

SOUTH AFRICA / JUDGMENT

M obo M v Member of Executive Council for Health, Gauteng Province (15141/21) [2024] ZAGPJHC 1253 (29 November 2024) [2024] ZAGPJHC 1253

COURT

South Gauteng High Court, Johannesburg

BEFORE

Nkoenyane

CASE / FILE NUMBER

15141/21

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REPUBLIC OF SOUTH
AFRICA

IN THE HIGH COURT OF
SOUTH AFRICA

GAUTENG DIVISION,
JOHANNESBURG

CASE NO:15141 /21

(1)

REPORTABLE: NO

(2)

OF INTEREST TO OTHER JUDGES: NO

(3)

REVISED: NO

29

November 2024

In the matter between: M[...]
M[...] obo
M[...]
J
PLAINTIFF
and
THE
MEMBER OF THE EXECUTIVE COUNCIL
FOR
THE HEALTH, GAUTENG PROVINCE
DEFENDANT

Summary: Delict – claim for medical negligence damages –
minor born with brain injury sustained during birth – whether
hospital staff were negligent – if so, whether such negligence
caused the brain injury – evidence did not establish
that the
hospital staff were negligent.

JUDGMENT

NKOENYANE AJ

Introduction

[1] The central issue in this defended action is whether the defendant (‘the MEC’) is liable, in his official capacity as the person responsible for the actions of employees of Gauteng Provincial hospitals, for the brain injury sustained by the plaintiff’s minor child (‘the minor child’) before or during her birth at the Tambo Memorial Hospital (‘TMH’ or simply ‘the hospital’) on [...] December [...]. The minor child, who is at present ten years old, permanently suffers from cerebral palsy. The questions to be answered in this matter is whether that condition resulted from negligence on the part of the hospital and the nursing staff at the TMH and whether such negligence can be causally connected to the aforesaid developmental outcome in relation to the minor child.

The Parties

[2] The plaintiff is M[...] M[...], a major female who is presently unemployed, born on 2 February 1987, residing in Benoni, Gauteng Province. The Plaintiff acts herein in her representative capacity as the biological parent and natural guardian of her son, J, a disabled minor son born on 26 December 2014, who resides with the plaintiff at the aforesaid address.

[3] Defendant is The Member of the Executive Council for Health, Gauteng Province, who is sued in his official capacity as the defendant responsible for all claims arising against the Tambo Memorial Hospital, situated at 39 Railway Street, Plantation, Boksburg, Gauteng, being an institution established, funded and managed by the Gauteng Provincial

Administration, and who in terms of Section 2(2) of the State Liability Act, 20 of 1957, is the official who is responsible in law for act and/or omissions of persons in the employ of the Department of Health of the Gauteng Provincial Government, with its head office at 45 Commissioner Street, Johannesburg.

Issues

in dispute

- [4] It is alleged that Ms. M[...] endured prolonged periods of labour. It is further alleged that the failure to timeously perform caesarean section resulted in the foetus suffering a hypoxic-ischaemic injury due to perinatal asphyxia and/or hypoxia, caused the baby to sustain brain damage and as a result of which he is permanently suffering cerebral palsy.

Assessment of expert evidence

- [5] In the matter of A M and another v MEC Health, Western Cape[1] the following was explained for the use of expert witnesses. The court stated at paragraph 17 of the judgment:

‘...The functions of an expert witness are threefold. First, where they have themselves observed relevant facts that evidence will be evidence of fact and 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.’

- [6] Further the court went on to state that before an expert witness may be called it is necessary to deliver a summary of the witness’s opinions and the reasons therefore in terms of Uniform Rule 36 (9)(b). This court held in *Coopers*

- [2] that the summary must at least include:

‘... the facts or data on which the opinion is based. The facts or data would include those personally or directly known to or ascertained by the expert witness, e.g., from general scientific knowledge, experiments, or investigations conducted by him, or known to or ascertained by others of which he has been informed in order to formulate his opinions, e.g., experiments or investigations by others, or information from text-books, which are to be duly proved at the trial.’

- [7] In the same case, Wessels JA said:[3]

‘... an expert's opinion represents his reasoned conclusion based on certain facts or data, which are either common cause, or established by his own evidence or that of some other competent witness. Except possibly where it is not controverted, an expert's bald statement of his opinion is not of any real assistance. Proper evaluation of the opinion can only be undertaken if the process of reasoning which led to the conclusion, including the premises from which the reasoning proceeds, are disclosed by the expert.’

