

SOUTH AFRICA / JUDGMENT

M.M obo G.M v MEC for Department of Health North West Province (CIV APP FB 11/2021) [2022] ZANWHC 14 (4 April 2022)

[2022] ZANWHC 14

COURT

North West High Court, Mafikeng

BEFORE

Hendricks, Petersen, Snyman

CASE / FILE NUMBER

CIV APP FB 11/2021

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IN THE NORTH WEST HIGH

COURT, MAFIKENG

CASE NO: CIV APP FB

11/2021

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YES / NO

Circulate to Regional

Magistrates: YES / NO

In the matter between: M[....] M[....]
obo
G[....] M[....]
Appellant
and
MEC FOR DEPARTMENT OF
HEALTH
NORTH
WEST PROVINCE
Respondent
CORUM: HENDRICKS DJP
et PETERSEN J et SNYMAN J
DATE
OF HEARING
:
05 NOVEMBER 2021
DATE
OF JUDGMENT
:
04 APRIL 2022
FOR
THE APPELLANT
:
ADV. WESSELS SC
FOR
THE RESPONDENT
:
ADV. MOKOENA SC
with
ADV. CASSIM

JUDGMENT

Delivered: 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 10h00 on 04 APRIL 2022.

ORDER

Consequently, the following order is made:

- (i) The appeal is dismissed with costs.
- (ii) Such costs to include the costs consequent upon the employment of two counsel (senior and junior) and to be taxed on a party-and-party basis on the High Court scale.

HENDRICKS DJP

[1] Ms. M[....] M[....] was either 38 or 39 weeks pregnant when she attended at the Mogwase Health Centre (clinic) on 07 October 2010 and was diagnosed with hypertension. She was consequently referred to the Moses Kotane Hospital (MKH) for treatment. She was subsequently sent back to the midwifery unit and dispensed anti-hypertensive treatment. The process was repeated on 13 October 2010 when she was again referred to MKH by the clinic. She was admitted and on 14 October 2010 induced with Cytotec which was administered two-hourly on seven occasions, with the last being administered at 22h00 on 15 October 2010. She was monitored until 03h00 on 16 October 2010 when the nurse recorded that she showed signs of being in labour, with a foetal heartrate measuring 148. At 04h00 the doctor was summoned as she was bleeding. The doctor diagnosed that she suffered an abruption placentae with a loss of approximately one (1) liter of blood. No foetal heartrate was observed. Around 08h00 she was transferred to the Job Shimankana Tabane Hospital (JSTH) when an ultra sound was performed and no foetal heartbeat could be detected. Her membranes were ruptured and at approximately 11h10 she was fully dilated. At 11h20 she delivered her baby vaginally and G[....] (baby G) was born. However, he was diagnosed with cerebral palsy (CP) and microcephaly.

[2] She instituted an action for damages, both in her personal capacity as well as in a representative capacity for her son, baby G, against the MEC for Health North West Province. The claim was based on breach of an agreement alternatively a duty of care to examine, treat and care for her as well as baby G and to provide gynecological and obstetric services with due skill, competence and care reasonably expected of doctors and nursing staff. After a lengthy trial and the presentation of a plethora of expert evidence, the trial court per Gutta J, dismissed the claim with costs on 08 August 2019, finding that despite the negligent conduct of the medical staff, there was no

causal relationship between the breach of the duty to monitor, to detect a foetal heartbeat, to do an emergency caesarean section as well as causing her to deliver vaginally and the damage caused to baby G. The court a quo further found “This Court cannot infer that causal relationship from the evidence before me. Plaintiff [M[....] M[....]] failed to prove on objective facts, that defendant’s negligence caused the CP. The facts are that the abruptio, a sentinel event and an accident was the trigger and the cause for the damage to G[....]. I am of the view that, ‘but for’, defendant’s wrongful and negligent failure to take reasonable steps, plaintiff’s loss would still have ensued. In the circumstances, plaintiff failed to discharge the onus of proving that defendant’s negligence caused the CP.”

[3] Dissatisfied with the findings and order of the trial court, an application for leave to appeal was launched which was heard by Gura J on 09 October

2020. Leave to appeal was granted to the Full Court of this Division against the judgment of the trial court on causality. This order granting leave to appeal is premised on the following ratio decidendi by Gura J:

“[30] In this current matter, the evidence points out to a definite delay in performing a caesarean procedure on the plaintiff. It was only after she had lost consciousness that the medical staff realized that this is an emergency. It is my view that there is a reasonable possibility that another court would find that this delay is causality linked to the child's insult.”

Leave to appeal was therefore granted only against the causality finding.

