Editorial note: Certain information has been redacted from this judgment in compliance with the law.

IN THE HIGH COURT OF SOUTH AFRICA

GAUTENG LOCAL DIVISION, JOHANNESBURG

CASE NUMBER:2017/9251

DELETE WHICHEVER IS NOT APPLICABLE

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

In the matter between:

M: S obo Plaintiff

M: T

and

MEC FOR HEALTH AND SOCIAL DEVELOPMENT, GAUTENG PROVINCE Defendant

Coram: Lagrange AJ
Heard: 16 October 2018
Delivered: 12 November 2018

Summary: Medical negligence– liability – joint minutes of experts.

JUDGMENT

LAGRANGE, J

Introduction

[1] This is an action to recover damages in respect of T M ('T'), a child born with cerebral palsy arising allegedly from negligence of nursing and, or alternatively, medical personnel at the Rahima Moosa Mother and Child Hospital ('the hospital') on 14 and 15 April 2010. The action is brought by her mother, Ms S M ('the plaintiff'), in her personal capacity and on behalf of her daughter. The sole issue in the trial proceedings at this stage is to determine the issue of liability.

[2] The parties were unable to agree on a stated case but were content to argue the matter of liability on the basis of the medical experts' minutes, subject to the court referring one or more issues to oral evidence if it believed felt that was necessary to determine the hospital's liability, bearing in mind the status according to experts' joint minutes as adopted in the Supreme Court of Appeal decision in *Glenn Marc Bee v The Road Accident Fund*[1], namely:

> 'Effect of agreement between experts
>
> [64] This raises the question as to the effect of an agreement recorded by experts in joint minute. The appellant's counsel referred us to the judgment of Sutherland J in *Thomas v BD Sarens (Pty) Ltd* [2012] ZAGPJHC 161. The learned judge said that where certain facts are agreed between the parties in civil litigation, the court is bound by such agreement, even if it is sceptical about those facts (para 9). Where the parties engage experts who investigate the facts, and where those experts meet and agree upon those facts, a litigant may not repudiate the agreement 'unless it does so clearly and, at the very latest, at the outset of the trial' (para 11). In the absence of a timeous repudiation, the facts agreed by the experts enjoy the same status as facts which are common cause on

[1] (093/2017) [2018] ZASCA 52 (29 March 2018).

the pleadings or facts agreed in a pre-trial conference (para 12). Where the experts reach agreement on a matter of opinion, the litigants are likewise not at liberty to repudiate the agreement. The trial court is not bound to adopt the opinion but the circumstances in which it would not do so are likely to be rare (para 13). Sutherland J's exposition has been approved in several subsequent cases including in a decision of the full court of the Gauteng Division, Pretoria, in *Malema v The Road Accident Fund* [2017] ZAGPHC 275 para 92.

[65] In my view, we should in general endorse Sutherland J's approach, subject to the qualifications which follow. A fundamental feature of case management, here and abroad, is that litigants are required to reach agreement on as many matters as possible so as to limit the issues to be tried. Where the matters in question fall within the realm of the experts rather than lay witnesses, it is entirely appropriate to insist that experts in like disciplines meet and sign joint minutes. Effective case management would be undermined if there were an unconstrained liberty to depart from agreements reached during the course of pre-trial procedures, including those reached by the litigants' respective experts. There would be no incentive for parties and experts to agree matters because, despite such agreement, a litigant would have to prepare as if all matters were in issue. In the present case the litigants agreed, in their pre-trial minute of 14 March 2014, that the purpose of the meeting of the experts was to identify areas of common ground and to identify those issues which called for resolution.'

Material facts

[3] The critical issue in determining liability in the matter concerns what occurred in the night of 14 April from about 22h00 until just after 01h00 the following morning, and subsequent thereto until the time T was delivered by means of an emergency caesarean section at 03h13, a few minute after surgery commenced.

[4] The essential opinions emerging from the experts' joint minutes are summarised below.

