely, is also confirmed by the evidence of Dr McLynn, the obstetrician for the Plaintiff, as in his view, the Plaintiff was at risk of cephalo-pelvic disproportion. He testified that the Plaintiff was of small stature

being under 1.5m in height. M was on the large side, namely 3.58kg at birth. The hospital notes before birth described the baby as 'big'. The Plaintiff was accordingly at risk for cephalo-pelvic disproportion, having regard to the proportion between the size of the baby and her probable smaller pelvic dimensions due to her smaller stature. It is not a case of absolute size, but baby size relative to the Plaintiff's pelvis. When a normal vaginal delivery proved impossible, any delay in extracting M would increase the risk of brain damage. The discharge summary indeed records that an emergency Caesarean section was required due to foetal distress and cephalo-pelvic disproportion.[13]

[20] In the end, the Defendant's case was that there was no evidence that an earlier Caesarean section would have prevented the full extent of the brain damage, Dr Batchelder opining that the outcome may not have been better. I do not, with respect, find that reasoning convincing. Dr Batchelder testified that brain damage increases with a delay in an HIE situation. At 10pm, the foetal heart was 169bpm and therefore non-reassuring. A CTG trace was scheduled. At 10:50pm the trace showed decelerations. A doctor was called who took half an hour to arrive. Dr McLynn testified that this is substandard. There was no evidence suggesting that earlier attendance was impossible. A Caesarean section was only then directed. Thereafter a delay of one and half hours ensued, which Dr Batchelder agreed is substandard. The explanation that emerges from the medical records is that a full blood count was requested and there were delays at the laboratory where the staff did not answer the telephone or begin with the analysis. These delays are consistent with the possible 'prolonged' diagnosis of the brain damage agreed to by the radiologists. There is

furthermore evidence of encephalopathy of seizures as recorded in the discharge form. Dr Wildenboer agreed that seizures imply some loss of

consciousness. This is the exact picture one expects. The evidence of Dr Kara established the most likely explanation causing M's

condition to be due to oxygen deprivation during child birth in consequence of delay and neglect.

[21] I accordingly conclude that as a matter of probability the HIE resulting in M's cerebral palsy was caused by, alternatively

materially contributed to by, the foetal distress he was exposed to during and towards the latter stages of active labour, that is peri-natally.

Negligence[14]

[22] The cause of, or factors materially contributing to, M's condition referred to in the preceding paragraph, to the extent that this is not already apparent from what I have said above, resulted from the negligent conduct of the Defendant's servants acting within the scope of their employment with the Defendant,[15] in one or more or all of the following respects:

- (a) They failed to adequately monitor the Plaintiff and the condition of M properly during the labour, particularly during the active labour phase. There was apparently no monitoring during the last two hours of labour, or alternatively no records have been kept in respect thereof. The probabilities suggest that had there been appropriate monitoring, foetal distress would have been apparent.
- (b) Being aware that the Plaintiff was HIV positive and hence more susceptible to possible HIE, the failure of the Defendant's staff to monitor adequately during labour was all the more serious in the circumstances.
- (c) Being aware of the Plaintiff's relative diminutive size and that her baby was 'big' they failed to recognize and appreciate the high risk of cephalo-pelvic disproportion timeously.
- (d) Having clearly identified the urgent need for M to be born by Caesarian section due to poor progress in labour, it took more than an hour, indeed an hour and a half for that procedure to be performed. That was outside acceptable time limits. The delays in both the time the doctor took to respond to the summons by the nurse and in performing the Cesarean section represented substandard care.
- (e) If, contrary to what I have found above, M's condition was caused by him being smothered accidentally by the Plaintiff when he was placed with her in bed, this would still constitute negligence. Dr Batchelder testified that it was inappropriate to hand the baby to his mother immediately after the operation since she was recovering from significant surgery and anaesthesia. That constitutes a further ground of negligence, and the Plaintiff would have been entitled had there been any such evidence to amend her particulars of claim to make

this case.

Costs

- [23] The Plaintiff produced a draft order reflecting the relief she will claim, including a detailed order as to costs.
- [24] The Plaintiff has inter alia sought the wasted costs occasioned by the adjournment on 10 October 2017. The matter had been heard on 9 October 2017 and was to have continued on 10 October 2018. The matter could not proceed on 10 October 2018 due to my unforeseen but urgent admission to hospital on the morning of 10 October 2017, where I was detained for three days. I tender my apologies to the parties for this unfortunate adjournment. It however, seems to me to be unfair to make any cost order in respect of that day, or to direct that those wasted costs should follow the result. I accordingly make no order in respect thereof.
- [25] The Defendant has not raised any other objections to the terms of the order granted should I find against the Defendant. There are aspects of the order which in my view are unnecessary and may unduly fetter the discretion of the Taxing Master. I have amended the order accordingly. The order sought is very specific in regard to various items of the costs. It is in my view undesirable for orders on costs to become this detailed. I have however been advised that if not specified with such particularity that problems are often encountered on taxation. I have accepted these assurances from both counsel in formulating the order, so as to avoid the possible need for any review of taxation. I do so hesitatingly though as I do not believe that such particularity is necessarily required.