- [4] In order to determine the issue of causality on appeal, an exposition of the expert medical evidence tendered must be considered, which the trial court embarked upon in a very detailed and well-reasoned judgment comprising 108 pages. In dealing with the evidence tendered and not to occasion any injustice thereto, I will only refer to the crucial evidence insofar as it is relevant to determine causality. I will also refer to the crucial parts of the evidence which has been aptly summarized by the trial court (Gutta J). Same may be regarded as incorporated in this judgment.
- [5] In order to establish liability in delict, a defendant's conduct must have been wrongful. This is a conclusion of law that a court draws from the facts before it. Wrongfulness is a distinct and separate enquiry for delictual liability and is a requirement distinctly separate from the negligence of the defendant's conduct. The wrongfulness issue is logically anterior to the fault enquiry and only when it is established that defendant acted wrongfully does the question arise whether the objectively wrongful conduct can be imputed to the defendant. Fault does not pre-suppose the existence of wrongfulness and is irrelevant unless wrongfulness is established. Otherwise stated, negligence is unlawful and actionable only if it occurs in circumstances that the law recognises as making it unlawful. In broad terms conduct is wrongful if it infringes a legally recognized right of the plaintiff or constitutes a breach of a legal duty owed by the defendant to the plaintiff.
- [6] The trial court per Gutta J concluded that the respondents' staff acted wrongfully. There was a legal duty of care which was breached. However, the question is not whether the respondent was at fault but whether it complied with the legal duty imposed. This is with regard to negligence. The Plaintiff in her pleadings alleges that, “the Plaintiff and the Defendant through the doctors and professional staff in 'defendants employ concluded an express, alternatively tacit agreement in terms of which the hospital through the doctors and other professional staff or nursing staff in its employ, undertook to examine, treat, care for and provide gynaecological and obstetric services to the Plaintiff and the minor with the skill, diligence, competence and care reasonably expected of doctors and nursing staff employed by a hospital” alternatively “the doctors and professional staff assumed a duty to the Plaintiff and the minor to provide professional medical services including examining, caring for and providing gynecological and obstetric services to the Plaintiff and the minor with the skill, competence, diligence and care reasonably expected of doctors and nurses employed by a hospital”. Plaintiff alleged further that, “As a result of breach of the agreement, alternatively negligent breach of duty of care, the minor is brain damaged and has cerebral palsy”.

- [7] The defendant in its plea alleged inter alia that, the medical practitioners exercised the necessary skills and diligence reasonably expected of them in their care and treatment of the plaintiff in accordance with the applicable and/or standing protocols. They denied any breach of contractual obligations, negligence and duty of care.
- [8] The enquiry as to whether the defendant (respondent) has contravened its duty is objective. The imposition of a legal duty depends on the particular circumstances of the case. In casu, defendant admitted to performing the skills and diligence reasonably expected of them and as the duty is recognized in law, it follows that a breach of that duty for the purposes of liability is wrongful. The existence of the legal duty (which is admitted) and its breach (the harm caused against the legal duty) would render defendant's conduct wrongful. The breach of that legal duty is implicit with the finding that harm was caused. Thus the question is not whether defendant was at fault but whether defendant complied with the legal duty imposed upon it.
- [9] As to negligence, the trial court concluded that there was insufficient monitoring of the appellant and the foetus and found that: "as plaintiff was not monitored from 22:00 on 15 October 2010 until 3:00 on 16 October 2010, I am of the view that the medical staff foresaw the reasonable possibility that by failing to monitor plaintiff and the foetus, it would cause harm to plaintiff and the foetus and they would have to take reasonable steps to guard against such harm, and they failed to take such steps. Accordingly defendant was negligent in failing to monitor both plaintiff and the foetus according to the standard protocol required after the last induction at 22:00 on 15 October
2010. Furthermore, that the respondent was negligent in not transforming the appellant to a level 2 hospital [JSTH] as soon as was reasonable and not performing a caesarean section. The medical staff at the MKH were not negligent in including the appellant, who had not reached 40 weeks, whose BMI was 38.85 and who had mild to moderate pregnancy induced hypertension." I align myself fully with this finding.
- [10] Section 3(1)(a) of the National Health Act, 2004 provides for access to health care services with what resources are available and is affordable. The existence of treatment guidelines and the categorisation of hospitals according to resource needs, is the practical manifestation of a limitation within the definition of a law of general application. In terms of the maternity case guidelines published in 2015, reference is only made to patients upward from a level 1 hospital if their BMI is 40 and above. From the evidence of Prof Adam, neither the maternity guidelines applicable at the time nor the current national guidelines contradict the induction of a patient presenting as plaintiff did at the time, from being treated in a level 1 hospital. The Court cannot ignore the 2012 Intrapartum guidelines which provides that level 1 hospitals such as the MKH is equipped to deal with the induction of hypertensive patients at 40 weeks and that in emergency and complex cases, patients would be referred to a level 2 hospital. In the circumstances, when considering the guidelines and protocols, I am of the view that the medical staff at the MKH were not negligent in inducing plaintiff who had not reached 40 weeks, whose BMI was 38.85 and who had mild to moderate

pregnancy induced hypertension. I am in full agreement with the finding of the trial court on this aspect.

