

SOUTH AFRICA / JUDGMENT

N.M v Member of the Executive Council for Health KwaZulu-Natal (8432/15) [2018] ZAKZDHC 44 (28 September 2018) [2018] ZAKZDHC 44

COURT
Kwazulu-Natal High Court, Durban

BEFORE
Mbatha

CASE / FILE NUMBER
8432/15

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REPORTABLE

IN

THE HIGH COURT OF SOUTH AFRICA

KWAZULU-NATAL

LOCAL DIVISION, DURBAN

Case

Number: 8432/15

In

the matter between:

N.
M. PLAINTIFF
and
THE
MEMBER OF THE EXECUTIVE COUNCIL FOR
HEALTH
KWAZULU-NATAL DEFENDANT
ORDER
Judgment

is granted in the following terms:

1.
It is
declared that the defendant is liable for 100% of the plaintiff's damages, as proved or agreed, arising from the birth with disability
of M. K., a boy, born on [...] 2014.
2.
The
defendant is ordered to pay the plaintiff's reasonable and necessary costs of the action to date on the party and party scale in
the High Court, as taxed or agreed, such costs to include (but not

limited to):

- 2.1.
The
reasonable and necessary costs of the plaintiff's legal representatives attending upon all consultations with the undermentioned
expert witnesses and the plaintiff.
- 2.2.
The costs
of Senior and Junior Counsel including their reasonable and necessary costs of preparation for the trial and the costs
for the attendance
by Senior and Junior Counsel upon consultations with the undermentioned expert witnesses and with the plaintiff.
- 2.3.
The
reasonable and necessary fees of the undermentioned expert witnesses including the costs of their preparation to qualify themselves
to
testify at the trial, the costs of their reports and consultations with the plaintiff's attorney and Counsel (as agreed
or to be

determined by the Taxing Master) namely:

- 2.3.1.
Dr D M
McLynn, specialist obstetrician and gynaecologist whose costs will include his qualifying reservation and attendance fees
(not limited
to R1 500.00, subject to the discretion of the Taxing Master)
and the costs of the preparation of Joint Minutes
with both the
defendant's obstetricians and gynaecologists.
- 2.3.2.
Mr Robert
Fraser, orthopaedic surgeon whose costs will include his qualifying fees.
- 2.4.
All
reserved costs.
- 2.5.

The costs
of the Rule 37 notices and conferences and Minutes and the responses
thereto and in having the matter certified ready
for trial at the
Rule 37(8) and case flow hearings.
2.6.
The costs
of the preparations of heads of argument.

JUDGMENT

Delivered on: 28 September 2018

Mbatha J

Introduction

[1] The plaintiff seeks an order that the defendant be declared liable for 100% of the plaintiff's damages, as proved or agreed

arising from the birth with disability of M. K., a boy born on [...] 2014, and other ancillary relief.

[2] The question before the court is whether the defendant was negligent in failing to inform the plaintiff of the risks of the natural delivery in the light of the estimated foetal weight of the child; whether the defendant failed to foresee harm to the baby and failed to take the necessary steps to prevent such harm occurring to the child and if the defendant owed a duty of care to the plaintiff. The principle issues for determination revolve around the correct assessment of the foetal weight of M. during the pre-natal stage of the plaintiff's pregnancy, the reasons for the failure to perform ultrasound scans during the last period of pregnancy between 9 and 29 [...] 2014, the implications relating to the failure to counsel the plaintiff regarding the delivery options available to her and the actual delivery of M..

The

facts

[3] As to the background and chronology of events I have borrowed freely from the heads of argument provided by both counsel in this matter. The following issues are common cause: The plaintiff gave birth to three minor children viz: Na., born on [...] 2000, W, born on [...] 2004 and Nb born on [...] 2009. The foetal weight of all three children upon their birth was approximately 3.4 kg which was accepted as being at the upper limit of a normal pregnancy. All three children were born by normal vaginal delivery (NVD). In 2011 the plaintiff was diagnosed as suffering from diabetes and a gastric ulcer and treated thereof. She fell pregnant with her fourth child at the end of 2013 and attended the King Edward VIII Hospital ("the hospital") Ante-Natal Clinic ("ANC") for the first time on 17 February 2014. As at the date, the plaintiff presented with six risk factors which increased her risk and that of

the foetus in relation to their management and care during the course of her pregnancy and in preparation for the delivery of her baby. The risk factors included the following, namely, that the plaintiff was a diabetic on treatment, was morbidly or grossly obese (being 119kg at the time of her original assessment), had a significantly increased Body Mass Index (BMI) of 56, was of a small stature being 145cm in height, was multiparous (having given birth to three surviving children) and was of advanced age being approximately 39 years and 10 months.

