

SOUTH AFRICA / JUDGMENT

L.S.M obo O.M v Member of the Executive Council for Health North West Province (1362/2019) [2023] ZANWHC 185 (2 October 2023)

[2023] ZANWHC 185

COURT

North West High Court, Mafikeng

BEFORE

Reddy

CASE / FILE NUMBER

1362/2019

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Policy**IN THE HIGH COURT OF****SOUTH AFRICA****NORTHWEST DIVISION –****MAHIKENG****Case No: 1362/2019**

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In
the matter between:-
L[...]
S[...] M[...] obo
[O]
[M]
PLAINTIFF
and
MEMBER
OF THE EXECUTIVE COUNCIL
FOR
HEALTH NORTH WEST PROVINCE
DEFENDANT

JUDGMENT

REDDY AJ

Introduction

- [1] The plaintiff acting in her representative capacity on behalf of the minor child, herein referred to as OM, instituted a claim for delictual damages against the defendant (“the MEC”), as the employer of the nursing staff at the Mafikeng Provincial Hospital.
- [2] The plaintiff’s claim is brought against the MEC on the basis that the MEC is vicariously liable for the negligent conduct or omission of the employees of the MEC who attended to the plaintiff (and her then unborn child) after her admission and/or who attended to OM from the onset and during the labour of the plaintiff, and the eventual delivery of OM on 31 January 2014.

The claim

- [3] The plaintiff contends that the prolonged labour, a lack of attention and medical care as may be reasonably required in the circumstances, and/or the failure to perform a caesarean section to deliver OM, caused OM to suffer a hypoxic ischemic encephalopathy (HIE) insult due to perinatal asphyxia and or/hypoxia, causing OM to

sustain severe brain damage, as a result of which OM is permanently suffering from mixed cerebral palsy with spastic quadriplegia and mental retardation.

- [4] In the particulars of claim, the plaintiff pleaded that the MEC owed her and her unborn child, OM, a legal duty of care and failed in that duty by asserting inter alia, that:

“They failed to take any care and/or reasonable steps to ensure the proper timeous and professional assessment of the plaintiff, monitoring and management of labor and/or assistance during the plaintiff’s labor and the process after birth.

They failed to implement such steps as could and would reasonably be required to prevent the occurrence of the injury.

They failed to avoid the injury when by the exercise of reasonable care, skill, and diligence they could have done so.

They failed to monitor the plaintiff’s general progress of labor and her foetal well-being approximately with sufficient particularity, or at all.

Failed to perform or request the performance of accurate and /or proper cardiotocographic tracings (“CTG tracings”) of the foetal heart rate and maternal contractions, and/or by failing to recognize that the foetal heart pattern on the cardiotocograph was unsatisfactory and /or medically unstable.

Failed to monitor the foetal heart rate appropriately, timeously or with sufficient frequency and/or at all, thereby failing to detect that the minor was in foetal distress.

Failed to note and/or appreciate the significance of the lack of appropriate and/or timeous progress of the plaintiff’s labor.

Failed to maintain a proper or accurate partogram.

Failed to provide and/or render the adequate and/or appropriate, neo -natal resuscitation immediately after birth of the minor.

Failed to prevent the minor child from suffering a prolonged hypoxic ischemic encephalopathy incident causing the minor child to sustain severe brain damage, as a result of which the minor is suffering from mixed cerebral palsy with spastic quadriplegia and mental retardation when the exercise of reasonable skill care and diligence, it could and should have been prevented.”

The MEC’s plea

[5] In an amended plea, the MEC, pleading over on the merits, contends that all employees (staff and medical professionals) that were involved and who attended to the plaintiff pre- and post-birth, exercised all the reasonable care and skill required of them and so acted in accordance with the law. In essence the MEC disputes all the elements of delict, without stating the material facts upon which the MEC relies. This logically brought all the elements of delict into sharp focus, inclusive of wrongfulness, negligence, and causation.

The issues for

determination

- [6] The parties further agreed to a separation of the issues of liability and quantum, which this acceded to, therefore only the issue of liability is to be determined at this stage of the trial.

A chronology of the evidence

- [7] The following witnesses testified at the trial in the plaintiff's case.

- (i) The plaintiff, Ms. M[...]
- (ii) Professor Du Plessis (Nursing specialist)
- (iii) Dr Mantata-Cruwagen (Gynaecologist and Obstetrician)
- (iv) Dr Mogashoa (Paediatrician/Paediatric Neurologist)

- [8] The defendant called the following witnesses to testify at the trial:

- (i) Dr Dlangamandla- Mokoka (Radiologist)
- (ii) Dr Mbokota (Obstetrician/ Gynaecologist)

- [9] The expert reports and joint minutes (where applicable) filed of record by both parties were admitted as evidence at the trial, by agreement. The available hospital and medical reports relied on by the experts to formulate their respective opinions were similarly admitted as evidence. The expertise and experience of the experts who testified at trial is not in dispute and is accepted by this Court.

The joint minutes

- [10] Before turning to the background facts, it would be prudent to deal with the joint minutes of the respective experts, to provide context to the issues calling for determination. The joint report and evidence of Dr Manthata-Cruwagen for the plaintiff and Dr Mbokota for the defendant, which forms the fulcrum of the cases of the plaintiff and defendant, will be elucidated later.

The Joint Minute of the Paediatric Neurologists: DR VR Mogashoa (plaintiff) and DR K Rammego (defendant) dated 16 February 2022

- [11] In their joint minute, there is consensus between the paediatric neurologists on the following:

“(i) The radiologists reported an MRI pattern in keeping with the acute profound hypoxia in a temp brain, this pattern is in keeping with the clinical findings of dyskinetic cerebral palsy.

- (ii) Antenatal and intrapartum records were not available to both experts.

- (iii) OM was depressed at birth, he did not cry, and had poor reflexes, he was resuscitated, his airways suctioned, and oxygen was administered, the 1 minute Apgar score was 5/10, the Apgar score improved to 7/10 at 5 minutes according to clinical records.
- (iv) OM was encephalopathic in the neonatal period, he had features of moderate or stage II HIE, the same diagnosis was stated in the neonatal records.
- (v) It was agreed to defer to obstetricians for discussion on the management of the pregnancy and the labour and for the discussion on sentinel events.
- (vi) Blood results from the neonatal period were not suggestive of septicemia and the MRI pattern is not keeping with meningitis. We defer to radiologists for further discussion on the MRI findings.
- (vii) The clinical and/or radiological picture is not in keeping with structural abnormalities of the brain, metabolic disorders as well as a stroke.”
- [12] The paediatric neurologists, however, disagree in the following respects. Dr Mogashoa, contends that OM, has dyskinetic cerebral palsy GMFCS V, MACS, CFCS V, EDACS IV, whilst Dr Rammego opines that OM has mixed cerebral palsy, dyskinetic, GMFCS V, MACS V, CFCS V, EDACS IV.

The Joint Minute of the Radiologists: Dr Jogi, Dr Ranchod (plaintiff) and Dr Dlangamandla (defendant)

- [13] In the joint minute of the radiologists, there is consensus between the experts, with no issues of contention. They agree that the MRI scans are consistent with chronic sequelae secondary to profound hypoxic-ischemic injury, demonstrating a combination of acute and prolonged changes. There are no MRI features of structural genetic abnormalities. They further agree that viewing of the clinical and obstetrical records by the appropriate specialists in the fields of obstetrics and neonatology is essential in determining the cause of probable timing of this hypoxic-ischemic insult.

The Amended Joint Minutes of the Paediatricians- Dr Maponya and Dr Sanyane (dated 2 March 2022)

- [14] The paediatricians agree that OM has mixed type cerebral palsy with global developmental delay, epilepsy, mental impairment, malnutrition due to perinatal asphyxia with hypoxia ischemic encephalopathy. Premised on the hospital and medical records, they note that OM was born at 22h35 with an Apgar score of 5/10 which improved to 7/10 after resuscitation by the nursing sisters. The resuscitation rendered by the nurses to the baby did not produce maximal effect, hence the doctor was informed. They opine that doctors only get involved as per a nurse's request and the clinical records indicate that the doctor was informed at 22h55 and saw OM at 23h13.

