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REPUBLIC OF SOUTH AFRICA

IN THE HIGH COURT OF SOUTH AFRICA
GAUTENG LOCAL DIVISION, JOHANNESBURG

CASE NO: 11/11642

(1) REPORTABLE: YES / NO
(2) OF INTEREST TO OTHER JUDGES: YES/NO
(3) REVISED.

....
DATE SIGNATURE

In the matter between:

KELEBOGILE MATLAKALA

Obo [K……..] Plaintiff

And

MEC FOR HEALTH, GAUTENG

PROVINCIAL GOVERNMENT Defendant

J U D G M E N T

KEIGHTLEY, AJ:

[1] The plaintiff in this matter, Kelebogile Matlakala ("Ms Matlakala") sues on behalf of her minor son, [K…….]. Her action is against the MEC for Health in the Gauteng Province ("the MEC"), and arises out of the alleged negligence of doctors and nursing staff employed at the Chiawelo Clinic and the Chris Hani- Baragwanath Hospital who attended to Ms Matlakala when she gave birth to [K……..] in 2004. Ms Matlakala alleges that [K……] suffered severe brain damage, and associated conditions, as a result of the negligence of the hospital staff. She seeks compensation from the MEC in the form of an award of both general and special damages.

[2] [K…….] is now almost 14 years old. The damages claim has been pending since 2011. Ordinarily, I would have preferred to have finalised the matter and delivered my judgment far sooner. However, as matters turned out, it was not possible to finalise the trial in the initial period allocated for the hearing, and the trial became part heard. After all the evidence had been led, there was a further delay as the parties undertook settlement negotiations. I was advised in the week of 21 September 2015 that no settlement had been reached, and I proceeded to prepare my judgment in the matter.

[3] The merits of the claim were dealt with by way of a stated case in terms of Rule 33 of the Uniform Rules of Court.

[4] The material undisputed facts, as set out in the statement of case, are as follows:

[4.1] On 29 November 2004 at approximately 12H00 Ms Matlakala, who was pregnant at the time, went into labour. She went to the Chiawelo Clinic for assistance.

[4.2] She was examined by staff at the clinic and informed that her cervix had dilated 1-2cm, and that she should remain at the clinic.

[4.3] Up to this point Ms Matlakala had experienced a normal pregnancy with no complications or illnesses. She had attended regular checkups at the Chiawelo Clinic.

[4.4] On the evening of the same day Ms Matlakala was again checked by nursing staff at the clinic. She was informed that she was not dilating sufficiently and would have to be transferred to Chris Hani-Baragwanath Hospital for further management of her labour.

[4.5] Ms Matlakala was transferred to the Hospital at approximately 07H00 on 30 November 2004, and arrived at approximately 08H00.

[4.6] She was examined by a doctor who advised her that she required a caesarean section as she had still not dilated further than 1-2cm.

[4.7] Ms Matlakala was sedated and received pain injections. She remained in bed in the maternity ward until 23H00 on 2 December 2004, when a caesarean section was performed on her.

[4.8] It is common cause that the labour was a prolonged labour lasting over 70 hours, and that the caesarean section was required due to cephalo-pelvic disproportion.

[4.9] It is common cause that the need for a caesarean section had been diagnosed on 30 November 2004 when Ms Matlakala was admitted to Chris Hani-Baragwanath Hospital and examined by a doctor.

[4.10] [K……] was born by caesarean section at 23H00 on 2 December 2004 with a recorded birth weight of 3.3kg and Apgar scores of 5 at one minute, 6 at five minutes and 6 at ten minutes.

[4.11] Immediately after [K……..] was born he was bagged and intubated.

[4.12] Thirty minutes after birth a paediatrician suctioned meconium from [K……..] 's pharynx and continued bagging him.

[4.13] A diagnoses of meconium stained liquor with possible meconium aspiration syndrome and possible pulmonary hypertension was made, and the baby was admitted to the intensive care unit.

[4.14] On 3 December 2004 a chest x-ray showed a right pneumothorax and changes in the lungs fields consistent with meconium aspiration syndrome.

[4.15] On 4 December 2004 x-rays showed a left sided pneumothorax that required draining.

[4.16] On 5 December 2004 [K……..] suffered cardiac arrest and needed to be resuscitated.

[4.17] On 5 December 2004 a MRI scan of his brain showed findings consistent with immediate perinatal / intrapartum / immediate postnatal hypoxic brain damage also consistent with a conclusion that he had suffered a stroke.

