IN THE HIGH COURT OF SOUTH AFRICA

(GAUTENG DIVISION, PRETORIA)

DELETE WHICHEVER IS NOT APPLICABLE

(1) REPORTABLE: YES/NO.

(2) OF INTEREST TO OTHER JUDGES: YES/NO.

(3) REVISED.

18 September 2020

DATE SIGNATURE

Case Number: 91622/2016

In the matter between:

DORAH THEMBA N.O PLAINTIFF

and

THE MEMBER OF THE EXECUTIVE COUNCIL FOR HEALTH, MPUMALANGA DEFENDANT

JUDGMENT

HUGHES J

Introduction

[1] On 24 March 2007, the plaintiff, Dorah Themba, presented herself at the maternity ward of Rob Ferreira Hospital (the hospital) and eventually gave birth to a baby boy, Bongani Mangaliso Themba (the minor child). This is a delictual claim for damages brought by the plaintiff, as the mother and natural guardian of the minor child, born with mixed cerebral palsy, microcephaly and profound intellectual disability (the injury). It is alleged that the injury to the minor child occurred as a result of the negligence of the nursing and medical personal of the hospital, which staff were in the employ of the defendant.

[2] At the commencement of the trial it was agreed by the parties that in terms of rule 33(4) of the Uniform Rules of Court, the matter would only proceed on the issue of liability, negligence and causation, whilst the issue of quantum will hold over.

[3] From the outset it must be pointed out that this trial proceeded on the basis that the hospital records filed to be utilised in these court proceedings were not complete. The documents which were not at hand were the intrapartum records of the plaintiff's maternity records. In addition, there were no CTG tracings, there were only two partograph readings and the neonatal records were not available at all. I deal with this later in the judgment.

[4] It must be mentioned that the trial proceedings in this matter commenced on 18 March 2019 and the trial was ultimately completed, amidst many hiccups and postponements, on 17 May 2019. The parties filed their heads of argument by the 25th June 2019 and closing argument was heard on 7 August 2019. The process of obtaining the record of the proceedings, due to the lengthily trial, culminated in a delay in dispatching this judgment.

Background

[5] The plaintiff was 21 years of age and the minor child was her first child. It is recorded that her first antenatal visit was on 7 November 2006 and at that stage she was 22 weeks pregnant. She was expected to deliver by 12 March 2007. During the course of her pregnancy she had four antenatal clinic visits with her last one being at 39 weeks, on 7 March 2007. At that visit it was recorded that she was a low risk and there were no abnormalities recorded at any of her antenatal clinic visits. She carried

her baby to term and at 11h00 on 24 March 2007 she presented herself at the hospital as she was experiencing labour pains.

[6] At 20h05 on 24 March 2007 the plaintiff delivered her minor child by way of normal vaginal delivery and the minor child weighed 3.05kg, with his Apgar scores recorded as 6/10 at 1 minute and 8/10 at 5 minutes. It was recorded that at birth the nuchal cord was wrapped around the minor child's neck, twice and was tight. The minor child had to be resuscitated and suctioned at birth.

[7] The plaintiff alleges that whilst she was in labour the nursing staff failed to afford her the necessary attention, failed to properly monitor the foetus and they provided no or unreasonable medical care, which resulted in the minor child suffering a hypoxic ischemic insult in the intrapartum period. Hence, the minor child has permanent cerebral palsy and mental retardation.

[8] On the other hand, the defendant submits:

'1. That the staff of the Hospital properly monitored the Plaintiff and that there was no record of distress until the last stage of labour;

2. That the minor child had a nuchal cord around his neck and that nothing in the Plaintiff's antenatal period, nor during her admission to the Hospital would have raised an alarm of a nuchal cord around the neck;

3. That the staff of the Hospital did everything in their ability to monitor the Plaintiff's labour until delivery, and that they could not predict or prevent the nuchal cord.'

Issues to be determined

[9] It is common cause that, on the day in question, the nursing staff administered sub-standard monitoring when they attended to the plaintiff and the foetus. The first order of determination is whether this sub-standard monitoring resulted in the minor child suffering from birth asphyxia. Second, did the nuchal cord wrapped twice and tight around the neck constitute a sentinel event? Lastly, whether the plaintiff has established causation.

Plea to the plaintiff's claim

[10] The defendant pleads as follows to the plaintiff's assertions that they are liable for the sub-standard monitoring, which culminated in the injury of the minor child.

[11] 'Ad paragraph 4-12

4.1 Each and every allegation herein contained is denied as if specifically traversed, and the Plaintiff is put to the proof thereof.

4.2 The Hospital staff properly monitored the Plaintiff according to the Health Standards. The Plaintiff progressed very well during labour and there is no record of distress until the last stage of labour.

4.3 The Defendant further pleads as follows:

4.3.1 The nuchal Cord around the neck of baby Bongani when the umbilical cord wraps around the baby's neck for 360 degrees.