The Amended Joint Minute of the Nursing Experts – Professor du Plessis (plaintiff) and Dr de Langen (defendant) dated 14 February 2022)

- [15] In the joint minute of the nursing experts, there is consensus, with no issues of contention. They agree that the plaintiff (Ms. M[...]) started antenatal clinic attendance early in pregnancy and attended without default. The pregnancy was uncomplicated and proceeded to term, according to the clinical notes. The midwives at the clinic delivered substandard care. This is evidenced by the incomplete antenatal card as well as the lack of a comprehensive initial assessment, which should include a complete history of all factors that could potentially influence the outcomes of the pregnancy, inclusive of a vaginal examination and physical assessment. The antenatal card was virtually blank.
- [16] The experts note that the plaintiff was booked for induction of labour and that sub-standard care was provided by the midwives during the induction of labour. The experts motivate this opinion as follows:
- (i) The lack of assessments during the latent phase of labour evidenced by a blank observation chart.
 - (ii) Lack of continuous monitoring of fetal wellbeing and frequency and intensity of uterine contractions during induction of labour.
 - (iii) Failure to perform an initial labour assessment which is necessary to establish a baseline for assessment, identify complications and plan actions during the whole labour.
 - (iv) Lack of writing progress reports. The assessments were not done nor documented, indicating that the progress of labour was unmonitored.
 - (v) Failure to execute an instruction for assessment of foetal well-being by means of an NST (as documented by the doctor), contrary to Regulation 387 and 2488, which stipulates that the midwife must execute a program of treatment, as prescribed by a medical practitioner.
 - (vi) Failure to inform a doctor that his prescription was not executed, when the doctor is under the expectation that it would be done.
 - (vii) An NST was not performed after the second insertion of Cytotec, again, directly not executing a program of treatment as instructed by a medical practitioner.
 - (viii) Uterine hypercontractility and foetal distress could have developed unnoticed due to the second dose of Cytotec.
- [17] The experts note that at 18h00 the latent phase of labour had commenced. At 19h30 the partograph, which had previously not copied, was started. The foetal heart rate (FHR) was documented ½ hourly on the partograph and according to the plotting, remained normal and without suspicion. Despite the second stage of labour being only 5 minutes, the baby was born asphyxiated, in contrast with the documented normal FHR at the onset of the second stage. The Apgar

score at 1 minute appears to be lower than 5/10. The nursing experts defer to the paediatricians to comment in this regard.

[18] The experts note that the midwives failed to document the progress of labour, especially during the active phase of labour, as per protocol. The plotting of information on the partograph must be accompanied by detailed progress reports. These were not written, and pages were left blank. Some assessments were plotted on the partograph. According to the partograph, the FHR remained normal until the second stage of labour commenced, and no decelerations occurred. It was further noted that it was uncommon for a midwife to plot assessments on a partograph but omit the progress report. Lack of accurate documentation of the progress of labour is regarded as sub-standard care.

[19] Furthermore, the observations immediately after birth were not done, as the page was also left blank. It is not within the scope of the expert midwife to comment on the authenticity of the partograph. The management and care of the newborn baby after discharge falls within the scope of the paediatrician.

The viva voce evidence

The plaintiff

[20] The evidence of the plaintiff, where necessary, is summarized with reference to accepted medical terminology, to align with the evidence of the experts. The plaintiff started antenatal clinic attendance early in her pregnancy and attended same without any default. Her pregnancy was uncomplicated and proceeded to term.

[21] On 30 January 2014, the plaintiff arrived at Mahikeng Provincial Hospital, which has a clinic section. At the clinic section, she intended to confirm the date of delivery. The doctor on duty requested that an appointment for an ultrasound be made. An appointment for 5 February 2014 was secured for the ultrasound. The records however indicated that the plaintiff was due for delivery on 30 January 2014. A doctor instructed that labour be induced as the plaintiff was at full term. The plaintiff agreed. Hospital admission protocol followed, resulting in the admission of the plaintiff in the maternity ward. Labour was to be induced the following day, 31 January 2014.

[22] The plaintiff upon admission on 30 January 2014 in the maternity ward went to sleep. At approximately 09h00 on 31 January 2014 labour was induced vaginally with a pill, which on the medical records is recorded as Cytotec. Continuous labour pains followed until approximately 19h00. A change of hospital staff resulted in another doctor being seized with the duty in the maternity ward. This doctor vaginally

administered a further dose of Cytotec and requested the plaintiff to remain on the bed for at least an hour for the Cytotec to take optimal effect. Routine checks by the changed nursing staff occurred. Whilst laying on the bed, the plaintiff experienced an urge to urinate, and before heeding the call of nature, more labour pains ensued.

[23] The continued labour pains was reported to a sister Rose. A student nurse, referred to as Neo, requested the plaintiff to return to her bed. The plaintiff informed Neo that the labour pains were severe, that she was unable to walk back to the bed due to the severity of the labour pains and that she required a wheelchair. Neo acquiesced and wheeled the plaintiff back to bed. A nurse referred to as Sister Sinah assisted the plaintiff to get back onto the bed.

[24] Sister Sinah proceeded to perform a vaginal examination of the plaintiff through the insertion of her fingers to establish the stage of dilation, upon which she remarked, “was still far.” Notwithstanding the intensifying labour pains, a request to be medicated was refused. As a result of the cries and disorientated

state of the plaintiff, Neo was requested to take the plaintiff outside because of the noise the plaintiff was causing.

[25] The plaintiff was, thereafter, moved to another ward. Neo remained with the plaintiff for a while. The plaintiff used a bedpan to relieve herself and verbalized that delivery was about to take place. The plaintiff, of her own volition, began bearing down through pushing movements. Sister Sinah was summonsed, and a joint effort ensued to assist with the delivery, with the plaintiff persisting in bearing down with the pushing. Sister Sinah, regarding the delivery, uttered “You see now you could have gone started back again. You see now the baby is coming out. The head is already protruding, the head of the baby.”

[26] At around 22h00 or past 22h00 delivery was complete. OM was not crying and was presenting with a pale blueish, greenish color. OM was then cleaned and put on the side; the plaintiff remained inside this room with Neo. Neo attended to the suturing of the vaginal tear of the plaintiff. The plaintiff noticed that OM was having fits. Ten to fifteen minutes later, a doctor arrived, who resuscitated OM, who began to cry at a low pitch. Between 23h00-00h00 a decision was made to admit OM at the Neonatal Intensive Care Unit (NICU). At 03h00, the plaintiff visited OM.

[27] Between 31 January and 8 February 2014, the plaintiff checked on OM. On 8 February 2014, the plaintiff was discharged with OM. No information was provided regarding any diagnosis of OM. Two weeks later, OM was taken for a checkup.

Professor du Plessis (nursing expert)

[28] Professor du Plessis had to compile several reports, the first of which was compiled in September 2019. The latter report was completed without any obstetric documents. The second report was completed on 20 September 2021 and upon discovery of the obstetric book (the partograph), a second amended report was necessitated and followed on 9 May 2022. A completed joint minute with Dr de Langen dated 16 May 2022 followed.

[29] Collectively, it was agreed that the midwives at the clinic delivered sub-standard care as evidence by an incomplete antenatal card. The antenatal card is a mother handheld one-page A4 document. It folds in thirds, best described as a “concertina”. The antenatal card contains vital information and must be completed at every antenatal visit. It includes vital

data amongst others, the medical obstetric social family history, blood testing as well as the results thereof, blood pressure, weight, any risk factors which could determine whether the patient could be managed by a midwife or needs to be overseen by a doctor. Any issues that are of concern to the mid-wife may also be recorded in an area designed for notes on the antenatal card. Given the importance of the antenatal card, it must be completed comprehensively on the first visit as the information

provided would form a baseline data for all future assessment.

- [30] At the back of the antenatal card there is a graph printed and on the same provision is made for the estimated date of delivery (“the EDD”). On the graph the growth of the womb or uterus is plotted. This is called the symphysis pubis foetal height measurement. Against this backdrop it was agreed that the baseline data was not completed. This resulted in an agreed finding that there was a “... lack of comprehensive initial assessment which should include a complete history of all factors that could potentially influence the outcomes of the pregnancy, a vaginal examination and physical assessment.”
- [31] Although risk factors were included in the antenatal card in this instance, the obstetric history of what happened in previous pregnancies, how was the delivery, were there any complications, what was the EDD, more particularly what was done on the first visit. The lack of the keeping of a comprehensive antenatal card was evidenced by the incomplete documentation of the data by an almost blank front page of the antenatal card.
- [32] It was agreed that there was sub-standard care during the induction of labour. The assessment of the standard of care is founded on the Department of Health in the form of National Guidelines. The National Guidelines are labelled Guidelines for Maternity Care. The objective of the Guidelines for Maternity Care was to address the issue of maternal and health care, caused by the high mortality rate. It served to standardize the care given at different levels of health care services.
- [33] Labour is divided into three stages. The first stage, which is medically defined as the latent phase, is where the cervix, the bottom part of the womb or uterus dilates from zero to ten centimeters. The assessment of the dilation is done by use of fingers, where the assessment of the opening is done. A cervix must be ten centimeters dilated for birth to occur. The second stage is the birth of the baby, and the third stage is the delivery of the placenta or after birth.
- [34] It was agreed that there was a lack of a continuously monitoring of the foetal wellbeing and the frequency and intensity of uterine contraction during labour. Further thereto, there was the lack of initial labour assessment which was essential to the establishment of a baseline assessment. There was also a lack of writing of progress reports.