[4.18] [K……..] now suffers from spastic dystonic cerebral palsy.

[4.19] The joint minutes of the experts were accepted as common cause, save for certain aspects, which I will refer to shortly.

[5] In terms of the stated case, as far as the merits are concerned, I am required to determine the issues of negligence and causation.

[6] In essence, Ms Matlakala's case is that the clinic and hospital staff acted negligently in permitting her to undergo a prolonged labour for an unacceptable length of time. The prolonged labour led to *foetal* distress, causing the *foetus* to pass meconium, which was then introduced into the amniotic fluid while still in *utero*. At birth, the attending medical staff acted negligently in bagging [K……] without first clearing his mouth and airways of amniotic fluid containing meconium. The effect of the bagging was to force meconium into [K……']s lungs. This resulted in meconium aspiration syndrome ("MAS"), and [K…….]'s subsequent cardiorespiratory arrest. The MAS and cardiorespiratory arrest in turn led to the presumed peri-natal

ischaemic strokes ("PPIS") suffered by [K…….], which is the cause of his spastic dystonic cerebral palsy.

[7] The crux of the dispute between the parties arises from the following difference of opinion expressed by the medical experts for each of the parties in their joint minute:

> "*Drs Gericke and Lefakane (for Ms Matlakala) are of the opinion that a cascade of events initiated by fetal distress led to meconium passage in utero resulting in meconium aspiration syndrome, subsequent cardio-respiratory arrest and these in turn led to bilateral PPIS involving both middle cerebral arteries. Prof Cooper (for the MEC) is of the opinion that meconium aspiration syndrome, if this was the cause of the lung disease, was not necessarily preventable in this case and that recent literature is not supportive of the link between perinatal asphyxia and PPIS. He is of the opinion that, as in most cases of PPIS, the etiology in this case is uncertain*."

[8] Ms Matlakala's experts' opinion is in line with my summary of her case. Their view is that the *foetal* distress caused a "cascade of events" culminating in the PPIS and brain damage. Prof Cooper, for the MEC, on the other hand disputes that the MAS was preventable in [K…….]'s case. In addition, he points to recent academic literature placing doubt on perinatal asphyxia (lack of oxygen before, during or immediately after birth) being a cause of PPIS, and he posits that the actual cause of [K……..]'s PPIS cannot be identified.

[9] Two experts testified on behalf of Ms Matlakala at the trial. Prof Davis, who is a specialist obstetrician and gynaecologist, and Prof Gericke, a specialist paediatrician. One expert, Prof Cooper, testified for the MEC. He is also a specialist paediatrician.

[10] It is not necessary to set out a full summary of the evidence of each witness. As I will indicate in my analysis of the evidence on the material issues, there is much common ground between them, and where there is a difference of opinion, it is easily identifiable.

[11] The first material issue to consider is whether there was negligence on the part of the clinic and/or hospital staff. There are two aspects to this issue. First, was there negligence in permitting Ms Matlakala to undergo a prolonged labour of approximately 70 hours. The second aspect is whether the staff on attendance at the birth acted negligently in bagging [K…….] without first clearing his air passages.

[12] As regards the aspect of Ms Matlakala's long labour, it was common cause between the parties that the pre-birth hospital records could not be located. Consequently, there was no evidence of the details of the actual medical care that Ms Matlakala received during her labour, and the decisions made by the attending staff. However, there are general guidelines regulating safe labour practices in hospitals in South Africa, and evidence was presented to the court in this regard.

[13] Prof Davis addressed the question of the acceptable time lapse between a diagnosis of the need for a caesarean section during labour, and carrying out

the operation. He testified that the international standard is 30 minutes. However, the accepted guideline in South African state hospitals is 1 hour. In other words, a caesarean should be performed within 1 hour of the need for the procedure being diagnosed in a labouring patient.

[14] As far as the total length of labour is concerned, according to accepted guidelines, this should not exceed 14 hours. Once a labour progresses beyond this period, the baby may go into *foetal* distress, causing hypoxia. This raises the risk of the baby becoming acidotic, i.e. there is increased acidity in the blood and other tissue. It also stimulates bowel movement by the baby in *utero*, with meconium being introduced into the amniotic fluid. Babies who are born in these circumstances are often in poor condition at birth.