4.3.2 In the antenatal period it may be suspected at CTG when you get variable decelerations, but it cannot be differentiated from an occult cord compression.

4.3.3 Experienced sonographers may identify it by ultra sound prior to labour.

4.3.4 Nuchal cord can cause perinatal hypoxia and numerous studies cited by Morarji (2017), do list tight nuchal cord as one of the causes of perinatal acidosis (birth asphyxia)

4.3.5 Predicting and diagnosing nuchal cord in the antenatal period and during labour is difficult, experience dependent and requires high tech equipment like colour Doppler ultrasound and a high index of suspicion.

4.3.6 Ms Themba was at 39 weeks when she was admitted, throughout her stay at the Hospital and during her labour the fetal [foetal] heart rate was normal when it was auscultated.

4.3.7 The membrane did not rupture early in labour and so she was not at risk of cord prolapse.

4.3.8 There was nothing in her antenatal period nor her admission that would have raised an alarm of a possible nuchal cord in this case.

4.3.9 The staff at the regional Hospital did everything in their ability to monitor the Plaintiff's labour until delivery; they could not predict or prevent the nuchal cord.

The evidence

Documented events of the 24 March 2007

[12] From the outset it must be pointed out that the available information in this case is insufficient. The defendant has informed this court that parts of the plaintiff's maternity records are missing and they are not aware how this came about. Be that as it may, with the information before me, it is evident that the plaintiff arrived at the hospital and was first attended to by nursing staff at 11h00 on 24 March 2007.

[13] The plaintiff informed the nursing staff that she had been experiencing labour pains since 23h00 on 23 March 2007. An examination was conducted and she was diagnosed to be in the latter stage of labour. From the recordings, the cervix was 60% effaced and 3cm dilated, membranes were intact, head was 5/5 and mild uterine contraction. Her next examination was at 15h00 and it was documented that her BP was 110/71 with her pulse 94bpm, whilst the foetal heart rate was 136bpm and measured by way of the CTG. The virginal examination indicated that the cervix was 5cm dilated and full affixed with contraction of 2 in 10 minutes'. This was indicative of moderate contractions. The membranes were still intact, vertex was above the spine and there was no caput or moulding.

[14] The available records indicate that the plaintiff was admitted at 11h00, then the first examination was at 15h00, followed by an examination at 17h00 and she delivered the minor child at 20h45. The examination at 17h00 recorded the following:

'Reassessment done, pv done, 8cm dilated. Well effaced 80% station and contractions strong. 3: turn vital signs. No capot no moulding patient encouraged to walk around in the ward.'

The next entry on that day was at 20h45 and the narration was:

'An alive male infant delivers spontaneously with an Apgar score of 6/10, 8/10 with cord around the neck times 2 and very tight, clamped on both sides and cut, baby not breathing but pulse rate felt. Child taken to the MICO and resuscitated and sanctioned by Dr Godi and Dr Sibiya. Injected on left thigh. Placenta delivered. Episiotomy sutured. Baby was taken to nursery by doctor and sister Dorothy.'

The joint minutes

[15] The diagnostic radiologists reading of the MRI indicates chronic evolution of acute-profound hypoxic ischaemic injury in a brain of term maturity. Whilst, the specialist paediatrician noted that there were no infective, structural, genetic or thrombotic disorders on the MRI. Further, the conclusion reached from the history and clinical findings indicated that the presence of a classical cerebral palsy related to a birth injury.

[16] The nursing specialists were *ad idem* that the midwives who took care of the plaintiff during the course of her labour delivered sub-standard care. They failed to do or record maternal and foetal observations in accordance with the Maternity Guidelines (2000) during both the active phase and second stage of labour, especially so as the foetal heart rate was recorded at <120bpm (below 120bpm). The maternal observation and progress of labour were supposed to be done 2 hourly and the foetal heart observation half hourly, during the active phase of labour (Maternity Guidelines 2000). In this case the foetal heart was only recorded at 15h00 and 17h00 on the partograph and not again after that, until 20h45 when the baby was born.

[17] The paediatric neurologists importantly conclude that there is evidence for the timing of the acute profound hypoxic ischaemic injury to the intrapartum period. The MRI indicates the minor child's brain changes are in keeping with chronic *sequelae* of acute profound ischaemic injury. They agreed that the child had mixed cerebral palsy

with microcephaly and profound intellectual disability. From the history obtained from the mother they agree that the child suffered a moderate neonatal encephalopathy. The child's motor disability is severe, such that it falls within, Gross Motor Function Classification System V. The limited medical records were considered to be suboptimal.