- [35] To place these findings in proper perspective, during the latent phase the patient has not reached the dilation of four centimeters, the Guidelines for Maternity Care requires that the patient and the baby be assessed four hourly. This assessment requires a repetition of the entire process of checking amongst others, the blood pressure, pulse and do an internal examination to determine how far the dilation of the cervix is, as well as the foetal heartrate.
- [36] A mid-wife must ensure that not only does the cervix dilate, but that the foetal head is on the descent. Before the cervix reaches the dilation of four centimeters, it is recorded in the observation chart. After four centimeters the descent must be plotted. The strength of the contractions must be noted during the latent phase.
- [37] The reason for the latter, if the patient fails to progress to a dilation of four centimeters eight (8) hours after admission, then the latent phase is regarded as prolonged.
- [38] It was agreed that there was a “lack of executing an instruction for the assessment of foetal wellbeing by means of NTS. This is contrary to Regulation 387 at 24488 which stipulates that the midwife must execute a program of treatment as prescribed by a medical practitioner.”
- [39] Placing this in context, the point of departure was that the plaintiff was not in labour when she was admitted. The finding that the plaintiff was not in labour was founded on the absence of a trilogy of factors. Firstly, there were no contractions. Secondly there was no mucoid discharge. Thirdly, there was no cervix dilation. Regardless of this a decision was made to induce her. Resultantly, the doctor inserted the induction himself. An instruction was given that a NST be done. This requires the putting of two external transducers. The highest transducer monitors the presence of contractions. The lowest transducer picks up the foetal heart rate.
- [40] The medication that was used to induce labour has an unwanted side effect; this is hyper contractibility. In lay terms this means the womb contracts too fast, too much, too strong and for too long. Hyper contractibility is important because during the contraction the baby gets less oxygen. Consequently, contractions that are protracted and too strong place the baby under stress. A NST was not performed. There was no assessment between the time that the doctor inserted the inducing agent, Cytotec, at about 9h30 until the reassessment of the patient at 18h00. In essence, the latent phase observations were not plotted on the observation chart (this included the monitoring of the foetal heart rate by means of technology if available or the midwife

must listen to the foetal heartrate before, during and after the contraction by means of a fetoscope or doptone). The doctor noticed

that the NST was not done. Notwithstanding this, he inserts another dose Cytotec to continue with the inducing of labour. The midwife should have checked the foetal heartrate and the uterus to ensure the absence of hyper contractility. There were no documents to evidence same. A follow-up instruction was given that another NST be performed, this was not done.

- [41] When the second induction was inserted, the plaintiff was in the latent phase, with the cervix dilated at two centimeters, when checked by the doctor at 18h00. The foetal heart rate was documented half hourly on the partograph and according to the plotting, remained normal and without suspicion. Notwithstanding the latter, the second stage of labour was only five minutes. The baby was born asphyxiated in contrast with the documented normal foetal heart rate at the onset of the second stage.
- [42] On entering the active phase of labor, where the cervix is more than four centimeters dilated, all assessments are to be plotted on the partograph. The partograph was seemingly lost or not copied for many years and on the partograph that was produced in May 2022, this partograph had half hourly foetal heart rate monitoring. The cervical dilation was noted but did not mark the descent of the head in the pelvis.
- [43] In terms of the Maternity Guidelines, the foetal heart rate must be taken before, during and after a contraction. The second stage of labour was not plotted neither was the birth of OM plotted on the partograph, that must be written on the progress reports. Further thereto, no progress reports were written, none during the patent and active phases of labour. A midwife has no discretion to deviate from the Maternity Guidelines.

Dr Manthata-Cruywagen (Specialist Obstetrician and Gynaecologist)

- [44] According to Dr Manthata-Cruywagen, there are varied reasons for the induction of labour, the most prominent, is because of the mother's or unborn baby's health. Before the induction of labour, several medical factors must be considered amongst others you must assess, the mother to ensure that no harm is to be caused to the baby.
- [45] Therefore, if you induce labour without checking if the baby is distressing, you may harm the baby. It is imperative that before you induce labour, the foetal heart rate must be checked before you administer anything that may impact on the wellbeing of the baby. The ineluctable conclusion is that the administering of medication without ascertaining the baseline foetal heart rate is sub-standard as was with OM.
- [46] The inducing agent is a pill called misoprostol which is the generic name. It trades as Cytotec. Cytotec, although not registered for induction of labour, is used off the label for the termination of pregnancy and the induction of labour.
- [47] According to Dr Manthata-Cruywagen, the dosage that was administered to the plaintiff would cause hyper stimulation. The plaintiff was assessed vaginally, no foetal heart contractions during an intensity check was done. No intrapartum foetal monitoring was done as a result foetal distress was missed. As a result, the injury to OM was sustained intrapartum. As you cannot predict the outcome of the delivery, you need to monitor. Due to lack of contraction monitoring, there was hypoxia that was not observed. In sum, Dr Manthata-Cruywagen opined that this outcome could have been avoided if foetal heart rate monitoring was adequate. OM suffered periods of prolonged hypoxia where there was no timeous intervention because foetal heart rate monitoring was done in an inadequate and

sub-standard manner, that foetal distress was not checked for.

Doctor Mogashoa (Paediatrician and Paediatric Neurologist)

- [48] In the preparation of his report, OM's Road to Health Card, commonly referred to as the clinic card of the baby, antenatal records, any complete maternity case record, maternal records and the medical history of the plaintiff, an examination of OM and the radiologist report was considered. The radiologists agreed that "the MRI scans are consistent with chronic sequelae secondary to profound hypoxic ischemic injury demonstrating a combination of acute and prolonged changes." Dr Mogashoa is of the view that on physical examination of OM, the predominant clinical pattern was that of acute profound injury but does accept the findings of the radiologist that there is a mixed pattern of acute and partial prolonged ischemic.
- [49] In a state of hypoxia, it depends on whether it is sudden, or it is hypoxia over a prolonged period. On sensing that there is hypoxia, there is inadequate amounts of oxygen in the body, it will always attempt to preserve the most critical organ, which is the brain. When prolonged hypoxia occurs, the body reacts by shunting blood away from all the non-critical organs in the body. The non-critical organs will be all other organs, but for the brain. This self-preservation mechanism results in blood being diverted to the brain, for the brain to receive adequate oxygen. The brain is therefore fed at the expense of other organs. This is what occurs in a prolonged injury. In short, the body's compensatory mechanism comes into play.
- [50] In a partial prolonged hypoxia, the findings on a physical examination indicate spasticity, that is brisk reflexes.
- [51] An acute profound injury, which is a sudden loss of blood supply to the brain which circumvents the body's mechanisms from coming into play. This type of injury causes damage to the parts of the brain that are most metabolically active, which is the basal ganglia. The basal ganglia are responsible predominantly for the movement and other parts of the brain are the most metabolically active are responsible for functions such as breathing. In a child where there is an acute profound injury, because of the injury to the basal ganglia and the brain stem, the injury is characterized primarily by abnormal movements. Resultantly, a child will not be able to control movements and will have abnormal posturing accompanied by abnormal movements which is uncontrollable. For purposes of succinctness, an acute profound injury results in a specific injury. A partial prolonged injury would result in different injury.
- [52] A further type of injury would be where there is a mixed pattern. This would include both acute profound injury and partial prolonged injury as explained by the radiologists. The conclusion that OM is dyskinetic cerebral palsy, is in line with what was described as the acute profound injury. Further thereto, OM has a microcephaly (a small head), complications of brain injury and that would be uncontrolled epilepsy as well as intellectual disability. OM suffers from cerebral palsy and mental retardation due to negligence in the

management of the intrapartum period. This resulted in intrapartum hypoxia and cerebral palsy.

