REPUBLIC OF SOUTH AFRICA

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

(1) REPORTABLE: **NO**
(2) OF INTEREST TO OTHER JUDGES: **NO**

DATE SIGNATURE

Case Number: **20454/2014**

In the matter between:

M: T Plaintiff
Obo M M

And

THE MEMBER OF THE EXECUTIVE COUNCIL FOR HEALTH AND SOCIAL DEVELOPMENT OF THE GAUTENG PROVINCIAL GOVERNMENT Defendant

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JUDGMENT

FISHER J:

INTRODUCTION

[1] The plaintiff claims damages on behalf of her minor son M, whose brain was profoundly injured at birth by an occurrence known an intrapartum hypoxic event. As a result he suffers from cerebral palsy. The plaintiff alleges that this condition was caused by the negligent conduct of the MEC for Health: Gauteng and specifically of the staff members of the Maternity Unit of the Charlotte Maxeke Hospital in Johannesburg. The Defendant disputes that her Department is liable for the damages claimed. It is, however, admitted that, to the extent that it is found that such negligence caused the brain injury to M, the MEC is vicariously liable for the loss sustained. The question of liability is conveniently dealt with as a separate issue and has been separated. This judgment is in respect of the merits.

[2] Cases such as these are all too common in our courts. The MEC faces claims which presently run into the billions of Rands and most relate to children who have suffered cerebral palsy at birth. It is, however, recognized the world over that the birth process is fraught with dangers which may be unavoidable even with the best will, expertise, and resources. Lord Denning MR observed in *Hucks v Cole1968] 118 New LJ 469 ([1993] 4 Med LR 393)*

> '*with the best will in the world things sometimes went amiss in surgical operations or medical treatment. A doctor was not to be held negligent simply because something went wrong.'*

[3] The plaintiff argues that she does not seek to hold the MEC liable merely because of the injury. She argues the Defendant, her Department and/ or persons employed by the Hospital were negligent. This negligence, she pleads, lies in a failure to:

- employ medical and nursing staff to manage the Plaintiff and perform the Caesarean section timeously, and ensure the Hospital was properly equipped to enable the timeous performance of caesareans if and when required;

- ensure the proper and timeous assessment, monitoring and management of patients and implement measures to prevent of deal with complications; and

- to take appropriate care of the Plaintiff and in particular to timeously perform a Caesarean section.

FACTS

[4] The plaintiff is a Zimbabwean citizen who lives in Zimbabwe. She discovered she was pregnant with M in late 2009. During her pregnancy, the plaintiff had come to live in Johannesburg. She says she was looking for a job. This was her second pregnancy. Her first child was born at Mpilo Hospital in Bulawayo, Zimbabwe, and is healthy. She has, since the birth of M, given birth to another healthy child in Zimbabwe.

[5] The plaintiff attended an antenatal clinic in central Johannesburg. She presented herself for antenatal care when she was already 6 months pregnant. This is generally regarded as late to seek antenatal care. It appears, however, that the pregnancy was progressing normally. On 20 August 2010 the plaintiff arrived at the clinic for an antenatal check-up, only to find it closed. She returned a week later, on 27 August 2010, to find it, once again, closed.

[6] That afternoon, at around 15h00, the plaintiff started to feel lower abdominal pains which were the early stages of labour. She had been told by staff at the clinic that she should attend the Hillbrow Hospital when her labour started. She went to the Hillbrow Hospital on the evening of 27 August 2010 and again found it closed. Early the next morning, the plaintiff again attended at the Hillbrow Hospital, but it was still closed. She was told that there was a strike on.

[7] The plaintiff then took a taxi to the Maternity Section of the Charlotte Maxeke Hospital. She arrived at approximately 13h00. On admission she was found to be 4cm dilated and her waters broke shortly after admission. She was admitted to the labour ward, and cardiotocographic (CTG) monitoring was started. There was no problem noted and her labour was allowed to progress.

[8] It is common cause that the plaintiff's labour progressed normally until an abnormal CTG reading, indicating foetal distress, was noted at 15:45. All the experts in the matter are agreed that an emergency Caesarean section was thus indicated. The decision that a Caesarean section be performed was duly made at 16:00. The Plaintiff's Caesarean section was, however, delayed until 18:15. All the experts agree that the baby was in distress for significantly longer than is regarded as acceptable. It was agreed by the experts that the outside limit would be an hour but that ,once the need for a Caesarean section was apprehended, the case had to be treated as one of emergency and the surgical intervention brought to bear without delay.

