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

CASE NO: 2571/13

In the matter between :

N. N. **PLAINTIFF**

And

MEMBER OF THE EXECUTIVE COUNCIL FOR HEALTH, EASTERN CAPE **DEFENDANT**

JUDGMENT

PAKADE J:-

[1] The plaintiff commenced this action by summons claiming damages against the defendant arising from the medical negligence of the medical and nursing staff in Mthatha General Hospital .

[2] The plaintiff brings this action in her personal capacity and in her

representative capacity as the mother and natural guardian of her minor child, Z. who was born on [……] 2007.

[3] The plaintiff alleged in the particulars of claim that the medical and nursing staff breached a duty of care which they owed the plaintiff upon admission in the labour ward at Mthatha General Hospital by negligently failing to examine her to determine the existence or otherwise of the need to perform a Caesarean section by reason of foetal distress and as a result of the prolonged labour on the plaintiff, Z. suffered with cerebral damage at birth. As a consequence of the negligent conduct of the medical and nursing staff of the defendant, the plaintiff suffered damages in her personal and representative capacities amounting to R 6 750 000.00 .

[4] The defendant pleaded prescription of the claim and a plea over. The pleaded prescription is premised on section 11(d) of the Prescription Act, 68 of 1969 which provides that a debt shall prescribe after three years. The defendant alleges in this respect that as the plaintiff was admitted at Mthatha General Hospital on 1 June 2007 and summons issued on 23 October 2013 over a period of six years four months the plaintiff's action has prescribed and should, for this reason, be dismissed with costs. I would dismiss the special plea out of hand as is apparent from the plaintiff's evidence that she became aware of the cause of action in 2013 when she met her Attorneys of record.

[5] The defendant pleaded a denial of the merits with an amplification that upon admission the plaintiff was examined and foetal signs observed and nursing staff noted that she was 4cm dilated at 13 h55 and that liquor was clear. Further plaintiff was put on a monitor (the ECG) for purposes of monitoring the foetal heart rate. Labour progressed normally with no alarming signs until 20h00 when , during the second stage of labour a decision was made to extract

the baby through a Caesarean section to prevent the prolongation of labour , so goes the defendant' s plea.

[6] In a pre-trial minute filed of record on 13 May 2015 the defendant admitted the contents of the medico- legal reports of Professor Lotz , Professor Smith and Dr Kara to be what they purport to be and to be handed in at the trial and received as conclusive proof of the evidence embodied therein . Further, the defendant admitted that the plaintiff's son, Z. presents with acute profound hypoxic -ischemic encephalopathy which occurred in a term brain. These reports were handed in Court by content together with the pre- trial minute.

[7] Further reports filed of record are those of Dr Burgin and Dr Ndlovu on the one hand, who did not testify and Professor Nolte, who gave evidence. The opinion of all these experts both in their reports and on viva vice evidence , in respect of those who had also testified are characterized by complaints of lack of hospital records which , to some extent , inhibited the conclusiveness of their opinion . The result is that they based their opinion on assumptions that there was lack of monitoring of the plaintiff's labour progress which resulted in foetal distress and to subsequent disability of the child.

[8] It is common cause that this was the plaintiff's first pregnancy at the age of sixteen years and all the experts are unanimous that she needed constant monitoring especially that she was also hypertensive. She attended antenatal clinic on 7 February 2007. She had a normal medical, surgical and family history. The expected delivery date was July 2007. The blood pressure was recorded as 110/70 mmHg and her weight was63 kg. Her gestational age was 23 weeks and the symphysis fundal height was 23cm. The foetal heart was heard and foetal movements were felt. The next antenatal visit was on 23 Match

2007. She recorded a weight of 60 kg, blood pressure of 110/70 mmHg and there was nothing abnormal in the urine. The foetal heart was heard and foetal movements felt. In the two antenatal visits the plaintiff's maternal and foetal conditions were normal and satisfactory.

[9] She started experiencing contractions on 1 June 2007 at about 7 am. She went to Mthatha General Hospital where she was admitted on arrival. At 13h55 the following was recorded: Bp-144/87; pulse 109bpm; cervix 4cm dilated; foetal heart 149bpm-regular .Presenting part 4/5 above brim; contractions mild; spontaneous rupture of membrane -clear liquor. This was the only hospital record of the history of labour and child birth of the plaintiff that was available. The plaintiff was eventually taken to the theatre for a Caesarean section and a boy was born with apgars of 3/10 and 4/10. The experts opined that the road of health chart recorded that the plaintiff was taken for Caesarean section because of a delayed labour in the second stage. Professor Nolte opined that the midwives were supposed to start a partograph at 13h55 when active labour started. They were supposed to monitor and record the foetal heart half - hourly, monitor the maternal vital signs and the progress of labour 2 hourly on the partograph. Professor Nolte recorded that her findings were based on assumption in the absence of records that it has not been done. Further Professor Nolte opined that the nurses failed to monitor the heart, failed to start a partograph when labour had started and did not diagnose foetal compromise.