- [53] In the report, the criteria for neonatal encephalopathy secondary to intrapartum hypoxia is discussed. Neonatal encephalopathy is defined by the American Colleges of Obstetricians Criteria as:

“.. a clinically defined syndrome of disturbed neurologic functioning in the earliest days of life in an infant born at or beyond 35 weeks of gestation and this syndrome is manifested by subnormal level of consciousness or seizures and often accompanied by difficulty initiating and maintaining respiration.”

- [54] Whilst there are few causes of neonatal encephalopathy amongst others, neonatal meningitis and septicemia were excluded. OM was depressed at birth. His Apgar score was 5 and 7 at one and five minutes respectively. OM required resuscitation at birth. OM was encephalopathic in the neonatal period and he had features of HIE too.

- [55] Resultantly, on the issue of HIE, it did find application in respect of OM, as he did have features of HIE. A probable cause of OM having a stroke was clinically excluded, due to both sides of the body being affected and the absence of the MRI suggesting a stroke. Medications and the use of drugs by the plaintiff were excluded as a potential cause. OM's growth parameters were appropriate and consequently OM was not restricted at birth in terms of his growth.

- [56] Dealing with a sentinel event, Dr Mogashoa testified that:

“ a typical sentinel event according to the obstetricians would be something I like if the mother collapses suddenly or the mother just has a heart attack suddenly or if her blood pressure drops suddenly or obstetric issues would be things like a sudden bleed vaginally and in keeping maybe with a placenta previa or an abruption maybe the, the placenta suddenly separate. So, sudden things, but thought the, I, I said there was no sentinel event documented on the summary of labour form. However, I defer to the obstetricians and to discuss further on whether there was sentinel events or not.”

- [57] According to Dr Mogashoa, in situations where one looks at a baby depressed at birth, the management of the labour is not only to be carefully considered, but one must look at other factors, pre-pregnancy, as well as any neonatal factors.

- [58] Dr Mogashoa, opined that the delay between when OM was born and the hiatus of being seen by a doctor when OM was not breathing adequately, was not ideal as the aim of neo resuscitation is to restore cardiorespiratory function. If the cardiorespiratory function is not restored immediately, it means there is a continuation of the inadequate breathing which most probably worsens the hypoxia. Seizures immediately after birth are typical of newborns who have suffered hypoxia during labour. The latter is one of the signs that help differentiate between hypoxia as a cause of neonatal encephalopathy and other pathologies like disorders and strokes. HIE babies fit soon after birth. Further thereto the reason you need to re-establish breathing as soon as possible is, if the newborn is not breathing and enough oxygen is getting to the tissues, then even outside of the intrapartum period the

newborn is still hypoxic. Although what occurred during intrapartum is irreversible, one needs to avert the second wave of injury, by a treatment of these newborns timeously and restoring the oxygenation.

- [59] Whilst Dr Mogashoa conceded that there is an element of subjectivity in the recording of the Apgar scoring, she opines that it is advisable for this reason, that two people do the Apgar score and confirm same. What, however, is indisputable is that it is improbable that a baby cannot be breathing but crying. For this reason, she opines that concerns are raised regarding the Apgar scores of OM. Having said this, though, it is unlikely that OM had an Apgar score of seven (7) at five (5) minutes.
- [60] Dr Mogashoa agreed with the findings of Dr Rammego, insofar as Dr Rammego found an additional spasticity, a factor which she had not found. This finding elicited by Dr Rammego is further supported by the MRI.
- [61] According to Dr Mogashoa, the injury to OM occurred intrapartum, which was from the onset of labour until the delivery of the placenta. Whilst an acute profound injury occurs fifteen (15) to thirty (30) minutes before the delivery, when one assesses the cause of intrapartum hypoxia, focus should not be exclusively on the intrapartum period but also proximal and distal factors.

The evidence for the defendant

Dr Dlangamandla-Mokoka (Radiologist): Date of report 3 July 2020

- [62] The evidence of Dr Dlangamandla-Mokoka, was superfluous given her admission in cross-examination, that she was not resiling from agreed findings in the joint minute. In fact, all the expert did was re-affirm the content of the joint minute.

Dr Meshack Mbokota (Obstetrician/Gynaecologist): Updated report 19 May 2022

- [63] To provide some context to the report of Dr Mbokota, at the genesis of his evidence he self-corrected certain paragraphs of same. These corrections formed the main contentions of Mr Moretlwe for the rejection of the entire report of Dr Mbokota and are deserving of capturing verbatim. The corrections by Dr Mbokota, are best illustrated with reference to the transcribed record:

DR MBOKOTA: And then the final report is page 101 to page 126. It is dated 19 May 2022.

MS SHIVE-NKOSI: Okay. So, doctor you confirm that that is your most updated report to which you then take through the court.

DR MBOKOTA: That is correct M'Lord.

MS SHIVE-NKOSI: Thank you doctor. Doctor so when compiling this report what documents if there are any that you took into consideration?

DR MBOKOTA: M'Lord the reason why there are so many versions of the report it is because there was new information coming in continually and on the last one, the one dated the 19 May the documents that I used were basically the clinical notes that were provided with[indistinct] to health card. There were new partograms and then there was a maternity case record that was there and I had interviewed the plaintiff around the 30 June

2020. So, just to make some I would call cosmetic corrections but I guess it would depend on how the Court sees them. There are some typos that I need to correct on the report first before I start so that it does not delay us as we go along. So, on paragraph 6 it is page 110, 6.1.1, I say a report of Doctor Kamolane concludes that the child suffered from an acute profound hypoxic injury. The error there is that it should say Dr Ndlangamandla.

MS SHIVE-NKOSI: Doctor before you proceed to the next typo error could you please possibly contextualize for the Court as to how this typo error could have possibly occurred?

DR MBOKOTA: Okay, what usually happens M'Lord I do a number of reports and there are certain radiologists that we normally deal with and so on writing this report in my head I thought I was dealing with and so on writing this report in my head I thought I was reading Dr Kamolane's report only to later when I saw this is the report of Dr Ndlangamandla. But I have worked mainly with Dr Kamolane on the majority of the cases.

MS SHIVE-NKOSI: You may proceed to the next

DR MBOKOTA: And the ...[intervenes]

COURT: But is it material to your report?

DR MBOKOTA: No, it just changes his name but the type of injury as mentioned is the same as what Dr Ndlangamandla has written in her report. Then in paragraph 7.8.4 I would request that we remove that paragraph because it does not belong to this report.

MR MORETLWE: Sorry, to interject which paragraph doctor?

DR MBOKOTA: 7.8.4. page 121

MR MORETLWE: Thank you.

DR MBOKOTA: And the last one is 7.10.3.3

MS SHIVE-NKOSI: What page is that doctor?

DR MBOKOTA: Page 124, Again, that statement does not belong to, so the type of injury there does not belong to this report. So, you just remove the entire paragraph.

MS SHIVE-NKOSI: Doctor...[intervenes]

COURT: What does the paragraph that you want to remove read?

DR MBOKOTA: It reads as follows:

“Neuro imaging evidence of acute brain injury seen on brain or magnetic resonance spectroscopy consistent with hypoxia ischemia and then it says MRI finding suggestive of chronic hypoxic-ischemic injury and or chronic perirolandic encephalopathy.”

Now this is basically a section which is mainly dealt with by the paediatric neurologist in determining whether there was intrapartum hypoxia and in this case there it starts with the MRI findings. Those MRI findings are not, do not belong to the report.

COURT: So where did it come from now?

DR MBOKOTA: No, as I said when I did this report I had, I was looking at an MRI report which I initially I thought was of Dr Kamolane and that comes from there.

COURT: But how did that paragraph if any influence your conclusion?

DR MBOKOTA: It does not.

COURT: Did you take that into account in the drafting of your report?

DR MBOKOTA: Yes

COURT: That particular paragraph?

DR MBOKOTA: No, in the drafting of the report, that is in my conclusion in the report that did not come into account.

COURT: Thank you.

MS SHIVE-NKOSI: Doctor I just want to look at the question that the Court has asked you on the previous error at 7.8.4. the paragraph that you just asked the Court to remove.

DR MBOKOTA: Yes.

MS SHIVE-NKOSI: Does that one have an effect on your conclusion?

DR MBOKOTA: No. No it has got no effect.

MS SHIVE-NKOSI: Okay. Like you said it does not belong in this report.

DR MBOKOTA: It does not belong there.

MS SHIVE-NKOSI: Okay. So, those are the errors? We are done?

