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

(1) REPORTABLE: NO
(2) OF INTEREST TO OTHER JUDGES: NO
(3) REVISED: ✓

SIGNATURE 20/9/2019 DATE

CASE NO: A5010/2018

In the matter between:

TEMBISA HOSPITAL	**FIRST APPELLANT**
MEC FOR HEALTH AND SOCIAL DEVELOPMENT, GAUTENG PROVINCE	**SECOND APPELLANT**

and

M.... N..... obo V.... K....	**RESPONDENT**

JUDGMENT

Thobane, AJ

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Introduction

[1] For convenience, the parties shall be referred to as in the main trial. The plaintiff instituted a civil action in which she sought in both her personal and representative capacity, damages suffered when her baby, whom I shall refer to as "V", was born at Tembisa Hospital ("the hospital"). It was common cause at the trial that V was born with cerebral palsy.

[2] The court *a quo* found, correctly in our view, that negligence had been conceded before it and that the only issue to consider was causality. After the trial had run its course, the court found in favour of the plaintiff. The court found that the defendants were liable for damages sustained by the plaintiff in the aforesaid capacities. The defendants were aggrieved at the finding and launched an application for leave to appeal before the court *a quo*, which proved unsuccessful. They then petitioned the Supreme Court of Appeal ("SCA") for special leave. The appeal before us is with leave of that court.

[3] Counsel for the defendants identified the following issues for determination by this court:

> 3.1. whether evidence showing that there was substandard care, is sufficient to lead to the conclusion that the defendants are liable for V's neurological condition;
>
> 3.2. whether the plaintiff's evidence to the effect that there was fundal pressure applied prior the birth ought to be accepted;
>
> 3.3. whether the plaintiff is entitled to damages in her personal capacity given that the acts of negligence relied upon in the particulars of claim are confined to V's neurologically impaired condition.

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[4] Counsel for the plaintiff is in agreement with the issues to be decided as raised by the defendants but puts a slant on the issue of fundal pressure. According to the plaintiff's counsel whether fundal pressure was applied immediately before the birth, as alleged by the plaintiff, is relevant to the issue of liability.

[5] It is trite that this court is confounded to the factual and credibility findings of the court *a quo*, unless they are vitiated by irregularities or the record reflects that they are patently wrong, in which case this court may transpose them with its own findings.[1] Therefore the factual and credibility findings of the court *a quo* are an appropriate point to begin.

[6] The court *a quo* found that:

6.1. the plaintiff who was expectant, presented herself at Tembisa Hospital on 3 April 2009, complaining of pain;

6.2. she was admitted and the nursing staff kept her under observation;

6.3. at about 15h30 and also at 18h00 the nursing staff assessed her and recorded their observations;

6.4. similarly at 21h30, when they recorded that she was 2cm dilated. The fetal heart rate was noted to be 144bpm. According to the nursing plan, the court noted, fetal heart rate was to be monitored 4-hourly;

6.5. at 23h10 it was recorded that the fetal heart rate was 132bpm. The plaintiff was then transferred to a labour ward where a partogram was set up to track her labour as well as the fetal heart rate.

6.6. at 01h15 the fetal heart rate was recorded to be 120bpm, followed by a recordal of another observation seemingly at 02h15 when it was recorded to be 115bpm;

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[1] R v Dhlumayo 1948 (2) SA 677 (A) at 705-706 and Mashongwa v Passenger Rail Agency of South Africa 2016 (3) SA 528 (CC) paragraph 45.

6.7. the fetal heart rate was last observed at 03h15, when it was recorded to be 128bpm;

6.8. the baby was delivered at 05h10;

6.9 the plaintiff gave birth as a result of fundal pressure having being applied by a nurse before she delivered the baby.

[7] The court *a quo* also found that having regard to consensus between the litigants' respective obstetric experts, to the effect that there was no fetal monitoring between 03h15 and 04h45, coupled with the fact that the neonatal neurologists were of the opinion that no other cause of V's brain injury presented itself other than the acute profound hypoxic injury, which he suffered before or during birth, causation has been established.