[9] In this case it took approximately 2½ hours (155 minutes) until the Caesarean section commenced. There is no dispute that the start of the procedure was delayed because the theatre was being used for other patients who required Caesarean sections.

[10] There is significant agreement between the parties' experts in relation to the possible causes of the cerebral palsy. It is agreed by the expert neurologists, Professors van Toorn and Kakaza that M has a mixed type of cerebral palsy (being spastic dystonic quadriplegia). They also agree that a possible cause of a mixed type of cerebral palsy is birth asphyxia in the peri-partum period. The MRI report revealed a profound hypoxic ischaemic injury pattern. There was no sentinel event (i.e. an event which points directly to the cause) which could have led acutely to the asphyxia. It was thus agreed that there was a subacute cause of the injury.

[11] The baby was found, at birth, to be severely acidotic. Professor Smith, the expert Neonatologist who testified for the plaintiff explained the process leading to acidosis as one which occurs when the tissues are deprived of oxygen which leads to the cells generating excess acid which, if allowed to accumulate, leads to a drop in the pH of the blood. This, in turn, can lead to an ischaemic injury.

[12] In essence then it is the opinion of Prof Smith that the cause of the brain injury was the lack of oxygen to the baby's brain caused by the contractions which affected the blood flow to the baby and specifically the brain of the baby, and which eventually overwhelmed him. Dr Murray (nee Vollmer as per the reports) the plaintiff's expert obstetrician, explained that, during birth, a foetus will move along the birth canal by virtue of the contractions that the maternal uterine muscle effect on the foetus. These contractions will

occur periodically through the labour and with greater frequency and intensity as the baby comes to be born. During this process the placenta and the umbilical cord are compressed and the oxygen flow to the foetus is temporarily occluded. As the contraction ends, the compression on the placenta and umbilical cord is relieved, and the oxygen flows freely to the baby. This is the natural birth process.

[13] Dr Murray explained further that, in the time that the foetus is constricted by the contractions of the uterine muscles, the occlusions to the cord and placenta affect free flow of oxygen to the foetus. This may eventually exhaust the foetus' reserves and ability to cope, and he will then succumb to the hypoxia and suffer brain injury. Dr Murray compared this to a person in a tub of water who is forced under water for a time and allowed up to catch their breath periodically. This process can be performed for a relatively long period, but, at a certain point, the person's energy reserves will deplete and that person will not be able to catch his breath.

[14] The defendant's expert paediatrician Prof Bolton agreed that the injury could have been caused by the fact that the distress of the baby was not alleviated before the child succumbed to the injury. He was however of the opinion that there could have been other possible reasons which rendered the baby compromised and thus unable to cope with the rigour of the birth process in the first place. The experts agreed that inadequate antenatal care, as a result of late booking for antenatal care can increase the chances of a poor outcome The Plaintiff had also slightly exceeded her due date when she went into labour which is also agreed to be a risk factor for intrapartum hypoxia. The amniotic fluid of the plaintiff contained meconium (which is the content of the bowel of a foetus). The ingestion and aspiration of meconium can lead to meconium aspiration syndrome (MAS) which could have contributed to the injury. Prof Bolton posited that the cause of the cerebral palsy may have been an intra-amniotic infection known as chorioamnionitis, which is a bacterial infection with attendant inflammation of the foetal membranes. This condition is associated with prolonged labour. The fact that antibiotics were prescribed to the baby and the mother and the fact that the plaintiff's wound became infected some days later were suggested to support this proposition. It was however conceded that these aspects were inconclusive as to the cause.

[15] Prof Bolton stated further that such underlying problems may not have been apparent by reason of the lack of proper ante -natal care or at least the record of care. It is not in dispute that the plaintiff did not seek antenatal support until the pregnancy was advanced and that this state of affairs was not optimal. The defendant sought an apportionment of the damages which was claimed on the basis that the plaintiff's failure to seek adequate or timeous antenatal care could have been a contributing factor to the loss. This was not persisted with. In any event, this case was not made out on the facts. There was also the added technical difficulty that the plaintiff was not joined to the cause in her personal capacity.

[16] One set of records provided by the defendant proved pivotal to an understanding of what happened on the day in question. This is a record termed the "Operation Register" which was filled in by the attending clinicians as a contemporaneous record of the surgeries conducted. It records the identity and age of each patient, the date of their admission to the surgical ward, the attending clinicians (i.e. surgeons, anaesthetists, and others assisting) in respect of each patient, the type of anaesthesia used, the type of operation performed, the time that they were taken into theatre, the time spent in theatre, and remarks as to condition of the mother and baby in each instance.