[5] The specialist nurses, Dr. C. Harris and Prof. A.G.W. Nolte agreed that:

5.1 In respect of antenatal care, they found no evidence of acts or omissions of negligence on the part of nurses or midwives in relation to the plaintiff's pregnancy. In particular they noted:

5.1.1 The plaintiff was a high-risk patient because of a previous stillborn baby as identified by the antenatal midwife timeously referred her to the doctors' clinic for antenatal care.

5.1.2 The mother first attended the antenatal clinic at a late stage of her pregnancy, namely at 28 weeks gestation.

5.1.3 They deferred to neonatal expertise on whether or not the child had suffered intra-uterine growth restriction.

5.2 They found that the care exercised by midwives during the mother's induction of labour was substandard in that:

5.2.1 There was no document available to them demonstrating the proper assessment and documentation of the foetal heart rate during the course of the mother's induced labour.

5.2.2 They failed to keep accurate and complete records of the case.

5.2.3 The failure to properly assess and document the foetal heart rate probably resulted in a failure to diagnose foetal disk dress time Wesley and take appropriate action.

[6] The joint minutes of Dr. D. Pearce (Paediatric Neurologist for the plaintiff) and Dr. V. Mogashoa (Paediatric Neurologist for the defendant) reveal, inter alia, the following material conclusions, namely that:

6.1 The timing of the insult was most likely intrapartum and based on records and history available, as far as possible, an antenatal insult could be excluded.

6.2 Having regard of ACOG 2014[2], and based on available medical records, intrapartum hypoxia was the most probable cause of the neonatal encephalopathy in the child.

6.3 T suffers from a mixed cerebral palsy (predominantly dystonic/ataxic) with a gross motor functional classification scale **II**, indicative that T's physical

[2] Proceedings of the American College of Obstetricians and Gynaecologists, 2014.

impairments restrict movement. In view of her family history and mixed picture they could not exclude an underlying genetic cerebellar ataxia as a contributing factor.

6.4 In view of the child displaying subtle dysmorphic features and if there was a family history of neurological impairments, an underlying genetic cerebella ataxia could not be excluded as a 'contributing factor'. However, no family history of neurological impairments was recorded.

6.5 In view of T's current neurological findings and based on her family history, they were unable to exclude a genetic cerebellar ataxia as a contributing factor to our clinical findings. Of note there has been no regression in her condition. Dr Peace was unable to find any supporting literature regarding the possible genetic condition and its role as a risk factor for intrapartum hypoxia however we will defer to the expert geneticist. They deferred to an expert geneticist on this issue.

6.6 They also deferred to expert obstetricians' opinion on possible risk factors including previous stillborn delivery, late booking and delay in the caesarian section.

[7] Prof G.F. Kirsten (neonatologist) for the plaintiff and N.N. Duma (paediatrician) for the defendant agreed that:

7.1 Foetal monitoring was poorly performed during Mrs M's induction of labour, with the result that foetal distress was not diagnosed timeously and there was also a delay in performing an emergency caesarean section after severe foetal distress was diagnosed, which resulted in severe intrapartum hypoxia.

7.2 According to the MRI brain scan reports of expert witness neuro-radiologists, T 's magnetic resonance imaging brain scan (MRI) changes were in keeping with an acute profound hypoxial insult to his brain.

7.3 There were no postnatal causes identified that could explain her poor long-term neurodevelopmental outcome.

7.4 As a consequence of the intrapartum hypoxial insult T suffers from spastic quadriplegic cerebral palsy.

[8] The most detailed joint minute was that of the obstetricians, professor G.B. Theron (the plaintiff's witness) and Dr M. Mbokota (the defendant's witness). Key elements of their opinion are:

8.1 The mother had a previous normal delivery in 1999 of a 2.9 kg infant and a normal delivery of a stillborn baby in 2009, both of which deliveries were at term. Her stillborn child weighed 2.1 kg and the placental weight was 231g. The placental histology revealed evidence of chronic hypoxia.