Order

[26] The order I grant is as follows:

1 It is declared that the Defendant is liable for 100% of the Plaintiff's damages, as proved or agreed, arising from the birth with disability of M N, a boy, born on [...] August 2012.

2 The Defendant will pay the Plaintiff's reasonable and necessary costs of the action to date on the party and party scale in the High Court, as taxed or agreed, which shall include:-

(a) the costs of the reports of the Plaintiff's experts:-

3 The matter is adjourned sine die for the determination of quantum.'

Koen J

Appearances

Plaintiff's counsel: L Pillay SC with ML Bahadur

Plaintiff's Attorneys: Justice Reichlin Ramsamy

Ref.: JRR/AB/N1368

C/O SURENDRA SINGH & ASSOCIATES

Tel.: 033-394 9683/95

Defendant's counsel: M.G Chetty

Defendant's Attorneys: STATE ATTORNEY KZN

Ref.: 24/003725/13N/P22/hvl

C/O CAJEE SETSUBI CHETTY INC

Tel.: 033 – 345 6719

- [1] The Plaintiff called two expert witnesses, Dr Kara, a Paediatrician, and Dr McLynn, a Specialist Obstetrician and Gynaecologist, and the Defendant called two expert witnesses to testify on its behalf namely, Dr Batchelder, Specialist Obstetrician and Gynaecologist, and Dr Wildenboer, who is a Specialist Paediatrician. The Plaintiff also testified.
- [2] The Defendant has argued that there is no evidence of an acute peri- or intrapartum sentinel event sufficient to cause severe hypoxia in a healthy foetus for example, cord prolapse, anti-partum haemorrhage or ruptured uterus, having occurred. That submission however appears to overlook the concurrent view of the radiologists of the possibility of the injury having been prolonged.
- [3] 1980 (1) SA 191 (A) at 196E.
- [4] The hospital records produced by the Defendant are incomplete. Records relating to crucial times during the labour process are missing.
- [5] DT Zeffertt and AP Paizes Hoffman and Zeffertt's The South African Law of Evidence 4th ed, at 183ff.
- [6] The Defendant placed considerable reliance on the Apgar scores and submitted that had the baby been unwell this would have been borne out by poor Apgar scores and he would not have been given to his mother to keep with her in her bed after his birth.
- [7] DT Zeffertt and AP Paizes Hoffman and Zeffertt's The South African Law of Evidence 4th ed, at 183ff.
- [8] This view is shared by all the experts.
- [9] In view of Dr Batchelder's subsequent concession that syphilis can safely be excluded as a possible cause I do not intend summarizing Dr Kara's evidence any further in this judgment.
- [10] Boberg Law of Delict at 278.

[11] Dr Batchelder relied on the ACOG (American College of Gynecologists) guidelines which specifies that a preponderance of certain factors must be present to conclude that HIE during child-birth caused the cerebral palsy. At least two of these factors, namely an early brain scan and cord blood analysis were not done, which Dr Batchelder testified is not commonly done in government hospitals. Another namely the apgar scores, were not proved by admissible evidence. Any reliance on this guide is accordingly unreliable. Ultimately, the issue is also not one of precise determination of the cause of the cerebral palsy, but what is the more probable cause or materially contributing factor to the cerebral palsy.

[12] Based on the heart rate of the foetus, the Defendant has submitted that there is no evidence that there was foetal distress during

labour. The heart rate of the foetus was 169 beats per minute which Dr Bachelder said is normal, a foetal heart rate between 100 and 160 beats per minute being the accepted norm. The Defendant criticised Dr McLynn's view that the normal foetal heart rate norm should be between 100 and 150 beats per minute, because unlike Dr Batchelder who bases his view on the NICE Guidelines, Dr McLynn could not categorically state the source of his information. In the light of the view I have taken of the matter it is not necessary to deal further with this aspect.

[13] The author of this document is unknown. As Dr Wildenboer testified, it may have been a nurse or doctor who had regard to the medical records. In so far as they are favourable to the Plaintiff's case in establishing negligence and liability generally, these recordings constitute admissions by the servants of the Defendant made in the ordinary course of discharging their duties, which are binding against the Defendant – see DT Zefferdt and AP Paizes Hoffman and Zefferdt's *The South African Law of Evidence* 4th ed, at 183ff. As the staff members are obliged to make these statements recording the medical position as it unfolds in the record, they have an obligation to speak on behalf of the Defendant and dispute what is recorded, if indeed incorrect.

[14] There is not surprisingly no allegation of negligence against the Plaintiff. *Van Vuuren v eThekweni* 2018 (1) SA 189 (SCA) paras 33 – 34, it was held that there cannot be contributory negligence against a Plaintiff who sues in a representative capacity. Accordingly all that is required is a proverbial one percent negligence that contributed to Mkhulisi's condition.

[15] The Defendant's vicarious liability for the conduct of his staff at the hospital attending to the Plaintiff and Mkhulisi is not in dispute.

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