[8] The court *a quo* had regard to the doctors' or the midwifes' notes and noted that at 01h10 on 4 April 2009, there was spontaneous draining of clear liquid and that the plaintiff was in effect in active labour. An entry made at 04h45 notes that the plaintiff was fully dilated at that time. Other entries made, this was explained by Dr Pistorius, meant that there was concern that the baby's head was too big to pass through the birth canal. At that stage the plaintiff was booked for a caesarian section. It is however, common cause that it never took place and that the plaintiff delivered the baby naturally in the ward at 05h10.

[9] When V was born, his Apgar scores were very low. The experts were in agreement that such low scores pointed to the fact that there was severe birth asphyxia. According to Prof. Kitsten, V was delivered very close to the time when he would have died. In determining causation the court *a quo* made the following finding;

"According to the experts, the critical time to assess causation is in this period. The uncontradicted evidence of Prof Kirsten and Dr Pistorius it is clear that monitoring every 30

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minutes is essential for purposes of detecting warning signs of a possible hypoxic episode. This essential monitoring was not carried out. Inevitably, this means that the nursing staff could not pick up on the warning signs that in all probability would have been evident had they monitored foetal heart rate (sic) *as required.*

Because they failed to monitor the foetal (sic) *(hence were ignorant of any warning signs of foetal distress* (sic) *caused by hypoxia) the plaintiff was denied the correct treatment that would have brought time for V while urgent steps were taken to speed up the birthing process so as to prevent the injury to his brain. From the expert testimony it is evident that had the hospital staff properly monitored V's foetal heart rate* (sic) *in the critical period, it is probable that they would have picked up the warning signs that something was amiss. It is further probable that with the proper emergency measures, V's brain injury would not have occurred."*

Legal framework

[10] Factual causation is difficult to establish. One must demonstrate that 'but for the nurses or doctors action or inaction' harm would not have occurred. In ***Minister of Safety and Security and Another v Carmichele***[2] the Court said:

> *"Causation has two elements. The first is that the factual issue which has to be established on a balance of probabilities by a plaintiff ... and the answer has to be sought by using the 'but for test' ...:*
>
> > *'In order to apply this test one must make a hypothetical enquiry as to what probably would have happened but for the wrongful conduct of the defendant. This enquiry may involve the mental elimination of the wrongful conduct and the substitution of a hypothetical course of lawful and posing of the question as to whether upon such an hypothesis plaintiff's loss would have*

[2] 2004 (3) SA (SCA) at paragraph [55].

ensued or not. If it would in any event have ensued, the wrongful conduct was not a cause of the plaintiff's loss; allter, if it would not so have ensued.'"

[11] In ***Minister of Safety and Security v Van Duivenboden***[3], the following was said about the 'but for' test:

> *"[25] There are conceptual hurdles to be crossed when reasoning along those lines for once the conduct that actually occurred is mentally eliminated and replaced by hypothetical conduct questions will immediately arise as to the extent to which consequential events would have been influenced by the changed circumstances. Inherent in that form of reasoning is thus considerable scope for speculation which can only broaden as the distance between the wrongful conduct and its alleged effect increases. No doubt a stage will be reached at which the distance between cause and effect is so great that the connection will become altogether too tenuous but in my view that should not be permitted to be unduly exaggerated. A plaintiff is not required to establish the causal link with certainty but only to establish that the wrongful conduct was probably a cause of the loss, which calls for a sensible retrospective analysis of what would probably have occurred, based upon the evidence and what can be expected to occur in the ordinary course of human affairs rather than an exercise in metaphysics."*

(Also see ***Lee v Minister of Correctional Services***[4], ***Mashongwa v Passenger Rail Agency of South Africa***[5], and most recently, ***AN v MEC for Health, Eastern Cape***[6].