[18] The specialist obstetricians noted that at admission 11h00, the foetal heart rate was recorded as 137bpm per the CTG and there were no foetal concerns raised. At 15h00 the plaintiff had progressed into active phase of the first stage of labour, the foetal heart rate was 136bpm and there were no concerns of the foetal well-being. Concerning was the fact that the foetal heart rate was not monitored every 30 minutes in this active phase as is required. Thus, before delivery there was no evidence of the foetal condition. Vaginal delivery took place at 20h05 with the child weighing 3050grams and the umbilical cord was tightly around the neck twice. Child did not cry and had to be resuscitated. They concluded that sub-standard monitoring took place during the active phase of labour especially so during the intra-partum care of the plaintiff.

The Plaintiff's testimony

[19] From the testimony of the plaintiff she was attended to by the nursing staff on only two occasions. The first being on her arrival and admission and the next being when she was giving birth.

[20] She testified that she started feeling pains at 23h00 on 23 March 2007, an ambulance was called and she was transported to the hospital. On her arrival she had to complete some forms, thereafter a nurse escorted her to a room where she was fitted with a belt around her stomach (CTG) for half an hour and was instructed to walk along the passage. She was persistent that the CTG was only fitted around her stomach in the morning only. It was put to her during cross-examination that there would be testimony from Sr. Mathebula that the CTG was also fitted at 16h00, she vehemently denied this. This proposition put to the plaintiff was in fact incorrect as Sr. Mathebula denied that she used the CTG on the plaintiff at 16h00.

[21] The plaintiff states that she did walk along the passage with difficulty, as she was in pain, eventually due to the strong pains she returned to the bed. She did try to scream for assistance from the nursing staff, but none was forthcoming. At some stage a nurse 'peeped into the room. The child was crowned with the head, because as I was screaming, I heard [felt] my legs open…she then called the others and they came running'.

[22] The plaintiff stated that she was told to push and she complied. An episiotomy was performed, as she indicated that she was 'cut' to assist the baby to be delivered. During cross-examination the episiotomy was an issue. This was so, as it was put to the plaintiff that this procedure was never performed. However, the plaintiff was adamant that it was performed and this was later corroborated by Sr. Sithole who conducted the procedure.

[23] As regards the delivery of the baby the plaintiff testified that the baby was removed with the assistance of an apparatuses and he was not crying on delivery. The four nurses who had been busy with the delivery then called a doctor. They administered to the minor child thereafter a nurse brought the child to her, to show her the child. He was thereafter removed to the nursery and only discharge on 23 April 2007.

Testimony of the nursing staff

[24] The first nurse who attended to the plaintiff was Sr. Mathebula, a nursing sister who had been working at that specific hospital since 1990. She had no independent recollection of the events of the day in question and used the record before her to assist in advancing what had transpired on that fateful day. She had examined the plaintiff and made the entry in the records of 15h00 and her next entry was made at 17h00. The latter entry was quite controversial as there were two plotting's on the partograph for that exact time, being 17h00. Sr. Mathebula testified that she had made an error and she failed to delete the incorrect entry of the two.

[25] She further testified that she had no independent recollection what the foetal heart rate was. She intended to plot the marker at 160, indicating the foetal heart rate was normal. However, she plotted in the wrong column, that being below 120, instead

of plotting in the column being above 120. According to Sr. Mathebula at 17h00 she had monitored the foetal heart rate with a fetoscope and did not fit a CTG belt on the plaintiff.

[26] Regarding the hand over at 18h30 to the nurse coming on duty, she testified that this was conducted 'verbally'. She concurred that there was no monitoring with the fetoscope or CTG of the foetus since her last entry at 17h00 until the child was delivered. Significantly, no foetal monitoring took place between 15h00 and 17h00 when she was the nurse on duty.

[27] The nurse who took over from Sr. Mathebula was Sr. Sithole and she saw the plaintiff at 19h20 and on examining the plaintiff, by way of PV, the plaintiff was fully dilated. During the course of the delivery process an episiotomy had to be performed to clear the way as the delivery method was NVD, which she did with the assistance of another nurse. This is when she noted the cord around the baby's neck tight x2, which she clamped on both sides and cut in the front and back.

[28] The records reflect that she had documented that there had been a placental clot. However, in her testimony she dismissed this as an incorrect entry. This is so, she stated, because the blood loss recorded was 200ml, which is low for the occurrence of a retro placental clot. The blood loss was within the normal range of 500ml for a normal birth.

[29] Apparent from her testimony is that no foetal heart rate was recorded at all by Sr. Sithole, though she testified that she had done so. Further, she acknowledged that the only way to detect foetal distress was by monitoring of the foetal heart rate. The signs of distress being that the baby would either have a tachycardia or a bradycardia in these circumstances. She examined the cord and noted it was normal as the three blood vessels was present. Sr. Sithole's note at 20h45 is set out above.

[30] Incidentally, Sr. Bembe was actually the senior sister in charge on that day with Sr. Sithole being an assistant nurse at that time. She testified that she was present when the delivery occurred and that she educated Sr. Sithole how to cut the cord on that day. This nurse brought in a new dimension to the missing records. She testified that during the course of delivery the nurses also drafted 'progress notes', which were

separate notes and these notes were also missing. This was to explain that if there was testimony of evidence which did not appear in the maternity record it would most certainly have been present in her progress report.