[17] It is not in dispute that, when the plaintiff's emergency arose at 16h00 the theatre was occupied as a result of another emergency.

[18] The Operation Register read with the related records in relation to patients treated on the day reveals that things started to go awry in the unit very early that morning. At 03h35 Mrs C Munchenzi was admitted. She was to have twins and one of the babies was breach. There was thus no question that she required a Caesarean section. The records show that she was duly scheduled to have her Caesarean section at approximately 05h00 – the previous surgery having come to an end at 04h35. The doctor's notes, however, record that the Ms Munchenzi's surgery was cancelled. The reason for the cancellation is recorded as being "due to no autoclaved theatre gowns". The Operation Register reveals at this time that the theatre was not in use from 04h35 to 06h05 – i.e. surgeries appear to have been held up for approximately 1 ½ hours because the unit ran out of sterilized theatre gowns. It was concede by Dr Chauke that this was due to mismanagement.

[19] At 06h05 a patient was put into theatre for a Caesarean section due to foetal distress. One must thus assume that, by this stage, the shortage of gowns had been resolved. The operation lasted for an hour – i.e. until 07h05. Thereafter, inexplicably, the theatre was not put into use for nearly 2 ½. At 9h30 the next patient was taken into theatre, also because of foetal distress. This operation lasted until 10h10. At 10h35 the theatre was put to use for another foetal distress case which procedure lasted until 11h40. The theatre then lay fallow for a period of 2 ½ hours, until Mrs Munchenzi was, at last, taken into theatre at 14h15 to be delivered of her twins. The delivery of the twins took until 15h20. She had been waiting to be delivered since the early hours of the morning.

[20] At 15h30 another case of foetal distress was dealt with. This was Ms D Maluleka. The admission of Ms Maluleka to theatre at this stage is important to this case. The reason is that, whilst her Caesarean section was in progress the plaintiffs emergency arose as did that of Ms X Gumbe. The problem with Ms Gumbe was that she had in the past had two CSs and could not be allowed to give birth naturally as this could lead to the rupture of her placenta and possible death.

[21] The doctors were thus put to the unenviable task of having to make a choice between the well-being of the distressed baby M and that of Mrs Gumbe and her baby. This process is known as “triage” in medical parlance. It involves the assessment and assignment of degrees of urgency in order to decide the order of treatment. They chose Mrs Gumbe over M. It is not suggested by the plaintiff that they were negligent in making this election.

DISCUSSION

[22] A compelling case is made for the plaintiff’s that the brain injury to the baby was sustained due to the inordinate length of time spent in distress. The Caesarean section, which is agreed to be the treatment for the alleviation distress, was not performed for 2 ½ hours after the distress was noted. There is no dispute that the Caesarean section should have been performed earlier. The fact that baby M was compromised in the birth process is also not in dispute. The suggestions that there were causes other than the fact that a Caesarean section was not performed in time to avoid the injury to M’s brain are speculative. This was readily conceded by Prof Bolton.

[23] There is but one cause proved: the baby M was in distress for an inordinately long time. Prof Smith is of the view that the brain injury occurred within the last hour of distress. This was not challenged in any real manner.

[24] The SCA in *Minister of Safety and Security v Van Duivenboden* [2002] ZASCA 79; 2002 (6) SA 431 (SCA) at [25] observed:

> "*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.*"

[25] And in *Minister of Finance and Others v Gore NO [2006] ZASCA 98; 2007 (1) SA 111 (SCA) at [33] the SCA* held:

> "*Application of the 'but-for' test is not based on mathematics, pure science or philosophy. It is a matter of common sense, based on the practical way in which the ordinary person's mind works against the background of everyday life experiences.*"

[26] To my mind, on a conspectus of the expert testimony, the plaintiff has established that it was the delay in performing the Caesarean section which caused M to sustain the injury which resulted in the cerebral palsy from which he suffers.

[27] The defendant argues that, even accepting that the delay was the cause, the doctors and staff cannot be faulted for choosing to attend to Ms Gumbe first as her condition was the more serious in relation to the possible risks (ie the death of the mother and possibly also the baby). This is not disputed by the plaintiff.

[28] The plaintiff counters however that there should have been a fall-back resource provided. There was only one operational theatre and one theatre team available. The plaintiff suggests that there should have been two. There is another theatre structure available, but the indications are that it was not in use at the time. She suggests also that the obstetricians on call could and should have been mobilised and other theatre facilities

sourced. The plaintiff raised whether the hospital's decision to operate only one theatre at the time was reasonable.