[10] Dr Ndlovu appears to have made no assumptions in the absence of hospital records. Professor Smith based his opinion on the records. The only records on which the experts founded their opinion is the Antenatal Record , Physical Assessment Form which was largely not completed suggesting that there was no assessment done on the plaintiff . There is a Progress Record which was completed up to 13h55 on 1 June 2007. The recordings shown are:

Bp 144/87, cervix 4-cm, contraction - mild and SROM clear liquor. This means that as at 13h55 the cervix had dilated from 1-4 cm .The Progress Record is where the contents of the Simplistic Chart are explained .; Road to Health Chart, Health Worker Consultation Sheet were also the documents that were available to the experts and are relevant to the first stage of labour.

[11] Professor Nolte opined that 1.3 cm dilation should take anything up to six hours. The second stage should not be longer than 45 minutes after the woman had started pushing. There are no records supporting this opinion and therefore it remains an assumption. The records supporting her opinion should have been kept by the doctor, midwife and the nurse who had something to do to the plaintiff whose identity is unknown due to absence of the maternity records. The midwife is responsible for the patient and checks on the work of student nurses. It is the midwife who checks the heartbeat. The CTG machine is used in accurately checking the heart beat in the child to make sure that there is no foetal breakdown. Dilation is checked 2 hourly. When one of these things becomes abnormal the midwife should call a doctor immediately. It is only by close monitoring and accurate record keeping that abnormality in the child and mother can be detected early in the process. If the abnormally is detected early and the doctor called the latter may decide to take the patient to the theatre. Based on her calculation she concluded that labour should have started at8pm. It is common cause that a decision was made at 8 pm that the plaintiff be taken to the theatre for a Caesarean section to take out the baby. Professor Nolte partially conceded to a question put to her under cross examination that the fact that a decision was made at 8 pm to take out the baby by Caesarean section entails that there has been monitoring . She agreed to that contention of Counsel for the defendant but added a rider that it would depend on when the observation was made. She further conceded that in the absence of records she assumed that the plaintiff should have fully dilated by 8 pm having regard to the

fact that dilation progresses at the rate of 1cm per hour. She could not conceded that she would rely on probabilities in finding that the decision to extract the baby was not made timeously.

[12] Professor Odendaal corroborated Professor Nolte on the lack of monitoring on the child. He further stated that there must have been a problem of oxygen during labour. But he conceded that he does not have in-depth knowledge of the use of labour equipment. He stated that the following should have been done on the plaintiff when she was 4cm dilated at 13:55 :

> *(a) A partogram should have been accurately completed (the partogram is a chart on which all maternal and foetal evaluations, medications and the progress of labour are recorded. There are also alert and action lines to demonstrate slow progress as indicated by cervical dilation. Accurate completion of the partogram is essential as it indicates what observations have been made and is of utmost importance when a woman is transferred to another facility as it provides an accurate record of progress and management up to that stage).*
>
> *(b) Ms Nkayiya's blood pressure and heart rate should have been observed hourly, temperature 4 hourly and urine tested 2 hourly.*
> *(c)Her foetal heart rate should have been determined half hourly -before, during and after contractions, using a hand- held Doppler instrument.*
> *(d) The colour and odour of the amniotic fluid should have been recorded 2 hourly.*
>
> *(e) Frequency and strength of urine contractions should have been recorded hourly and the level of the presenting part, cervical dilation , can put and moulding 2 hourly.*
>
> *(f)All medications given and all fluids administered, by whatever route, should have been recorded.*

(g) Prolonged labour should have been detected .As the cervix was 4 cm dilated at 13:55, one would have expected it to be fully dilated at 20:00, based on a dilation of 1cm per hour. Yet a Caesarean section was only done at 22:00. There was obviously a great delay in the progress labour which had most probably caused severe asphyxia .The asphyxia was most probably aggravated by the safe administration of oxytocin, commonly used to stimulate contractions during the periods of slow progress .
(h)Pain relief should have been offered to the plaintiff and support and companionship provided.
(i) The plaintiff was treated in the most inhuman way, totally ignoring her labour pains and concerns about the condition of her new-born son.
(j)Plaintiff should have been observed closely for postpartum haemorrhage.
(k) It should have been checked if the uterus was well contracted with no excessive vaginal bleeding.
(l) The plaintiff's heart rate, blood pressure and temperature should have been recorded immediately after delivery.
(m) The plaintiff's pulse rate and blood pressure should have been recorded again after one hour, with continuous assessment of uterine contraction and vaginal bleeding.