8.2 Her antenatal progress was uneventful and she was admitted at 38 weeks gestation in the morning of 13 April because of the previous stillbirth.

8.3 Observations recorded in the labour admission chart showed antenatal movement was normal on admission, at 14h00, 18h00 and at 06h00 the following morning on 14 April.

8.4 A cardiotacograph (CTG) reading done shortly after 08h00 on 14 April was recorded as being reactive.

8.5 Similarly a non-stress test, which measures the fetal heart rate was noted as reactive at 12h40 on the same day. The medical records show that a request was made to repeat the non-stress test after one hour and to assess if more medication was required to induce labour after six hours.

8.6 At 22h00 the same day, the non-stress test conducted by a doctor was again reactive and a further dose of labour inducing medication was administered. It was also recorded that the non-stress test needed to be repeated after an hour.

8.7 Until that time the standard of care was normal and the decision to induce labour at 38 weeks was correct in view of the previous stillborn child whose placental histology showed evidence of chronic hypoxia. Before the second dose of Prandin was administered the physician had the assurance of a reactive CTG.

8.8 However, there was no hospital record kept between 22h00 and 01h05 the following morning. At 01h05 a progress note records that a doctor was requested to review a non-stress test. The mother was experiencing contractions and the CTG 'showed deep red current decelerations were present with poor

variation'. A diagnosis of severe foetal distress was made and the mother was booked for an emergency caesarean section and intrauterine resuscitation began. She was placed on her left side, oxygen was administered and the contractions were suppressed with salbutamol. It was recorded that Dr Kgomo was busy in the theatre with another caesarean section at the time.

8.9 Fifteen minutes thereafter, at 01h20 the mother was having mild contractions and was receiving a slowly administered dose of Salbutamol five minutes later.

8.10 The CTG result recorded at 01h05 is classified as an abnormal or pathological CTG and may indicate foetal hypoxia. Professor Theron found that a relevant consideration was how long the pathological CTG was evident before it was reported to the attending physician. Dr Mbokota is recorded as not agreeing with this, though his point of disagreement relates to when the abnormality in the CTG would have been detected. He assumed that the CTG was done at 23h00 as requested by the doctor, even though there was no record of this. He also assumed that the doctor was called when the abnormalities were noted, even though the records do not show when the midwives noted this.

8.11 In any event, there was a delay of two hours and five minutes before the commencement of the emergency caesarean section.

8.12 Subsequent to the decision to commence this procedure the correct management of the situation was to proceed 'with the shortest possible delay'. The hospital medical records contained no further explanation for the undue delay apart from recording that another caesarean section was in progress 'in theatre' at 01h05.

8.13 The hospital anesthetic notes revealed that the administration of anesthetic commenced at 03h00 and surgery commenced at 03h10 with the easy delivery of a female baby taking place at 03h13.

8.14 The postnatal examination of the newborn child recorded that her birth weight was 2.37kg which was small for her gestational age compared with the norm of 2.509 kg at 38 weeks.

8.15 They concluded that the most likely reason for foetal distress developing was placental insufficiency due to possible intro uterine growth restriction.

8.16 Professor Theron was of the view that T's asphyxiation at birth was the result of a possible delay in reporting the abnormal CTG and a subsequent undue delay in performing the emergency caesarean operation. However, his counterpart felt it would be speculative to agree with this statement because there were no records between 22h00 and 01h05 to indicate when the midwives noted the abnormal CTG. He did not take issue with the existence of an undue delay in the operation being a factor in her asphyxiation.

[9] There were no disagreements between the expert radiologists Professor L. Lotz and Dr T. Kamolane about their diagnosis of an MRI scan of T's brain. In short, they found:

9.1 The MRI pattern was consistent with an acute profound hypoxic ischemic injury to a term brain.

9.2 There were no congenital malformations of the brain nor did the scan suggest any inflammatory or infective causes as likely causes of her brain damage.