[31] Sr. Bembe conceded that if there had been no monitoring, it stands to reason the nursing staff would not be able to pick up that the foetus had a problem. She further conceded that she did not check and counter sign the maternity records of the plaintiff, as she was required to do. Notably she stated that she did not have an independent recollection of this specific delivery and she was relying on what procedure ought to have been followed.

Expert's evidence

[32] Critically and of relevance is the fact that all the expects, Dr Mbokota, Prof. Hofmeyr and Solomons, concur that from the records on hand monitoring of the plaintiff and the foetus was sub-standard and not in terms of the Maternity Guidelines. They also considered the defendant's submission that a *sentinel event* occurred, being the nuchal cord wrapped twice tightly around the child's neck. Which could have resulted in a nuchal cord occlusion that resulted in hypoxia during the labour process.

[33] Commencing with the evidence of Prof. Solomons is best in these circumstances as his evidence was not challenged. He primarily addressed the importance and accuracy of the Apgar scoring in this specific case. He testified that as this system of scoring is subjective, it is notoriously inaccurate, especially so in this instance as there was no cord gas recording confirming acidosis. He opined that as the child '… was not breathing and they have noted that he was not breathing so this would have been the type of child that you would want to know what the cord gas shows...'. He concluded that the available evidence supported hypoxic ischaemic encephalopathy as the cause of the condition of the child. As regards the issue of the nuchal cord around the neck he advanced that this can occur in one to three births out of ten, stressing that there is no definitive link between that and outcome in large studies.

[34] Prof. Solomons commented on an article relied upon by Dr Mbokota, the defendant's expert, that nuchal cord occlusion could cause birth asphyxia. Regarding

the reliance on such article Prof. Solomons stated the following in summary: '…I think for me to summarise this article, there is a potential that nuchal cord can cause issues but it is based on very selective articles but one has to weigh the article up against sort of fairly recent articles which is a large sample in size…'. Notably, he did not dismiss the fact of the nuchal cord being a potential cause of the injury.

[35] Both Prof Hofmeyr and Dr Mbokota agree that the monitoring by the nursing staff of the plaintiff and the foetus was substandard. The real bone of contention lies with the issue of the nuchal cord tight and x2 around the foetus' neck. Whether this cord occlusion was such that it complicated and resulted in the injury to the minor child.

[36] Prof. Hofmeyr took issue with the fact that there was no record of monitoring between 15h00 and 17h00, at the latter there were two conflicting dots plotted on the partograph indicating the foetal heart rate, one in the normal range and the other below 120bpm. Coupled with this there were no notes explaining the conflicting dots in respect of the foetus. This abnormality required continuous monitoring and a consult by a senior obstetric, which was not done. She opines that the second dot could be considered as a deceleration and as such this is indicative that the foetus is experiencing difficulties.

[37] She testified that a nuchal cord around the neck is fairly a common finding in term deliveries. The time when the nuchal cord around the neck becomes relevant is when it causes a vascular obstruction, causing some form of cord compression to cause a symptomatic nuchal cord. This she states is only measurable by monitoring the foetal heart rate since cord compression is not visible during labour. The foetal heart rate informs one how the foetus is fairing during the delivery process.

[38] Significantly the professor points out that if there was any nuchal cord compression this would take a while to compromise the foetus, as the foetus is able to reserve and manage the stress of low oxygen for a while. This relief occurs when there are contractions and the foetus will also overcompensate by making its heart beat faster take place. Thus, in the foetal heart rate readings one will detect decelerations if monitored correctly.

[39] In this instance it was first two hours to the next reading then three hours to delivery that had elapsed. The deceleration recorded on the partograph should have been a marker to indicate that the heart rate was getting worse. At that stage, she opines, there would have been time to implement corrective measures and oxygenate the mother as it was three hours before delivery when this marker showed up. She suggests that intrapartum resuscitation could be implemented and/or an expedited delivery by caesarean section.

[40] From the outset it must be pointed out that Dr Mbokota confirmed that the nursing staff failed to comply with the prescribed procedure as set out in the Maternity Guidelines with respect of the monitoring of the plaintiff and the foetus. Critically of Dr Mbokota's evidence is that he admitted that he could not comment on the partograph and the controversial two dots as he had not been placed in possession of those documents when he was called upon to advance an opinion. However, he was adamant in respect of the allocation of 160bpm on the partograph that:

'If the heart rate of the foetus is 160, even if it is regarded as being in the normal range…Yes. That is a red flag. --- It is a red flag because now it is on the upper limit of normal.'[1] [That underlined is the Dr's evidence]

[41] Not much of Dr Mbokota's evidence was relied upon in the defendant's argument but for the reliance on his analysis on the article he placed on reliance. However, he confirmed that the nuchal cord around the neck would only result in hypoxia if it was tight and is occluded. Further though the nuchal cord may cause hypoxia, it does not always cause hypoxia. Having been made aware of the information that was omitted for his assessment. Dr Mbokota proceeded to amend his report and sought to now include the intrapartum stage. He now took into account the information that had not been provided and stated that in the antenatal and intrapartum stages, it may be suspected on the indication of decelerations. That being hypoxia occurring, however he stated that it could not be differentiated from occult cord compression.