Discussion

[12] The court *a quo* relied heavily on the expert evidence of Prof Kirsten and Dr Pistorius. Firstly, the court isolated the period between 03h15 and 04h45, when no

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3 (209/2001) [2002] ZASCA 79; [2002] 3 All SA 741 (SCA).

4 [2012] ZACC 30; 2013 (2) SA 144 (CC) at paragraph 38.

5 [2016] ZACC 36; 2016 (3) SA 528 (CC) at paragraph 65.

6 (585/2018) [2019] ZASCA 102 (15 August 2019).

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monitoring took place, as the critical period to assess causation. Secondly, the court identified fetal monitoring, which was supposed to take place every 30 minutes, as an essential mechanism to assess fetal distress. This posture by the court *a quo* cannot be faulted. The court then reasoned that as a result of failure by the nursing staff to monitor the fetus, signs of fetal distress, which *'in all probability would have been evident'*, could not be picked up. Had the nursing staff monitored the fetal heart rate at the prescribed times, emergency measures would probably have been implemented and the brain injury, would not have occurred.

[13] The court *a quo's* reasoning, which has been summarised above, attracted criticism from counsel for the defendants. The court *a quo* was further criticized for its conclusion set out in paragraph [24] of the judgment where, in rejecting the argument that the hospital records do not contain a diagnosis of fetal distress, said the following;

> *"..... In the first place, it is so that there was no diagnosis of foetal distress* (sic) *in the hospital records. The only diagnosis was for CPD at 04h45. However, this point goes nowhere. If there was no foetal heart rate monitoring* (sic) *(which both parties accept was the case) between 03h15 and the CPD diagnosis, then no foetal distress* (sic) *could have been diagnosed. Thus, in these circumstances, the absence of a foetal distress diagnosis* (sic) *is not evidence of the absence of foetal distress* (sic). *Furthermore, the diagnosis of CPD, and the recording of moulding +++ and caput+++, together with the direction that a caesarian be performed are all indications that there was some foetal distress* (sic)."

[14] The nub of the criticism, as I understand it, is that no witness testified that the recording at 04h45 of moulding+++ and caput+++ as well as an instruction to perform a caesarian section, were all indications of fetal distress. I take the view that the criticism is unwarranted for the following reasons. Firstly, I did not read the court *a quo's* judgment to mean that what was summarised in paragraph 24 is what a witness/es testified about. I understood it to be conclusions. Secondly, one must have regard to the entire mosaic of

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evidence presented. Uncontroverted evidence suggests that at 01h10 on 4 April 2009, there was draining of clear liquid and that the plaintiff was in active labour. The trial judge would have had regard to such evidence. In paragraph 16 of the court *a quo's* judgment the following is said;

> *"[16.1] (If the CTG recordings were of V's foetal heart rate)* (sic), *the foetal heart rate decelerations (vaguely)* (sic) *visible on the tracings reveal patterns with possible signs of foetal compromise* (sic)."

[15] I pause to point out that the above comment was made when the trial judge was dealing with evidence of readings extracted from the CTG, which showed, *inter alia,* that the fetal heart rate fluctuated in that it accelerated and decelerated between 220b/min and 60b/min.

It is correct that Dr Pistorius testified that if there had been fetal distress, then he would have expected to see a different pattern of injury reflected on the MRI. He however did not end there. He also testified that there was a difference between partogram monitoring as well as the continuous monitoring of the fetal heart rate ("CTG monitoring").[7] He testified further that where there is a high likelihood of fetal distress, for whatever reason, then one can move from partogram to CTG monitoring. It is common cause that in this case fetal heart rate monitoring was moved or escalated from partogram to CTG. It is not known whether the reason why fetal heart rate monitoring was escalated to CTG was because there was a concern of fetal distress.

[16] The testimony of Prof Nolte, amongst others, was to the effect that her reading of the clinical notes, particularly the fact that at 23:10 the plaintiff's cervix was fully dilated and standing at 8cm, conveyed to her that the plaintiff was quiet advanced in the active phase

[7] Page 94 line 23 of the record.

