

SOUTH AFRICA / JUDGMENT

L.B and Another v Member of the Executive Council for Health North West Provincial Government (1637/2022) [2025] ZANWHC 64 (20 March 2025) [2025] ZANWHC 64

COURT

North West High Court, Mafikeng

BEFORE

Titus

CASE / FILE NUMBER

1637/2022

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IN

THE HIGH COURT OF SOUTH AFRICA

(NORTH

WEST DIVISION, MAHIKENG)

Case

No: 1637/2022

Reportable:

YES / NO

Circulate

to Judges: YES / NO

Circulate

to Magistrates: YES / NO

Circulate

to Regional Magistrates: YES / NO

In

the matter between: L[...]
B[...]
First Plaintiff
B[...]
J[...]
R[...]
Second Plaintiff
and
THE
MEMBER OF THE EXECUTIVE COUNCIL (MEC)
FOR
HEALTH, NORTH WEST PROVINCIAL
GOVERNMENT
Defendant

Coram: Titus AJ

Reserved: 10 March 2025

Delivered: 20 March 2025

ORDER
It

is ordered that: (i)
The defendant is liable for any damages that the
parties may agree upon or that the plaintiffs may prove arising from
the defendant's
negligence.
(ii)
The defendant is ordered to pay the plaintiffs'
reasonable costs, including the costs of counsel, taxed on Scale A.

JUDGMENT

TITUS AJ

Introduction

- [1] This is an action for damages arising out of alleged negligent conduct of medical staff at Lehurutshe Hospital, Dinokana Clinic ('the Clinic') and Mafikeng Provincial Hospital ('the Hospital') during the management, treatment and birth of the plaintiffs' newborn baby, ('the baby'). The baby died of medical complications after a barely two days of life.
- [2] The claim was lodged against the Member of the Executive Council for Health, North West Provincial Government who is vicariously liable for damages caused by negligent conduct of medical staff in the province.

- [3] To compound their injury, medical staff at the Hospital mishandled the baby's remains by releasing the wrong remains to the plaintiffs for burial. By letter dated 18 November 2020, the defendant apologized to the plaintiffs for their negligence, acknowledging the consequent harm that they endured.
- [4] The matter is before this Court for the determination of the merits[1]; the determination of quantum having previously been postponed sine die.
- [5] At the trial, the first and second plaintiffs were represented by Advocates DP Mogagabe and T Raikane respectively and the defendant by Advocate Mokhoebe. This Court is indebted to the plaintiffs' counsel for their combined heads of argument; albeit that it was more extensive than should otherwise have been the case. This Court did not have the benefit of the defendant's heads of argument.
- [6] Be that as it may, before the start of proceedings, the plaintiffs' counsel made an application, without objection, that the evidence of the medical experts be received into evidence as provided for by Uniform Rule 38(2). This Court granted the application as it would be convenient, and in the interests of justice, to do so.
- [7] For its part, the defendant recorded during the pre-trial proceedings that it would not be appointing any expert witnesses on the merits of the plaintiffs' claim and would rely solely on lay witnesses.

As it would appear later in this judgment, the defendant ultimately called no witnesses nor presented any other evidence.

- [8] When proceedings started, Advocate Raikane informed this Court that the defendant would not persist with its special pleas. These special pleas relate to the plaintiffs' alleged failure to observe the requirements of the Institution of Legal Proceedings Against Certain Organs of State Act, No 40 of 2003 and the second plaintiff's

alleged lack of locus standi.

The

Issues

- [9] The issue in dispute before this Court is whether the defendant's medical staff were negligent when they treated the first plaintiff and whether that negligence caused the death of the baby; with the emotional sequelae that resulted.
- [10] As it appears from the introduction to this judgment, what is not in dispute is that the defendant's medical staff mishandled the baby's remains and that, by doing so, they caused the plaintiffs' the emotional and psychological harm alleged.

Applicable Principles

[11] The jurisdictional requirements for delictual claims are trite[2]. To determine negligence, our courts apply the classic objective 'reasonable person test'. [3] In essence, courts will measure the person's act or omission, as the case may be, against the conduct of the reasonable person

acting under the same or similar circumstances[4].

[12] The test is upgraded for medical professionals[5] as their conduct is measured against the standard of the 'reasonable medical professional' in the relevant field of practice. This is not an unduly onerous standard for medical professionals as, more than 100 years ago, the Appellate Division (as it was then known) in *Mitchell v Dixon* 1914 AD 519 recognised that this 'upgraded' standard does not require the impossible of medical personnel. All a medical professional is called on to do is to employ reasonable care and skill and, if he does not, he is liable for the consequences thereof[6].

Background

facts

[13] The first plaintiff was a single, 23-year-old female during her pregnancy. She was short of stature at 1,51 meters and weighed 69,4 kg. It was her first pregnancy.