[1] Volume 4, lines 1-5, pg. 494 of the record.

[42] Dr Mbokota in his testimony explained that such a nuchal cord around the neck resulted in hypoxia if it was tight and got occluded. However, a nuchal cord such as in this case can cause hypoxia but not always.

[43] Dr Mbokota was at pains to stress that '[no]w when there is no mention of meconium in a case of birth asphyxia, then it means it is an important negative that was not mentioned. It means that the liquor was clear, because liquor can either be clear or it can have meconium, or blood stained.' Even though there appeared no inscription about the liquor being clear in the records, he was adamant that the liquor was clear.

The hospital records or lack thereof

[44] In *Khoza v MEC for Health and Social Development of the Gauteng Provincial Government*[2] it was pointed out that not only must the 'records on hospitals and clinic be maintained and safely stored but also that adequate controls of access are put in place.' Thus in terms of sections 13 and 17 of the National Health Act 61 of 2003, 'the person in charge of a health establishment must ensure that a health record containing such information as may be prescribed is created and maintained at that health establishment for every user of health services' (s13) and 'must set up control measures to prevent unauthorized access to such records' (s17).

[45] Failure to adhere to the protocols set out by the legislature as regards compliance with the National Health Act attracts criminal sanctions and stiff penalties in relation to medical records disappearing, being falsified or tampered with.

[46] It must be stressed that the defendant provided the plaintiff with incomplete hospital records. This is not an instance where there are no hospital records at all. However, this is a case where vital hospital records are missing from the maternity file. No attempt has been made to proffer an explanation for the disappearance of these essential records, at all. Clearly, this will have an adverse effect on the probative value of such evidence, I say so as the plaintiff is the party who needs the evidence to prove her case against the defendant.

---

[2] *Khoza v MEC for Health and Social Development of the Gauteng Provincial Government* 2015 (3) SA 266 (GJ) at para 34.

[47] Thus, the argument for an order of *res ipsa loquitur* does not resonate with the facts of this particular case. Even though the documentary evidence is sparse there is still the evidence of the medical staff that attended on the plaintiff on the day in question. Their evidence in fact substantiated the medical notes of the nuchal cord x2 tight around the baby's neck.

[48] In my view, the documentary evidence ought to be admitted, even though it may be found, later having heard the secondary evidence of the witness, that in fact the evidence is untruthful or unreliable. This is in line with the courts rational in *S v Ndlovu and others*[3] as the interest of justice dictates its admissibility.

Delictual claim

[49] To succeed with her delictual claim the plaintiff has to demonstrate that the defendant was wrongful/negligent, that the wrongfulness/negligence of the defendant caused the injury and that it was only through the fault of the defendant that the harm ensued. In this case the defendant takes issue with the causation component. [4]

[50] In approaching the case before me I am guided by the dicta in *Oppelt*.[5]

'The correct approach to the evaluation of medical evidence is the one laid down by the Supreme Court of Appeal in *Linksfield* where it held that—

'it is perhaps as well to re-emphasise that the question of reasonableness and negligence is one for the court itself to determine on the basis of the various, and often conflicting, expert opinions presented. As a rule, that determination will not involve considerations of credibility but rather the examination of the opinions and the analysis of their essential reasoning, preparatory to the court's reaching its own conclusion on the issues raised.'

[51] The first enquiry would be if the nursing staff were negligent in their conduct and if there was a negligent breach in monitoring the plaintiff and the foetus. If answered in the positive, then the next enquiry is whether the negligent conduct or omission was the cause of the injury or harm of the minor child. If it did then, the next

---

[3] *S v Ndlovu and others* 2002 (6) SA 305 (SCA) at para 32.
[4] *Oppelt v The Head: Health, Department of Health, Provincial Administration: Western Cape* 2016 (1) SA 325 (CC).
[5] *Oppelt* at para 36.

enquiry is 'whether the negligent act or omission is linked to the harm sufficiently closely and directly for legal liability to ensue or whether the harm is too remote'.[6]

Whether there was negligence?

