

SOUTH AFRICA / JUDGMENT

N.P v MEC for Health, Eastern Cape (1196/2012) [2014] ZAECMHC 28 (24 July 2014) [2014] ZAECMHC 28

COURT

Eastern Cape High Court, Mthatha

BEFORE

Griffiths

CASE / FILE NUMBER

1196/2012

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IN

THE HIGH COURT OF SOUTH AFRICA
EASTERN

CAPE LOCAL DIVISION : MTHATHA
CASE
NO. 1196/2012
In

the matter between: N.
P.
Plaintiff
and
MEC
FOR HEALTH, EASTERN
CAPE Defendant

JUDGMENT

GRIFFITHS, J.:

- [1] The plaintiff in this matter has sued the defendant on behalf of her minor child, I., for damages arising out of the alleged negligence of the defendant's staff both at the Zwelichumile clinic and at the Mthatha General Hospital.
- [2] At the commencement of the trial it was indicated that the only remaining issue, apart from damages, which required adjudication was the question of whether or not the servants of the defendant had acted negligently in their dealings with, and management of, the plaintiff's pregnancy, and whether or not such negligence was causally connected to the injuries suffered by I., namely, a brachial plexus injury to the left arm and a fracture of the right.
- [3] Mr. Schoeman, who appeared with Mr. Sambudla for the plaintiff, furthermore indicated that the parties were in agreement that this issue should be determined first before embarking on the question of damages. Accordingly, a ruling was made in terms of rule 33(4) to the effect that liability only be considered at this stage.
- [4] The evidence in support of the plaintiff's case consisted in the testimony of the plaintiff herself, that of a specialist obstetrician, one Dr. Ebrahim and the evidence of an orthopedic surgeon, Dr. Olivier.
- [5] According to the plaintiff, her pregnancy with I. was her eighth pregnancy, she having delivered seven previous babies, some in hospital and some at home. At the time of delivery of I., she was [...] years of age. On 17 June and 8 July 2008 she attended at the clinic for an examination relating to the pregnancy. On both of those occasions she was examined but no abnormality was apparently detected. On both occasions her blood pressure was taken. On the first visit her weight was reflected as being 104kg and on the second, as 107kg. On neither occasion was she given any form of advice by the nurses, nor was she informed of any potential risks in her pregnancy. Likewise, she was not advised to attend at the hospital or a doctor for any further examination or treatment. No scans were done.
- [6] After these visits to the clinic she attended at the surgery of a private doctor in Mthatha and was informed that the foetus was too big. This was apparent from a scan done by this doctor.
- [7] She went into labour at 2 AM on 25 July 2008 and arrived at the hospital at 7am. On arrival, she was assisted by a nurse during the course of which her waters broke. She was told to lie on her side on a labour ward bed. She informed this nurse that the scan had revealed that the baby was big and requested that she have a caesarean section.
- [8] In response to this request the nurse caused her to sign a document which apparently dealt with the caesarean section and, from this, she understood that her request would be granted. She waited until 10am when a doctor arrived and perused this document. Thereafter he put it aside, inserted a drip and placed an oxygen mask on her face. He

instructed her to lie on her back and, using his fists, applied downward pressure to her upper abdomen. She was not lying with her legs on the bed as they were up with her feet flat on the bed.

- [9] A nurse attended to the actual birth whilst the doctor was pushing. Although the head emerged, it seemed that there was some difficulty with the birth. Accordingly, the nurse pushed her hands inside the plaintiff's vagina and began to manipulate the head of the baby. She felt movement inside her vagina which alerted her to this fact. After some time, the baby was born.
- [10] Two days later and whilst still in hospital she noticed that the child was crying excessively. She noticed that his right arm was green. She also noticed that the bones in the right arm appeared to be protruding into the skin. Prior to this, none of the medical staff had apparently noticed these problems as they had not drawn her attention to them. As a consequence, the baby was referred to Bedford.
- [11] She confirmed, in accordance with the hospital records, that the baby was 4.95kg in weight at birth. None of her previous children had weighed more than 3kg at birth.
- [12] Dr. Ebrahim, a specialist obstetrician and gynaecologist, testified that he had been tasked with an investigation into the reasons for I.'s disabilities. In essence, his evidence was to the effect that the plaintiff's pregnancy had not been managed correctly by the clinic staff and that this mismanagement and failure to recognize a number of risk factors present resulted in a failure to have her properly examined in advance of her entering labour at the hospital, or by a doctor. Had these risk factors been detected, as they should have been by the nursing staff at the clinic, this information would have been recorded on the plaintiff's maternity chart and, at the very least, have thereby been conveyed to the hospital staff in the labour ward tasked with the childbirth. Had the hospital staff been given this information in advance of the plaintiff's admission to hospital, they would have, or should have, been prepared and ready with a management program for the purposes of ensuring that the childbirth progressed safely and correctly.
- [13] In the view of Dr. Ebrahim, there were a number of risk factors patently present or, at the very least and with the necessary

