IN THE HIGH COURT OF SOUTH AFRICA
EASTERN CAPE LOCAL DIVISION :MTHATHA

CASE NO. 789/2016

IN THE MATTER BETWEEN:

NOLUBABALO NDISANE **PLAINTIFF**

AND

MEC, DEPARTMENT OF HEALTH
EASTERN CAPE PROVINCE **DEFENDANT**

JUDGMENT

GRIFFITHS J:

[1] The plaintiff in this matter has claimed damages on behalf of her minor child, Simamkele, from the defendant arising from the alleged negligent treatment she received during the course of her confinement and the birth of Simamkele at St. Patrick's Hospital.

[2] At the outset of the matter, and on the application of Mr. Rowan who appeared for the plaintiff, the issues of liability and quantum were separated in terms of rule 33(4) and the court was called upon to deal solely with the question of liability.

[3] It appears from the pleadings, as confirmed by counsel, that the only issue on the question of liability was as to whether or not the cerebral palsy which afflicts Simamkele was caused by the negligent treatment of the plaintiff during the course

of her labour after she was admitted to the hospital in full labour at 11H00 on 14 September 2009, it being common cause that she was so admitted and that Simamkele was delivered by caesarean section at 15H10 on the same day. It was also common cause that the medical staff who treated the plaintiff and Simamkele were employed by the defendant and were acting within the course and scope of such employment in this regard.

[4] The plaintiff's first witness was Dr. Kara, a qualified paediatrician and neonatal expert who has extensive experience in similar matters and has testified in this regard on many previous occasions. Dr. Kara had occasion to examine Simamkele and to interview the plaintiff with regard to her memory of what happened during the course of her confinement. He was at pains to make it clear that his evidence related to his area of expertise which was to determine, insofar as he could, the stage at which the damage to Simamkele's brain occurred and the mechanism by which it occurred. After such examination and interview and on an examination of the medical records available to him, including the maternity case record from the hospital, he concluded that the damage to the brain was caused by hypoxic ischemic encephalopathy ("HIE") after excluding other possible causes as having been unlikely in the circumstances. He concluded furthermore that it was most probable that the HIE occurred during the course of her labour, that being sometime after 06H00 when the plaintiff, on her own version, went into labour and the time of delivery at approximately 15H00. This much, judging from the joint minute which was also put up as an exhibit and signed by both this witness and the defendant’s expert in this regard, Prof. Christensen, was agreed between them.

[5] Dr. Kara went further to say that the indications were such that the insult or injury would have occurred to the brain of the foetus during the latter stages of labour, that is, in all probability during the period of time whilst she was in the care of the defendant's medical staff after having been admitted at 11AM. This was so, so he testified, for a number of reasons. Firstly, Simamkele suffers from what is referred to as a mixed cerebral palsy being a mixture of spastic quadriplegic cerebral palsy and diskynetic cerebral palsy. Had the cerebral palsy been solely of the spastic quadriplegic variety, there was a slightly less chance of it having occurred later during labour. On the other hand, where the cerebral palsy is of the diskynetic type,

studies have shown that it is 80% more likely to have occurred later during labour. Secondly, the radiological report of Dr. Mnguni indicates that the damage to the brain "*is in keeping with a partial prolonged hypoxic encephalopathy in a term brain*". Whilst, in his view, there are some indications that indeed there was an acute profound insult, one would have expected, if there had been such a partial prolonged encephalopathy which commenced in the early stages of labour whilst the plaintiff was still at home or her way to hospital, that upon her admission examination the foetal heart rate ("FHR") would have reflected as being abnormal. According to the hospital records, the foetal heart rate at that stage was at that stage perfectly normal. If indeed it had been an acute profound insult, this is always more probable than not to have occurred during the latter stages of labour when there are increased contractions and thus a heightened likelihood of compromise or obstruction in the blood flow and oxygen to the brain of the foetus.

[6] Under cross-examination it was put to him that, although the plaintiff had indicated to him that she had not had any form of herbal or traditional medicine prior to her labour, such medicine could have increased the pace of the labour in that it would increase the number of contractions. He was unable to comment on this as, in his view, such medicines generally are marketed on the basis that they might increase the number of contractions but whether they indeed would have that result would depend entirely upon what the ingredients of such medicine were, and that cannot be determined. He did however concede that, because this was the plaintiff's first experience of labour, the labour did advance far quicker than expected. Once again, under cross-examination he was asked a number of aspects which fell within the province of an obstetrician and he indicated that he did not feel comfortable in dealing therewith.