[15] Prof Cooper did not dispute that the guidelines required a caesarean to be performed within one hour. Under cross-examination he accepted that after a 70-hour labour, it was objectively likely that the baby was suffering from *foetal* distress at the time of his birth.

[16] Ms Matlakala's 70-hour period of labour was well outside of the accepted guidelines applicable in state hospitals. On the facts set out in the stated case, the need for a caesarean was identified on her admission to the hospital on the morning of 30 November 2004. The procedure was only performed more than 2 ½ days later. There is no explanation for this delay. The only reasonable inference to draw in these circumstances is that the delay was caused by negligence on the part of the hospital staff in failing to

ensure that the procedure was performed timeously, and in permitting her labour to proceed for an unacceptable period of time.

[17] The second aspect of negligence relates to the conduct of the hospital staff at the birth. It is common cause that [K……] required resuscitation at birth. The medical notes record that when the paediatrician arrived after birth he found medical staff bagging the baby. In other words, they were using a hand-operated apparatus to squeeze air through his airways into his lungs.

[18] Prof Davis testified that when a baby is born its mouth will be full of amniotic fluid. A health, active baby will cough out the fluid when it makes its first cry. However, a baby that requires resuscitation because it is not breathing will not be able to clear the amniotic fluid from its mouth. If there is meconium in the fluid this introduces an additional danger. Meconium is acidic and it should not be swallowed. Where there is meconium staining visible in the amniotic fluid at birth and the baby requires resuscitation it is necessary to first suck the meconium from the mouth and airways. If this is not done, the bagging will have the effect of forcing the meconium into the lungs. If this occurs, the meconium gets trapped in the lungs, ultimately causing MAS.

[19] Prof Davis testified further that it is a requirement in state hospitals to have a person skilled in resuscitation at every caesarean birth. This need not necessarily be a paediatrician, but it should be someone who is competent in resuscitation techniques. A skilled person would not resuscitate a non-vigorous baby using the bagging technique without first checking the airways

and clearing any meconium in circumstances where there is meconium staining in the amniotic fluid. To do so would represent sub-standard care.

[20] Under cross-examination Prof Cooper for the MEC agreed with Prof Davis' opinion that a skilled person should have been present at [K…….]'s birth. He also accepted that from the medical notes it appeared that no-one had cleared [K……..]'s airways of meconium before bagging him. It was only after the paediatrician arrived and took over that meconium was cleared from his pharynx.

[21] Prof Cooper did not immediately concede that the effect of bagging [K…….] without clearing the airways would have forced meconium into his lungs. His initial view under cross-examination was that this was not necessarily the case. However, when pressed, he ultimately agreed that it was likely that [K…….]'s MAS was caused by him being bagged without his airways being cleared of meconium. Furthermore, he agreed that this constituted negligence on the part of the medical staff present at the birth. He also agreed that [K……..] was likely to have been suffering *foetal* distress at the time of his birth. His view was that in cases of *foetal* distress, an expert should be present at the delivery. Under cross-examination he accepted that it would be negligent not to have a skilled resuscitation expert on hand at a delivery in those circumstances.

[22] In the circumstances, I find that there is sufficient evidence demonstrating negligence on the part of the hospital staff in the manner in which they resuscitated [K…….]. There was also negligence in the failure to ensure that

the paediatrician, or another competent person, was present at the time of the birth. The paediatrician arrived too late to prevent [K……..] from being bagged without the meconium first having been cleared from his airways. It is common cause that there was meconium staining in the amniotic fluid, and proper steps ought to have been taken to prevent or reduce the risk of the meconium entering [K…….]'s lungs. This was not done.

[23] Accordingly, I find that Ms Makalaka has satisfied the negligence requirement of her claim.

[24] I turn to consider the issue of causation.

[25] There was some initial dispute as to whether it could be concluded with any certainty that [K…….] was diagnosed with MAS in the days following his birth, or whether pneumonia was a possible diagnosis. Ms Matlalaka's experts were of the opinion that there was a MAS diagnosis. In his evidence in chief Prof Cooper's view was that although it can never be stated with certainty, the probable diagnosis was MAS. As I have already indicated, he also conceded under cross-examination that it was likely that the MAS was caused by the medical staff proceeding to bag [K…….] without first clearing his airways.

[26] In the circumstances, I proceed on the basis that on the probabilities, [K……..] developed MAS after his birth, and that this was caused by the resuscitation method used by the medical staff on hand at the delivery.