- [11] Insofar as causation is concerned, the question for consideration is whether respondent's negligence as aforementioned, caused the CP. In other words, is there a nexus between the failure to monitor the appellant and foetus, the failure to detect a heartbeat, the delay in transferring the appellant to the JSTH for a caesarean section, causing her to deliver vaginally and the CP diagnosed. Put differently, 'but for' the respondent's wrongful and negligent conduct? The trial court concluded that the probabilities are that baby G's impairments are secondary to intrapartum hypoxia due to an acute profound hypoxia from a sentinel event, an abruptio and not in the last hours before birth and that the acute insult was not preceded by a partial prolonged insult. The opinions of Prof. Cooper, Prof Adam and Dr. Mogashoa were accepted by the trial court as it is based on scientific evidence. The trial court dealt extensively with the evidence tendered in this regard and I do not need to do the same in this judgment. Suffice to state that I fully agree with these findings.
- [12] The trial court concluded when considering the totality of evidence, that the probabilities are that G[....]'s impairments are secondary to intrapartum hypoxia due to an acute profound hypoxia from a sentinel event, abruptio placentae, which occurred at the time of the abruptio and not in the last hours before birth, and that the acute insult was not preceded by partial prolonged insult. The trial court accepted the opinions of Prof Cooper, Prof Adam and Dr. Mogashoa as their opinions are supported by scientific evidence set out more fully herein below, which I quote extensively from the judgment:

"(1) An abruptio placenta occurred according to Dr. Parvateneni and Sister Modikwe at 3:30 - 4:00 on 16 October. The abruptio placentae was significant in that Dr. Parvateneni noted that the blood loss was 1 litre and plaintiff's blood pressure dropped significantly. Prof Adam said in this case the acute insult occurred at 4:00 and plaintiff had the effect, namely the big bleed and there are no indications of late decelerations or even any decelerations before this happened. There is no clinical evidence that there was an abruption before 4:00. She said, "It was a big bleed that caused plaintiff's blood pressure to drop. As it was significant to the mother it was significant to the baby in the light of the MRI without any further effects or an effect of ongoing hypoxia and also the fact that there was no ongoing bleeding in the mother and in the light of the paediatric report. I would say that this was the sentinel event when looking at the MRI and the fact that plaintiff's pressure dropped significantly one can conclude that the sentinel event was a catastrophic event". Dr. Mogashoa and Prof Cooper corroborated Prof Adam and said when there is a sudden severe loss of blood there is also sudden severe loss of oxygen to the brain of the baby and that is the sentinel event. The sentinel event was accompanied by shock and plaintiff was resuscitated and received blood. Dr. Mogashoa said "in my view the damage to the baby occurred at the time of the blood loss with hypotension and this was the sentinel event that occurred. We know that there was a sentinel event. The abruption was significant enough to cause hypovolemic shock and according to ACOG sentinel events will result in acute profound insults as in this case". Prof Adam said you can have a partial abruptio which is so severe because of the bleeding and it causes the mother's blood pressure to drop significantly as in plaintiff's case. She said the acute profound is associated with a sudden catastrophic effect like an abruption. The FH recovers but the damage at that time was so

severe that the baby had damage to the brain.