[7] Dr. Hulley, an obstetrician and gynaecologist, testified that he had examined the medical records together with the opinion of Dr. Kara and had also interviewed the plaintiff herself. His evidence was to the effect that when the plaintiff was admitted to the hospital at approximately 11H00, the foetus presented with a normal foetal heart rate and all the other indicators as recorded in the medical notes, particularly on the partogram, appeared to be normal. However, it is common cause that when the baby was born by caesarean section at approximately 15H10 that very

same afternoon, the baby was compromised and suffered from HIE. Having examined the medical documents, he was of the opinion that because of the fact that all the indicators, such as foetal heart rate, lack of meconium, spontaneous rupturing of the membranes etc. appeared to be normal during the first two hours or so of her admission, the foetus must have suffered from foetal distress during the course of the last two hours prior to his delivery by caesarean section. This foetal distress clearly led to the HIE and the compromised baby (as reflected, inter alia, on the low Apgar scores) at birth.

[8] In his opinion, there was a clear lack of proper monitoring of the plaintiff during the last few hours of labour and this is evidenced by the medical records and in particular the partogram as contained in the maternity case record. A minimal amount of monitoring took place during that period according to the partogram and that which did take place prior to the vital period of time when the baby clearly became compromised. This must be so because when the foetus was monitored earlier in the labour and after admission, there was no indication that indeed there was any form of foetal distress. Had, indeed, the medical staff correctly and properly monitored the plaintiff and the foetus in accordance with, *inter alia*, the relevant nursing guidelines, and particularly during the course of the crucial period as I have mentioned, the foetal distress would have been noticed.

[9] In turn, had the foetal distress been noticed, in his view alternative measures could have been taken such as, possibly, a forceps delivery. In this regard he was challenged by Mr. Gqamane for the defence as the doctor’s note at 13H40 reflected that there was "CPS" which apparently refers to a possible contracted pelvis. It was put that the presence of CPS would negate the possibility of a forceps delivery. Mr. Hulley's view was, however, that the doctor concerned was very inexperienced and because the baby's head was already within the pelvic area, it is most unlikely that there would have been CPS in existence.

[10] Apart from forceps delivery, the possibility of which was not mentioned anywhere in the medical records, there ought to have been proper management of the plaintiff whilst awaiting the caesarean section. This would have included laying her on her left lateral side so as to take the pressure off the uterus and in turn the

aorta so as to increase the blood flow to the uterus. She should also have received an intravenous line with ringers lactate; administered a drug to reduce the uterine contractions and administered oxygen to increase the amount of oxygen in the plaintiff's bloodstream which would have in turn assisted in providing more oxygen to the foetus. Dr. Hulley could not find any suggestion in the medical records that indeed any of these management procedures were undertaken as, it appears, the foetal distress was simply not diagnosed due to lack of monitoring.

[11] It was further put to him by Mr. Gqamane that the defence expert, Dr. Koranteng, would testify that the plaintiff had indicated to him that she had taken certain herbal or traditional medicines. In Dr. Koranteng's view this would have caused her to have preterm contractions which was the cause of the HIE. Dr. Hulley did not agree at all. Apart from indicating that there is little literature on the effect of such herbal medicines, he testified that the fact that all the indications in the medical records were to the effect that the foetus had not been compromised at this stage of admission and had not gone into any form of foetal distress, ruled out conclusively the possibility of the herbal medicines having had any effect prior to admission.

[12] It was at this stage of the trial that the parties agreed to an adjournment based on the fact that Mr. Rowan was taken by surprise by the various allegations relating to the traditional medicines, as foreshadowed in an amended plea filed the previous day. At this stage, Doctor Hulley was still in the witness box facing a re-examination.

[13] On recommencement of the trial, on 4 March 2019, re-examination of Dr. Hulley was completed during the course of which, by agreement, the content of a recent report from Dr. Wright was put to him. This report was filed on behalf of the defendant shortly before the trial recommenced. Apart from one or two minor matters, Dr. Hulley agreed with this report.

[14] That was the plaintiff’s case.