testing, detectable, which the clinic staff ought to have diagnosed, all of which factors either in themselves, or cumulatively, pointed to the probability that this pregnancy would involve shoulder dystocia. Shoulder dystocia is, in essence, an unusual condition at birth where, because the baby's head is smaller than its shoulders, its anterior shoulder becomes ensnared within the vaginal passage usually against the pubic rami. This prevents a smooth childbirth and creates a number of dangers for both the mother and the baby. If the probability of such a condition is diagnosed in advance, as it ought to be, a management program can be put into place and in particular the mother can be advised (strongly in circumstances where many risk factors are present) that it would be better for her to have a caesarean section as opposed to normal childbirth as this, for obvious reasons, would eliminate the risk associated with normal

childbirth should there be a likelihood of shoulder dystocia. Alternatively, in advance a proper management program for the normal childbirth may be put in place to all but eliminate the risks associated with shoulder dystocia. For example, a doctor would attend to the birth, the mother would be placed in what is referred to as the McRoberts position with her legs pushed back into her abdomen and four staff members would be made available to ensure that she is kept in that position during the birth process. In addition, the mother should be placed at the edge of the bed so that when the baby's head protrudes there is sufficient space for manoeuvrability.

- [14] These risk factors were many in number and included the fact that the plaintiff was clearly obese; this was a multi-parity pregnancy, the plaintiff having given birth to seven babies previously; the age of the plaintiff ([.....] years of age – consistent with a multiparity pregnancy); the fact that the child was large (a fact which was established in advance of her labour by a separate doctor and which ought to have been diagnosed by the clinic staff at one or other of the visits thereto); the fact that mothers in the plaintiff's condition, particularly her obesity, are highly susceptible to what is commonly referred to as gestational diabetes, a temporary diabetic disease which exists during pregnancy. The most important factor of all of these was the fact that the baby, at best, turned out to be what the doctor referred to as a "massive" baby weighing in at 4.95 kg.
- [15] Accordingly, the gist of his evidence was to the effect that even with the relatively limited number of visits to the clinic prior to her admission to hospital, the nursing staff at the clinic ought to have established that there existed a large number of risk factors and ought to have performed further tests to establish, for example, whether gestational diabetes indeed existed. This information should have been reflected properly on the maternity chart which would have relayed the necessary information (and a red flag) with regard to shoulder dystocia to the hospital staff on her eventual admission thereto. Such information would have placed the hospital staff on alert to the possible danger of shoulder dystocia and a proper management plan would have been developed, even within the 2 1/2 hour period available to them after her admission and before she apparently went into full labour. Because the risk factors were not diagnosed, such relevant information was not relayed to the hospital staff together with the necessary red flag and consequently a management plan was not put into place, which Dr. Ebrahim regarded as negligence.
- [16] In addition, he was adamant that any properly trained medical staff including doctors and midwives will have gone through the necessary training in order to be fully alive to the dangers of shoulder dystocia. They would thus be alert to the various risk factors and danger signs which might exist thereby placing the staff on much higher alert to the potential of this condition arising.
- [17] Dr. Ebrahim also maintained that the actual management of the labour in the labour ward was far less than the standard required of a doctor and midwife. In this regard he pointed to a number of factors. The first of these was that in the time available the medical staff would have been able to assess that a caesarean section was necessary in order to avoid the consequences of a possible shoulder dystocia. This was exacerbated by the fact that the

plaintiff was possessed of the knowledge that the foetus was very large and that at the first available opportunity she imparted this information to the medical staff with the accompanying request that she undergo a caesarean section. The plaintiff was clearly alert, probably because of her previous pregnancies, to the fact that a caesarean section would be the proper course. However, it appears that the doctor disregarded this information and went ahead with a normal, vaginal, birth.