- (2) The undisputed fact is that plaintiff lost approximately one litre of blood and was in shock. Prof Adam said, they gave plaintiff 3 units of FFP (Fresh Frozen Plasma) and 4 units of blood. Based on this she said the rupture was severe, 4 units of blood in 24 hours is almost a replacement of the blood volume and 5 units is a replacement. According to Dr. Mogashoa even though pregnant women have two litres more blood than non-pregnant women, a 1 litre loss is a significant loss and plaintiff had to be resuscitated with two drips. Plaintiff was resuscitated within half an hour and the blood pressure increased from 63/54 to 93/54 and 105/64 at 8:05. The haemoglobin was 9.1 before resuscitation, is regarded as normal.
- (3) Dr. Mogashoa explained that peripartum refers to the time of labour. It is the time from onset of labour to just after delivery. She said you need to look at everything in totality which includes the Apgar scores and the events that transpired. The Pasternak article says if there is an acute profound disaster close to the time of delivery the Apgar scores will be lower and the baby will be more depressed suggesting in this case that the insult was not very close to delivery. She said the Apgar score is a standardised form while the assessment of new born babies is just a physical examination that is ticked after the baby is born.
- (4) G[...]’s Apgar were 6 at one minute and 9 or 10 at five minutes. Dr. Mogashoa said that the Apgar score at five minutes was probably 7 or 8 and not 9 or 10. Both Dr. Mogashoa and Prof Cooper corroborated each other that the Apgar’s in the Pasternak samples were very low, namely 1 at one minute while in this case it was 6 at one minute which suggests that the damage to G[...] could not have occurred in the last hour. Dr. Mogashoa said G[...] cried a little so he was not really depressed. A cry is very important at birth, it is very reassuring. There is no reason to give a baby who cries an Apgar of less than 6. A cry is equivalent to an Apgar of 6. Dr. Wessels also said “the baby came out crying with not a good but not a bad Apgar. Babies with acute profound are born with a low Apgar.” A baby who is blue, pale and lifeless is not going to cry. If there was bradycardia of under 100, the Apgar would be less than 6. They assigned a 1 for respiration at one minute which is in her view correct. G[...] was depressed at birth but according to Pasternak study not so grossly depressed at birth to conclude that the acute profound event occurred in the last stage of labour. The Apgar’s were not indicative of a severe insult in the last hour.

Although this court accepts that the Apgar’s are not always reliable and accurate, I accept Dr. Mogashoa’s opinion that Apgar score remain helpful to determine what G[...]’s condition was at birth, the need for resuscitation and the response to resuscitation and as one goes on with the resuscitation, the lower the Apgar remains, the more likely the chance of morbidity. The American College of Obstetricians and Gynaecologists (ACOG) looks at the condition of the baby at birth and also refers to the Apgar scores. Dr. Mogashoa said ACOG helps one to conclude when the insult occurred. According to ACOG 2014 an Apgar score less than 5 at five and at ten minutes is supportive of intrapartum hypoxia. The article on Apgar scores by the American College of Obstetricians and Gynaecologists and American Academy of Paediatrics reads “the Apgar score provides an accepted and convenient method for reporting the status of the new born infant

immediately after birth and the response to resuscitation if needed. The Apgar score alone cannot be considered to be evidence of or a consequence of asphyxia, does not predict undivided neonatal mortality or neurological outcome and should not be used for that purpose". Accordingly I have taken the Apgar scores into consideration when viewing the evidence in totality.

- (5) Prof Cooper also corroborated Dr. Mogashoa evidence supra and said that it was highly unlikely that the acute profound damage occurred in the last hour before birth because of the Apgar score, the description of the amount of resuscitation that was required and the admission diagnosis which did not mention birth asphyxia. Prof Cooper said there must have been a severe insult on the foetus and the picture of acute profound injury on the MRI confirms this. He disagreed that plaintiff's description of G[...] after birth namely that he cried for a short moment, attempted to suckle for a short period and then made grunting noise was irreconcilable with Apgar score of 10. He said it is noted that there was grunting respiration. He said G[...] showed signs of respiratory distress and it is quite common for babies to have normal Apgar scores if they have pulmonary disease and show signs of respiratory distress. He said he does not think the signs of encephalopathy were there immediately after birth which you would expect if there had been an episode an hour before delivery. He reiterated that the only grunting respiration that was documented was respiratory distress. There was nothing about abnormal neurological signs at that stage. They developed presumably later. One cannot say with any confidence that the grunting respiration was due to acidosis. He acknowledged that Apgar scores are not always

accurately done but he said the score excludes a baby who requires cardiac compressions, prolonged assisted ventilation with bag and mask or tracking. He said whether the scores are out by 1 or 2 points is quite possible but it does not correspond to an Apgar score of 0 or 1 at one minute and less than 5 at five minutes. He was asked "you would not expect a baby with an Apgar score of 10 out of 10 to receive oxygen for 18 days". He said "I think you are talking about two different things. The first is to change the baby from intrauterine fluid environment to an extra uterine environment. This involves the Apgar score of 6 is not normal, it required suctioning and oxygen was given appropriately. The Apgar score of 9 or 10 is normal and did not require ongoing oxygen".

- (6) Prof Cooper also referred to the article by Pasternak supra which has a table listing 11 babies with amongst others, uterine rupture. In the first minute, the Apgar scores for 5 babies were two 1's and three 0, which is technically stillbirths. He said what one would expect in a preceding severe acute hypoxic ischemic episode are babies who require extensive resuscitation. If the heart rate is less than 60, they would commence with ventilation, cardiac massage. He said that the damage did not occur in the last hour before birth because resuscitation of G[...] was not extensive. What we know is that G[...] was given oxygen and that he was placed in an incubator on oxygen with a feeding tube. The nurse documented that he responded well to resuscitation. Counsel for plaintiff's submission that G[...] was in a bad condition before the resuscitation is in the

light of the foregoing evidence unfounded.