[52] The inquiry in respect of negligence commences from the following premise, especially so in this case: 'There is, in my opinion only one enquiry namely: has the plaintiff having regard to all the evidence in the case discharged the onus of proving, on a balance of probabilities, the negligence he averred against the defendant?' [7]

[53] It is common cause amongst the medical experts and nursing experts that monitoring by the nursing staff on the day in question, of the plaintiff and the foetus was substandard. It is further common cause that the records are incomplete, vital information is lacking and important information is missing or lost. Critically, the defendant failed to abide by the Maternity Guidelines (2000) at the time in question. The lack of monitoring by the defendant's medical staff which is borne out by the evidence adduced and that fact that all the medical expert concurred that there was indeed substandard monitoring, is sufficient to conclude that the one or more of the defendant's medical staff was negligent. This conclusion is the only conclusion that could be drawn on the facts, evidence and the admission of substandard monitoring by the medical staff.[8]

[54] Put in another way, but for the medical staff failing to monitor the plaintiff and the foetus in terms of the Medical Guidelines would the harm have occurred? Further, the negligence of failing to keep proper medical records does not assist the defendant in any way. In fact, it just makes the situation worse for the defendant.

[55] The defendant argues that even though there is consensus that the monitoring by the medical staff fell short of that which is required in terms of the medical guidelines

---

[6] *Lee v Minister of Correctional Services* 2013 (2) SA 144 (CC) at para38.
[7] *Arthur v Bezuidenhout & Mieny* 1962 (2) SA566(A) at 574B; *Ratcliffe v Plymouth and Torbay Health Authority* [1998] EWCA Civ 2000 (11 February 1998):
'At the end of the trial, after all the evidence relied upon by either side has been called and tested, the judge has simply to decide whether as a matter of inference or otherwise he concludes on the balance of probabilities that the Defendant was negligent and that negligence probabilities that the Defendant was negligent and that that negligence caused the Plaintiff's injury. That is the long and short of it.'
[8] *Sardi v Standard and General Insurance Co Ltd* 1977 (3) SA 776 (A) at 780C-H.

for maternity care in South Africa, the defendant in these circumstances could not be held liable for the injury suffered by the minor child.

[56] But for the substandard monitoring by the medical staff the harm of the injury on the minor child could have been averted with corrective measures and other option being adopted sooner. Thus, in my view, but for the negligent omission on the part of the medical staff the harm would not have ensued. Added to the omission of substandard monitoring is the lack of records to even put the pieces together or scrutinise the steps taken by the medical staff. It is conclusive that the outcome would not have occurred had there been monitoring and proper record keeping in terms of the Maternity Guidelines. This much is the sentiment of all the experts.

[57] In this case we are dealing with evidence and testimony that the monitoring of the plaintiff and foetus was substandard, this is common cause or undisputed. The injury to the minor child according to the expert evidence, Prof Hofmeyr and Dr Mbokota, could have been averted had there been proper monitoring and record keeping. The nursing staff had a total of five hours before delivery to have reversed the possibility of the injury to the foetus coming to fruition.

[58] The defendant's assertion in its plea that the nursing staff did everything in their ability to monitor the plaintiff and the foetus cannot be correct in light of the records before this court and the admission on the part of the nursing staff that the maternity guidelines were not followed at all. This is even signalled out by all the experts thus the defendant cannot place reliance on the manner in which the plaintiff and the foetus was monitored. It was substandard, period.

[59] Would it have made a difference if there was proper monitoring in terms of the maternity guidelines and if there was proper record keeping in terms of their statutory obligations? The event of the nuchal cord around the neck could not have been determined externally. However, through monitoring the foetal rate would have given an indication that the foetus was in distress and that there was a problem within, which would have given the staff ample time to encage intervention, as a nuchal cord around the neck is not a strange phenomenon in delivery procedure.

[60] It was negligent of the nursing staff and the defendant in failing to adhere to their statutory duty in terms of section 13 and 17 of the National Health Act. In my view, what compounds the aforesaid is that no explanation has been advanced as to the whereabouts of the records and how it was only possible to obtain partial records with other missing. There is no explanation from the defendant at all, yet they the responsible persons, who are to ensure that the records are kept safely.

Is there a causal link between the injury and the negligence?

[61] In advancing its defence in respect of causation the defendant place reliance on a sentinel event, that is nuchal cord around the neck x2, having occurred which led to the injury of the minor child.

[62] A description of a sentinel event was advanced by Pro. Hofmeyr during her testimony: 'a sentinel event is any anticipated event in a healthcare situation resulting in death or serious physical injury that is not related to the natural cause expected…something happens that is not predictable and that has a … impact and a [is so] catastrophic ...'.

[63] As regards the issue of a sentinel event Dr Mbokota relied on an article of literature from Morarji Peesay on 'Nuchal cords and its implications', where the following was stated:

'All cases met criteria for perinatal asphyxia, had neuro emerging, findings consistent with acute hypoxia ischemia, and had no evidence for a non-hypoxic ischemia cause of their encephalopathy. On logistic regression analysis only one antepartum factor (gestation greater 41 weeks) and 7 intrapartum factors (prolonged membrane rapture, abnormal cardio topography, thick meconium, sentinel event, shoulder dystocia, thigh nuchal cord, failed vacuum) remain independently associated with HIE (area under GAV0.88; confidence intervals 0.85-0891; P.001). Tight nuchal cord was noted in 45/396 cases and 15/237 in control group with odds ratio of 1, 1.89 (1, 03-3, 5). The results do not support HIE is attributable to antepartum factors alone but they strongly pointed to the intrapartum period as the necessary factor in development of this condition. It is our speculation that the established terminology compression asphyxia is for forensic medicine (35) could be applied to this infant with tight nuchal cord because of the similarities in the pathophysiological mechanism and clinic findings. This may help in distinguishing birth asphyxia from infant with effects of a tight nuchal cord.'