9.3 They deferred to the opinion of specialists in neonatology and obstetrics in determining the cause and probable timing of the brain injury and to exclude other possible causes of the MRI pattern observed.

Evaluation

[10] The critical question to answer is whether the injury to T's brain was most probably a result of a failure to detect foetal distress timeously and, or alternatively, to perform an emergency caesarean section promptly, or whether it was more probably a result of other independent factors. It is important to mention that in the hospital's pleadings, apart from baldly denying all the plaintiff's claims, the only positive factual

statement it made was that the monitoring of the mother and child was adequate according to the standards of care. It is also noteworthy that the hospital had not specifically pleaded a defence of impossibility in relation to the delay in performing the emergency caesarean section, nor did it plead that the cause of the injury was a result of a pre-existing condition.

[11] On the evidence of the joint minutes, it is common cause that there was no cause for concern for the condition of the mother and the baby *in utero* at least by 22h00 on 14 April. What is also certain is that by the time a doctor was alerted to an adverse CTG result over three hours later, the condition of the foetus had deteriorated dramatically and to such an extent that an emergency caesarean section was deemed necessary and intra uterine resuscitation was commenced.

[12] The first question which arises is whether asphyxiation of T probably commenced before this diagnosis at 01h05 on 15 April. Secondly, whether it would have been detected earlier had reasonable care been exercised in monitoring the foetus's condition during that period. There is simply no record of what was done, but we do know that there had been an instruction for the non-stress test to be repeated at 23h00. In Dr Mbokota's view the fact that the request was made was sufficient reason to presume that the test had been conducted at 23h00 and that the absence of any record of the CTG reading at this time should not be assumed to mean that the test was not conducted.

[13] With the greatest respect to Dr Mbokota's medical expertise, it is difficult to agree that the most probable inference to draw from the absence of a record of any CTG reading between 22h00 and 01h05 is that the test probably *was* conducted at 23h00. His assessment is not explained with reference to standard hospital practices, but appears to be simply based on an inference that merely because there is no test result for that time, it cannot be said that the test was not conducted. However, in assessing the probabilities the absence of any test result during this period, given that test results were available up to 22h00 and at 01h05, the more natural inference to draw is that there was no test result in that interval because no test was conducted during this period. No alternative explanation was pleaded or advanced by the hospital for the

absence of such records. In *Khoza v MEC for Health and Social Development, Gauteng*[3]*,* Spilg, J set out possible implications of such missing records:

> '[47] In summary, the failure to produce the original medical records which are under a hospital's control and where there is no acceptable explanation for its disappearance or alleged destruction —
>
> (a) may result in the inadmissibility of 'secondary' evidence if the interests of justice so dictate, whether such evidence is of a witness who claims to have recalled the contents of the lost document or to have made a note of its contents on another document;
>
> (b) cannot of its own be used to support an argument that a plaintiff is unable to discharge the burden of proof because no one now knows whether the original records would exonerate the defendant's staff from a claim of negligence;
>
> (c) may result in the application of the doctrine of res ipsa loquitur in an appropriate case;
>
> (d) may result in an adverse inference being drawn, that the missing records support the plaintiff's case in matters where the defendant produces other contemporaneous documents that have been altered, contain manufactured data or are otherwise questionable, irrespective of whether the evidence of secondary witnesses called in support is found to be unreliable or untruthful.[4]'

[14] In this instance there is no suggestion of records having been falsified, but given the existence of a CTG record before and after the critical period in question, the probabilities point to no test being conducted at this time. It is possible that a non-stress test was conducted earlier than 01h05. Nevertheless, if that was the case it is reasonable to expect that it would have been reported immediately to the doctor, or as soon as possible, after such an adverse result was observed. Accordingly, it is more probable that the foetal distress was detected in a non-stress test conducted shortly before the doctor is recorded as being made aware of it at 01h05.