- (7) Prof Cooper said when looking at the notes, there was no obvious sign of neurological abnormality but subsequently there were and this is in keeping with an insult that occurred several hours earlier rather than an hour to delivery. The neurological symptoms are a baby that is not active, with poor tone. They test certain reflexes, primitive reflex for example a grasp reflex, a more reflex and the sucking reflex. Sucking is very important because it requires a certain integrity of the nervous system and the development of convulsions is very common. He said the Rennie study reviews the animal data and the human data and does not represent any of their own cases. He agreed with the Rennie study that the question whether G[....] was able to

recover depends on the extent of the brain damage.

- (8) Prof Cooper said the initial assessment was completed by a professional nurse who usually has extensive experience of baby's both at birth and in the early period after birth so he has no problem with her assessment. He said that with acute profound damage as found on the MRI, the baby would be dead after approximately 40 minutes if not delivered but in this case at 4:30, plaintiff's blood pressure partially recovered and fluid was given to plaintiff so if the condition of the mother improved the condition of the baby as supplied by the placenta would also improve. Because there was recovery to plaintiff's vital signs there would be recovery to the foetus as the baby was still alive. The baby will only die if the bradycardia continues without foetal improvement. Pasternak said the insult might occur in some cases prior to labour. So in this case there must have been some insult and there was recovery prior to labour.
- (9) Although counsel for plaintiff submitted that the Apgar's were not proved by calling the author and is accordingly not evidence before court, no objection was made during the trial proceeding and both parties referred to the Apgar scores. According to Volpe, it is inappropriate to use the Apgar score alone as it does not predict individual neonatal mortality or neurological outcomes. Prof Cooper submitted that the encephalopathy that occurred and the Pasternak study shows that 7 out of 11 babies had moderate encephalopathy after birth therefore placing G[....] who had moderate encephalopathy, within the category of injuries as found by Pasternak. This court cannot ignore the empirical evidence which clearly indicates much reduced Apgar scores in babies where the mothers experienced acute profound damage in the last hours. There is no evidence of good Apgar scores where the baby suffered the acute profound injury in the last hours before birth.

- (10) Dr. Wessels in his report said G[...] is suffering from a “clear picture of spastic quadriplegic cerebral palsy with mental retardation and microcephaly while” Dr. Mogashoa in her report said “G[...] has microcephaly, mixed cerebral palsy predominantly dystonic” Dr. Mogashoa opined that because of the predominance of dystonia that an acute profound abrupt insult occurred at the time when plaintiff needed resuscitation. This Court a quo accepts Dr. Mogashoa opinion for the following

reasons:

- Dr. Mogashoa is a paediatric neurologist and her field includes neonatal neurology while Dr. Wessels is a paediatrician. Dr. Mogashoa spent more time than Dr. Wessels looking at children with CP and was able to fine tune her skills. This is corroborated by Prof Cooper who said Dr. Wessels in his report said G[...] is suffering from a “clear picture of spastic quadriplegic cerebral palsy with mental retardation and microcephaly” while Doctor Mogashoa in her report said “G[...] has microcephaly, mixed cerebral palsy predominantly dystonic”. Prof Cooper deferred to a neurologist who differentiate the types of rigidity and can classify it as either being predominantly dystonic or spastic. Prof Cooper said he would accept Dr. Mogashoa's report as she is trained as a paediatric neurologist and this is her field of expertise. Dr. Mogcishoa said it is very easy for a clinician who does not do neurology every day to just label all four limb involvement as spastic quadriparesis. G[...] has involvement of all four limbs and she understood how Dr. Wessels could have made the mistake.
- Dr. Mogashoa provided the Court with a detailed explanation of the different types of CP. She conducted a physical examination of G[...] and she determined the type of CP G[...] has clinically, what the clinical findings were and whether the clinical findings fits with the history that was obtained and with the MRI.
- She admitted that she found indications of spastic quadriplegics but said it is not pure spastic quadriparesis. G[...] has got predominantly dystonia but he has variable tone and variable tone is more suggestive of dystonia than spasticity.
- Dr. Mogashoa said that although the acute profound supports the finding of dystonia and partial prolonged supports a finding of spasticity she reiterated that 'many patients who have purely dyskinetic CP or deep basal ganglia thalamic involvement also have motor sign involvement evidenced by spasticity.
- Dr. Wessels did not find any features of dystonia and his assessment is incomplete.
- Prof Cooper said the change in the clinical presentation is mainly in the first two years because the motor track is complete by 18 months to 2 years. There is not much change thereafter. There may be some changes but not a complete reversal of the findings. He said what is surprising is that Dr. Wessels didn't find dystonic CP and that should have been well established.