- [4] The plaintiff testified in her case. The plaintiff's evidence was that she was not counselled about the risks associated with her obesity, diabetes, raised BMI and small stature especially in relation to Cephalopelvic Disproportion (CPD) which is ordinarily

noted in people of small stature; she was not advised that the aforementioned risk factors are indicators of a potentially macrosomic baby; she was not advised about the option of an elective caesarean section; she was not advised about the risks associated with a caesarean section and she was not given an opportunity to make an informed decision as to the option of birth delivery.

- [5] Throughout her entire testimony and cross-examination she maintained that, had she been informed, she would have opted for a caesarean section despite the risk factors that were present at the time. She stated that she would have rather risked her life than risked the life of her child. She described to the court how "a Nigerian" doctor, delivered the baby and a group of students assisted albeit in what she described as a painful and unsatisfactory manner. She appeared to have been traumatised by this method of delivery as she vividly described how the students were pushing on top and on the sides of her stomach, whilst her legs were pulled up at a 90 degree angle and then folded towards her shoulders. She broke down in tears when she related what she described as a very painful and traumatic experience.
- [6] As a consequence of the aforesaid acts of negligence on the part of the employees of the defendant, at the hospital, her child M. suffered severe shoulder dysfunction as a result, was born with Erb's palsy of the right shoulder, a limp right arm and throughout his life will not be able to use his right arm. As a result thereof M. will be permanently impaired and disabled, which will have an effect on any physical activity which he would have enjoyed and most probably suffer loss of earnings as a result of his inability to use his right dominant hand.
- [7] The plaintiff called as an expert witness, Dr McLynn, whose opinion was that the defendant's employees failed to appreciate the high risks associated with the plaintiff's state of health and well-being in that she presented factors such as gross obesity, uncontrolled diabetes, a significantly high BMI of 56, was of short stature, was of advanced age at 39 years, 10 months and was multiparous. According to Dr McLynn the aforementioned factors were indicative of a huge foetus. Despite all these factors M.'s size was misestimated before delivery to be about 3.2 kg, when he was born weighing 4.8 kg. His opinion was that when these factors are present, the plaintiff should have been under the supervision and

management of a specialist obstetrician well versed in dealing with the artisanship of managing shoulder dystocia and that she should have been specifically counselled on the high risk of shoulder dystocia and given the option of an elective caesarean section.

- [8] Dr McLynn concluded that, in his opinion, the staff at the hospital were negligent by their failure in not considering the risk of shoulder dystocia in the clinical and medical circumstances of the plaintiff; not counselling the plaintiff on the risk of shoulder

dystocia with resulting bronchial plexus nerve damage and discussing the option of a pre-emptive caesarean section; not arranging for pre-delivery ultrasound to determine baby weight; not writing details of the delivery process of shoulder dystocia in the clinical notes and thereby giving the impression that the vaginal delivery was normal, when in fact it was abnormal; not considering the options of induction of labour or caesarean section at between 36 and 38 weeks on the basis of her diabetic status; and not ensuring that an experienced labour ward obstetrician supervised the labour process of the plaintiff.

- [9] The entire issue in this matter relates to the missed diagnosis of a macrosomic baby. The plaintiff presented with diabetes, gross obesity and short in stature. It is the plaintiff's case that the lack of pre-natal management, ultrasound scans towards the end of the third trimester to the birth of M. were not done, where ultrasound scans were done the head circumference was not measured which is vital to the determination of the size of the foetus, her age and the fact that she had three previous deliveries was also not taken into account by the hospital. The foetus weight was estimated to have been 3.2 kg at 36/37 weeks which indicated that this was an abnormal pregnancy. It was submitted that the failure to counsel the plaintiff regarding the risks she faced in the light of the aforementioned factors and to give her an option to consider a caesarean section also indicated negligence on the part of the hospital staff. This was briefly the evidence of the expert witness, Dr McLynn who testified on behalf of the plaintiff.