[13] Dr Kara was engaged to assess the level of disability of the child and to also advise as to whether or not the state is liable for the neurological state if the child. He reviewed the reports of Professor Nolte, Professor Lotz, Professor Smith, Maternity Case Record, Road to Health Card,Paediatric Records and history from the child's mother. He also examined the child. He found the following disability on the child: Spastic quadriplegic cerebral palsy- GMFCS level 3; Delayed speech; Delayed intellectual function both receptive and expressive; History of epilepsy (generalized) on Phenobarbitone 60 mg/d. He

observed a minimal antenatal history and lack of labour records as observed by his colleagues. He opined that this was a low risk pregnancy basing that from the fact that the mother attended antenatal clinic only twice with no risk having been diagnosed. He confirmed foetal distress and birth by Caesarean section due to delayed labour in the second stage. Deducing from the poor apgar score of 3/10 at 1 minute and 4/10 at 5 minutes he assumed that the baby would have required resuscitation at birth which would continue for more than 5 minutes and expressed a surprised that a 10 minute apgar score was not recorded. Having regarded to the absence of labour records an opinion of what was recorded and what was not recorded seems to be misplaced. Dr Kara also stated that there should at least have been two doctors at the delivery who would have known of the basic resuscitation and would also have known that a blood gas analysis is essential in a child with low apgar scores. How does the doctor know that there were no two doctors present at the delivery that they did not know of the basics of resuscitation and blood gas analysis in the absence of the records? He did not give an opinion on negligence. He merely found that this was a prolonged labour with foetal distress, emergency Caesarean section was done, and baby had low apgar scores and was resuscitated without much improvement on the score. He observed that the baby had a normal head size at birth which makes it less likely that there was an antepartum insult. The baby was not growth impaired, does not have dysmorphic features and there was no maternal illness or obstetric complication that could be a confounding factor. He knew of no postnatal factor that could have caused hypoxic brain injury.

[14] On the day of labour, there was a foetal distress and a delayed second stage of labour. Professor Smith observed that the plaintiff had been in labour for 8 hours when she was taken to the theatre. He draws a conclusion from this to mean that if the cervix dilated at the normal and expected rate of 1 cm per hour, she would have been fully dilated around 20:00 which means that the

second d stage of labour was already 120 minutes in duration when she went for Caesarean section. He says this is excessive and would set the foetal up for decompression, especially with on-going uterine contractions compressing the foetus head against the pelvic bones. His opinion is therefore that the second stage of labour should not exceed 45 minutes in any patient. He then concludes by saying that "the likelihood of that suboptimal / substandard management of the 2nd stage of labour caused foetal distress, foetal acidosis and neonatal encephalopathy is high". As alluded to already in paragraph [6] above, the report of Professor Smith is among the reports which were admitted by the defendant.

[15] Dr Singh also submitted a report and testified on behalf of the defendant at the closure of plaintiff's case. She differs with other experts in that the present condition of the child is not associated with labour service rendered to the plaintiff. Her opinion is based on assumptions in the absence of labour records I the same way as other experts who find the medical and hospital personnel culpable for the condition of the child. Mr Kincad , counsel for the plaintiff sought to discredit her under cross examination on the basis that she is not qualified as obstetrician expert as other duly qualified obstetricians are who have furnished reports and testified in this case. Dr Singh conceded that her opinion would be inadmissible in this respect.

[16] Labour process is legislated and regulated. There are guidelines which guide the midwives and medical practitioners when a person is on labour. These are:

(a) National Health Act 61 of 2003;

(b) Guide for Maternity Care in South Africa 2007; and

(c) Rules of the South African Nursing Council issued under the Nursing Act 50 of 1978.