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of labour and that she was ready to deliver the baby. In cross-examination she stated that there was a big possibility that the recordal of the cervix as 8cm dilated was wrong. In fact she testified that it was impossible for the cervix to be 8cm dilated then two hours later to be only 4cm dilated. Prof Nolte further testified that the midwives who cared for the plaintiff delivered care of a poor and substandard nature in that they did not record maternal and fetal observations during the latent and active stages of labour, which was not in conformity with the maternity guidelines.

[17] From the above, it would be safe to conclude that the failure to apply sufficient monitoring amounts to negligence. Counsel for the defendants argued, with reference to the opinion of the obstetricians, that it is doubtful that something could have been done to produce a different outcome even if there had been proper monitoring. In their joint minute of 22 January 2017, Dr Koll and Dr Pistorius agreed that it was unlikely, given the fact that by all accounts there was fetal wellbeing up until 03h15, that a sentinel event severe enough to cause an acute profound hypoxic event would have occurred before then. They also agreed that the acute profound hypoxic event, must have occurred between 03h15 and 04h45. Their conclusion that: *'it is doubtful whether it would be possible to perform a caesarian section quickly enough to prevent the neurological sequelae of an acute profound hypoxic event in this time interval'*, is relied upon by counsel for the defendants in submitting that nothing could have been done to produce a different outcome. It is common cause that a partial prolonged type of brain injury was excluded by the experts.

[18] Once the trial court had found that the lack of fetal heart rate monitoring between 03h15 and 04h45 which was essential for purposes of detecting signs of possible hypoxia, amounted to negligence, the question becomes whether, had there been adequate monitoring, warning signs would have been picked up and that there was then enough

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time to engage proper emergency measures which would have avoided the brain injury, this being the very question in many of these cases, including in AN referred to above. By emergency measures we take it to mean performance of a caesarian section. There is no indication in the judgment that the court *a quo* arrived at that conclusion by applying the 'but for' test. The approach of the court *a quo* appears to be similar to that of the minority judgment per Majiedt and Tshiqi JJA in ***M v MEC for Health, Eastern Cape***[8], where there was, just as was *in casu*, an acute, catastrophic hypoxic ischemia as opposed to a gradual evolution of hypoxia and where, on the facts of that case, there was lack of proper monitoring. The minority found that:

> *"[36] The outcome could have been prevented through proper, adequate monitoring. Had there been proper monitoring, the forewarning of foetal heart abnormalities (sic), which must on the probabilities have been present from approximately 07h35 on 5 May 2010, could have been heeded. Urgent intervention would in all likelihood have followed, most probably by way of an emergency caesarean section."*

[19] The minority further found that the negligent lack of monitoring and care for extended periods resulted in the risk of hypoxia developing unnoticed. This, the minority found, established factual causation on a balance of probabilities. Drawing on the reasoning in ***Lee v Minister of Correctional Services***[9] *(supra)*, the minority went on and said the following;

> *"[42] The majority furthermore cautioned that it is wrong to reason that factual causation can never be proved where the specific incident or source of infection cannot be identified'[25] It concluded that 'it would be enough . . . to satisfy probable factual causation where the evidence establishes that the plaintiff found himself in the kind of*

[8] M v MEC for Health, Eastern Cape (699/17) [2018] ZASCA 141 (1 October 2018)

[9] Lee v Minister of Correctional Services (CCT 20/12) [2012] ZACC 30; 2013 (2) BCLR 129 (CC); 2013 (2) SA 144 (CC); 2013 (1) SACR 213 (CC) (11 December 2012)

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situation where the risk of contagion would have been reduced by proper systemic measures'.[26] On this basis, the majority found for Mr Lee on factual causation.

[43] Here, too, Ms M. was unable to locate the source and time of the hypoxic ischaemia, largely due to the poor and deceitful record keeping by the hospital staff. On Professor Buchmann's testimony the absence of proper monitoring would create a risk for Ms M. and the foetus. On this basis, factual causation had been proved on a balance of probabilities. K's injury would not have occurred on the probabilities, had his mother been properly monitored. That, in my view, is the most plausible inference on the available evidence."