- [10] It is common cause that five ultrasound scans were conducted on the plaintiff during the period of pregnancy on 19 February 2014, 12 March 2014, 26 March 2014, 11 June 2014 and 9 July 2014. The 11 June scan revealed a gestational age of 26+ weeks and the 9 July 2014 scan revealed a gestational age of 36+ weeks. As the pregnancy progressed there were indicators that the foetus was bigger than normal. The records reflect that on 25 June 2014 the height of the fundus had increased, the records of 16 July 2014 showed the increased growth of the foetus, on 24 July 2014 the plaintiff's uterus was measured as being equivalent to 40 weeks palpation, on 26 July 2014 the records reflected the gestational age of the foetus to be 34 weeks and on 29 July 2014 the Symphysis-fundal height (SFH) was recorded as being 43cm at 09h20 and 42cm at 12h15. Dr McLynn pointed out that since 9 July 2014 up to the date of birth of the child no scans were conducted by the hospital staff irrespective of these factors indicating that the foetus was bigger than normal.

- [11] The plaintiff having been admitted for diabetes treatment on 26 March 2014 and for abdominal pains on 23 July 2014 with a diagnosis of false labour the plaintiff was released and returned to hospital on 29 July 2014 for delivery. Dr McLynn's view was that she should have been kept for a longer period in hospital for monitoring and evaluation. On the hospital chart handed in as, Exhibit 'A23', according to Dr McLynn who examined the patient's hospital records testified that, there was no record of the initial labour assessment of the plaintiff or the foetus on Exhibit 'A23'.
- [12] The evidence of the plaintiff as to how the labour and birth progressed until delivery was unchallenged by the defendant. She

stated with certainty that she was never counselled and advised of what could happen if she delivered an obese baby naturally. She testified that she would have opted for caesarean section to save the life of her baby and not hers, had she been counselled of the risks that were presented by her pregnancy.

- [13] Dr McLynn's views were that the plaintiff was not counselled about the size of the baby and the risks attached thereto were due to the failure of the hospital to manage the plaintiff. A plan should have been put in place to manage a person of the plaintiff's circumstances as abnormalities are increased in diabetic mothers; more scans other than the five that were conducted should have been done particularly as the weight of the foetus is not easy to estimate in obese women; it required skilled ultrasonic personnel to attend to her; the hospital records showed that the scans were also not adequately conducted as the head and abdominal circumference which are indicators of a big baby were missing, for instance on the scan conducted on 11 June 2014 the head circumference was missing. There was no indication that she was referred to a dietician, though at the initial stage of her pregnancy she lost six (6) kilograms, nor is there evidence that she kept a diabetic diary, suggesting lack of management on the part of the hospital. In the circumstances he opined that obesity alone does not call for a caesarean section but her short stature, diabetes, and previous births and age needed to be accumulatively considered to engage with her about the risks presented by these factors. He accepted that though both a caesarean section and NVD have risks, the risks were to be discussed with the plaintiff and weighed against each other. Had there been a management plan delivery could have been made at 36-38 weeks to avoid foetal distress or any other complication. He stated that in European countries (first world countries) women who are diabetic are medically managed as early as at pre-conception stage. In this case Dr McLynn's view is that she should have been given an option of electing to have a caesarean section.
- [14] Dr McLynn was of the opinion that the hospital failed to provide care during labour. This was evident from the lack of any record of the delivery of the baby. He described shoulder dystocia as an emergency situation but no record of complications or problems were recorded during the delivery. The shoulder injury was not even recorded. The only recordings that appear on the delivery chart are those made on the following day, post-delivery. He concluded that the injury was due to the pulling under the arm of the baby

which resulted in nerve damage – Erb’s palsy. Dr McLynn testified that when the shoulder dystocia occurs the shoulders get stuck in the pelvis and if they are not released within 10 – 20 minutes the baby may die.