[8] As to the principles of assessing expert evidence, these have been espoused in a long line of cases. In MEC for Health and Social Development, Gauteng v MM on behalf of OM, it was said:

‘...The opinion must be properly motivated so that the court can arrive at its own view on the issue. Where the opinions of experts differ, the underlying reasoning of the various experts must be weighed by the court so as to choose which, if any, of the opinions to adopt and to what extent. The opinion of an expert does not bind a court...’[4]

The Experts

[7] The following experts were employed by the Plaintiff:

7.1. Midwife - Professor Nolte

7.2. Paediatrician

- Dr. Maponya

7.3. Radiologist - Dr. Kamolane

7.4. Gynaecologist- Dr. Mbokota

7.5. The following experts were employed by the Defendant:

7.6. Midwife - Dr. Harris

7.7. Paediatrician

- Dr. Kganane

7.8. Radiologist

- Dr. Dlangamandla

7.9. Gynaecologist

- Dr. Cruywagen

7.10. Neurologist - Dr. Mogashoa

Discussions and Analysis

- [8] Ms. M[...] - then 28 years old - was admitted to hospital on the 26th of December 2014 and was pregnant for the third time in 2014, and it was not disputed that she attended Ante-Natal Care (hereinafter referred to ANC). In the joint minutes of the Gynaecologists it was disagreed with regards to her ANC, in that the Defendant's raised the issue of use of antibiotics to treat vaginal discharge. Dr. Manthatha-Cruywagen contends that "the use of antibiotics and vaginal discharge in pregnancy are associated with adverse neonatal outcome. Vaginal infection in the antenatal period causes cerebral palsy".
- [9] Having considered the gynaecological experts reports regarding the use of antibiotics in pregnancy, there was no strong case presented which would be a definitive factor that the use of the antibiotics could cause the cerebral palsy.
- [10] In this matter, there was no conclusive evidence that suggested that the use of antibiotics could have contributed to the cerebral palsy.
- [11] The parties, as part of their bundle, referred the court to "Guidelines for Maternity Care in South Africa 2007"

(hereinafter referred to as GMCSA). This is a manual for clinics, community health centres and district hospitals. On page 51, the manual indicates that the presence of meconium-stained liquor Grade 3 (hereinafter referred to as MSL III) is not an indication to or even reason to perform caesarean section. It further states what is required if the MSL is associated with an increased risk of fetal distress.

- [12] Ms. M[....] was presented with MSL III at around 18h45. The medical records indicates that some of the correct and preventative procedures were taken and she was put on continuous Cardiotocography (hereinafter referred to as CTG).
- [13] Evidence was presented by the gynaecologists that early deceleration are considered as normal, if there is no fetal distress.

I will now turn to the medical records and follow the summarised sequence.

- [14] The medical records indicate that Ms. M[...] after admission at the hospital progressed in labour for nine hours

(9) and she was only 7cm dilated.

- [15] Summary of Medical Events:

15.1. 18:45: Membranes ruptured, Meconium-Stained Liquor (MSL) II diagnosed, cervix 7 cm dilated, fetal heart rate (FHR) 140 bpm.

15.2. Post-Amniotomy: Cardiotocography (CTG) showed FHR 150-160 bpm. Patient was pushing and uncooperative.

15.3. Doctor Notified.

15.4. 19:50: Doctor's notes indicate cervix 9 cm dilated, with early decelerations observed on CTG.

15.5. 20:00: Patient actively pushing with every contraction; on continuous CTG monitoring.

15.6. 20:15: CTG tracing was inadequate due to patient's pushing.

15.7. 20:30: CTG revealed early decelerations, obstructed labour diagnosed, and MSL III noted. Decision made to proceed with caesarean section.

15.8. 21:00: Patient wheeled to the theatre.

15.9. 21:05: Arrived in the theatre.

15.10. 21:15: Spinal induction performed; maternal hypotension recorded three times (BP 80/40).

15.11. 21:45: Baby delivered, with a 30-minute delay from the recorded blood pressure drop.

[16] This was Ms. M[...]’s first caesarean surgery. Dr. Manthahta-Cruywagen opines that the baby should have been delivered within 8 minutes post-induction. Instead, there was a 30-minute delay between the onset of maternal hypotension and delivery, as indicated in the medical records.

[17] In the trial and within the bundles, there is minimal documentation concerning the time spent in the theatre. From the

available records, it appears that once Ms. M[...] was in the theatre, there was an unexplained delay of 30 minutes. The only

potentially significant detail is a recorded blood pressure reading of 80/40, which may provide some critical insights.