[15] The hospital advanced alternative causes for the injury suffered by the child. In particular, the hospital highlighted the fact that the obstetricians agreed that:

---

[3] 2015 (3) SA 266 (GJ).
[4] At 279.

> 'The birth weight of baby M [2370g] was small for gestational age [below the 10th percentile for gestational age]. According to the center aisle chart for birth weight used in South Africa the 10th sent I will at 38 weeks would be a birth weight of 2509 g. The most likely reason why foetal distress developed is placental insufficiency due to possible intro uterine growth restriction.'

[16] The hospital argued that on this ground alone the case should be dismissed as the experts agreed that the cause of foetal distress was a consequence of the mother's pre-existing condition. The plaintiff's case is that since her condition was known to the hospital, it was required to adopt the appropriate level of care for a mother with such a history. The plaintiff argues in effect that the hospital should have been alive to the higher risk she ran of foetal distress occurring and monitored her condition accordingly.

[17] In so far as a genetic factor may have been a contributory cause of the injury that appears to be unlikely in light of the argument radiologist joint findings.

[18] In argument, the hospital also contended that even if hypothetically there had been proper monitoring of the foetus that would have prevented the acute and profound injury suffered by the unborn infant. In this regard, the court was referred to the recent Supreme Court of Appeal judgment in *Magqeya v MEC for Health, Eastern Cape*.[5] In that case the majority accepted that the infant in question suffered a hypoxic event immediately before delivery. The court found, in the circumstances of that case, that a failure to properly monitor the mother between 23h45 and 8h20 could have had no causal effect on what happened subsequently. At 08h20, the condition in of the foetus was still 'reassuring'.[6] The consensus of the experts was that the injury probably occurred within the last hour of birth which took place at 10h00.[7] Another important finding in that case is that the mother was in an advanced state of labour and if foetal distress had been detected at that point there was little the staff could have done to make a difference to the outcome because a caesarean section could not have expedited delivery at that stage.[8] In that case the injury had been characterized as

[5] (699/17) [2018] ZASCA 141 (1 October 2018).
[6] At para [54].
[7] At para [59].
[8] At para [64].

acute, profound and catastrophic. The court concluded that the failure to conduct proper monitoring would only have been relevant if the case had

> '. . . concerned "a partial prolonged type of brain injury" that occurs over hours, it is not for "an acute profound type" as in this case.'

[19] The hospital argues that the injury sustained by the unborn infant in this case was also of a similar nature and therefore unforeseen. However, there are important distinguishing features in this matter. Firstly, the mother was not in an advanced state of labour, so the hypoxia could not have been caused by strong contractions. Secondly, the foetal distress was detected before any advanced labour could commence. Thirdly, none of the experts suggested that a caesarean operation, even if performed promptly, could not have improved the prospects of averting the injury suffered. In other words, they did not suggest that it was too late to conduct a caesarean section. Fourthly, it is common cause that T suffered an acute profound hypoxic ischemic injury despite the mother not undergoing advanced labour and a easy delivery by caesarean section. Finally, the hospital knew of the previous still birth and should have been alive to her higher risk profile. On the probabilities, there is a greater chance that foetal distress would have been detected earlier had monitoring occurred regularly and that the injury suffered might have been averted or been severe if the caesarean section had been performed promptly.