- [18] Furthermore, the doctor had the plaintiff lie prone on her back with her legs in an arched position, fully on the bed. He then exerted fundal pressure to her upper abdomen immediately below the breasts. According to Dr. Ebrahim, all the literature indicates that this is not the correct procedure in such circumstances. The application of fundal pressure as was done in this case only served to exacerbate the dangers because the application of such pressure would have caused more pressure on the foetus. As the foetus was in a compromised position consequent upon the shoulder dystocia, this would have resulted in traction in the shoulder area and hence the brachial plexus injury to the nerves located there. Indeed, Dr. Ebrahim described the application of fundal pressure as being gross mismanagement.
- [19] Had there been a proper management program in place, as there should have been, the plaintiff would have been placed in what is known as the McRoberts position (as described earlier) with the appropriate number of staff to ensure that she remained in this position throughout childbirth. Because she was not placed in such position[1] the midwife who was conducting the birth was placed in a difficult position in manipulating the child whose head had at that stage been born. Additionally, the plaintiff was not at the edge of the bed giving the midwife less space to work with in manoeuvring the baby.
- [20] A further factor which in Dr. Ebrahim's view was causally connected to I.'s injuries was the fact that an episiotomy was not performed. The fact that the plaintiff had been through multiple childbirths prior to this which would have resulted in a stretching of the vaginal passage, is immaterial. The midwife required the maximum amount of space to manoeuvre the child's shoulders so as to release the blocked anterior shoulder and thereby to release its body from the vaginal passage. Any extra space would thus have assisted in this endeavour. An immediate episiotomy would have provided extra space for the midwife to place her hands within the vagina and to assist in the birth of the child and may well have prevented both the brachial plexus injury and the fracture of the right arm. In his view, the mere fact that the midwife put her hands into the plaintiff's vagina was a clear indication that an episiotomy was a necessity.
- [21] In Dr. Ebrahim's view, had the medical staff followed all of these guidelines and strategies correctly, I. would not have been

compromised and, if he was, such compromise would not have resulted in the permanent injury in the form of the brachial plexus which he suffers from at present. He was further of the view that, with the facts at hand, the presence of the various risk factors and the injuries suffered to I., he could safely say that on a balance of probabilities there was mismanagement rather than the rare possibility that the injuries occurred pre-delivery.

[22] Doctor Olivier, an orthopaedic surgeon, also testified on the plaintiff's behalf. He examined the child when he was [.....]

years of age. The fracture to the humerus of the right arm had healed satisfactorily and was unlikely to present a problem in future.

However, there was a brachial plexus injury to the left limb which he described as incomplete. It was accordingly a "whole arm injury" and has resulted in a permanent loss of use of the left arm.

[23] The damage to the nerves in the left shoulder involved a number of nerves emanating from the spinal cord in the neck area which was indicative to him that there must have been an extensive amount of power exerted in order to cause injury to five such nerve roots. This was consistent with a difficult birth and, in his experience, was as a result of traction exerted during the course of delivery. In his view furthermore, the traction was exerted during the course of delivery, and not before. An additional factor which indicated to him that a significant degree of force had been applied during the course of the delivery of this child was the fact that it appeared from the evidence of the plaintiff that he had suffered a displaced fracture of the right arm. Clavicle or humerus fractures are, in his experience, the result of a difficult birth. Because fractures of infants' bones are known as "green stick" fractures, it is very difficult to displace the bones during the course of such fracturing. This can only be done through the exertion of a significant degree of force.

[24] That was the plaintiff's case.