- [15] He stated with certainty that the damage was due to a combination of factors including the wrong application of the McRoberts manoeuvre. All these mistakes, he opined, occurred because there was no anticipation of shoulder dystocia despite the apparent personal circumstances of the mother, even though this happens unexpectedly. This explanation put paid to defendant’s counsel suggestion that the injury could have happened before birth as Dr McLynn stated that such injuries occur in the second birthing stage being the delivery of the baby.
- [16] The defendant called an expert witness Dr Batchelder who described shoulder dystocia as an uncommon occurrence and it varies from 0.58% to 0.7% of all deliveries. He described bronchial plexus injury as a complication of shoulder dystocia. The frequency being between 2.3% to 16% of such deliveries. Fewer than 10% of all cases of bronchial plexus injury result in permanent disability. Brachial plexus injury can also occur during a normal caesarean section delivery. His evidence was that the plaintiff was managed adequately by staff, her diabetes was well controlled, though there was no record of her being counselled about her diabetes, obesity and the risks attached thereto. Dr Batchelder’s view was that well controlled pregnant diabetics have less risk of foetal macrosomia than poorly cared diabetics, but macrosomia can still occur. His authority for this assertion is from a publication, “Diabetes in Pregnancy. Management from pre-conception to post-natal period. National Institute for Health and Care Excellence (NICE). 25/02/2015.”
- [17] Dr Batchelder maintained throughout his testimony that the management of the plaintiff at a pre-natal stage was good, as her diabetes was appropriately managed and that proper management of diabetes did not overrule the occurrence of macrosomia. He maintained that there was a record of counselling, though details thereof were missing on her file. His opinion was that the risk of shoulder dystocia was minimal, there was no need for an elective caesarean section as the degree of macrosomia was not recognised. His view was that the plaintiff was not a candidate for a caesarean section as she was a high risk candidate for surgery. He testified that the central obesity of the plaintiff was a factor that contributed to the inaccurate scan results and there was no other alternative method to determine the foetal weight. His views were that CPD is an emergency situation, which is diagnosed only during labour when there is slow or poor progress in the head moulding and poor head descent, in the presence of strong contraction. In this case labour progress did not appear to be abnormal.
- [18] Dr Batchelder’s views were that the plaintiff’s diabetes was well managed, as she was supposed to keep a booklet to record the daily insulin readings. He stated that her weight had dropped by seven kg’s to 112 kg which should be accepted as evidence of a proper diet management by the hospital. He made reference to an entry made on the hospital records on 24 July 2014, referring to induction, as evidence that there was a plan in place for delivery

for a normal baby, not a big baby. The plaintiff was told to return for an induction on 30 July 2014 after being discharged for a false labour.

- [19] On whether she was properly managed during labour he acknowledged that the vaginal examination was not done, but did not believe that it had an effect on the delivery, as the hospital records indicate that she was assessed by a doctor. He also found it strange that no notes were made during the delivery, which is a crucial stage, and required in terms of the rules in obstetrics. His view was that no recommendation was made for an elective caesarean section to prevent shoulder dystocia because it is too rare and unpredictable, and also on the basis of a policy applied at other hospitals and not King Edward Hospital. He agreed that the size of the baby was not clinically diagnosed and even if that were the case there was no need for more scans. Dr Batchelder concluded that taking into account the risks presented by a caesarean section, the high costs thereof and that if every patient was to have an elective caesarean section to prevent a shoulder dystocia, this would be regarded as bad obstetrics in the field.