[20] An alternative defense advanced in argument by the hospital that the failure to conduct the caesarean operation promptly was due to an unavoidable lack of resources available to it. This submission was based on the supposition that only one operating theatre was available and the only specialist available was engaged in another caesarean operation in that theatre. The hospital accepted that in terms of the National Department of Health Guidelines for Maternity Care in South Africa (4th edition), all hospitals should be able to perform an emergency caesarean section within an hour of the decision to operate. The hospital argued that there were other emergencies being attended to in the operating theatre which necessitated the applicant's caesarean section only commencing at 03h10. The question is firstly whether a proper evidentiary

foundation for such a justification was laid. In the obstetricians joint minute it was recorded that:

> *'10 . . . A note was also made that Dr Kgomo was busy in the theatre with another caesarean section at that time. A nursing note in the Progress Report at 1:20H states that Ms M was prepared for caesarean section and that she was having mild contractions.*
>
> *. . .*
>
> *13. The correct management subsequent to the decision to do a caesarean section 4 foetal distress is to proceed with the procedure with the shortest possible delay. The medical and hospital records contain no further explanation as to the undue delay prior to commencing with the caesarean section for severe foetal distress apart from stating that a caesarean section was in progress in theatre at 1:05H.'*

The extracts cited are the sole references to the existence of any constraints on performing the emergency caesarean section more promptly. Even if there was only one operating theatre available and one doctor who could perform the operation, there is nothing in the joint minutes to explain why the theatre in question only became available after two hours. There is certainly no evidence to suggest that Dr Kgomo had more than one other caesarean to attend to, let alone the emergency status of the surgery he was performing. There is also no evidence as to why the caesarean section which was in progress at 01h05 took so long if indeed that was the reason why the plaintiff could not be attended to earlier. It was contended that it is evident from the joint minute that there was only one theatre available. However, the joint minute was simply reflecting what was stated in the hospital record namely that 'Dr Kgomo busy with another caesarean section in theatre' (abbreviations expanded). I cannot agree that this note is indicative that only one theatre was available. If anything, it speaks more to the availability of a specialist, but even so is insufficient on its own to explain why the emergency caesarean could not have been done earlier.

[21] The plaintiff points out that the defendant did not plead a lack of resources as a justification for its inability to conduct the emergency caesarean. I was referred by the hospital to the Constitutional Court judgment in *Soobramoney v Minister of Health*

(KZN) [9], in which the court declined to order the state to provide dialysis treatment to the plaintiff and accepted that the availability of dialysis machines was limited and the choice as to how to use those limited resources was one best left to medical experts.[10] Leaving aside the basis of the cause of action in that matter, the question of scarce resources and need was extensively canvassed in the evidentiary material before the court on that case. That is not the case here. There is simply insufficient basis for the court to conclude that the failure to conduct an emergency caesarean operation timeously by the hospital was justified.

[22] In the circumstances, I am satisfied that the most probable cause of T being asphyxiated at birth and consequently suffering cerebral palsy was the failure to regularly monitor her foetal heart rate between 22h00 and 01h05 on the night of 14 April 2010 and the subsequent delay in performing an emergency caesarean section once the foetal distress was diagnosed, which resulted from the negligence of medical and nursing personnel at the hospital on 14 and 15 April 2010.

Order

[1] The defendant is liable for the plaintiff's damages in her personal capacity as well as her representative capacity on behalf of the minor child.

[2] The defendant shall pay the plaintiff's party and party costs of suit on a High Court scale in respect of the determination of the issue of liability, which costs shall include:

2.1 the qualifying, preparation and reservation fees, if any of the following expert witnesses appointed by the plaintiff:

2.1.1 Prof. G.F. Kirsten (neonatologist);

2.1.2 Prof. G.B. Theron (obstetrician);

2.1.3 Prof. J.W. Lotz (neurological radiologist);

2.1.4 Dr. D. Pearce (pediatric neurologist);

[9] 1998 (1) SA 765 (CC).
[10] At 784 para [59].

2.1.5 Prof. A.G.W. Nolte (professional midwife/nurse);

2.1.6 Dr. G. Gericke (specialist pediatrician and geneticist).

2.2 The costs of senior counsel.

_____

Lagrange J

Acting Judge of the High Court

APPEARANCES

APPLICANT:	G J Strydom SC instructed by Edeling Van Niekerk Inc.
RESPONDENT:	M C Makgato assisted by PM Mahlatsi, instructed by the State Attorney (Johannesburg)