[17] The Constitution enjoins the State to take reasonable and legislative and other measures within its available resources to achieve the progressive derealisation of the right of the people of South Africa to have access to health care services, including reproductive health care[1]. National Health Act 61 of 2003 was enacted in compliance with the provisions of section 27(2) of the Constitution (the Act). The Act was amended by the National Health Amendment Act 12 of 2013. Section 13 of the Act imposes an obligation on the person in charge of a health establishment to ensure the creation and maintenance of health records containing prescribed information for every user of health services. Properly reproduced the section reads thus: " Subject to National Archives of South Africa Act, 1996(Act 43 of 1996), and the Promotion of Access to Information Act, 2000(Act 2 of 2000), the person in charge of a health establishment must ensure that a health record containing information as may be prescribed is created and maintained at that health establishment for every user of health services ". The person in charge of a health establishment in possession of a user' s health records is obliged to set up control measures to prevent u authorised access to the health records and to provide storage facility for purposes of keeping the health records of patients [2]. Any person who fails to perform the duty imposed on them by s 17(1) of the Act commits an offence punishable upon conviction.

[18] In this case there were no health records kept and made available to experts. The absence of these records made it impossible for the experts to have recourse to them in their investigation of the plaintiff's case, resulting in them relying solely on probabilities and assumptions in their finding of negligence of the hospital personnel. There was no explanation proffered by the defendant for the absence of the health records of the plaintiff and the child. The Guidelines

[1] S. 27(2) of the Constitution of the Republic of South Africa, Act 108 of 1996
[2] S17(1) of the Act

For Maternity Care of 2007 about which Professor Nolte testified that all the nursing staff in South Africa are aware of provide for the recording of all findings of maternal and foetal condition and of progress in labour, on the partogram. They direct that, " as soon as the active phase of labour is diagnosed, they [the maternity personnel] must draw an alert line at a slope of 1cm/hour from the first cervical dilation that is >_4cm dilated. Alternatively , if the partogram has pre-drawn alert line , the cervical dilation should be moved up to coincide with the alert line .The action lines drawn 2 hours to the right and parallel to the alert line and represents the extreme of poor progress where ' action ' is mandatory (e.g. transfer to hospital , oxytocin infusion or Caesarean section)".

[19] The guidelines also contain the following information: “The second stage commences when the cervix reaches full dilation (10cm). From the time that full dilation of the cervix is first noted, up to 2 hours may pass before the mother starts to bear down. Time can only be allowed for the head to descend onto the pelvic floor if foetal distress and cephalopelvic disproportion have been ruled out. The bladder should be emptied, using a catheter if necessary. The observation of the first stage of labour should continue. Efforts at bearing down are only encouraged when the foetal head starts to distend the perineum and the mother has an urge to push". There are no health records to show that the maternal guidelines were followed.

[20] The essential averments in the particulars of claim are that the defendant was negligent in the following respects; namely by:

> *(a) failing to permanently or temporarily employ the services of suitably qualified and experienced medical practitioner who would be available and able to examine , manage and/or give appropriate advice about the patient's labour , particularly the plaintiff and to perform a Caesarean*

section as and when required at any hospital under his authority where patients in labour are admitted and managed ;

(b) failing to ensure that at least one medical practitioner was in attendance at the Mthatha General Hospital at the material time hereto;

(c) failing to permanently or temporarily employ the services of suitably qualified and experienced nursing staff who would be able to properly assess , monitor and/or manage the plaintiff' s labour ;

(d) failing to ensure that the Mthatha General Hospital was suitably , adequately and /or properly equipped to enable the timeous and proper performance of a Caesarean section if and when required;

(e) failing to ensure that patients who were admitted to the Mthatha General Hospital would and could be transported timeously to another hospital or suitable medical facility should such transfer be indicated required and/or requested ;

(f) failing to take any or all reasonable steps to ensure proper , timeous and professional assessment of patients , their monitoring and management of labour and transfer of patients to a suitable hospital or medical facility when indicated , required and / or requested ; and

(g) failing to prevent Z. from suffering celebral damage at birth and the consequences thereof when, by exercise of reasonable care , skill and diligence He could and should have done so .