[25] The defendant relied on the evidence of one witness, that being an obstetrician and gynecologist, Dr. Nelson. Dr. Nelson, likewise,

submitted a full report dealing with his findings and conclusions in this matter. His report, and indeed his evidence, dealt in the main with the assertions made by Dr. Ebrahim as I have already dealt with. He largely took issue with Dr. Ebrahim's assertions that the medical staff at the hospital had had sufficient time available to them to, firstly, identify a number of risk factors which were present and which indicated the possibility that shoulder dystocia might occur, and, secondly, to have considered the alternative of a caesarean section or to have put in place at proper management program in the event of a natural birth which would seek to prevent, or at the very least minimize, the prospects of a shoulder dystocia occurring during the course of childbirth. The second aspect with which he took issue was the question of whether or not the brachial plexus injury to the left arm was indeed caused through excessive traction having been applied by the midwife during the course of the birth, or whether it had occurred at an earlier stage pre-delivery as a consequence of the propulsive forces to the foetus which would have

arisen naturally from the mother's contractions.

- [26] Dr. Nelson was strongly of the view that the birth occurred fairly quickly and that because, according to the medical records from the hospital, the mother only presented herself at 9.30am, there was insufficient time for the doctor and midwife to prepare for a caesarean section. Added to this, in his view there was insufficient time to diagnose, insofar as such a diagnosis could be made, the possibility of shoulder dystocia. He testified further that the limited indicators available for such a diagnosis were insufficient to suggest that shoulder dystocia was a real possibility as this condition is very rare. In the circumstances, bearing in mind the inherent risks involved with a caesarean section, the high cost thereof and the fact that if one followed this course in every case where certain risk factors might be evident this would result in a large number of caesarean section procedures to prevent a single case of shoulder dystocia, his view was that it would have been acceptable medical practice not to have performed a caesarean section in the plaintiff's case.
- [27] With regard to the second issue, namely the "propulsion/traction" debate, he quoted certain studies and in particular a paper by Dr. Henry Lerner on shoulder dystocia upon which he relied to make his point that obstetric brachial plexus injuries are not injuries which are inevitably associated with shoulder dystocia, and that there have been cases where it has been established that shoulder dystocia was indeed not the cause of such injury in the particular infant concerned. He also referred to an unreported English case of *Jack Beggs v The Medway NHS Trust* which was dealt with in a review by a British solicitor and involved a claim for damages resulting from a brachial plexus injury allegedly caused by the medical staff during birth consequent upon shoulder dystocia. In that matter the judge found that it had not been established that the "birth attendants" had caused the injury to the posterior shoulder (traction injury) which was the direct cause of the brachial plexus injury, and found that it was more probable that maternal propulsive forces had been the cause thereof.
- [28] Dr. Nelson was also critical of Dr. Ebrahim's testimony to the effect that there were a number of "risk indicators" present in the case of the plaintiff which pointed to the likelihood that shoulder dystocia might occur. Whilst he accepted that the bigger the baby the greater the risk of shoulder dystocia and that where the foetus is more than 4.5 kg there is a 22% chance of shoulder dystocia occurring, he maintained that there is insufficient scientific means available to determine the exact size of the foetus. He also accepted that where the mother, as in this case, was grossly overweight and small of stature, and in addition had diabetes, the percentage chance of shoulder dystocia in a foetus weighing more than 4.5 kg would increase to 50%. However, he pointed to the fact that in this matter there was no evidence of diabetes.
- [29] With regard to Dr. Ebrahim's assertion that fundal pressure should never be employed where there is a likelihood of shoulder dystocia, he maintained that there is no scientific proof of this and that he has employed fundal pressure extensively during the course of his 40 years in practice. He did however concede that suprapubic pressure would have assisted.