[29] The defendant called Dr Chauke to testify in relation to the running of the gynaecology and obstetrics unit at the hospital. He is the current clinical head of the department. He testified as to the numbers of patients undergoing Caesarean sections at the hospital during 2010. It was his opinion that two theatres were not justified because of the cost of employing additional professional staff to operate a second theatre.

[30] Dr Chauke went on to testify, that at present, although two theatres are now operational in the unit during normal operating hours, after 16h00 on weekdays and on the weekends only one theatre is operational. Thus if two emergencies now arose simultaneously , he and his staff would still have make a judgment call as to which patient should be prioritised, and the second theatre would not be opened as there would still be no team available to run a second theatre in the case of such emergencies. The extra staff, he testified, were not budgeted for. He testified further as to the severe challenges which are experienced in the South African hospital system. It is not disputed that there is a severe lack of resources and attendant budgetary constraints. I heard tell of the fact that our hospitals must be available to many who are not citizens of South Africa and even of a practice of some to travel from neighbouring countries to South Africa for the express purpose of giving birth in what are regarded as preferable conditions.

[31] On the evidence at hand, I am unable to make a determination as to whether the allocation of resources was a proper one in relation to the department in issue. The task of budgetary prioritisation is indeed a complex political and social issue. It involves the implementation of utilitarian political and social theories and reference to distributive justice.

[32] This dilemma is highlighted in the case of *Soobramoney v Minister of Health (Kwazulu-Natal)* (CCT32/97) [1997] ZACC 17; 1998 (1) SA 765 (CC); 1997 (12) BCLR 1696 (27 November 1997) where the Constitutional Court was faced with deciding the proper allocation of resources in a case where potentially lifesaving dialysis treatment had been denied Mr Soobramoney who was suffering from acute renal failure, on the basis of

a lack of resources. In construing sections 26 and 27 of the Constitution[1] Chaskalson P held as follows at [11]:

> "*What is apparent from these provisions is that the obligations imposed on the state by sections 26 and 27 in regard to access to housing, health care, food, water and social security are dependent upon the resources available for such purposes, and that the corresponding rights themselves are limited by reason of the lack of resources. Given this lack of resources and the significant demands on them that have already been referred to, an unqualified obligation to meet these needs would not presently be capable of being fulfilled. This is the context within which section 27(3) must be construed.*"

The learned Judge went further and stated the following:

> " *The provincial administration which is responsible for health services in KwaZulu-Natal has to make decisions about the funding that should be made available for health care and how such funds should be spent. These choices involve difficult decisions to be taken at the political level in fixing the health budget, and at the functional level in deciding upon the priorities to be met. A court will be slow to interfere with rational decisions taken in good faith by the political organs and medical authorities whose responsibility it is to deal with such matters."*

[1] "26. Housing
(1) Everyone has the right to have access to adequate housing.
(2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of this right.
(3) . . . .

27. Health care, food, water and social security
(1) Everyone has the right to have access to–
(a) health care services, including reproductive health care;
(b) sufficient food and water; and
(c) social security, including, if they are unable to support themselves and their dependants, appropriate social assistance.
(2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.
(3) No one may be refused emergency medical treatment."

[33] To my mind, the picture that emerges from the records in this instance is not one of a misallocation or lack of resources, but rather of a mismanagement of the available resources.

[34] The treatment of Ms Gumbe assumes importance in this regard. Ms Gumbe told the attending clinicians that she had experience lower abdominal pain from 03h00 on the day in question. It is not clear from the records when Ms Gumbe was admitted to the hospital but it is recorded that she was first examined at 09h50. At this time, it was already clear that she needed a Caesarean section. By 15h55 (some 6 hours later) she was fully dilated and her membrane was bulging. She thus needed emergency surgery. At this time the plaintiff was also in need of emergency surgery, but she had to wait for surgery to be performed on Ms Gumbe who was operated on from 16h45 to 17h55. All the while baby M was suffering distress.

[35] Thus, the argument that the doctors and other staff of the hospital are not at fault as there was proper triaging of the plaintiff and Ms Gumbe, loses sight of the manner in which the unit was managed on the day in question. Had the theatre been put to use efficiently on the day, the bottleneck which led to the delay would not have occurred. In essence, like that of Ms Munchenzi, the labour of Ms Gumbe was allowed to progress over many hours notwithstanding that there was no question that her Caesarean section had to be performed as soon as possible and notwithstanding that the theatre was open for long periods leading up to the collision of the two dire emergencies.