[20] The majority (Ponnan, JA) rejected that reasoning, as did the court in AN, referred to above. The court *a quo* and with reference to the testimony of Prof Kirsten, stated in its judgment in relation to poor fetal heart rate monitoring, as follows:

"[17] ..... Midwives should also put in place emergency measures to "buy time" for the foetus (sic) *while preparations are made for urgent delivery. This involves, among others, putting the mother on her left side, and administering oxygen to her. The doctor must be called immediately to assess whether medication should be given to suppress contractions (which affect the flow of oxygen to the foetus* (sic)*). If these measures are introduced, the foetal heart rate* (sic) *can be improved before an emergency caesarian section is performed."*

[21] The possibility of successfully carrying out a caesarian section, and whether it would have yielded positive results, after a CPD was diagnosed at 04h45, was not seriously explored by the court *a quo.* Such a possibility is what the 'but for' test is all about. That possibility was canvassed with Dr Pistorius, when he testified in chief. His evidence is that from 04h45, which is the time when a diagnosis for caesarian section would have been made, a number of standard protocols would have been expected to be undertaken to

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prepare for the procedure. The list is lengthy and would have included; obtaining informed consent, preparing the patient for theatre, including applying intravenous infusion, preparing the theatre to receive the patient and to carry out the procedure, and securing the attendance of an anesthetist, a doctor and an assistant. Where there is a suspicion or conclusion, so he testified, of a form of fetal distress, intra-uterine resuscitation would be performed.

[22] Dr Pistorius was of the view that in terms of international standards, the hospital staff had 30 minutes, from the time the decision to refer the patient for caesarian section which in this case was 04h45, to perform an emergency caesarian section. Given that the baby was delivered vaginally at 05h10, the 25 minutes window of opportunity would have been insufficient to perform the emergency procedure. Hence the conclusion that: *'it is doubtful whether it would be possible to perform a caesarian section quickly enough to prevent the neurological sequelae of an acute profound hypoxic event in this time interval'.* In ***M v MEC for Health, Eastern Cape*** (*supra*), whose facts are to an extent the same as those *in casu*, Ponnan JA writing for the majority said the following:

> *"[64] It thus came to be accepted that baby K. suffered a HI event immediately before delivery. At such a late stage in labour, according to Professor Buchmann, the staff would not have been able to make a difference to the outcome. That is because if foetal distress* (sic) *had been detected at that stage, a caesarean section would have taken about an hour to arrange and the appellant would have delivered spontaneously before then as she in fact did at 10 o'clock. Professor Smith agreed. He testified: 'Between 09:00 and 10:00 if you pick up an abnormal foetal heart rate* (sic) *at that point in time expediting delivery with a caesarean section is not going to be of assistance because it will take much longer to perform a caesarean section.*

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[65] It was for the appellant to prove on a balance of probabilities that the conduct complained of caused the harm. Assuming in the appellant's favour that the MEC's employees negligently failed to: (i) re-examine the appellant on the 4 and 8 hour mark after her admission and (ii) properly monitor the appellant between 23h45 and 8h20, such failure could have had no causal effect on what happened after 8h20 on 5 May 2010. Whilst such failure may well have been relevant had we been concerned with what has been described as 'a partial prolonged type brain injury' that occurs over hours, it is not for 'an acute profound type', as in this case."

[22] It is undisputed that the defendant was negligent. It is also accepted that an acute profound hypoxic event took place between 03h15 and 04h45. When a determination was made at 04h45 to perform a caesarian section, on the evidence, there was insufficient time to carry it out. By parity of reasoning, the plaintiff in our view has failed to show that the negligent conduct, which has been isolated as lack of sufficient monitoring, had a causal effect on the neurological sequelae.