[18] Dr. Manthatha- Cruywagen gave evidence that the presence of MSL III together with early deceleration is not an indication that caesarean section is required. She stated that the GMCSA, American Medical Association (hereinafter referred to as AMA) and International

Federation of Gynaecology and Obstetrics (hereinafter referred to as FIGO) teaches all medical practitioners.

[19] She gave further evidence on the process of tocolyses. I summarise her evidence in relation to the concept, tocolyses is a medical intervention in obstetrics aimed at delaying preterm labour by using specific medications called tocolytics. She further opined that there was no need to tocolyses.

[20] It became clear from the medical records and the evidence led in court that Ms. M[...] was attended to and given proper medical attention from admission until the events of between 18h45 and 19h45.

[21] Dr. Mbokota who testified on behalf of Ms. Mughada gave evidence and his opinion which can be summarised as follows: “Ms M[...] was pregnant for the 3rd time in 2020 and she did not have any identifiable ANC problems. She went into labour on the 26th December 2014 and presented to the maternity unit in the latent phase of labour. She progressed in labour and 9-hours after admission she was 7cm dilated and MSL III was diagnosed with fetal heart decelerations. Labour was allowed to progress at 18h45 despite these

signs of fetal distress and fetal acidosis. This was substandard because in presence of MSL III with fetal heart abnormalities, the only way prevent permanent harm to the baby, is by delivering via a c/section since she was only 7 cm at this time. At 20h30, which was 105 minutes later she is now diagnosed with obstructed labour and MSL III, a c/section is ordered, and the baby is delivered at 21h45.

Dr Mbokota further opines that this decision was correct but late as it was supposed to have been made at 18h45. The baby is delivered at 21h45 asphyxiated with APGAR score of 4/10, 7/10 and 10/10 in 1,5 and 10 minutes respectively ; the child was resuscitated and admitted to neonatal unit. He is of the opinion that the outcome could have been different if: decision for c/section was made at 18h45 , IPFR including tocolysis was implemented from 18h45. He further advances his opinion in that the child suffered a partial prolonged hypoxic ischaemic brain damage in the absence of a sentinel event, meaning that there was a gradual evolving fetal distress during labour and fetal decompensation and fetal heart failure occurred during the late 1st stage of labour resulting a temporary total lack of oxygen and blood supply to the brain which resulted in brain injury. The APGAR score of 4/10, and 7/10 indicates that severe hypoxia occurred in the 1st stage of labour. Finally he opines that this was a preventable outcome.

[22] It is trite that when the court considers an appropriate quantum, it would be guided by previous comparable cases. The court refers to the case of *M.N.K. and Another v M.E.C. for Health, Gauteng Province*,[5] where the mother, at 17 years old, gave birth to a child who had cerebral palsy, mental retardation, spastic quadriplegia,

microcephaly, severe developmental delay, permanent neuro-physical and intellectual impairment. The mother completed her schooling at a grade 12 level. She later completed a mining qualification and was employed at a mine as a winch operator. On her personal claim for general damages, she was awarded an amount of R350 000.

[23] In *Mngomeni (obo EN Zangwe) v M.E.C. for Health, Eastern Cape Province*,[6] the mother was awarded R300 000.00 for emotional shock and severe depression due to cerebral palsy of her child. In casu, both the plaintiff and the defendant seem to agree that an award in the amount of R400 000 will be fair and reasonable.

Conclusion

and Costs

- [24] The delivery of a child is a deeply complex and delicate process, uniquely designed by nature yet requiring the utmost care and vigilance from the medical team. Each case must be treated with individual attention, as some pregnancies present critical risks that demand heightened monitoring by both the midwife and the medical doctor. In such cases, the seamless collaboration of the maternity team becomes paramount to ensure the safe delivery of the baby.
- [25] In this instance, the medical evidence presented during the trial, supported by reports from various experts, underscores a delay in taking necessary corrective measures. It is evident that the decision to move the patient to the operating theatre should have been made between approximately 18h45 and 19h45. This critical delay, unfortunately, contributed to the circumstances leading to the baby's condition.
- [26] Furthermore, essential medical records from the theatre were incomplete, and an unaccounted delay of 30 minutes was identified.

This gap in documentation highlights the need for better communication and record-keeping within the team during such crucial moments.