The medical guidelines

- [20] Both experts relied on the Royal College of Obstetricians and Gynaecologists, Green-top Guideline No. 42, Second Edition, 1 March 2012 commonly referred to as “NICE Guidelines” for their opinions. These guidelines define shoulder dystocia as ‘a vaginal cephalic delivery that requires additional obstetric manoeuvres to deliver the foetus after the head has delivered and gentle traction has failed’. The guidelines go on to state that ‘There can be significant perinatal morbidity and mortality associated with the condition even when it is managed appropriately,’ that ‘The NHSLA (NHS Litigation Authority) has reported that 46% of the injuries were associated with substandard care,’ that ‘Elective caesarean section should be considered to reduce the potential morbidity for pregnancies complicated by pre-existing or gestational diabetics, regardless of treatment, with an estimated foetal weight of greater than 4.5 kg,’ that ‘there is no evidence that McRoberts manoeuvre before the delivery of the foetal head prevents shoulder dystocia’ and that ‘an episiotomy is not always necessary.’
- [21] On page 10 paragraph 7.2 of the Guidelines it emphasises the importance of the birth record, reflecting time of delivery of the head and time of delivery of the body; the anterior shoulder at the time of dystocia, the manoeuvres performed, staff in attendance and their time of arrival up to the time of neonatal assessment of the baby.
- [22] On page 22, Pre-pregnancy Chapter, Item-Prenatal it states that ‘in obese women, it can be difficult to assess foetal and presentation clinically.’ ‘Ultrasonography is used in resolving presentation problems’. ‘However, poor sound visualization in obese women lessens the accurate measurements and assessments of foetal anatomy.’

The law

[23] The onus in such cases rests on the plaintiff to prove that the damage she suffered was as a result of the negligence of the

defendant's employees. It is accepted in our law that a doctor who manages, treats or performs a procedure on a patient is under an obligation to perform his duties with a degree of care and skill reasonably expected from a doctor of his position.[1] This position applies to medical institutions as well.

[24] Therefore the question is (i) factually what was the cause of the ultimate condition of M. and (ii) whether negligence on the part of defendant's staff caused or materially contributed in the sense that by the exercise of reasonable professional care and skill could have prevented it from developing.[2]

[25] On the evidence presented this court has to decide whether the defendant's employees acted wrongfully. An objective test is, the standard required in the determination of wrongfulness. If there is an omission on the part of the defendant's employees their conduct will be regarded as wrongful if they had a duty to act positively to prevent harm from occurring and failed to comply with their legal duty. In *Le Roux & others v DEY (Freedom of Expression Institute and Restorative Justice Centre as Amici Curiae)*,[3] the Constitutional Court stated:

'...in the context of the law of delict: (a) the criterion of wrongfulness ultimately depends on a judicial determination of whether - assuming all the other elements of delictual liability to be present - it would be reasonable to impose liability on a defendant for the damages flowing from specific

conduct; and (b) that the judicial determination of that reasonableness would in turn depend on considerations of public and legal policy in accordance

with constitutional norms.' (Footnotes omitted.)

It went on to state that:

'...what is meant by reasonableness in the context of wrongfulness has nothing to do with the reasonableness of the defendant's conduct, but it concerns the reasonableness of imposing liability on the defendant for the harm resulting from that conduct.' (Footnote omitted.)

[26] The Supreme Court of Appeal in *Michael & another v Linksfield Park Clinic (Pty) Ltd & another*[4] gave guidelines as to the considerations in assessing expert medical evidence. It further held that the court has to evaluate the evidence to determine whether, and to what extent, the opinions of experts 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.[5] This approach to expert evidence was followed by the SCA in *Road Accident Fund v Zulu & others*,[6] where the court held that:

‘[I]t would be wrong to decide a case by simple preference where there are conflicting views on either side, both capable of logical support. Only where expert opinion cannot be logically supported at all will it fail to provide "the benchmark by reference to which the defendant's conduct falls to be assessed.’

The court further stated:[7]

‘It is the court’s duty to assess the evidence and decide the probabilities.’

The caution here being that experts at times overstep their mark by giving opinions without supporting authorities and drawing conclusions which can only be drawn by the court.

[27] The correct approach to expert evidence as aptly stated in *Daniels v Minister of Defence*[8] and the aforementioned legal principles stated above is the approach I have adopted in this matter.

Evaluation of the evidence

[28] The evidence of the plaintiff as to her testimony was unchallenged, as to the lack of counselling regarding her diabetes and obesity and the inherent risks affected thereto. It also remains unchallenged as to what happened during labour and the delivery of baby M.. She clearly articulated her evidence and I see no reason why I should reject her evidence.