[21] On the premises set out in paragraph [21] above the plaintiff draws the following conclusion there from, namely that the defendant's employees and /o agents were negligent in on or more of the following respects, in that they:

(a) failed to properly assess and examine the plaintiff upon her admission;

(b) failed to monitor the plaintiff 's labour and foetal well- being appropriately and with sufficient regularity ;

(c) failed to note or appreciate that the plaintiff developed complications during her labour and that her labour was not progressing appropriately or as required in the circumstances ;

(d) failed to request examination of the plaintiff by a qualified medical practitioner when the plaintiff complained about severe abdominal pain;

(e) failed to monitor foetal heart appropriately , timeously with sufficient frequency or at all ;

(f) failed to note or appreciate the significance of the lack of appropriate or timeous progress of the plaintiff's labour;

(g) failed to monitor the plaintiff' s labour appropriately , timeously , with sufficient frequency or at all;

(h) failed to request that a Caesarean section be performed on the plaintiff;

(i) failed to arrange timeously for the transfer of the plaintiff to an appropriate facility for performance of a caesarean section;

(j) failed to inform the plaintiff of the reasonably associated or expected risks associated with an unduly prolonged period of labour; and

(k) failed to prevent Z. from suffering celebral damage at birth and the consequences thereof when By the exercise of reasonable skill care and diligence , it could and should have been prevented .

[22] The evidence shows that according to the two antenatal visits the plaintiff had the maternal and foetal conditions were normal and satisfactory but there was no physical assessment, pelvic assessment and scan done on her. It is common cause that the sequelae of foetal distress was cerebral damage at the birth of the child. The foetal distress developed at the second stage of labour while the defendants' employees had a duty to ensure that it does not develop. They owe the court an explanation on a balance of probability as to what caused the foetal distress .There are no records of the plaintiff' s labour at

Mthatha General Hospital to indicate what must have caused foetal distress and what steps were taken to prevent it from occurring . The persons who should know what caused it and who could and should have prevented it from occurring are those who were assigned the duty to manage the labour to the plaintiff. These are the persons who were obliged to record every step relating to the progress of the plaintiff's labour, record the steps they had taken and indicate up to what stage they made a decision to extract the child by Caesarean section. It is that record which would indicate that the second stage of plaintiff's labour was effectively managed and monitored. There is no indication whatsoever proffered by way of an explanation that the defendants' employees exercised a duty of care towards the plaintiff and that explanation would have been embodied in the Mthatha General Hospital records and from the staff including the doctor who were assigned to manage and monitor the labour of the plaintiff. The mere saying so by Mr Jozana, counsel for the defendant from the bar, that the plaintiff's labour was monitored does not carry the day. As already alluded to above, that information should been on Mthatha General Hospital records and from the medical doctor and nurses and midwives who giving labour to the plaintiff.

[23] A case similar to the case in *casu* is the reportable but not yet reported judgment of the Southern Gauteng High Court of Lungile Ntsele v MEC for Health , Gauteng Provincial Government , case no. 2009/52394, the judgment of Mokgoatlheng J delivered on 24 October 2012. The learned Judge invoked the doctrine of *Res Ipsa Loquitur* and found that the defendants' employees were negligent. He reasoned at paragraph (113) of the judgment that " There is an obligation on the defendant to explain how A's cerebral palsy occurred if the plaintiff and A were accorded the requisite treatment, because quite clearly the evidence raises a prima facie case of negligence against the defendant's employees. The defendant has not explained how the cerebral palsy attributable

to peri- natal asphyxia could have occurred without his employees negligence " The duty of care is linked to the skill which the defendants' employees had to the plaintiff which by failure to record that they exercised it to the plaintiff and by failure to adduce evidence thereon resulted in their failure to exercise a duty of care and thus negligence on their part. I agree with the reasoning of the learned Judge in the Ntsele judgment. The duty of care arises from the National Health Act and the universal guidelines for Maternity Care in South Africa 2007 in terms whereof the maternity staff have to manage and monitor the labour of patients admitted in a hospital for labour, to record what they have done and keep the records relating to each patient. The defendants' employees failed to adhere to these guidelines and to the provisions of the Act.

[24] In the result, the following order is made:

1. The defendant is liable to pay 100% of such damages as the plaintiff may have been able to prove;

2. The defendant shall pay costs of suit, such costs to include the costs of two counsel and the qualifying expenses of the following expert witnesses, including their travelling expenses of April and 13 May 2015 respectively:

(a) Prof Smith;

(b) Prof Nolte;

(c) Prof Odendaal;

(d) Prof Lotz;

(e) Dr Ndlovu;and

(f) Dr Burgin

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L.P.Pakade

JUDGE OF THE HIGH COURT

FOR THE PLAINTIFF	**:**	**Adv Kincaid**
Instructed by	**:**	**Mpambaniso Attorneys**
		63 Grey Street
		Queenstown
FOR THE DEFENDANT	**:**	**Adv Jozana**
Instructed by	**:**	**State Attorney**
		Sisson Street
		Fortgale
HEARD ON	**:**	**13-15 May 2015**
DELIVERED ON	**:**	**09 July 2015**