[14] On 16 October 2020, the first plaintiff was admitted to Lehurutshe Hospital complaining of lower abdominal pain. Her cervix was 1 cm dilated on admission. The vaginal examination also revealed a sexually transmitted infection that she was by then treated for.

[15] That same day the first plaintiff was referred to and admitted at Dinokana Clinic, the medical staff noted the onset of labour and opened a maternal case record. She was diagnosed as being in the latent phase of labour. Although she still complained of lower abdominal pain, no risk factors were identified and the medical staff allowed labour to progress normally.

[16] At 06h30 on 17 October 2020, the first plaintiff complained of severe pain. Her cervix was by then 4cm dilated with mild contractions. She was draining blood-stained urine and meconium-stained liquor was found present.

[17] At 10h35 that day, the doctor on call took the decision to transfer the first plaintiff to the Hospital where she received treatment.

[18] At 17h28 the first plaintiff gave birth vaginally to a female baby with normal Apgar scores. No complications nor birth injuries were noted. Breastfeeding was initiated and the baby latched well.

[19] However, at a time unknown, medical staff noted that the baby was pale; her right eye appeared larger than the other and that she cried continuously. A doctor was alerted who then admitted her, after an assessment, to the Hospital's neonatal intensive care unit.

[20] On 18 October 2020 at 05h15, the baby passed away as a result of respiratory distress and dehydration.

Plaintiffs' evidence

[21] Plaintiffs allege that the defendant's medical staff owed them a duty of care but that they were negligent and that their negligent conduct caused the baby's untimely death; and their consequent emotional and psychological harm. It is trite that 'he who alleges must prove' and consequently it follows that the plaintiffs bear the burden to prove that the defendant was negligent and that its negligent conduct caused the harm alleged.

[22] The plaintiffs did not testify personally during the proceedings, relying only on expert medical evidence for their case on the merits. All the experts had regard to the relevant medical records and clinical notes on which their opinions were based.

[23] In broad terms, the experts report variously that the defendant's medical staff failed to act in accordance with the standard of the reasonable medical professional and that their failure to do so caused[7] the death of the baby. Stated differently, had the medical staff acted to the standard expected of them, the baby would not have suffered the harm that she did nor would the plaintiffs have suffered the emotional and psychological harm they allege.

[24] In *McGregor and Another v MEC Health, Western Cape*[8], the Court explained that the:

"...functions of an expert witness are three-fold. 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 litigation. This includes evidence of the current state of knowledge and generally accepted practice in the field in question....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"

[25] Dr du Plessis ('du Plessis'), a retired Adjunct Professor of the University of Fort Hare, qualified in advanced Midwifery and Neonatology, reported on the conduct of the midwives at the treating facilities. She found, amongst other things, that the midwives at the Hospital ignored the first plaintiff's pre-admission history and, consequently, failed to record the prolonged nature of the active phase of labour in contravention of SANC[9] Regulation 2488 (Scope of Practice of the Midwife).

[26] In terms of this Regulation, the midwife must report all abnormal findings to the medical practitioner. In this case, for example, the midwife had noted that the first plaintiff was still draining blood-stained urine and that there was lack of cervical dilation. There is also no documented evidence that the treating doctor was informed of the poor progress of labour.

- [27] Du Plessis concludes that the nursing care delivered to the first plaintiff by the midwifery staff at the Hospital was substandard although she acknowledges that the baby was born with normal Apgar scores[10]; albeit that the baby developed medical complications a few hours later.
- [28] Dr Andre Diedericks ('Diedericks'), an Obstetrician and Gynaecologist, reported and commented on the obstetrical management of the first plaintiff from documents supplied to him, including an earlier report by Dr JPH Basson ('Basson'), a specialist Obstetrician and Gynaecologist. Basson had also reviewed the hospital records, the maternal case and antenatal records of the first plaintiff.
- [29] He identifies several risk factors associated with the first plaintiff, not least of which that being her first pregnancy, she had unproven pelvic capacity and, given her relatively short stature, an increased risk of obstructive labour. As it turned out, the risk eventuated. The foetal head was not engaged into the pelvis at term which indicated cephalon-pelvic disproportion. In lay terms, this means simply that the capacity of the pelvis is inadequate to allow the foetus to negotiate the birth canal.
- [30] Unsurprisingly therefore, the first stage of labour was prolonged and, as Diedericks records, medical staff summoned the duty doctor to manage the labour process further. Caput (swelling of the presenting foetal head) was documented and blood noted in the first plaintiff's urine. Diedericks reports that this is caused by the foetal head pressing on the bladder when the pelvis is disproportionally small completed to the foetal head. Further, meconium-stained amniotic fluid was noted at 09h30 on 17 October 2020 which indicates foetal distress.
- [31] The treating doctor augmented the first plaintiff's contractions with oxytocin. This treatment is used to expedite births but it is contra-indicated where there are signs of foetal distress and disproportion present.
- [32] The use of oxytocin, Diedericks reports, forced the foetal head through the maternal pelvis causing massive intracranial haemorrhage the day after birth. He finds ultimately that, had the staff performed an emergency Caesarian section instead, which is the procedure indicated to prevent injuries and complications for any vaginal delivery, the intrapartum events that caused the baby's neurological damage could have been prevented.
- [33] Diedericks agrees with Basson's findings that the first stage of labour was mismanaged because the accepted guidelines[11] of the Department of Health, as it would appear from his report, were roundly ignored.
- [34] Quite aside from the requirement that medical professionals maintain meticulous documentary record of the process of labour, which the treating medical staff did not[12], the accepted guidelines require medical personnel, amongst other things, to monitor foetal blood pressure and heart rate hourly; urine tests every two hours and temperature readings every four hours.