[29] Dr McLynn and Dr Batchelder made extensive references to the hospital records relating to the plaintiff from the time of her diagnosis of the pregnancy up to the time of delivery of the baby. Dr McLynn relied on seven authorities and Dr Batchelder on two authorities. They both extensively relied on the NICE Guidelines, which I have referred to above. The defendant did not call any witnesses either the doctor or any person who was present during the delivery of baby M. and relied only on the evidence of the expert witness.

[30] Dr Batchelder indicated that he was not aware of any policy in place on elective caesarean sections at the hospital but relied on a policy applied at Grey’s Hospital, which he had no knowledge whether it was used in the hospital or not. However, this generalisation does not accord with the Royal College Recommendations which state that the plaintiff should have had an elective caesarean section. In this case he found that central obesity of the plaintiff could have been the cause of the inaccurate clinical prediction of the foetal weight, even in the most skilled hands. The hospital relied on the ultrasound scans which did not show that the foetus was abnormally big for vaginal delivery. His view was that her labour had progressed normally and her history of three previous deliveries supported the decision that she gives birth naturally. The plaintiff went into spontaneous labour at just under 38 week’s gestation. He referred to the NICE Guidelines 2015 which on diabetic patients recommend induction to type 1 and type 2 diabetics at 37 – 39 weeks of pregnancy. This occurrence excluded the use of an induction procedure. He stated that correct management of shoulder dystocia situations does improve perinatal outcomes, but due to the lack of any recorded detail about the delivery of the baby it made it impossible to establish whether the delivery was conducted correctly or not. However, he believed that since the records reflected the

presence of the senior registrar in obstetrics during the delivery it should be accepted that the plaintiff was managed properly. He also found it very sloppy of the defendant's staff that there were no records of the delivery up to the birth of the infant M..

- [31] Counsel for the defendant contended that the question that needs to be determined is at what stage did shoulder dystocia occur and if it was caused by the excessive traction applied at birth or if it occurred at an earlier pre-delivery stage. He submitted that there was a probability that it was caused by the propulsive forces to the foetus. He relies for this contention on an unreported English case of *Jack Beggs v The Medway NHS Trust*,^[9] where the court found that it could not be established that the medical staff had caused the injury to the posterior shoulder (traction injury) which was the direct cause of brachial plexus injury and found that it was more probable that maternal propulsive

forces were the cause thereof. In this case the only direct evidence we have of the delivery is that of the plaintiff who described as to how the medical officer struggled in delivering the baby. She described how her legs were pulled apart at almost 90% to her body and how her legs were folded against her chest in what both experts regarded to have been the McRoberts manoeuvre. Pressure was applied on the sides of her abdomen by a group of attendants, supposedly interns and above her abdomen. The strange contention by counsel for the defendant is made against the backdrop of the expert witness Dr Batchelder conceding that the application of what appeared to be the McRoberts manoeuvre was incorrect and probably aggravated the effects of shoulder dystocia suffered by the foetus. It was never at any stage suggested by any of the expert witnesses that it occurred at any other time than at delivery or that it was due to the maternal propulsive forces.

- [32] Counsel for the defendant submitted that at pre-natal stage indicators for possibility of shoulder dystocia were insufficient.

This argument is fallacious as both expert witnesses testified that people of a short stature like the plaintiff, who are obese and diabetic generally give birth to macrosomic babies. Dr Batchelder conceded that the assessment of the foetal weight as being 3.2kg as of 9 July 2014 was incorrect and that had further ultrasonic scans been performed there was a probability that it would have revealed that the foetus was bigger than previously assessed. I find that this would have given the hospital staff an opportunity, though late, to counsel the plaintiff regarding the risks and weigh the risks of a natural birth vis-à-vis a caesarean section. This would have greatly mitigated the chances of an injury to the foetus or the risks of CPD.

- [33] The NICE Guidelines on page 3 deal with the question whether shoulder dystocia can be predicted. The authors thereof state that the best combination of variables to identify neonatal injury associated with shoulder dystocia were the maternal height, gestational age and birthweight. The Guideline states that infants of diabetic mothers have a two to four fold increased risk of shoulder dystocia compared to the infants of non-diabetic mothers. The high water mark of the plaintiff's case is to be found in the nexus between these factors and shoulder dystocia. These factors presented themselves in the plaintiff and did not need any

further scientific determination. The defendant's staff were negligent in failing to determine the high probability of the plaintiff giving birth to a macrosomic baby.