[27] The main dispute between the parties on the issue of causation is whether it can be concluded that the MAS was the probable cause of the PPIS, or strokes suffered by [K……..] that have left him with spastic dystonic cerebral palsy.

[28] As I noted earlier, both experts who testified for Ms Matlalaka concluded that the most probable cause of the PPIS and resulting spastic dystonic cerebral palsy was the cascade of events flowing from [K……..'s] *foetal* distress, asphyxia, MAS and cardiorespiratory trauma flowing from the circumstances of his birth. Prof Cooper's main point of departure from this view was based on recent literature that, in his opinion, does not establish a link between perinatal asphyxia and PPIS. In his view, the literature also does not identify cardiac arrest as a risk factor for PPIS. Prof Cooper's view, based on the literature and his own expert opinion, was that the causes of PPIS are poorly understood, and that it is often not possible to identify a determinative cause.

[29] Prof Cooper expressed the view in his oral testimony that it was possible, but not probable, that the hypoxia and cardiorespiratory arrest caused the strokes. He explained his view by stating that because the causes of PPIS are not well understood, the actual causes of the PPIS in [K…….]'s case could not be determined conclusively.

[30] However, in cross-examination, he conceded that [K……] was severely ill following his birth, and that a sick baby is at a higher risk of PPIS than a healthy baby. He conceded that if steps had been taken to ensure [K……..]'s health, he would have been at a lower risk of developing PPIS.

[31] In my view, it is not necessary to resolve the academic disputes in the literature in order to reach a conclusion on the issue of causation. I accept that the causes of PPIS are not well understood. I also accept that it is always possible that [K……]'s strokes were caused by factors completely unrelated to the circumstances of his birth. It is not possible to determine with any certainty what caused them. However, these are civil proceedings. Civil proceedings are all about probabilities, not absolutes. Even the MEC's expert, Prof Cooper, accepts that the asphyxia and cardiac arrest were possible causes of the PPIS. He also accepts that [K…….] was at greater risk of PPIS because of his poor state of health. In my view, the probabilities in this case overwhelmingly come down in favour of the view of Ms Matlakala's expert witnesses. The most probable cause of the PPIS was the "cascade of events", described earlier, flowing from the initial *foetal* distress. This caused the introduction of meconium into the amniotic fluid, and the hypoxia. [K……..]'s condition was compromised by the MAS he developed as a result of the resuscitation attempts at this birth, and his cardiorespiratory problems. In these circumstances, in my view it is more probable that the PPIS was a culmination of these traumatic events rather than it being a completely isolated and unrelated event.

[32] In the circumstances I find that Ms Matlakala has succeeded in establishing that [K……..]'s spastic dystonic cerebral palsy was caused by the negligence of the hospital and medical staff who attended Ms Matlakala during her labour and at the birth of [K…….].

[33] Therefore, on the merits, I find in favour of Ms Matlakala. It is common cause that the MEC is liable for the negligent conduct of staff members involved in the provision of health care in the clinic and hospital in which Ms Matlakala was treated. There is no question of contributory negligence in this case, and the MEC must be held to be solely liable.

[34] On the issue of quantum, counsel for Ms Matlakala submits that an amount of R1, 5000 00. 00 in respect of general damages is appropriate. The expert reports submitted in support of the claim indicate that [K……..] is totally uncommunicative and unalert. He does not make eye contact with anyone and cannot communicate by means of facial expressions. He has never learned to sit, stand or walk. He is regarded as ineducable. He will never be able to walk. He has been assessed as having the lowest level of gross motor function classification, and all areas of motor function are affected. He produces sounds, not words and his higher mental functions are severely disabled with no purposeful function. He has no social activity. He needs constant care for event the most basic functions. His condition is irreversible.

[35] This is a case involving substantial levels of pain, suffering and disablement, with a devastating loss of the amenities of life. In my view, an amount of R1,5 million for general damages is appropriate in a case of this nature.

[36] As regards special damages in the form of future loss of earnings, Ms Matlakala's actuary, Mr Jacobson, has estimated an amount of R1, 607 244.00, including a 20% contingency. The defendant did not make any

contrary submissions in this regard. In the circumstances, I accept the amount as calculated by Mr Jacobson.

[37] The major difference between the plaintiff and defendant is in relation to the costs of caregivers and residential care. Here there is a difference between the parties in the amount of R3, 202 850. 00. Mr Jacobson indicates that the figure reached by him is based on 3 caregivers at a cost of R8 350 per month over a period of 13 months per annum until [K…….] turns 30. This is to make provision for relief caregivers and an annual bonus. Mr Kramer's calculation on behalf of the MEC is based on 2 caregivers at 12 months per annum. He makes no provision for relief caregivers.