- [30] With regard to the McRoberts position, he agreed that this ought to have been employed as, although there is no real scientific basis for it, it appeared to assist in cases of shoulder dystocia. However, he said that because the plaintiff had suffered from pain in her hip joints, this was an indication that she had indeed been placed in the McRoberts position.
- [31] When Dr. Nelson was cross-examined by Mr. Schoeman he tempered a number of his positive assertions. With regard to the question of time available for assessment regarding the caesarean section procedure, it was put to him that the plaintiff had testified that she had arrived at the hospital and had reported to the medical staff at 7am and that, therefore, the medical records were incorrect where they indicated that she had first been assessed at 9:30am. He initially took issue with this on the basis that his experience was such that patients generally had bad memories with regard to times and procedures but ultimately accepted that had this been so, the failure by the hospital staff to have continually examined and monitored the plaintiff after her admission and until she was fully dilated was less than acceptable medical practice. He also agreed that this would have given sufficient time for the medical staff to have properly assessed the necessity of a caesarean section procedure.
- [32] It was also put to him that relying, as he had done, solely on the medical records and not having taken into account the plaintiff's own testimony, resulted in him having a one-sided view of the matter. In particular, he was unaware of the fact that the plaintiff had been advised by her doctor that according to the ultrasound scan he had performed, the baby was large and that it was important to convey this fact to the hospital staff. When it was put to him that she had indeed advised the nurse on admission of this fact, he accepted that because of this fact and the fact that the plaintiff was grossly overweight; the risk of shoulder dystocia would have been doubled. In this regard, although he initially agreed that the hospital staff themselves could have established whether the baby was a big baby by palpating the plaintiff's abdomen, he subsequently appeared to change his stance to some degree.
- [33] Dr. Nelson accepted that the medical staff would have been trained to deal with shoulder dystocia and that they ought to have complied with an international regimen of norms and standards dealing with the management of this condition, a copy of which was handed in as an exhibit "B". He further accepted that the hospital staff had indeed not followed or complied with a number of aspects of this regimen and that this, of itself, amounted to substandard treatment. Because of its importance, I reproduce the content of exhibit "B" hereunder:

" 9. SHOULDER DYSTOCIA

This occurs with large babies (usually > 3.5 kg) when delivered of the head is not followed by delivery of the shoulders

Emergency management is as follows

1. Call for at least 2 assistants to help with delivery

2. Explain the problem to the mother
3. Immediately move the mother to the edge or end of the delivery bed
4. Tell the mother to hyperflex the hip joints (McRoberts' position with the help of assistants. Her knees should almost touch her shoulders)
5. Cut a wide episiotomy
6. Apply suprapubic pressure to force the anterior shoulder under the symphysis pubis
7. Push the head downwards to apply traction on the anterior shoulder. Do not stretch the neck, and avoid forceful jerking movements
8. If unsuccessful at this stage, deliver the posterior arm by locating the posterior shoulder in the vagina and sweeping the arm in front of the fetal chest. Once the posterior arm is delivered, proceed to deliver the anterior shoulder as mentioned above
9. If this fails, rotate the baby through 180 degrees through a face-to-pubis position, to bring the posterior shoulder forward and make it anterior. It important to hold both the arm and head together to facilitate rotation and reduce the risk of injury. Rotation is by rotary pressure on shoulders.
10. If delivery has not been achieved so far, the baby is likely to die
11. If the baby is dead, await spontaneous delivery, although breaking the clavicle(s) may assist the process"

[34] It seems that the two real issues which I am to determine in this matter are the following:

1. Has the plaintiff established on a preponderance of probability that the medical staff acted negligently in their treatment and management of the plaintiff's labour?
2. If indeed the plaintiff has established negligence and consequently fault, has the plaintiff established a causal link between the negligence of the hospital staff and the brachial plexus injury to the left arm of the minor child? To put this another way, is it more probable than not that the negligent handling of the plaintiff's labour by the hospital staff (and in particular the manner in which the midwife assisted with the birth process) caused the brachial plexus injury, or is it equally probable that this injury could have been caused and would in any event have been caused as a consequence of the natural propulsion pressure created by the mother's contractions?

[35] As the law stands it seems that a medical practitioner is required to exercise the degree of skill and care to be expected from a skilled practitioner in his or her field[2]. The test for such professional negligence is as to how a reasonably competent practitioner in that branch of medicine would have acted in a similar situation. It must be established that a reasonable practitioner in such circumstances would have foreseen the likelihood of harm, would have taken the necessary steps to guard against its occurrence and that the

practitioner concerned failed to take such steps[3]. In *Van Wyk v. Lewis*[4] Wessels, JA said in this regard[5]:

'We cannot determine in the abstract whether a surgeon has or has not exhibited reasonable skill and care. We must place ourselves as nearly as possible in the exact position in which the surgeon found himself when he conducted the particular operation and we must then determine from all the circumstances whether he acted with reasonable care or negligently. Did he act as an average surgeon placed in similar circumstances would have acted, or did he manifestly fall short of the skill, care and judgment of the average surgeon in similar circumstances? If he falls short he is negligent.'