Fundal pressure

[23] The defendant contends that the court *a quo* erred in finding that the plaintiff is entitled to damages in her personal capacity arising from the application of fundal pressure by a nurse before she could deliver the baby. The overarching reason why it is contended that the fundal pressure allegation should be rejected is that it was not pleaded. There is no reason to interfere with the factual as well as credibility findings of the court *a quo* on this issue. However, of importance on appeal, is the implication this court's conclusion that the plaintiff has failed to establish causal negligence on the part of the hospital staff in respect of the child's condition, on the plaintiff's claim in her personal capacity.

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[24] The plaintiff's claim in her personal capacity is set out in her particulars of claim at paragraphs 8.1.2 (R50 000 for medication and/or treatment arising from the psychological and/or psychiatric conditions caused by the defendant's negligence); 8.2.2 (R500 000 for psychiatric and psychological therapy and support as well as medication prescribed to treat an array of psychological and/or psychiatric conditions which are present and are expected to remain as a result of the circumstances in which the plaintiff finds herself, such circumstances arising from the negligence of one or more or all of the defendants); 8.3 (R500 000 for accrued loss of earnings claimed by the plaintiff in her personal capacity); 8.4.2 (R2 000 000 claimed by the plaintiff for future loss of earnings and/or earning capacity); and 8.5.2 (R2 500 000 for general damages for pain, suffering and discomfort, loss of amenities of life and psychological shock and trauma).[10]

[25] As I see it, all of these heads of damages claimed by the plaintiff in her personal capacity are claims that arise from the fact that her child was born with cerebral palsy, and from the contention that that condition was caused by the defendants' negligence. Her obligation to support her child has no doubt been burdened additionally by the child's condition. However, the defendants' liability therefore, would only arise where the child's condition is causally a function of the hospital's negligence. But I have found that although the defendants were negligent, the plaintiff has not shown that that the negligence caused the child's condition: the circumstances that caused the cerebral palsy occurred too late to have taken steps that would as a matter of probability have prevented the cerebral palsy. Therefore, the court *a quo's* conclusion in respect of the plaintiff's claim in her personal capacity cannot survive this court's finding on causation.

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[10] The minor's claims for patrimonial loss are likely available to both the minor and the parent; see Guardian National Insurance Co Ltd v Gool, NO 1992(4)SA 61(AD).

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Conclusion

[26] I find that the 'but for' test was not applied in the evaluation of evidence by the court *a quo* and it must follow that the appeal succeeds.

[27] As to costs, I would – considering the plaintiff's unavoidable inability properly to have assessed her prospects of success in advance of embarking on the litigation – not have made a costs order against her. I would thus uphold the appeal, with no order as to costs; and I would substitute for the order of the trial court, an order dismissing the plaintiff's action, again with no order as to costs.

[28] I propose the following order:

1. The appeal is upheld, with no order as to costs.
2. The order of the trial court is set aside, and there is substituted for it the following order:

   "(a) The plaintiff's claims are dismissed.

   (b) No order as to costs is made."

MR JUSTICE S.A THOBANE
ACTING JUDGE OF THE HIGH COURT

I agree and it is so ordered.

MR JUSTICE W.H.G VAN DER LINDE
JUDGE OF THE HIGH COURT

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I agree.

MADAM JUSTICE L.T. MODIBA
JUDGE OF THE HIGH COURT

Date appeal: 17 April 2019
Date judgment: 20 September 2019

For the appellants: Adv. V Soni, SC
Adv. B Shabalala

Instructed by:
The State Attorney
Appellants' attorneys
10th floor, North State Building
95 Market Street, cnr Kruis Street
Johannesburg
Tel: 011-330 7796
Fax: 011-337 7182
Ref: 8346/13/P4/SMI442

For the respondent: Adv. GJ Strydom, SC

Instructed by:
Edeling Van Niekerk Inc
Respondent's attorneys
Clearview Office Park, Block A, Unit2
Wilhelmina Avenue
Constantia Kloof
Roodepoort
Tel: 011 – 475 3800
Fax: 086 – 293 8480
Ref: T van Niekerk/as/MOD13/1/MAT1355

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