· The MRI findings according to both Dr. Ranchod and Dr. Tracey were features of acute profound hypoxia and there were no features of partial prolonged injury. Both Volpe and Rennie supra go into detail about the radiological signature. Dr. Mogashoa, Prof Adam and Prof Cooper accept the finding of the MRI. Dr. Mogashoa said one cannot downplay the role of MRI but one has to be aware of its pitfalls and its significance. She said the MRI has many issues and that is the reason why they work together with the radiologists to give them clinical information and they must interpret the MRI together with the clinical information. Dr. Wessels in his report also states that “A MRI investigation is a very sensitive tool to determine the cause of the neurological damage, and gives a very good indication of the timing and of the extent of the insult to the brain.”

· This Court has when considering the totality of evidence accepted the MRI findings which supports the clinical findings of predominately dystonia or dyskinetic CP. The radiologists agree that there was predominately basil ganglia involvement with the thalamic involvement and they speak of proththalmic involvements. And those are the hallmarks of acute profound insults to the brain. With a partial prolonged injury you get watershed injury. There are distinct and well described radiology patterns and there is no trace of any watershed injury. None of the radiologists’ allude to elements of partial prolonged injuries. (own emphasis) The radiological signature for partial prolonged and acute profound is well described and detailed. There is no evidence to gainsay the MRI picture coupled with the evidence of defendant’s experts supra.”

[13] Having analysed the evidence tendered, the trial court concluded that “the inference that plaintiff [appellant] asks the Court to draw is not the most apparent and acceptable inference. Plaintiff [appellant] has not proffered any factual evidence of the existence of a partial prolonged event or insult or injury. There are no objective

facts

from which to infer a partial prolonged insult. It is void of any factual basis. I am of the view that this is pure conjecture and speculation. When considering the totality of evidence the Pasternak study, defendant’s [respondent’s] expert opinions based on the clinical records and the radiologists MRI findings which is decisive, as well as Giotsimodimo’s Agpar scores, his condition at birth, namely, that he cried, he sucked and he did not require extensive resuscitation, then I am of the view that Goitsimodimo’s impairments are secondary to intrapartum hypoxia due to acute profound hypoxia from a sentinel even which occurred at or around 4:00 on 16 October 2010.” The appellant takes issue with these findings and the ultimate conclusion reached by the trial court.

[14] Adv. Wessels SC, on behalf of the appellant contended that there is no direct evidence of when exactly the damage occurred. An inference must be drawn from the facts and that there is indeed causality established. The plaintiff and the foetus were not monitored for a considerate period of time. The plaintiff gave natural birth to the baby some seven (7) hours later. If the plaintiff and the baby were closely monitored, the event would not have occurred as the birth process is a slowly developing process before the abruptio. The plaintiff was resuscitated within 30 minutes. The blood loss of 1 liter was not much and a caesarian

section could have been timeously performed. In any event, so the contention further goes, the abruption was partial and not complete. Based on a common sense approach, the damage was done up to the time when the baby was born. Based on the decision in the case of *Oppelt v Department of Health* 2016 (1) SA 325 (CC) case the plaintiff was entitled to sufficient emergency medical treatment in the form of a caesarean section. She should have been transported to the Rustenburg hospital where a caesarean section should have been performed as soon as the abruption occurred. This was not done.