[15] The defendant led one witness, that being the obstetrician and gynaecologist, Doctor Wright. In essence, Doctor Wright agreed entirely with the evidence of Doctor Hulley to the effect that the HIE must have, in all probability, occurred during the last

two hours of labour, whilst the plaintiff was in active labour. His report continues as follows in this regard:

> "During the period from 11H15 to 13H15 the FHR (fetal heart rate) was recorded every half hour. This is in accordance with the Guidelines. The FHR then rises to above 160 and no action is taken. At this stage monitoring should have become more regular. This is substandard care. Then there is a period of about two hours when there is no monitoring at all and this is also substandard care. Given the fact that the baby was born in an obviously asphyxiated state, it is probable that the prolonged partial hypoxia happened at least during the period after 13H15. She was never seen by a Doctor during all of this time because the doctor was busy in theatre.
>
> This suggests again a dereliction of duty by the MEC for Health in terms of not providing adequate staff. The partogram clearly indicates the descent of the fetal head. Therefore, had the FHR abnormalities been detected, it would have been possible to expedite delivery with either an episiotomy, vacuum extraction or forceps delivery…."

[16] And then again later:

> "During the delay in getting the caesarean section done, there is some mention regarding the administration of oxygen, turn on side etc. But there is no mention of the most basic measure viz. the administration of an agent to stop uterine activity. This is probably because the management of the patient was left solely in the hands of the Nursing staff who would not be empowered to order such drugs.
>
> All the above is indicative of substandard care and this poor care is probably resultant of the final outcome where the brain

> scan shows prolonged, partial hypoxia which has probably resulted in the eventual neurodevelopmental changes in this child."

[17] With regard to the question of traditional medicines, Doctor Wright excluded this as being a cause of the minor child's cerebral palsy because there were no complications present during the antenatal period. In addition, the brain scan shows damage to a term brain and had any of such medications been causative of such damage, one would have expected the damage to have commenced a long time prior to term.

[18] That then was the defence case.

[19] There is no dispute that the plaintiff bears the *onus* in this regard. This would be discharged were the plaintiff to establish, on a balance of probability, that a reasonable medical practitioner in the circumstances in which the nurses and/or doctors at the hospital found themselves would have foreseen the likelihood of harm occurring (in this matter the likelihood of harm occurring to Simamkele) and would have taken steps to have guarded against its occurrence, and the practitioner concerned failed to take such steps.[1] In the case of an expert, such as a surgeon, the standard is higher than that of the ordinary layperson and the Court must consider the general level of skill and diligence possessed and exercised at the time by the members of the branch of the profession to which the practitioner belongs.[2]

[20] Furthermore, where the plaintiff has presented evidence which of itself raises, at the very least, a *prima facie* case of negligence on the part of the defendant's servants, an obligation in the form of an evidential *onus* passes to the defendant to rebut such *prima facie* case and to explain how the injury came about.

[21] The only evidence which I have before me is the evidence of the three esteemed medical practitioners. From their evidence it emerges as a high degree of

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[1] Kruger v Coetzee 1966 (2) SA 428 (A) at 430; Mukheiber v Raath & Another. 1999 (3) SA 1065 (SCA)
[2] Mukheiber op cit at paragraph 32

probability that the HIE occurred during the last two hours of labour and that, during this period, there was no monitoring of the fetal heart rate and other vital signs. As I have indicated previously, both the plaintiff's and the defendant's gynaecologists are *ad idem* that this amounts to substandard care. There is no doubt that this failure on the part of the employees of the defendant was the direct cause of Simamkele's asphyxia, and consequent cerebral palsy. The failure on the part of such employees to foresee such harm and their consequent failure to take any steps to guard against its occurrence, amount, in my view, to negligence on the part of such employees.

[22] In the circumstances, I find that the plaintiff has established that the defendant is liable for any damages flowing herefrom, and grant an order in terms of a draft order handed up.

R E GRIFFITHS
JUDGE OF THE HIGH COURT

COUNSEL FOR PLAINTIFF	**:**	**Mr P A C Rowan Sc**
INSTRUCTED BY	**:**	**Manitshana, Tshozi Attorneys**
COUNSEL FOR DEFENDANT	**:**	**Mr N Gqamane Sc**
	:	**with Mr Mhambi**
INSTRUCTED BY	**:**	**The State Attorney**
HEARD ON	**:**	**04 MARCH 2019**
DELIVERED ON	**:**	**05 MARCH 2019**