[36] The proper approach for establishing the existence or otherwise of negligence was formulated by Holmes JA in *Kruger v Coetzee* 1966 (2) SA 428 (A)
Holmes JA stated as follows at 430 E-G:

> *"For the purposes of liability culpa arises if—*
> *(a) a diligens paterfamilias in the position of the defendant—*
> *(i) would foresee the reasonable possibility of his conduct injuring another in his person or property and causing him patrimonial loss; and*
> *(ii) would take reasonable steps to guard against such occurrence; and*
> *(b) the defendant failed to take such steps.*
>
> *. . .*

Whether a diligens paterfamilias in the position of the person concerned would take any guarding steps at all and, if so, what steps would be reasonable, must always depend upon the particular circumstances of each case. No hard and fast basis can be laid down."

[37] In *Sea Harvest Corporation (Pty) Ltd and Another v Duncan Dock Cold Storage (Pty) Ltd and Another*[1999] ZASCA 87; 2000 (1) SA 827 at [19], the Court stated:

> *"It should not be overlooked that in the ultimate analysis the true criterion for determining negligence is whether in the particular circumstances the conduct complained of falls short of the standard of the reasonable person. Dividing the inquiry into various stages, however useful, is no more than an aid or guideline for resolving this issue. . . . It is probably so that there can be no universally applicable formula which will prove to be appropriate in every case. . . . [I]t has been recognised that while the precise or exact manner in which the harm occurs need not be foreseeable, the general manner of its occurrence must indeed be reasonably foreseeable."*

[38] In *Pitzer v Eskom* [2012] ZASCA 44; JOL [2012] 29007 (SCA) at [24] the Court stated:

> *"What is or is not reasonably foreseeable in any particular case is a fact bound enquiry. . . Where questions that fall to be answered are fact bound there is seldom any assistance to be had from other cases that do not share all the same facts."*

[39] The defendant argued that, in order for the Plaintiff successfully to rely on the non-usage of the theatre at the times indicated, she would have to prove that a reasonable doctor managing the unit would have foreseen, at the times of the non-use, that later in the day (at 16:00) she would decide that a Caesarean section should be performed on the Plaintiff.

[40] I disagree. The inquiry in this matter is less specific. When one is dealing with a facility that is set up for the purposes of attending to emergency cases and there is one

working theatre, one would expect that cases which are not pressing would be attended to so as to free up the theatre for possible dire emergencies. This seems an elementary feature of triage. The fact that available facilities were compromised by strike action is something that should have made the staff even more alert to the need to clear backlogs and attend to available cases as efficiently as possible so as to free up the resources for possible incoming emergencies.

[41] Liability for wastage of resources cannot always be connected causally to the injury suffered. It this case one can, however, see a direct link between failure to treat patients efficiently throughout the day in question and the injury that occurred. It was indeed foreseeable that if the theatre facility was not used optimally, it may not be available to the most urgent cases which may arise or come in. The possibility of such cases arising was not remote. Indeed the nature of the unit was such that it held itself to be primed and ready for such eventualities. The staff were aware that there were two cases already admitted where labour was being allowed to progress under circumstances where this was clearly not indicated treatment in that they could not be allowed to give birth naturally.

CONCLUSION

[42] The staff of the unit neglected to treat Ms Gumbe timeously thus contributing to the dire emergency which arose as a result of her labour being allowed to progress over the day to a point where she was in grave danger and had to be preferred over other emergency patients. This poor management led directly to the delay in attending to the plaintiff with the resultant injury to baby M.

[43] I thus find that those responsible for managing and staffing the Maternity Unit were negligent in not seeing to it that the facility was not managed in a manner which would have rendered the theatre available to the plaintiff sooner than occurred. It is not in dispute that the defendant is vicariously liable for their conduct.

ORDER

[44] I thus make the following order:

i) The defendant is liable for any damages that are proved or agreed to be due to the plaintiff in her capacity as parent and natural guardian of M.

ii) The costs of the determination of this issue are to be borne by the defendant.

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FISHER J

HIGH COURT JUDGE

GAUTENG DIVISION, JOHANNESBURG

Date of Hearing: 17 August 2018.

Judgment Delivered: 27 September 2018.

APPEARANCES:

For the Plaintiff **:** Adv W Munro.

Instructed by **:** Wim Krynauw Attorneys.

For the Defendant **:** Adv Vas Soni SC.

Instructed by **:** The State Attorney.