DR MBOKOTA: Ja, I think when we deal with the joint minutes there is just one that refers to Dr Kamolane that we will deal with.

MS SHIVE- NKOSI: Oh okay. Thank you doctor. Doctor moving on now back to the report having removed the errors could you please take us through your report possibly step by step in terms of how that [indistinct] to your conclusions.”

- [64] Dr Mbokota subsequently testified as follows. The plaintiff was thirty-one (31) years old in 2014 and was pregnant for the third time in 2014. When attendance at antenatal care commenced, she was thirty
- (30) years old. She was uncertain of her dates, and that was important as the dates determine the date of delivery. On the antenatal card it was noted that there was almost a four-week discrepancy between the plaintiff's dates and the clinical findings. The gestational age, the age of the plaintiff's pregnancy, was determined clinically rather than on dates.
- [65] At around 14 January 2014, the plaintiff was thirty-three weeks of gestation by symphysis fundal height and thirty-six weeks by date. It was established that she had a profuse white vaginal discharge. This is described as a vaginal discharge syndrome. It was treated using a combination of antibiotics for what is termed syndromic management. The latter course of treatment was preferred over collecting a swab for laboratory analysis, as this is disadvantageous in terms of time.
- [66] Resultantly, syndromic management has been devised over the years with vaginal discharges and other sexually transmitted diseases, the vaginal discharge is examined to identify the common bacteria distinguishing between pregnant and non- pregnant women then prescribing the combination of antibiotics. With this approach, treatment is affected earlier rather than later, intercepting any harm that may happen. The plaintiff was requested to return on 11 February 2014, where she would then be forty weeks by dates and thirty-six weeks by symphysis fundal height.
- [67] On 30 January 2014, the plaintiff proceeded to go and check her due date. She was assessed by a doctor and found to be at term by clinical palpation with a NST being reactive. Quintessentially, reactive means that the foetal heart was normal. The plaintiff was required to return the following day for the induction of labour.
- [68] However, on 30 January 2014 at about 13h00, she was assessed and found not to be in labour. Induction of labour was to take place on 31 January 2014.
- [69] On the morning of 31 January 2014, at 5h50 the plaintiff was assessed. Her blood pressure was found to be 150/88 with a pulse of
111. Three hours later the cervix, the mouth of the womb was assessed. This is termed the Bishop Score; the Bishop Score will assist in finding if the cervix is favourable or unfavourable to the inducing of labour. It was found that the cervix was unfavourable. A quarter tablet, Cytotec was inserted vaginally. The doctor ordered that an electronic foetal heart rate monitor be done an hour after and if not in labour after six hours Cytotec would be repeated.
- [70] There is a gap between 8h10 and 18h21, when she assessed again. It was noted the foetal heart rate monitoring was not done after the insertion of Cytotec at 8h10, however the plaintiff was clinically stable. The vaginal examination exhibited that the cervix was still two centimetres long and had a show. A show is one of the first signs indicative of labour. It is a

combination of mucus and blood that gets passed and indicates that labour is about to commence. A quarter Cytotec was repeated by the doctor. At 20h20, the blood pressure was assessed to be 156/72, with a pulse of 80.

- [71] Foetal heart rate monitoring commenced at 19h30. When the plaintiff was assessed between 19h30 and 20h00 in the 30-minute segment, the foetal heart rate of 130 to 140 beats per minute was noted. This indicates that the foetus was in a good condition. It can then be deduced that if there had been an abnormality that had occurred prior, that would show with an abnormality in the foetal heart rate condition. As a result, the fact that there was no recording of foetal heart rate condition between 8h10 and 18h20, at 19h30 the foetal heart rate confirms that the foetal condition was adequate prior to that. The presence of clear amniotic fluid provided the assurance that there was no period of hypoxia during labour. There was an absence of meconium (a stool passed as a response to stress or to an intrauterine infection). As a collective, clear amniotic fluid and the absence of meconium is suggestive of a normal foetal condition.
- [72] Dealing with the partogram, it contained certain essential information, amongst others, the name and age of the patient. There were no risk factors identified and the pelvis adequate. An overview of the partogram confirms that the monitoring of the foetal heart rate was largely normal. There was no evidence of foetal distress, neither was there any evidence suggesting a delay in the labour in the first stage and the second stage of labour.
- [73] In dealing with the recording of the foetal heart rate which commenced at 19h30 Dr Mbokota testified as follows:

“Okay, M’ Lord I did mention earlier on that between 10 past eight in the morning when they put the first quarter of Cytotec and 18:21 when they put in the second quarter tablet of Cytotec there was no record of monitoring of either the mother or the baby. Now normally what happens when you induce a patient before they go into labour you would monitor fetal condition, meaning the fetal heart condition, at least every two hours until she goes into labour. And the progress of labour means the dilatation of the cervix you would monitor that every four hours until she goes into active labour. So, in this case we do not have record of what the fetal heart rate was between 10 past eight in the morning and 18:21 when the second dose of Cytotec was given.....

Yes, so when she was assessed at 19, between 19h30 and 20h00 in the 30-minute segment the fetal heart rate of 130 to 140 beats per minute after contraction with no decelerations indicates that the fetus was in good condition. Therefore, we can then, normally we then deduce from there that if there was any abnormality in the fetal heartrate condition at that time if there was any abnormality it would have occurred prior to that. So, in summary despite the fact that there is no recording of fetal heartrate condition between 10 past eight and 20 past six in the afternoon, in the evening. That 19h30 fetal heartrate assures us that the fetal condition was adequate prior to that.”

- [74] Cytotec does have side effects. The most common of which is uterine hyperstimulation. Given the timelines, between the insertion of the Cytotec and the fact that the plaintiff was not in labour, there were no contractions, therefore uterine hyperstimulation did not occur.
- [75] The plaintiff was fully dilated at 22h30 and she delivered at 22h35. The second stage of labour was just five minutes. The foetal heart rate was present, with no delivery complications recorded. According to Dr Mbokota OM was born with no injuries as an alive male weighing 2.6 kilograms. OM was resuscitated with a suctioning Ambu bag and Nar Chem to make OM active again. Nar Chem is administered to reverse the side effects of opioids. (Opioids is medication used for pain relief during labour, which may result in the baby being a little sleepy).
- [76] The duration of the first stage of labour was four hours and thirty minutes from 18h00 to 22h30. The second stage was five minutes from 22h30 to 22h35. The third stage was two minutes from 22h35 to 22h37. The third stage is the delivery of the placenta. The placenta was delivered complete with membranes. There was no recto placental clot. The presence of a recto placenta clot suggests that there may have been what is termed a premature separation of the placenta (abruptio placentae.) When an abruptio placentae occurs, it then qualifies to what is called a sentinel event, because it cannot be predicted or foreseen.
- [77] On the first examination of the neonate, OM had a fast respiratory rate, he was grunting, with the absence of a cry, basically meaning OM did not cry immediately after birth. The Apgar score was measured to be 5/10 in one minute and 7/10 in five minutes. The weight of OM was 2.6 kilograms. At 23:13 the doctor notes:
- (i) Day naught, male baby.
 - (ii) Normal vaginal delivery.
 - (iii) Baby resuscitated with moderate effort.
 - (iv) Oxygen on nasal prongs pink with respiratory distress, central nervous system, hypotonic, fisting but fontanelle is no more tensive. In essence, mild respiratory distress.
 - (v) Congenital pneumonia was queried.
- [78] OM was admitted to neonatal and started on antibiotics to prevent and treat convulsions. OM's vitals were to be monitored three hourly, to nurse and do blood tests. A fit chart was to be kept. Both OM and the plaintiff were admitted for eight days because OM was weak.
- [79] Mahikeng Provincial Hospital is what is identified as a level 2 hospital and would have specialists. Therefore, the Guidelines for Maternity Care would not be applicable. This does not exonerate the duty of care that servants of the defendant are espoused with. The presence of a specialist results with the specialist being enjoined with a discretion depending on his/her experience to decide the method of treatment that should be given to the patient.

- [80] The plaintiff was diagnosed with vaginal discharge syndrome on 14 January 2014 and treated with a combination of antibiotics. Swabs were not taken as syndromic management was adopted. This entails that the patient is started on a combination of three antibiotics. Swabs are not routinely taken; it is not recommended. The only time that it is indorsed is when a patient who has had recurring miscarriages or premature labours, who may have also lost pregnancies. Dr Mbokota summarizes as follows:

“Thank you. So, in a nutshell my view is that the impact, the possible impact of Group B strep cannot be ignored in this case. That it may have contributed to the outcome of the baby and the details and the impact of that is usually explained by the neurologist because they are the ones who will look after the baby and tell us if the congenital pneumonia was there if it was there once it is called congenital it means it was acquired in utero.”