- [35] The medical staff also did not timeously record, as required by the guidelines, their findings of maternal and foetal condition and the progress of labour on the Partogram[13]. The recording of the baby's condition was also only started more than 10 hours after the commencement of the active phase of labour.
- [36] In Diedericks' opinion, if the guidelines had been followed, and the progress of labour properly recorded, it would also have been evident that the first plaintiff's labour was not progressing as it should; that there was obstructive labour due to pelvic disproportion; that there were early signs of foetal distress; and that an emergency Caesarian section should have been performed for the safety of mother and baby, rather than forcing the foetal head through the maternal pelvis.
- [37] From the litany of failures, both Diedericks and Basson conclude that there was gross mismanagement of the first plaintiff's labour and that the care provided by the hospital was not in keeping with current standards of care. These failures caused the baby's death.
- [38] Dr PZ Mtsehana ('Mtsehana'), a paediatric neurologist, found that the baby displayed all the symptoms of Neonatal Encephalopathy ('NE') on day one of her life. He writes that NE is a general term that is used to define disease, malfunction or damage of the brain in the newborn. The major symptom of encephalopathy is an altered mental state or disturbed neurological function. He finds that the baby displayed all the signs of NE on the first day of life. She had signs of raised intracranial pressure that could have been caused by intracranial bleeding.
- [39] The occurrence of NE establishes the link between intrapartum asphyxia (oxygen deprivation to the brain) and later cerebral palsy[14]. However, Mtsehana reports that the baby only fulfilled 2/5 of the criteria necessary for a diagnosis of intrapartum asphyxia. He is unable to definitively find, in the absence of any neuroimaging records, an antenatal or intrapartum cause for the baby's later neurological damage and eventual death.
- [40] Dr Narropi Sewpershad ('Sewpershad'), a clinical psychologist, conducted a comprehensive clinical assessment of the plaintiffs to establish the clinical psychological effects on them of negligent treatment that they had received during the birth of their newborn and their baby's passing after barely a day of life.
- [41] Sewpershad also assessed the psychological effect on them of being given the wrong baby to bury. Having buried what they thought was their deceased newborn, the plaintiffs had to identify the corpse of their newborn after approximately two weeks in the hospital mortuary. The first plaintiff described to her in harrowing detail what she saw when viewing her baby's remains. The mental images that the first plaintiff has of her baby's lifeless body haunts her to this day.

[42] In her assessment of the plaintiffs, she finds that the first plaintiff displays severe symptoms associated with anxiety, somatoform disorder, depression and posttraumatic stress disorder ('PTSD'). The second plaintiff, while these were less severe in him, also displays symptoms associated with anxiety, depression and PTSD. These events are a result of the sudden loss of their newborn baby and the medical staff's mishandling of their deceased baby's remains. Sewpershad recommends that both undergo psychiatric assessment for appropriate psychiatric treatment.

Evaluation of the Defendant's Plea and Evidence

- [43] The defendant's plea amounted to a bare denial as it denied every aspect of negligence which the plaintiffs had alleged in their particulars of claim, without stating the material facts on which it was relying.
- [44] Contrary to its defensive position on the pleadings and during the pre-trial proceedings, the defendant ultimately tendered no evidence at the hearing and also called no witnesses. This strategy also perhaps explains why the defendant's counsel did not trouble herself to prepare heads of argument. Be that as it may, the expert medical evidence is not seriously disputed.
- [45] The expert evidence holds that the defendant had a duty to ensure that the first plaintiff and her baby received proper medical care and that the defendant did not discharge that duty.

Causation

- [46] It is trite that where the defendant has negligently breached a legal duty and the plaintiff has suffered harm, it must still be proved that the breach caused the harm suffered[15]. There are two aspects to consider on the issue of causation, namely factual and legal causation.
- [47] Factual causation is determined by the common sense *conditio sine qua non* test or, as commonly known, the 'but for' test. Simply put, one must make a hypothetical enquiry as to what would have

happened but for the wrongful conduct of the defendant[16].