[36] With regard to the evidence of the plaintiff, I listened to her testimony carefully and gained the distinct impression that she was telling the truth. For example, she did not merely maintain that she had arrived at hospital at 7am but gave a reason for remembering the time, namely that she arrived at the time of a shift change, which occurred at 7am. The defendant has in any event offered no testimony to counter her evidence, save for the vague assertion that because the hospital records commenced at 9:30am, they must be correct. I have no hesitation in accepting the evidence of the plaintiff as being the truth. She is a woman who had endured multiple births prior to this one and was thus in a position not only to compare what happened, or did not happen, during the course of this labour with her earlier births, but was also aware of her responsibilities in dealing with labour and childbirth as evidenced by the fact that she, as early as possible, reported the fact that the foetus was a large one and that she consequently required a caesarean section. She was also more qualified to, for example, know whether or not she had been placed in the McRoberts position during childbirth as her previous labours had not required her to be placed in such position. She almost certainly would have noticed that she was being placed in the McRoberts position in the circumstances, more especially because she was obese and would have required a number of attendants to place her in this position, and to hold her there. On her evidence, she was not placed in this position and no attendants assisted.

[37] With regard to the question of negligence, Dr. Ebrahim testified that the failure in the circumstances to undertake a caesarean section and, in the alternative, given the list of risk factors present, the failure by the hospital staff to develop a proper management plan so as to ensure that the birth went smoothly by, in particular, following the regimen set out in exhibit "B", amounted to negligence on the part of the medical staff. Whilst Dr. Nelson initially appeared to be unhappy with these assertions, he ultimately came around to accepting, as I have indicated, that in a number of respects the treatment given to the plaintiff by the medical staff was substandard. In my view, given the fact that any doctor and midwife performing obstetrics would be fully trained in the norms and standards of managing shoulder dystocia, Dr. Ebrahim's evidence that the series of risk factors present (which would have been reasonably obvious to any alert midwife and doctor) required such staff to immediately set about putting the necessary management plan in place, conforms with both reason and logic. At the end of the day Dr. Nelson conceded that the majority if

not all of these indicators were indeed present in this matter, save for the question of diabetes. The entire debate with regard to the size of the foetus and whether it could be scientifically determined falls away on the evidence of the plaintiff

as she informed the nurse that her baby was large. The nurse must have accepted this because this information spurred her into filling out the necessary forms required to set in motion the caesarean section procedure and one can only thus conclude that she believed that the foetus was indeed large. Dr. Nelson, in addition, initially accept that palpitation of the plaintiff's abdomen (had it been done) would have at least established that the baby was either "large" or "small". It seems that the baby was very large, having been described as "massive" on birth (at 4.95 kg), and that in all likelihood such a large object in the plaintiff's womb would have been detected on palpitation despite the size of the plaintiff herself.

- [38] Regarding the question of diabetes, it was common cause that no test had been done for this condition, either during the clinic visits or at the hospital. This, in itself, it appears to be substandard but it resulted in the hospital staff not being aware as to whether or not the plaintiff indeed suffered from diabetes. Dr. Ebrahim made it clear that in many cases gestational diabetes occurs, more particularly in obese mothers. There thus seems to be a fair likelihood that diabetes may well have been present which, according to both Dr. Ebrahim and Dr. Nelson, kicked the possibility of shoulder dystocia onto a higher rung.
- [39] To an extent, I can understand the argument that the high cost of a caesarean section and the rarity of shoulder dystocia might cause some reluctance to carry out the clearly more complicated procedure of a caesarean section as opposed to a natural birth, but I cannot understand this argument in the context of a natural birth itself. Surely, when one has the time as the staff had in this case, and when multiple risk factors are present, it is a relatively simple matter to put in place those things necessary to minimize the risk of shoulder dystocia even if it is a rarity and unlikely to happen. I am of the view that medical staff who choose to ignore such risk factors and blithely proceed with a normal birth without employing the norms and standards which are internationally recognized to minimize the risk, are playing with fire. Because of the rarity of shoulder dystocia their failure will not be detected in the normal course, but the time will inevitably come when shoulder dystocia will occur, as in this case, and they will have to take responsibility therefor.
- [40] Whether or not the circumstances required a caesarean section, I am of the view that the following factors indicate that the doctor and midwife did not act with reasonable care and without negligence in failing to prevent or at least minimize the effects of the shoulder dystocia. These are:
1. The failure to detect all the risk indicators and to assess their cumulative effect in diagnosing the likelihood of shoulder dystocia;
 2. The failure to, accordingly, prepare and put in place a management regimen or plan for dealing with the potential of shoulder dystocia;