- [81] On admission of OM to the neonatal unit he was suspected of having congenital pneumonia and possible birth asphyxia. Induction of labour is the artificial initiation of labour before its spontaneous onset to help achieve vaginal delivery within 24 to 48 hours. Prior to the induction of labour, a mother must be carefully examined to confirm the gestational age and presentation. The Bishop Score must be assessed and the preinduction CTG must be performed.
- [82] Regarding the plaintiff, her Bishop Score was found to be unfavourable. The cervix was found to be 2 centimetres long and closed, meaning that it was unfavourable and needed to be ripened.
- [83] A quarter (50 micrograms) of Cytotec (or Misoprostol) was inserted as alluded to. To avoid confusion, I make use of misoprostol as per Dr Mbokota’s evidence. This inducing agent has not been registered by the manufacturer for use in pregnant women at all.

“Misoprostol has been widely used for obstetric and gynaecological indications such as induction of labour. Misoprostol itself is a prostaglandin E1 analogue and has been approved and marketed for prevention and treatment of gastric ulcers which are associated with the use of what you call nonsteroidal inflammatory. It has been found to be effective in ripening the cervix and induction of labour and though we say it is used “off label” it has been widely adopted and used around the world and approved by the World Health Organisation. The reason why it is approved it is because it is inexpensive, it is easily stored at room temperature and has a few systemic side effects. Systemic side effects meaning side effects where it is applied, outside where it is administered and the one common systemic side effect that it causes is diarrhoea and in others it just raises the temperature of the patient.”

- [84] The doctors in casu, chose to use misoprostol, starting with 50 micrograms and 10 hours later followed with another 50 micrograms, instead of the normal 6-hour repeat. The dosages that were used were within acceptable limits. The plaintiff went into labour after the second dose of misoprostol. Misoprostol was inserted at 8h10 according to Dr Mbokota. There is no record in clinical notes of the foetal condition being assessed prior to the insertion except the foetal heartrate of 136 beats per minute that was recorded at 13h00 the previous day. This was sub-standard. A cardiotocography (CTG) was ordered by the doctor to

have been performed an hour after the insertion of misoprostol. The clinical notes at 18h21 confirm that the CTG was not performed. Again, this was sub-standard. Another dose of misoprostol was inserted as the plaintiff was not in labour. The foetal condition was assessed an hour later at 19h30 as per the partogram and it was found to be normal without any uterine hyperstimulation. From this point onward foetal monitoring was done as per expected norms and standards.

- [85] In respect of Hypoxic Ischemic Encephalopathy, Dr Mbokota testified that hypoxia means reduced oxygen to the brain, ischemia means reduced blood flow to the brain. There are two recognized patterns of injury. The first pattern is called acute profound injury (Basal Ganglia-Thalamic injury). This involves the central part of the brain which is the life sustaining part of the brain. It is the part of the of the brain that controls the vital organs, the heart, and the adrenal glands. This injury usually follows events where there is a sudden and complete cessation of blood flow to the brain for a period of less than 10 minutes or permanently. When this happens, the entire brain is exposed to total or near shutdown. The foetus has insufficient time to compensate as there is no blood flow and all the brain is deprived of oxygen.
- [86] The partial prolonged injury involves what is called a watershed area of the brain and generally called the cortex and the subcortical white matter. This occurs when you have a gradual decrease in the blood and oxygen supply to the brain. The brain shuns blood away from the outer part of the brain to the more life sustaining parts which is the Basal Ganglia to keep those alive so that the baby remains alive. When this occurs, you get this pattern of partial prolonged injury and when the baby is born, the baby is obviously hypoxic. Later, the baby develops cerebral palsy which is typical of what is a

partial prolonged injury.

- [87] In respect of Mixed Pattern of acute profound and partial prolonged, Dr Mbokota testified that there are instances where you would encounter a mixture of acute profound and partial prolonged, and one may predominate over the other. Radiologist would perform an MRI scan, study it, and describe the type of injury. Dr Mbokota concludes as follows regarding his expert opinion:

“So, just in summary then of the report was that she was admitted for induction of labour. She was induced with misoprostol, and which was inserted 10 hours apart. She went into labour after the second dose of the induction agent. Both the first and second stage of labour were not delayed. The second stage of labour only needed an episiotomy assistance to be completed. The baby was delivered requiring moderate resuscitation by the doctor and was admitted to the neonatal unit for eight days. The neonatal admission notes suggest that the differential diagnosis included congenital pneumonia, birth asphyxia and mild respiratory distress syndrome. Fetal and labour monitoring when the induction agent misoprostol was first administered was substandard as it is not recorded in the clinical notes. This did not impact on the outcome. Subsequent management of the induction of labour was according to standards. There was no identifiable intrapartum event that could have resulted in the current condition of the child. Meaning that there was no identifiable event during the labour that, in

the notes that show that there was any evidence of hypoxia during labour that

could have resulted in this outcome. So, that is the, and then it is said there is no evidence of fetal distress and compromise during the labour process, there is no evidence of uterine tachysystole or hyperstimulation during the labour. There is however a suspicion that the baby had congenital pneumonia with mild respiratory distress which may be the actual cause of the current condition of the baby. So that is my summary M'Lord."

- [88] Regarding the labour and delivery on 31 January 2014, no maternity records were provided. Therefore, all the information was provided by the plaintiff. On 31 January 2014, around 9h00, labour was induced by the insertion of an inducing agent into her vagina. The doctor indicated that if around 16h00 if she was not in labour a second dose of the inducing agent would be inserted. Labour had not commenced between 9h00 to 19h00. During this time hospital staff were assessing foetal condition with CTG, which was done at least on three occasions.
- [89] At 19h00 another tablet was inserted into her vagina to induce labour, as labour had not yet commenced. The plaintiff was requested to sit for an hour for the tablet to dissolve. At 21h00, she started to experience contractions, the nursing staff requested that she return to her bed. A student nurse came to her assistance. A request for pain relief by the plaintiff was declined as it would delay labour. She was assisted with the use of a bed pan to pass a stool. Immediately thereafter she felt that she was about to deliver.
- [90] Regarding the second stage of labour, the plaintiff started to bear down for at least five (5) minutes, as she was struggling another nursing sister was called to come and assist. An episiotomy was performed, and delivery of the baby occurred. OM did not cry immediately as he was "weak". OM was attended to by midwives while another was attending to the suturing of the episiotomy. Whilst being sutured, she noticed that OM seemed to be having convulsions or jerky movements. A doctor was called and on arrival, he started to resuscitate OM and after a while OM cried with a tiny voice. At around 23h00, OM was admitted to the neonatal unit. The RTHC shows that the Apgar scores of OM was 5/10 and 7/10 in 1 and 5 minutes respectively.
- [91] Regarding post-delivery treatment, there is no underscoring the need to keep clinical records. In the case of OM, the only notes available were the RTHC, neonatal admission notes and referral letters to the local clinic and the South African Social Agency. There were no clinical records that pertain to antenatal care labour and delivery.
- [92] In addressing his findings, Dr Mbokota, opined that the first and second stages of labour were not delayed. The second stage of labour only needed episiotomy assistance to be completed. OM was delivered requiring moderate resuscitation by the doctor and was admitted to the neonatal unit for 8 days. The neonatal notes suggest that the differential diagnosis included congenital pneumonia, birth asphyxia and mild respiratory distress syndrome. Foetal and labour monitoring when the induction agent was first administered was sub-standard. As it is not recorded in the clinical notes, this did not have an impact on

the outcome. Subsequent management of the IOL and labour was according to standards. There was no identifiable intrapartum event that could have resulted in the current condition of OM. There is no evidence of foetal distress and compromise during the labour process. There is no evidence of uterine hyperstimulation during labour. There is however, a suspicion that OM had congenital pneumonia with mild respiratory distress which may be the actual cause of the current condition of OM.