- [34] Defendant relied on *Sibisi NO v Maitin*,^[10] where the plaintiff relied on her right to have been informed of the risks of vaginal delivery given the size of the foetus, where the court held that informed consent was not an issue once negligence has not been established. The facts of this case are distinguishable from *Sibisi*. In *Sibisi* matter the negligence was not proved, unlike in this case where there is even a lack of delivery records. The plaintiff in *Sibisi* did not plead that she had any right to be informed of any risk that was significant. On appeal she had principally relied on the right to have been informed of the risks of vaginal delivery given the estimated size of the baby. That was not the case pleaded by her. *Sibisi* did, not have the recognised signs as presented by the plaintiff in this matter. She had no history of diabetics. In the plaintiff's case, a patient with diabetes, of short stature which is a sign of a smaller pelvis, morbid obesity and advanced age were good predictors for shoulder dystocia.
- [35] At delivery stage, the plaintiff's delivery was treated as a normal delivery. The only evidence relating to an emergency situation that arose on the day of delivery was related only by the plaintiff. There is no documentation of the delivery by the senior registrar or other staff members. The McRoberts manoeuvre was incorrectly applied as conceded to by Dr Batchelder. This can only indicate that there was no plan for delivery in the event of macrosomia presenting itself. Even if this was unexpected there is no evidence of any steps taken by the hospital staff to alleviate the problem. Dr McLynn's opinion was that the underarm nerves were damaged by the pulling of the right arm. He testified that if the baby was not delivered within 10 to 20 minutes it would have died. Interns were assisting the registrar, and there is no evidence whether they had been taught of how to perform the McRoberts manoeuvre. This chaotic scene can be the only cause of the injury to the infant. It was negligence on the part of the staff.
- [36] At that emergency stage, the plaintiff was not even informed of what was happening which is completely against the NICE Guidelines which advocate that she be informed of what risk she was facing. She was subjected to pulling of her legs; pumping of her sides as she described it in isiZulu as 'bangimpompa'. She stated that though she was in excruciating pain, she was encouraged to push, supra-pubic pressure was not applied, routine axial traction was not done and an episiotomy was not done. All the manoeuvres were not in line with the NICE Guidelines. In all probability I find that these incorrect procedures extensively contributed to the injury suffered by the infant.
- [37] The conclusions drawn by Dr McLynn as the probable cause of M.'s injury and disability are consistent with the evidence. There was poor management of the plaintiff from the pre-natal period to the time of delivery of M.. I can only conclude that in all probability when normal delivery proved to be impossible, the infant was pulled out incorrectly, damaging the nerves on the arm. The stance adopted by the defendant that there was proper management of the plaintiff is not persuasive, as nothing positive was managed from the pre-natal stage

up to the birth of the child.

[38] Dr Batchelder remained steadfast on the view that a caesarean section was risky and costly however, in my view this cannot mitigate the case in favour of the defendant. The lack of management was a crucial factor here. The plaintiff presented with the medically known factors which lead to shoulder dystocia at birth but no counselling was done as to the consideration of a caesarean section as an alternative to NVD. In *Pinchin & another, NO v Santam Insurance Co Ltd*[11] confirmed the nasciturus fiction principle, in which foetuses if subsequently born alive, will acquire all rights of born children.

This right extends to a disabled child, a right to sue for failing to prevent such a birth, where a mother would have opted for a termination of the pregnancy. I cannot see why such a right cannot be extended to a child whose disability could have been prevented by exercise of a choice by a parent for an elective caesarean section. The expert witnesses before the court testified that the most difficult and life threatening birth of all mammals is that of a human being. I cannot understand that when a more difficult delivery is foreseeable, why a woman, cannot have an elective caesarean section. Women have a right to dignity and right to make an informed decision when facing peril. A right enshrined in the Constitution. The costs of a caesarean section in the cases where disability is foreseeable cannot be compared to the lifelong costs of living with disability, the stigma and the socio-economic conditions that attach to disability.