3. The failure to take into account the obvious and important information imparted to them by the plaintiff to the effect that a medical doctor had ascertained that the foetus was a large one and the failure to palpitate the plaintiff to confirm this;
4. The failure to arrange for an attendant or nurse to take exact notes of what was going on as matters unfolded;
5. The failure to have sufficient assistants on standby;
6. The failure to place the plaintiff at the edge or end of the delivery bed so as to assist with the delivery;
7. The failure to place the plaintiff in the McRoberts position with the help of assistants, more especially as there were apparently at least two other nurses or assistants available in the labour ward who did not assist or who were not called upon to assist;
8. The failure to cut a wide episiotomy;
9. The failure to apply suprapubic pressure to force the anterior shoulder under the symphysis pubis;
10. The application of fundal pressure.

[41] I shall now turn to the question of causation. It was the evidence of Dr. Ebrahim that most cases of brachial plexus injury follow shoulder dystocia. He testified further that where brachial plexus injury occurs in association with shoulder dystocia (as is the clear case here, the medical records reflecting that shoulder dystocia occurred) and where, in addition, it is shown that there had been clear mismanagement of the labour and childbirth (particularly in the case where shoulder dystocia should have been anticipated as a possibility and no management plan was put in place therefor), there exists a high probability that the injury was caused as a consequence of the mismanagement.

[42] Doctor Olivier supported this view and testified that in his experience, brachial plexus injuries such as existed in the instant

case result in most cases from difficult births. In the instant case, the birth was a difficult one by virtue of the fact that there was shoulder dystocia. In addition, he testified that brachial plexus injuries often occur due to traction on the head. Furthermore, it was his evidence that the displaced mid shaft fracture to the right arm is, in itself, indicative of the fact that substantial force was used.

[43] Dr. Nelson, whilst initially pointing to exceptional cases where brachial plexus injuries have occurred without the existence of shoulder dystocia, ultimately and under cross examination conceded that it is more likely that, given the facts of this case, the brachial plexus injury was caused as a consequence of the shoulder dystocia. Once this concession was made by Dr. Nelson, which fits hand in glove with the evidence of both Dr. Ebrahim and Dr. Olivier, it follows that there is no real dispute that the causal nexus between the

mismanagement of the shoulder dystocia, as I have detailed earlier in this judgment, and the brachial plexus injury has been established on a balance of probabilities.

[44] It is also necessary for me to deal in this regard with the case referred to by Dr. Nelson, in argument by the defendant's counsel Mr. Luzipo, and to which I have referred above[6]. The judgment was referred to in an article by a London solicitor, Matthew Trinder, entitled "Erb's Palsy Alert" in which he quoted from that judgment as follows:

"The evidence of the obstetric experts reveal that in medical science and literature a change in the view of the profession has occurred over the last 10 to 15 years. Whereas formerly it was the universally accepted view that OBPI (obstetric brachial plexus injury) was caused by the efforts of the obstetric staff to deliver a shoulder that is stuck, typically due to shoulder dystocia, the consensus view now is as follows, and I cite from a guideline paper of December 2005 from the Royal College of Obstetricians and