- [15] Adv. Mokoena SC, on behalf of the respondent submitted first and foremost that in an appeal of this nature, the appellant is confined to the grounds of appeal and also the pleaded case during the trial. The appellant cannot augment her grounds of appeal in the heads of argument. The case at all material times was based on a partial prolonged abruption event. This appeal centers around causation and not negligence. Leave to appeal was granted on causality only. The issue of negligence is not alive and the appellant should not be allowed to re-argue the merits of the trial in its entirety. The issue of this appeal is very specific. Negligence should be distinguished from causation. There can be negligence but it may not be the cause of the ultimate resultant harm. The injury could be as a result or event beyond anyone's control, like an acute abruption that is totally unforeseen and unpreventable. The facts of this case as so aptly found and pronounced upon by the trial court, should not be disturbed insofar as causation is concerned.
- [16] The appellant initially, during the trial, relied on its expert reports, which included the radiologist, gynaecologist and paediatric reports which all pointed to the damage having been of an acute profound type (there is no reference to a partial prolonged pattern of injury in these experts' reports) and that the injury was associated with the abruptio placenta which is a separation between the placenta and the uterus. Abruptio may be partial or complete, and has varying degrees of severity. Whether an abruptio is complete or not and the degree of severity are distinct definitions and ought not to be conflated.
- [17] The reason why the appellant set out to reconstruct its case from what was originally set out in the expert reports, namely that the injury is of an acute-profound type, associated with the abruptio and to attempt to introduce a partial prolonged element in its case, lies in the judgments of two matters, the case of *A M obo K.M v The MEC for Health, Eastern Cape* (Case No. 726/14 delivered on 30/03/2017) ("the Eastern Cape case") in which Nhlangulela DJP delivered judgment in favour of the defendant and a second Eastern Cape matter, *AN v Member of the Executive Council Responsible for Health in the Eastern Cape Province* 2019 JDR 0313 (ECG) in which Dawood J handed down judgment on 19 February 2019, likewise in favour of the defendant.
- [18] Both these judgments involved claims for damages allegedly predicated on negligence of the personnel at the respective hospitals, resulting in the minors presenting with cerebral palsy. Both cases further feature MRI scans which illustrate the cause of the damage as an acute-profound pattern of damage. The Eastern Cape cases further involved the occurrence of a sentinel event, albeit of unknown origin, and the Court in those cases held that since a

sentinel event is an accident, that the lack of monitoring, which was alleged, was not the cause of the injury to the baby. Those cases therefore fell on the issue of the absence of causation.

- [19] The resemblance of the Eastern Cape cases to the facts in this matter is striking in that in both instances the plaintiff developed cerebral palsy from the advent of a sentinel event which occurred during the labour period. Both Eastern Cape matters were appealed to the SCA. The SCA, in majority judgments in both instances, dismissed the appeals and the judgments of the courts a quo were upheld. The Constitutional Court was approached to appeal the SCA judgment in the matter of AN v MEC for Health EC, which appeal was dismissed on 26 February 2020.
- [20] In an endeavor to avoid the pitfalls which led to the dismissal of the Eastern Cape judgments by the SCA, the appellant in this instance set out fervently to distinguish the present matter from the Eastern Cape cases through a process of reverse engineering of the appellant's case. That this was the case was a point correctly taken by Adv. Mokoena SC. The facts are unalterable and the appellant's endeavor to create the impression of nuanced facts (through a process of purported subtle differences on an interpretation of the facts) by steering this Court into a territory of conjecture, speculation and scientific obscurity cannot be overlooked and must be seen for what it is worth. The facts of this case are very clear and speak for themselves. The trial court pronounced on the issue of a partial prolonged insult and concluded that it was not the case in this matter. There was no evidence presented to form an opinion that baby G suffered a partial prolonged insult. Instead, it was proven that it was due to acute profound hypoxia from a sentinel event that occurred. The trial court's finding in this regard cannot be faulted and it puts paid to the contention based on speculation, that it was as a result of a partial prolonged insult or injury.
- [21] In the recent Constitutional Court judgment of NVM obo VKM v Tembisa Hospital and Another (CCT 202/20) [2022] ZACC 11 (25 March 2022), in an application for leave to appeal a finding that a negligent omission by the medical staff at Tembisa Hospital factually did not cause the applicant's baby to be born with cerebral palsy had to be considered. Essentially the contentious issue was factual causation. The majority judgment found that where the question was one of factual causation, section 7(2) (the duty to respect, protect, promote and fulfil the rights in the Bill of Rights) and section 27 (health care rights) of the Constitution, along with considerations of accountability and responsiveness, shed no light on the answer to that question. The majority further held that if section 27 was implicated in the matter, it would find application in every medical negligence case, in circumstances where the issues raised by the case were purely factual.

- [22] The majority further pointed out that difficult or borderline cases of factual causation could manifest itself in any action for delictual or contractual damages, whilst factual causation in medical negligence cases is often straightforward. Very importantly it found that the application of an established test to particular facts is not a question of law. The majority consequently ordered that leave to appeal be refused.
- [23] In the present matter the issue of causation on which leave to appeal was granted is a purely factual issue which is straightforward. In this regard the court a quo per Gutta J correctly identified and dealt with the factual issue very succinctly.
- [24] On the eve of the hearing of this appeal, supplementary heads of argument were filed on behalf of the appellant by Adv. Wessels SC in which it was submitted that paragraph 5.4 of appellants' heads be amended by deleting the last sentence and authority of *Wright v Mediclinic Ltd 2007 (4) SA 325 (CPD)* and replacing it with the following:

"It would still be material and the defendant would be liable for such damage."