[64] The evidence of Prof Hofmeyr during cross-examination is crucial to this sentinel event factor and I set out same here below:

'… the cord occlusion can happen in variant degrees at various stages during the labour process. If it is a cord around the neck, what I think is important to mention is that as the labour progress remember the contractions intensify, they become stronger, they become more regular. The baby moves down the birth canal…So whatever that connection to the cord it gets tighter and tighter and tighter. And this is a situation that intensify over time. So where might be initial reversible compression of the cord as it just starts, the contractions start putting pressure, it will definitely get worse towards delivery. And ultimately by the time that the baby's head is out and it is noticed and there are two cords around the neck and it is tight, you know that already tells me that cord was under strain and it is impossible to see for how long…you know the average cord length and the length from the placenta twice around the baby. It will have progressively gotten worse and to me that is not something that will have no signs for hours at end and then suddenly expressed just before delivery. That is something that will have shown with earlier signs of foetal compromise. And that brings me back to the partogram at 17h00.and that worries me. As that heart rate below 120 was possibly already a sign that the foetus was compensating intermittently and monitoring had been appropriately it would have shown a pattern. It would have shown that look this correlates with contractions. This is happening regularly. The heart rate is getting worse and worse. And there would have been time to implement corrective measures and oxygenate the mother. Give her supplemental oxygen so we increase her blood supply of oxygen so the baby can get more oxygen in the intervals between…That was three hours before delivery. [9] [My emphasis]

[65] Prof Hofmeyr was at pains to explain that she could not say it was the cord around the neck that had an impact on the injury to the baby or the clot on the placenta. However, she could say with the little information before her that it was a strong possibility that there was foetal compromise as a result of the tight cord wrapped around the baby's neck. She stressed that 'we do not have enough information and the critical information that is lacking is the foetal heart rate for me, that is the minimum standard of observation which would have given us an indication of whether this baby remained in a stable state or in a state of none distress in the 5 hours prior to delivery and we do not have that information'.[10]

[9] Volume 1, lines 5, page 75 to line 15 on page 76.
[10] Volume 2, 8-12, page 99.

[66] Critically, Dr Mbokota also contributed and the import of his testimony is set out below, firstly he confirmed that the nuchal cord gets tighter as the baby moves down the bath canal, 'Yes it gets worse and ultimately by the time the baby's head is out and it is noticed and there are two cords around the neck and it is tight you know that it already tells me the cord was under strain and it is impossible to say how long.'[11] [My emphasis]
He went on further to state that, 'What I could agree with is that you will see if it will compromise as the cord tightens and I will stress that to qualify that for me the cord would tighten in second stage. And unfortunately there was no monitoring also in the second stage, so that foetal compromise and foetal heart rate abnormalities if the monitoring was there would have been picked up.'[12] [My emphasis]

[67] Dr Mbokota went on further to testify when questioned by the court:
'So in fact, if I am working backwards, had there been monitoring in that second phase which was documented as being 45 minutes, the birth could have been speeded up at least, the birth would not have taken the whole 45 minutes, because they would have detected now that there is a problem. Am I right in saying that? …Yes, they would have detected that there is a problem and they would have to decide what intervention at the time…'[13][My emphasis]

[68] The options that were available to the plaintiff in the 45 minutes that had lapsed Dr Mbokota stated '...Yes, there would have been those options. The option of a Caesarean section for example you will need to conduct a safe Caesarean section….Yes it does limit that time where the cord is much tighter, but when you and when you are doing a vaginal delivery, you are pulling the baby you are literally further tightening the cord.'[14] [My emphasis]

[69] I am satisfied that in light of the evidence set out above the nuchal cord around the foetus neck tight and x2 does not, in my view, justify as a sentinel event. A nuchal cord around a foetus neck is not uncommon in delivery proceedings. For that matter even a tight nuchal cord x2 is not uncommon. Where the problem lies is that there are mechanisms in place by way of the maternity guidelines to pick up that the mother or foetus is encountering difficulties and these were not adhered to by the nursing staff. Had they been followed the nursing staff would have picked up the foetus' difficulties sooner and they would have been able to circumvent the injury earlier.

---

[11] Volume 4, lines 19, page 652 to lines 3, page 654.
[12] Volume 4 lines 2-17, page 620.
[13] Volume 4, lines 15 -20, page 659.
[14] Volume 4, lines 9-25, page 661; lines 1-4, page 662.