[38] It seems that both parties accept that [K……] requires the assistance of 2 caregivers at a time. The question is how best to provide for relief caregivers while the permanent caregivers are on leave, and for an annual bonus for the permanent caregivers. In my view, this will be adequately provided for by way of a calculation of an amount based on 2 caregivers, at the rate indicated by Mr Jacobson, for 14 months per annum each. This calculation should be made up until the age of 30 years. Thereafter, Ms Matlakala will be entitled to the amount calculated by Mr Jacobson for residential care for [K……].

[39] As far as the other disputed aspects between the calculations by Mr Jacobson and Mr Kramer are concerned, I find as follows:

[39.1] I accept the amounts calculated by Mr Jacobson based on Prof Erksen's report, as set out in paragraph 2 of Mr Jacobson's report dated 23 June 2015.

[39.2] I accept the amounts calculated by Mr Jacobson based on Mrs Aires and Dr Mosisi's report, as set out in paragraph 4 of Mr Jacobson's report dated 23 June 2015.

[39.3] The remainder of the itemized differences between the parties in paragraphs 3, 5 and 7 of Dr Jacobson's report dated 23 June 2015 relate to various smaller items in respect of which it seems the parties cannot agree. Without the benefit of having heard specific submissions from either of the parties in this regard, the most equitable solution I am able to reach is that these differences should be split between the parties.

[40] Save for the above, Ms Matlakala is entitled to the amounts calculated by Mr Jacobson as set out in appendix 1 attached to his report of 23 June 2015.

[41] I accordingly make the following order:

1. The defendant shall pay to the plaintiff, in her representative capacity as mother and natural guardian of [K…….] [M…….] ("[K……]"), the following amounts:

1.2 R1, 5 million for general damages;

1.3 R1, 607 244.00 for future loss of earnings;

1.4 In respect of the cost of care for [K…….], an amount calculated on the basis of two caregivers, at the rate identified by Mr Jacobson in his report of 23 June 2015, for 14 months per annum for the period until [K……] turns 30 years old, and, in addition, the amount calculated by Mr Jacobson in the aforesaid report for [K……'s] residential care for the period from the age of 30;

1.5 An amount calculated on the basis of the total of the remainder of the medical and non-medical costs itemised by Mr Jacobson in appendix 1 of his report of 23 June 2015, save that in respect of the differences between plaintiff and defendant indicated by the amounts identified in bold and underlined in paragraphs 3, 5 and 7 of page 2 of Mr Jacobson's report ("the identified amounts"), Mr Jacobson's calculation in favour of the plaintiff must be reduced by half of each of the identified amounts.

2. Interest on the aforesaid amounts at the rate prescribed in terms of section 2A of the Prescribed Rate of Interest Act 22 of 1975 from the date of judgment.

3. Du Plessis Attorneys are directed to cause a deed of trust, to be named the ["K…….] Trust" to be registered by the Master of the High Court incorporating the provisions normally to be found in an *inter vivos* trust within 3 (three) months of the date of this Order, or such longer period as the Master may on application direct, with the following additional provisions:

3.1 that there will be, if practically possible, three trustees consisting of the plaintiff, an attorney and a chartered accountant;

3.2 that the trustees appointed or their successors in title shall have the powers of assumption;

3.3 the trustees shall be exempt from furnishing security;

3.4 the trustees shall hold and administer the trust fund for the benefit of [K……..];

3.5 the Trustees shall apply the nett income of the Trust fund for the maintenance and benefit of [K……..] and, if at any time it is not adequate for the purpose, the capital thereof;

3.6 the Trust shall terminate on the death of [K…….], alternatively in accordance with the Trust Deed.

4. The defendant is ordered to pay the plaintiff's party and party costs of suit.

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R KEIGHTLEY
ACTING JUDGE OF THE HIGH COURT OF SOUTH AFRICA
GAUTENG LOCAL DIVISION, JOHANNESBURG

Dates Heard:	12 & 30 June 2015
Date of Judgment:	2 October 2015
Counsel for the Applicants:	Adv D Brown
Instructed by:	Du Plessis Attorneys
Counsel for Respondent:	Adv URD Mansingh
Instructed by:	State Attorney, Johannesburg