Submissions on behalf of the plaintiff

- [93] Mr Moretlwe for the plaintiff submitted that the evidence of the plaintiff and the plaintiff's expert witnesses have proved on a balance of probabilities a clear case of negligence. The sub-standard care administered to the plaintiff is beyond question. The insertion of the inducing agent Cytotec was not administered in terms of generally accepted medical practice. It was further contended that Cytotec causes uterine hyperstimulation.
- [94] The foetal heart rate was not monitored. To dismiss the failure to monitor the foetal heart rate, the defendant relies on an inaccurate partogram and medical records. The defendant's failure to keep proper medical reports was bemoaned by experts and same hampered the expert's ability to express an opinion on certain relevant aspects. There was no explanation for the whereabouts of the CTG tracings which would have shed light on the foetal heart rate. Mr. Moretlwe opined that had the defendant monitored the foetal heart rate, employees of the defendant would have been able to intervene timeously. This would have resulted in the averting of the injury that had occurred.
- [95] The defendant's case is based entirely on the evidence of Dr Mbokota, who in the view of the plaintiff based his reports and findings on incorrect and irrelevant facts. The evidence of Dr Mbokota is that the injury occurred intrapartum and could not be avoided because it was a sentinel event. It was contended by the plaintiff that reference to a sentinel event by Dr Mbokota, is purely an attempt to assist the defendant to avoid liability. The latter, so the contention ran, is at odds with the role of an expert witness. That being trite, Dr Mbokota was criticized for basing his conclusions on speculation.
- [96] Mr. Moretlwe contended that the failure by the defendant to monitor the foetal heart rate is intrinsically linked to the injury that OM suffered, as reinforced by the evidence presented in the plaintiff's case. Reliance for all these contentions was reinforced with reference to the test for factual causation in *AN v MEC for Health, EC supra* and *NVM obo VKM v Tembisa Hospital and Another* (2022) CC at 11, paragraph [86], where the following was stated:

"However, 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."

[97] Within the four corners of the present action, it was submitted that anything that could have increased the risk that OM could be at risk would be sufficient to establish causation. Resultantly, by failing to monitor the foetal heart rate, the defendant denied itself an opportunity to detect warning signs of intrapartum hypoxia.

Submissions on behalf of the defendant

[98] Mrs. Shive-Nkosi contended that a defence had been made in the pleadings and the plaintiff's contention that no negligence can be attributed to the employees of the defendant.

[99] In respect of the partogram, it is submitted that by the plaintiff's own admission, the accuracy of the contents and authenticity of the partogram was admitted. This is then the end of the enquiry regarding the partogram. The partogram was completed based on the records and assessments done on the plaintiff. The information in the partogram is therefore not based on speculation. It is founded on all the material information extracted from the initial labour assessment form. The information appears only in the partogram "as not in the initial labour assessment form to avoid double recording as there is hardly time for that."

[100] The information that was elicited from the plaintiff on 30 January 2014 on admission, which included the assessment and elimination of risk factors was transferred to the partogram. The information is only recorded in the partogram to avoid duplicity of recording, given the absence of time.

[101] In respect of the absence of a CTG, Dr Mbokota, explained that the CTG is not the only instrument that can be used to measure the foetal heart rate. This includes a handheld dobbler or a foetal stethoscope. It is not peremptory to use a CTG. Mrs. Shiva-Nkosi for the defendant underlined that the Professor Du Plessis confirmed the alternative practices to the

monitoring of the foetal heart rate does exist.

[102] Regarding, sub-standard care, two instances were conceded to by the defendant. These are delineated as follows in the defendant's written heads:

"21. On 31 January 2014 at 8h10 in the morning, before vaginal insertion of 50 mcg Cytotec pill into the plaintiff to induce labour, there was no CTG done on her, and even an hour later after inserting the pill it was still not done despite an instruction to do so by the doctor.

22. Secondly another doctor came at 18h21 and realized that the plaintiff was still not in labour, and he inserted another dose of 50 mcg Cytotec without doing the CTG, then he gave instruction to do NST after an hour."

[103] Regardless of the afore concessions, the defendant maintains that the lack of the foetal heart rate monitoring or not doing the NST earlier did not cause nor result to any foetal distress. Had foetal distress occurred it would have been detected when foetal heart rate

monitoring commenced at 19h30 until 22h35 when the plaintiff gave birth. Further, there was no uterine hyperstimulation. Uterine hyperstimulation is basically five strong contractions which lasts more than forty seconds at every ten-minute segment. Herein, there exists no such recording, what is recorded is a maximum of four strong contractions in a space of ten minutes, consequently this eliminates uterine hyperstimulation.

The law

[104] It is commonly recognized that an actionable wrong or delict has five elements or requirements, namely;

- (a) the commission or omission of an act (actus reus), (b) which is unlawful or wrongful (wrongfulness), (c) committed negligently or with a particular intent (culpa or fault) (d) which results in or causes the harm (causation) and (e) the suffering of injury, loss or damage (harm). These are separate and distinct components of the same delict, each having its own requirements and test. The case under consideration falls under delict, and the five elements referred to above must be established by the plaintiff to succeed in her claim.

[105] The proper approach for the establishing the existence or otherwise of negligence was formulated by Holmes JA in *Kruger v Coetzee* 1966 (2) SA 428(A) at 430 E-F where the following was said:

“For the purposes of liability culpa arises if-

- (a) A diligens paterfamilias in the position of the defendant-
- (i) Would have foreseen the reasonable possibility of his conduct injuring another in his person or 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.

..... Whether a diligens paterfamilias in the position of the person concerned would take any guarding steps at all and, if so, what steps would be reasonable must always depend upon the particular circumstances of each case. No hard and fast basis can be laid down.”

[106] In *AN v MEC for Health, Eastern Cape* (585/2018)

(2019) ZASCA at 102, the test for causation was stated as follows:

“The test for factual causation is whether the act of omission of the defendant has been proved to have caused or materially contributed to the harm suffered, Where the defendant has negligently breached a legal duty and the plaintiff has suffered harm, it must still be proved that the breach is what caused the harm suffered.”

[107] In *Minister of Safety and Security v Van Duivenboden* 2002 (6) SA 431 (SCA) at paragraph [25] the following was stated in respect of a causal link:

“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 loss, which calls for a sensible retrospective analysis of what could 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.”

[108] In *Minister of Finance and Others v Gore* NO 2007 (1) SA 111 (SCA) at paragraph [33] the application of the “but-for test” was clarified as follows:

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

Discussion

[109] It is not in dispute that the defendant had a duty of care to ensure that, the plaintiff received proper medical care and that defendant is vicariously liable for the acts or omissions of the hospital staff. It is also not in dispute that the plaintiff received sub-standard care. The sub-standard care is not isolated to only the failure to adequately monitor the plaintiff and OM, as the defendant sought to advance. I will return to this.

[110] As this action calls for an assessment of expert evidence, which the case for the defendant is predominantly founded, it would be prudent to restate certain trite principles as extrapolated from our case law. The functions of an expert witness were explained by the Supreme Court of Appeal (SCA) as follows in *McGregor and another v MEC Health, Western Cape: A M and another v MEC for Health, Western Cape* 2021

(3) SA 337 (SCA) at 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.”

[111] In *Michael and Another v Linksfield Park Clinic (Pty) Ltd and Another* [2002] 1 All SA 384 (SCA) para [36], the SCA 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. There is no underscoring that the role of an expert is an exceptional one, founded on the expert’s specialized knowledge,

which is not within the court's domain. An expert witness owes a special duty of impartiality and provide fair, objective, and unbiased assistance to the court.

- [112] An expert witness should remain objective notwithstanding being called by a party to testify in support of the latter's case. The principle of objectivity was adopted in the matter of *Stock v Stock* 1981
- (3) SA 1280 (A) and reaffirmed by the Supreme Court of Appeal (SCA) in the matter of *Jacobs and Another v Transnet Ltd t/a Metrorail and Another* 2015
- (1) SA 139 (SCA). In *Jacobs* at para [15] the following was stated:

"It is well established that an expert is required to assist the court, not the party for whom he or she testifies. Objectivity is the central prerequisite for his or her opinions. In assessing an expert's credibility an appellate court can test his or her underlying reasoning and is in no worse a position than a trial court in that respect. Diemont JA put it thus in Stock v Stock: "An expert . . . must be made to understand that he is there to assist the court. If he is to be helpful, he must be neutral. The evidence of such a witness is of little value where he, or she, is partisan and consistently asserts the cause of the party who calls him. I may add that when it comes to assessing the credibility of such a witness, this court can test his reasoning and is accordingly to that extent in as good a position as the trial court was."

- [113] The plaintiff's evidence, although not perfect is unassailable, as regards her factual account. The same rings true of the findings regarding the various joint minutes of the experts. It is trite that where experts agree on a matter of fact in a joint minute, the parties are bound by the agreement and may not, without more, deviate from the agreement, without proper explanation and the consideration of prejudice.