[70] The foetus would not have been deprived of oxygen, which ultimately led to foetal distress, if proper monitoring of the foetus was undertaken. The foetal heart rate if monitored in accordance with the maternity guidelines would have indicated that the foetus was experiencing difficulties. Following from these facts the nursing staff left the plaintiff and the foetus unattended and not monitored, which ultimately made the foetal situation worse as the time went by which culminated in the injury which ensued.

[71] At the least when the contradictory plotting's at 17h00 took place, the nursing staff should have taken this as a marker to indicate all was not well with the foetus. The explanation advanced by Sr. Sithole is simply untrue as she only remembers this birth with the assistance of the sparse records before us. But miraculously she remembers she made a mistake and she forgot to sign the mistake as is required in the maternity guidelines. This I find hard to believe as true and I reject this explanation.

[72] Turning to Dr Mbokota's persistence that since there is no mention of meconium in this case of asphyxia it then would mean that the liquor was clear and this is a positive for the defendant, cannot be relied upon considering the state of the record that are before the court. No reliance can be placed on the fact that meconium is not mentioned, had we had the complete records, which we do not, the picture might have been different. Thus, in my view, Dr Mbokota' persistence is misplaced.

[73] The relevant processes of recording by way of the partograph were totally overlooked and principle maternity guidelines were totally ignored to the detriment of the foetus. This is a classic case of 'but for the omissions' the disaster could have been averted. This is so because once there is foetal distress, deceleration in the foetal heart rate it culminates to less oxygen for the foetus for such a long period of time, at best 3hour and at worst 5 hour without monitoring. The eventuality would of cause be hypoxic ischaemic encephalopathic insult. In the result the plaintiff succeeds with proving a delictual claim against the defendant.

Costs

[74] In addressing the issue of costs, these are to follow the result and are awarded on a party and party scale.

Order

[75] Accordingly, I make the following order:

[1] The Defendant is liable for payment of 100% of the proven or agreed damage of the Plaintiff in her representative capacity on behalf of the minor child, arising from the irreversible hypoxic-ischemic brain injury, and neo-natal hypoxic-ischemic encephalopathy manifesting as mixed cerebral palsy and mental retardation, which the minor child suffered as a result of the negligent and sub-standard monitoring, management and treatment rendered to the plaintiff and the minor child relating to the Plaintiff's labour process as well as the delivery of the minor child, by the medical doctors and nursing staff of the Hospital on the 24th of March 2007.

[2] The Defendant is ordered to pay the Plaintiff's taxed or agreed party and party costs on the High Court scale relating to the issue of liability, negligence and causation, such costs to include; -

2.1 the reasonable costs of obtaining the medico-legal reports of the following experts of the plaintiff, of whom due notice was given in terms of Rule 36(9) (a) and (b); -

2.1.1 Dr Gericke – specialist paediatrician;

2.1.2 Dr Hofmeyr – specialist gynaecologist/obstetrician;

2.1.3 Dr Andronikou – specialist radiologist;

2.1.4 Prof Nolte – nursing expert;

2.1.5 Prof Solomons – paediatric neurologist

[3] the reasonable taxable qualifying and reservation fees, if any, of the following experts of whom notice have been given by the Plaintiff in terms of Rule 36(9) (a) and (b);-

[3.1] Dr Gericke – specialist paediatrician;

[3.2] Dr Hofmeyr – specialist gynaecologist/obstetrician;

[3.3] Dr Andronikou – specialist radiologist;

[3.4] Prof Nolte – nursing expert;

[3.5] Prof Solomons – paediatric neurologist;

[4] the reasonable taxable costs of the following experts of the Plaintiff relating to their preparation for and holding of joint meetings with their respective counterparts, if any, including their costs of drafting and finalising the joint minutes emanating from such joint expert meeting;-

[4.1] Dr Gericke – specialist paediatrician;

[4.2] Dr Hofmeyr – specialist gynaecologist/obstetrician;

[4.3] Dr Andronikou – specialist radiologist;

[4.4] Prof Nolte – nursing expert;

[4.5] Prof Solomons – paediatric neurologist;

[5] costs consequent upon the employment of senior junior counsel;

[6] The plaintiff's taxed or agreed party and party costs shall be paid into the trust account of the Plaintiff's attorneys, MED Attorneys, details of which are as follows; -

Mokoduo Erasmus Davidson Attorneys Trust Account
First National Bank, Rosebank Branch
Account Number: 62222488290
Branch Code: 253305

[7] The quantification of the claim is postponement *sine die.*

W. Hughes
Judge of the High Court Gauteng, Pretoria

Heard: 18 March 2019 – 22 March 2019; 13 May 2019 -17 May 2019

Electronically Delivered: 18 September 2020

Appearances:
For the Applicant: Adv A Viljoen
Instructed by: M.E.D Attorneys

For the Defendant: Adv P Managa
Instructed by: Mashaba Attorneys