[39] I am reluctant to criticize the evidence of Dr Batchelder. He may have testified in a robust manner but I found that he made

concessions unreservedly where they needed to be made.

Conclusion

[40] Accordingly I find that the plaintiff has proved on a balance of probabilities that the negligence of the defendant's employees caused the plaintiff's son M. to suffer a brachial nerve plexus injury and consequentially Erb's palsy.

[41] Judgment is granted in the following terms:

2.1 The reasonable and necessary costs of the plaintiff's legal representatives attending upon all consultations with the undermentioned expert witnesses and the plaintiff.

2.2 The costs of Senior and Junior Counsel including their reasonable and necessary costs of preparation for the trial and the costs for the attendance by Senior and Junior Counsel upon consultations with the undermentioned expert witnesses and with the plaintiff.

2.3 The reasonable and necessary fees of the undermentioned expert witnesses including the costs of their preparation to qualify themselves to testify at the trial, the costs of their reports and consultations with the plaintiff's attorney and Counsel (as agreed or to be determined by the Taxing Master) namely:

2.3.1 Dr D M McLynn, specialist obstetrician and gynaecologist whose costs will include his qualifying reservation and attendance fees (not limited to R1 500.00, subject to the discretion of the Taxing Master) and the costs of the preparation of Joint Minutes with both the defendant's obstetricians and gynaecologists.

2.3.2 Mr Robert Fraser, orthopaedic surgeon whose costs will include his qualifying fees.

2.4 All reserved costs.

2.5 The costs of the Rule 37 notices and conferences and Minutes and the responses thereto and in having the matter certified ready for trial at the Rule 37(8) and case flow hearings.

2.6 The costs of the preparations of heads of argument.

Date of Hearing: 29 June 2018 (E & G Court Durban)

Date of Judgment: 28 September 2018

Appearances

For Plaintiff/Applicant: Adv Gajoo SC

Adv M A Oliff (Junior Counsel)

Instructed by: Justice Reichlin Ramsamy Attorneys

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Durban

For First Defendant/Respondent: Adv S Giba

Instructed by: State Attorney

6th Floor, Metlife Building

[1] Mitchell v Dixon 1914 AD 519 at 525.

[2] Blyth v Van den Heever 1980 (1) SA 191 (A) at 196E.

[3] Le Roux & others v DEY (Freedom of Expression Institute and Restorative Justice Centre as Amici Curiae) 2011 (3) SA 274 (CC) para 122.

[4] Michael & another v Linksfield Park Clinic (Pty) Ltd & another 2001

(3) SA 1188 (SCA) at 784.

[5] Ibid paras 34-37.

[6] Road Accident Fund v Zulu & others (50/11)

[2011] ZASCA 223 (30 November 2011) para 14.

[7] Ibid para 15.

[8] Daniels v Minister of Defence 2016 (6) SA 561 (WCC) – The correct approach to expert evidence is that encapsulated in Daniels v Minister of Defence as follows: '[134] The duties of an expert witness are aptly stated by Justice Cresswell in National Justice Compania Naviera SA v Prudential Assurance Co Ltd (also known as 'The Ikarian Refer' case) as follows: "THE DUTIES AND RESPONSIBILITIES OF EXPERT WITNESSES The duties and responsibilities of expert witnesses in civil cases include the following:

1. Expert evidence presented to the Court should be, and should be seen to be, the independent product of the expert uninfluenced as to form or content by the exigencies of litigation.
2. An expert witness should provide independent assistance to the Court by way of objective unbiased opinion in relation to matters within his experience.
3. An expert witness should state the facts or assumption upon which his opinion is based. He should not omit to consider material facts which could detract from his concluded opinion.
4. An expert witness should make it clear when a particular question or issue fall[s]outside his expertise".

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[9] Jack Beggs v The Medway NHS Trust, 24 October 2008.

[10] Sibisi NO v Maitin 2014

(6) SA 533 (SCA).

[11] Pinchin & another, NO v Santam Insurance Co Ltd 1963 (2) SA 254 (W).

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