- [48] The question in this case is then the following: was it more probable than not that the baby's death could have been avoided if the defendant's medical staff had followed the accepted guidelines and acted accordingly to avoid harm to the baby?

Evaluation of the Plaintiff's Evidence

- [49] The defendant does dispute that it owed the plaintiffs a duty of care. As the expert evidence of the medical professionals indicate, the treating medical personnel, almost without exception, did not perform that duty and their failure to do so ultimately caused the untimely death of the baby. This evidence stands uncontested.

[50] The emotional and psychological harm suffered by the plaintiffs as a result of the defendant's employees' negligence, and in mishandling the remains of the newborn, was not unforeseen. It follows naturally from that negligent conduct. The defendant is liable to compensate the plaintiffs for that harm[17].

[51] Had the defendant's medical staff acted as reasonable medical professionals in the circumstances, the baby would have been delivered by Caesarian section and not have suffered massive intracranial haemorrhage. Consequently, the 'but for' test in respect of factual causation has been proven. On a balance of probabilities[18], the evidence is, therefore that the negligence of the defendant is directly linked to the baby's death; Mtsehana's

non-definitive finding notwithstanding. The plaintiffs are not required to establish a causal link with certainty; only that the

wrongful conduct was probably a cause of the loss[19].

[52] The second enquiry of legal causation, namely whether the factual link[20] is strong enough and whether the harm is sufficiently connected to the negligent conduct, is also satisfied.

[53] For all these reasons, on an evaluation of the evidence, the plaintiffs established, on a balance of probabilities, that the death of their baby was caused by the negligent and wrongful failure of the defendant's medical staff, charged with the management of the first plaintiff's labour, to take steps that would have prevented the harm to the baby. They have also established, on that same basis, that they have suffered emotional and psychological harm as a result of the mishandling of their deceased baby's remains by the Hospital staff.

Order

[54] In the premises, it is ordered that:

(i) The defendant is liable for any damages that the parties may agree upon or that the plaintiffs may prove arising from the defendant's negligence.

(ii) The defendant is ordered to pay the plaintiffs' reasonable costs, including the costs of counsel, to be taxed on Scale A.

RR TITUS

ACTING JUDGE OF THE HIGH COURT

NORTH WEST DIVISION, MAHIKENG

[1] In terms of Uniform Rule 33(4)

[2] AN v MEC for Health, Eastern Cape [2019] ZASCA 102

[3] The test for negligence rests on two enquiries, namely reasonable foreseeability and the reasonable preventability of damage and failure to act accordingly.

- [4] See *Kruger v Coetzee* 1966(2) SA 428 (A) at 430 E-G; *Sea Harvest Corporation (Pty) Ltd and Another v Duncan Dock Cold Storage (Pty) Ltd and Another* [1999] ZASCA 87
- [5] *Oppelt v Department of Health, Western Cape* 2016 (1) SA 325 (CC) at para 106-108
- [6] *Supra*.
- [7] *Cecilia Goliath v Member of the Executive Council for Health, Eastern Cape* 2015 (2) SA 97 (SCA) at para 8
- [8]
- [2020] ZASCA 9
- [9] The South African Nursing Council (SANC) is the body entrusted to set and maintain standards of nursing education and practice in the Republic of South Africa. It is an autonomous, financially independent, statutory body, initially established by the Nursing Act, 1944 (Act No. 45 of 1944), and currently operating under the Nursing Act, 2005 (Act No. 33 of 2005).
- [10] The Apgar score is a scoring system doctors and nurses use to assess newborns after they're born. A score of 7 to 10, five minutes after birth, is reassuring, 4 to 7 is moderately abnormal, and 0 to 3 is concerning.
- [11] Department of Health RSA Guidelines for Maternity Care in South Africa 3 ed (2007)
- [12] Diedericks reports that there is no record of any cardiotocography ('CTG') tracings of foetal heartbeat and contractions
- despite the fact that it is a legal requirement for the Hospital to have it.
- [13] A composite graphical record of key data (maternal and foetal) during labour entered against time on a single sheet of paper.
- [14] A group of disorders caused by damage that occurs to the immature, developing brain, most often before birth.
- [15] *A N obo E N v Member of the Executive Council for Health, Eastern Cape* [2019] ZASCA 102; [2019] 4 All SA 1 (SCA) para 4
- [16] *Supra*, note 5
- [17] *Bester v Commercial Union Versekeringsmaatskappy van SA* 1973 (1) SA 769 (A)
- [18] See *Minister of Safety and Security v Van Duivenboden* 2002 (6) SA 431 (SCA), [2002] ZASCA at para 25
- [19] *Supra* 18, para [25]
- [20] See *International Shipping Company (Pty) Ltd v Bentley* [1990] 1 All SA 498 (A)

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