- [114] The viva voce evidence of the plaintiff's experts was founded on logical reasoning. When dealing with the evidence of experts in a field where medical certainty is virtually impossible, a court must determine whether, and to what extent their opinions advanced are founded on logical reasoning. The court must be satisfied that such opinion has a logical basis, in other words that the expert has considered comparative risks and benefits and has reached "a defensible conclusion." See *Michael & Another v Linksfeld Park Clinic (Pty) Ltd and Another* 2001(3) SA 1188 (SCA), paragraphs 36-37. An opinion expressed without logical foundation can be rejected. Having

carefully considered the totality of the evidence, I am of the view that plaintiff's experts evidence provided the most reasoned and cogent explanation of why an intrapartum brain injury was most likely.

- [115] I turn to the defendant's primary expert, Dr Mbokota. I must emphasise that it is not suggested that the Dr Mbokota was not a credible witness, rather he was an unreliable witness. There are conceptual differences between credibility and reliability, which should not be conflated. Credibility has to do with a witness's veracity. Reliability, on the other hand, concerns the accuracy of the witness' testimony. Any witness whose evidence on an

issue is not credible cannot give reliable evidence on the same point. Credibility, on the other hand, is not a proxy for reliability: a credible witness may give unreliable evidence. See *R v H C* 2009 ONCA 56; 241 C.C.C.(3d) 45 at paragraph [41], *R v Morrissey* 1995 CanLII 3498 (ONCA); 22 OR (3d) 514 at 52.

- [116] I have quoted *supra*, the self-corrections that was made to his amended report, which Dr Mbokota termed “cosmetic changes”. Dr Mbokota held the view that these corrections did not alter the substance of his report, but the lack of care goes to the heart of the purpose of an expert, which beyond any shadow of doubt, Dr Mbokota is. It is far-fetched to have expected Dr Mbokota to have conceded that the “cosmetic changes” varied the substance of his report, given the impact it would axiomatically have on the reliability of his evidence as an expert. To my mind, it casts a serious cloud of suspicion over the reliability of his report. In addition, Dr Mbokota conceded critically in cross examination that his report did not adequately address certain main contentions of the plaintiff’s experts.
- [117] Notwithstanding this, Dr Mbokota sought at every opportunity to defend the conduct of the employees of the defendant, instead of being neutral. Elementary concessions he intentionally rebuffed, which diminished his already faltering reliability.
- [118] The test for establishing negligence is commonplace, the concession by the defendant that there had been sub-standard care in the failure to properly monitor the plaintiff on 31 January 2014 and the failure to perform the NST is fanciful and is just the use of semantics in lieu of admitting the legal concept of negligence. Negligence rests on two primary pillars, namely, reasonable foreseeability and the reasonable preventability of damage and failure to act accordingly. What is or is not reasonably foreseeable in a particular case is a fact-bound enquiry. See: *Pitzer v Eskom* [2012] ZASCA 44 (SCA) para 24.
- [119] Professor Du Plessis in some depth emphasized in her evidence, the standards that were applicable in clinics, community health centres and district hospitals in South Africa at the time OM’s birth were those specified in the maternity guidelines, which emphasise the necessity to monitor a woman in labour. They set out the monitoring that is considered appropriate as well as the keeping of adequate hospital notes and records. It is clear from the maternity guidelines that certain steps need to be taken when labour is prolonged. These steps include frequent monitoring, especially to enable the hospital staff to identify foetal distress. Whilst Dr Mbokota may have had a contrary view, it is undeniable that the monitoring of the plaintiff and the condition of the foetus is infused in the duty of care that the staff of the MEC owed to the plaintiff and OM.
- [120] It is well-established that causation has two elements, namely: (i) factual causation, determined by applying the ‘but for’

test; and (ii) legal causation, which answers the question of whether the wrongful act is linked sufficiently closely to the harm suffered. If the harm is too remote, then there is no liability. See *International Shipping Company (Pty) Ltd v Bentley* [1990] 1 All SA 498 (A); 1990

- (1) SA 680 (A) at 700E-I. In *Za v Smith and Another*, at paragraph [15] Brand JA described the applicable test as follows:

‘The criterion applied by the court a quo for determining factual causation was the well-known but-for test as formulated, eg by

Corbett CJ in *International Shipping Co (Pty) Ltd v Bentley* 1990

- (1) SA 680 (A) at 700E-H. What it essentially lays down is the enquiry – in the case of an omission – as to whether, but for the defendant’s wrongful and negligent failure to take reasonable steps, the plaintiff’s loss would not have ensued. In this regard this court has said on more than one occasion that the application of the “but-for test” is not based on mathematics, pure science or philosophy. It is a matter of common sense, based on the practical way in which the minds of ordinary

people work, against the background of everyday-life experiences. In applying this common sense, practical test, a plaintiff therefore has to establish that it is more likely than not that, but for the defendant’s wrongful and negligent conduct, his or her harm would not have ensued. The plaintiff is not required to establish this causal link with certainty (see eg *Minister of Safety & Security v Van Duivenboden* 2002

- (6) SA 431 (SCA) para 25; *Minister of Finance v Gore* NO [2006] ZASCA 98; 2007

- (1) SA 111 (SCA) para 33. See also *Lee v Minister of Correctional Services* [2012] ZASCA 30; 2013

- (2) SA 144 (CC) para 41.)’

[121] To my mind the probabilities are clear. There is no underscoring that the

plaintiff’s labour required more careful monitoring than was performed. Maternal and foetal heartrate monitoring are critical. The accepted sub-standard of record keeping exacerbated same. The careful and consistent monitoring has a specific purpose, that is to indicate the foetal health. If there are indications of the foetal health being questionable prompt intervention is called for. On the admitted facts, the management of the plaintiff’s labour was negligent in that inadequate monitoring was carried out. In fact, it is uncontested that the bare minimum was not done.

[122] What follows is whether on the probabilities OM, would have been inflicted with “but for” the negligence attributable to the MEC’s staff. The experts for the plaintiffs have set out with logical reasoning which I accept, the cause of the brain injury. Dr Mbokota makes deductions which I do not accept as reliable, given my findings as regards the overall tenure of his evidence which is not corroborated by proper record keeping. I am alive to the fact that the partogram was admitted as correct. That to my mind does cure the absence of critical information on it. There is no record of the sentinel event that Dr Mbokota referred to. Further thereto, the CTG tracings that was relied upon could not be presented. No witnesses were called by the defendant, regarding the factual recordings on the obstetric records. Given corrections to his report as well as the failure to adequately address

concerns raised by the plaintiff's experts, diminished any evidential weight that could be attached to Dr Mbokota's report as well as his evidence.

[123] What sticks out on the probabilities, had the foetal condition been adequately monitored an "intrapartum hypoxic insult" would be noted. It is as alluded to, it is common cause that there was a failure to monitor foetal heart rate continuously as is reasonably required. To my mind, had the foetal heart rate been monitored, foetal distress could have been detected timeously and the necessary medical steps would have been implemented. This would have had the logical step of having ensured that the stable condition of OM was maintained for a natural birth to reach its fruition. Consequently, on the balance of probabilities the failure to consistently monitor the foetal heartrate also resulted in the failure to take evasive medical steps to maintain a healthy foetal condition, which caused the brain injury. Therefore, there is a causal link between the negligence and the harm suffered.

[124] As regards costs, the general rule is that the successful party should be given his costs, and this rule should not be departed from except where there are good grounds for doing so. I can think of no reason why I should deviate from this general rule. Costs should therefore be awarded against the defendant in favour of the plaintiff.

Order

Resultantly, I make the following order: -

- (i) It is declared that the defendant is liable for 100% of the damages that are proven or agreed to be due to the plaintiff in her capacity as parent and natural guardian of her minor child OM arising from his brain injury.
- (ii) The defendant shall pay the plaintiff's costs of the determination of this issue relating to his liability.

A REDDY

ACTING JUDGE OF THE HIGH COURT,

NORTH WEST DIVISION, MAHIKENG

APPEARANCES

For the Applicant: Adv Moretlwe Attorneys for Applicant Semaushu Attorneys 29 Proctor Avenue Golfview Mahikeng For the Respondent: Adv Shibe Nkosi Attorneys for Respondent: State Attorney Megacity Complex East Gallery 3139 Sekame Road Mmabatho Date of hearing: 13 March 2023 Date of judgment: 02 October 2023 Revised: 10 October 2023

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