- [27] With great compassion for the baby who suffered cerebral palsy as a result of these events, I find that there was negligence in the care provided. However, this negligence does not extend to the midwives. Damages will be apportioned accordingly, with a focus on addressing the profound impact on the child and their family, ensuring accountability and justice.
- [28] I note that there was no actuarial report submitted in support of the claim of twenty-one million two hundred and eighty thousand rands [R21 280,000.00].
- [29] It has become apparent from trial evidence that medical staff often adhere rigidly to the GMCSA guidelines, seemingly as a strategy to avoid medical liability. While the GMCSA serves as a useful framework, it is ultimately a guideline and not a substitute for professional judgment.
- [30] There is a pressing need for enhanced training of maternity staff to deepen their understanding of the complexities of delivery and empower them to apply their expertise in situations that may fall outside the guidelines.
- [31] I urge the MEC of Health in Gauteng Province to explore innovative and resource-efficient methods to strengthen this training. For instance, partnerships with retired nurses and medical doctors, who possess valuable experience, could offer cost-effective mentoring and training opportunities. While budgetary constraints may pose challenges, creative solutions such as incentivised volunteer programs or collaboration with academic institutions should be considered. The responsibility lies with the MEC's office to develop and implement effective strategies to address these critical gaps without compromising the quality of care.

Order

[32] The defendant is ordered to pay the plaintiff, on behalf of the minor child, the amount of R11 000,000.00 (eleven million rands) as payment in the full and final settlement of the claim instituted by the plaintiff on behalf of the minor, which payment is to be made within 90 days of the date of this order. I direct that a inter vivos trust be created in the name of the minor child and at least one independent trustee be appointed. Amongst the terms of the inter vivos trust it must be stipulated that the minor child must receive monthly allowance for their proper care and maintenance, that must not deplete the capital invested, if possible. The Trustees must use their fiduciary responsibilities to preserve the capital as much as possible.

[33] The said total is calculated as follows:

[33.1] Future medical expenses: R 7,000,000.00

[33.2] General damages suffered by Junior: R 2,000,000.00

[33.3] Loss of earning capacity: R2,000,000.00

[34] Insofar as the defendant fails to make the payment as prescribed in Order in paragraph 28 supra, the defendant is ordered to pay interest to the plaintiff on the aforesaid amount (less any payments made) at the prescribed interest rate per annum, a tempore mora, calculated from the 91st day after the date of the order to the date of final payment, both days included.

[35] The defendant shall pay the plaintiff's taxed or agreed costs of suit, on the High Court scale C, such costs to include the following:

[36] Insofar as not paid in terms of any previous order, the reasonable preparation costs of the following expert witnesses:

Midwife - Professor Nolte

Paediatrician - Dr. Maponya

Radiologist - Dr. Kamolane

Gynaecologist- Dr. Mbokota

[37] The costs attended upon the appointment of counsel, day fees for the trial period.

[38] The defendant shall pay interest on the plaintiff's taxed or agreed costs of suit at the prescribed statutory rate calculated from 45 (forty-five) days after agreement in respect thereof or from the date of affixing of the taxing master's allocatur to date of payment.

ME NKOENYANE

Acting Judge of the High Court of South Africa

Gauteng Division, Johannesburg

This judgment was handed down electronically by circulation to the parties' representatives via email. The date and time for hand-down

is deemed to be 15h00 on 29 November 2024.

Heard on:

Judgment

date: 22 August 2024 29 November 2024 For the Plaintiff: Instructed by: Adv D Brown Jerry Nkeli & Associates For the Defendant: Instructed by: Adv AM Masombuka The State Attorney, Johannesburg

[1] A M and Another v MEC for Health, Western Cape (1258/2018) [2020] ZASCA 89; 2021 (3) SA 337 (SCA) (31 July 2020)

[2] Coopers (South Africa) (Pty) Ltd v Deutsche Gesellschaft für Schädlingsbekämpfung MBH 1976

(3) SA 352 (A) at 371 A-H.

[3] AM and Another v MEC for Health, Western Cape (n 1 above) at 371F-H.

[4] (Case no 697/2020) [2021] ZASCA 128 (30 September 2021), paragraph 17; Buthelezi v Ndaba (575/2012) [2013] ZASCA 72 (29 May 2013), paragraph 14; AD and Another v MEC for Health and Social Development, Western Cape Provincial Government (27428/10)

[2016] ZAWCHC 116 (7 September 2016), paragraph 39.

[5] (9407/2017) [2022] ZAGPJHC 175 (25 March 2022).

[6] 2018 (7A4) QOD 94 (ECM).

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