See: *Wilsher v Essex Areas Health Authority* [1987] UKHL 11; [1988] AC 1074 (HL) [1988], All ER 871 AC.

Furthermore, reference to *Wright v Mediclinic* in paragraph 57 must be replaced with *Vallaro N.O and Another v MEC for Health and Social Development* Appeal case no A 5009/16, Gautheng Division, Johannesburg. A copy of the *Vallaro* case is attached to the supplementary heads obo the appellant. For the sake of fairness, this Court also allowed Adv. Mokoena SC on behalf of the respondent an opportunity to make written submissions based on this belated filed supplementary heads and the cases cited, which he did.

- [25] On the submissions of Adv. Mokoena SC this is a further attempt by the appellant to introduce a new cause of action not initially pleaded nor substantiated by any evidence led. These two cases, so it was further contended, are starkly different from the present case. In the *Mediclinic* case, there were multiple defendants and the issue of apportionment arose in light of a clear case of causative negligence having been proven. The issue was the ratio of the apportionment between the two defendants. In the present *M[...]* case, there is only a single defendant and the issue of causative negligence cannot be upheld in light of the insult being a sentinel event and the injury resulting from such a sentinel event. A sentinel event is defined as: "any unanticipated event in a healthcare setting that results in death or serious physical or psychological injury to a patient, not related to the natural course of the patients illness."

- [26] In the *Vallaro* case, there is clear evidence of a secondary insult as a result of the delay in the surgery. There was evidence of such deterioration clinically and on objective MRI evidence. In the present *M[...]* case, there is only one insult and only one cause of damage based on the MRI evidence. There is no secondary damage that is evident clinically or on MRI evidence.

[27] Since the claim is that of the minor child, how is it that an apportionment can be made? In MEC for Health & Social Development, Gauteng v TM obo MM (38012019) [2021] ZASCA 110 (10 August 2021), Ledwaba AJA and Saldulker JA (the minority) stated in relation to the MEC's plea of contributory negligence that:

"[5] I think I should mention at this early stage that there is no merit in the MEC's plea that Ms. TM's negligence contributed to the complications of the foetal condition because Ms. TM is not claiming damages in her personal capacity but on behalf of her minor child. Contributory negligence cannot be raised against the child."

[28] I echo the sentiments expressed by Mokoena SC that, sad as a case may be, apportioning damages cannot be used as compensation for sympathy for a plaintiff or parent. In M and another v MEC Health, Western Cape (1258/2018) [2020] ZASCA 89 (31 July 2020), Wallis JA, writing for the majority stated in his conclusion as follows:

"[107] In the result the appeal must fail. What happened to J was a tragedy and his parents deserve every sympathy for what they have suffered as a result. However, medical science has not advanced to the stage of diagnostic infallibility and there will be cases where, notwithstanding the best efforts of the medical profession, a tragedy like this occurs. Sympathy is not a ground for imposing legal liability in this or any case."

[own emphasis]

[29] To conclude insofar as causation, which is the only issue for determination on appeal by this Full Court, unlike the finding by the court a quo per Gura J in granting leave to appeal, which concluded that the delay in performing a caesarean procedure "is causality linked to the child's insult", I am of the view that in concluding that "but for" the negligence, there is no causal link between the negligence and the resultant harm suffered by G[...] (baby G).

[30] Adv. Mokoena SC pointed out the importance of this case for the respondent. He said that it is imperative for this Court to make it categorically clear that not every case of CP and negligence entails that the Department of Health's medical personnel is liable for damages suffered. There may well be cases where negligence is established but that it does not lead to liability. Causality between the negligent act or omission and the harm suffered must still be proven. This submission by Adv. Mokoena SC has merit. Proof of negligence does not axiomatically lead to prove causation of damages suffered.

See: The unreported case of MEC NW v NAM obo TM (035/2020) [2021] ZASCA 105 (26 July 2021).

[31] The appeal should consequently fail. Costs should follow the result and be awarded in favour of the successful litigant, the respondent as there is no plausible reason to order otherwise. This includes the costs of the application for leave to appeal which was ordered to be costs in the appeal. Because of the import of this case to both parties as well as the complexity thereof, the employment of two counsel (senior and junior) was warranted.

Order

[32] Resultantly, the following order is made:

(i) The appeal is dismissed with costs.

(ii) Such costs to include the costs consequent upon the employment of two counsel (senior and junior) and to be taxed on a party-and-party basis on the High Court scale.

R D HENDRICKS

DEPUTY JUDGE PRESIDENT OF THE HIGH COURT,

NORTH WEST DIVISION, MAHIKENG

I agree

A H PETERSEN

JUDGE OF THE HIGH COURT,

F M M SNYMAN

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