Gynaecologists: 'Not all injuries are due to excess traction by the accoucheur and there is now a significant body of evidence that maternal propulsive force may contribute to some of these injuries. Moreover, a substantial minority of brachial plexus injuries are not associated with clinically evident shoulder dystocia. In one series, 4% of injuries occurred after a caesarean section. Specifically, where there is Erb's Palsy, it is important to determine whether the affected shoulder was anterior or posterior at the time of delivery, because damage to the plexus of the posterior shoulder is considered not due to action by the accoucheur. Whilst I heard that there are a minority who maintain that OBPI caused by propulsive forces of labour is an unproven hypothesis, Mr Jarvis [expert for the Claimant], while essentially maintaining that position, accepted in cross-examination that, where OBPI has occurred during birth to a posterior shoulder, it is more likely that this is due to the propulsive forces of labour, and in the absence of forceps or ventouse delivery it is overwhelmingly likely not to be the fault of the delivery attendants There was, in any event, no expert evidence in this case or cited in the literature that could support a finding that the actions of the birth attendants could at any stage cause injury to the posterior shoulder of a baby delivered in the manner Jack was delivered. Neither did Mr Jarvis, the Claimant's expert, suggest that any such injury could be so caused".

[45] Mr. Schoeman has submitted that the present case is distinguishable from the Beggs case. I agree. It was Dr. Ebrahim's evidence that, although there was no direct evidence of this, by inferential reasoning he could establish as being more probable than not that the baby's left arm (the arm which suffered the brachial plexus injury) was indeed the anterior arm during birth. He put forth a number of convincing reasons for this, the most important of which being the fact that in the majority of cases the brachial plexus injury occurs in the left arm and the fact that it was the right arm which suffered a displaced fracture. As testified to by Dr. Olivier, it was the right arm which had suffered from a high degree of traction, an indication that this was the posterior shoulder and arm which had been used by the midwife in order to manipulate the foetus out of the blockage caused by the shoulder dystocia. He thus agreed with the judgment in the Beggs case but maintained that there was sufficient

evidence in this case to establish that it was more than probable that, unlike in the Beggs case, the infant's left shoulder was in the anterior position.

[46] Furthermore, in this matter there was the evidence from the plaintiff that the midwife had to insert her hands into the plaintiff's

vagina in order to undertake a series of manipulations which, in themselves, are indicative of the fact that she had had to either

force the right posterior shoulder sideways in order to alleviate the blockage and/or had to apply downward force to the head of the baby.

[47] I did not understand Dr. Nelson to seriously contest the foregoing. It appeared to me that he relied largely on the exceptions to, in his argument, prove the rule. I accordingly find that the plaintiff established on a balance of probability that indeed the brachial plexus injury resulted from the negligent conduct of the medical staff.

[48] In the result, I rule in favour of the plaintiff and grant the following orders:

1. The defendant is found to be liable for such damages as the plaintiff may prove arising from the injury caused to her minor child, I. P.;
2. The question of the minor child's damages is adjourned sine die for later determination;
3. The Defendant is to pay the costs of suit, together with any costs which may have been reserved, such costs to include:

3.1 the cost of two counsel;

3.2 the traveling and accommodation costs of plaintiff's legal representatives, their costs in preparing for and consulting with the expert witnesses and preparation of heads of argument;

3.3 the appearance and qualifying expenses, if any, and traveling costs, if any, of the expert witnesses Dr. Olivier and Dr. Ebrahim;

4. It is furthermore recorded, for the purposes of taxation, that it was necessary for Dr. Ebrahim to attend court on 17 June 2014.

JUDGE OF THE HIGH COURT

HEARD ON

: 18 JUNE 2014

DELIVERED ON

: 24 JULY 2014

COUNSEL FOR PLAINTIFF : Mr Schoeman

: with Mr Sambudla

INSTRUCTED BY

: Dayimani Sakhela Inc.

COUNSEL FOR DEFENDANT : Mr Luzipho

INSTRUCTED BY

: State Attorney

- [1] Whether or not this was even contemplated is not clear, but there was in any event an inappropriate number of staff to do so.
- [2] Mitchell v Dixon 1914 A.D. 519 at 525; Blyth v Van den Heever 1980 (1) SA 191 (A);
- [3] Buls v Tsatsarolakis 1976 (2) SA 891 (T) at 894; Mukheiber v Raath 1999
- (3) SA 1065 (SCA) at 1077
- [4] 1924 AD 438
- [5] at pp. 461 - 2
- [6] Jack Beggs v The Medway NHS Trust – see paragraph 27 above.
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