OFFICE OF THE CHIEF JUSTICE
REPUBLIC OF SOUTH AFRICA

IN THE HIGH COURT OF SOUTH AFRICA

GAUTENG DIVISION, PRETORIA

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

07 FEBRUARY 2024

DATE SIGNATURE

CASE NO: 79912/2014

In the matter between

L[redacted] M[redacted] obo P[redacted] PLAINTIFF

And

THE MEMBER OF THE EXECTUIVE COUNCIL DEFENDANT

FOR HEALTH AND SOCIAL DEVELOPMENT

OF THE LIMPOPO PROVINCIAL GOVERNMENT

This judgment is issued by the Judge whose name is reflected herein and is submitted electronically to the parties/their legal representatives by email. The judgment is further uploaded to the electronic file of this matter on CaseLines by the Judge's secretary. The date of this judgment is deemed to be 7th February 2024.

JUDGMENT

COLLIS J

Introduction

"Patients of public health institutions are entitled to be treated in the same way as patients in private medical institutions. What is required is a public health delivery system that recognizes the dignity and rights of those who are compelled to use its facilities. It is that basic sensitivity that the Constitution demands."[1]

[1] Premier, KwaZulu-Natal v Sonny and Another 2011 (3) SA 424 (SCA) in paras 33 and 34.

1. The Plaintiff before this court issued summons in her personal and representative capacity, as the mother and natural guardian of her minor child, P[redacted] ("*the child"*) born on 11 April 2012 at the W.F. Knobel Hospital ("*the hospital*").

2. In her Particulars of Claim it is alleged that the medical and/or nursing staff of the Goedgevonden Clinic ("the clinic") and the W.F. Knoebel hospital was negligent during the labour and delivery of the mother and child at the clinic, resulting in the minor child suffering from cerebral palsy.

3. It is the pleaded case of the plaintiff that staff of the defendant was negligent in the following respects, namely:

3.1. The Defendant's employees at the clinic and at hospital failed to assess the Plaintiff's labour properly, sufficiently, or adequately after her admission to the clinic and the hospital and therefore failed to detect that the progress of the Plaintiff's labour was delayed and therefore prolonged.

3.2. The Defendant's employees failed to monitor the foetal well-being of the Plaintiff's child properly and with sufficient regularity during Plaintiff's labour at the clinic and at the hospital and therefore failed to detect that the foetus

was developing hypoxia and a consequent **hypoxic ischemic encephalopathy** (brain injury caused by an insufficient supply of blood and oxygen to the infant brain).

3.3. In addition, the Defendant’s employees at the Welgevonden Clinic failed to refer the Plaintiff to a hospital when they examined her at 08h15 on 11 April 2012 and detected that her blood pressure was significantly elevated.

3.4. The Defendant's employees further failed to administer the correct dosage of Magnesium Sulphate to the Plaintiff when required to do so in order to prevent the Plaintiff from suffering an eclamptic seizure or to control the development of pre-eclampsia and eclampsia in the Plaintiff.

3.5. The Defendant’s employees at the clinic and at the hospital failed to take the appropriate actions as prescribed by the maternity guidelines, when they realized or should have realized that the Plaintiff was eclamptic and had suffered an eclamptic seizure, which required the immediate delivery of the child by assisted delivery or a caesarean section to mitigate any harm which the child suffered.

4. The Plaintiff further alleges that as a result of the negligence of the staff employed by the defendant the minor suffered the injury which is directly or

causally linked to the failure by the Defendant's employees at the clinic to timeously identify that the Plaintiff's labour was prolonged resulting in their failure to timeously take appropriate action to intervene and ensure that the minor did not suffer a hypoxic ischemic injury.

5. In addition the Plaintiff alleges that the Defendant's employees at the clinic failed to appreciate the urgency or the need to refer the Plaintiff to a hospital when she presented with an elevated blood pressure which resulted in her developing eclampsia which in itself can be causally linked to the hypoxic ischemic encephalopathy which the minor suffered.

6. Furthermore, that the failure of the Defendant's employees at the hospital, to expedite the delivery of the Plaintiff's child on her arrival at the hospital led to the further prolonged exposure of the Plaintiff's child to hypoxic ischemia which is common cause was the cause of the child's injury.

7. The Defendant denies in broad and general terms that any of its staff acted negligently or that the child sustained an injury while the Plaintiff was in labour and/ or when the child was delivered.

Onus

8. The plaintiff carries the *onus* of proof to satisfy the Court on a balance of probabilities that her version of events is the truth. In this regard the plaintiff was the only factual witness called during the trial and the maternity records, including the obstetric and neonatal records from the hospital were by agreement submitted into evidence by the parties.

Issues to be determined

9. The issues this Court was called upon to determine were whether the reasonably skilled and careful staff member(s) in the position of the staff member(s) at the clinic and/or hospital would have realized that a serious condition was developing or threatening to develop and, if so, when they would reasonably have come to realize this. Secondly, whether there was remedial action which could reasonably have been taken. Thirdly, whether the same notional staff member(s) would have known of this remedial action and would have realized that it had to be taken and lastly, whether the remedial action, if taken when the need for it ought reasonably to have been realized, would have prevented the damage suffered by the minor. Lastly, this Court was called upon to determine whether the relevant member or members of the staff failed to take such a remedial action.

10. Within the context of the present matter, the main issues therefore for this Court to determine, is whether there was negligence on the part of the staff member or members at the clinic and/or hospital and, if so, whether there was a causal connection between the said negligent conduct and the damages which ensued.

11. The plaintiff, in addition to testifying also presented the evidence of an expert witness namely, Prof John Anthony, her Obstetrics Gynaecologist.

12. Before this Court several other experts also compiled joint minutes, which by agreement between the parties was handed into the record. The joint minutes were prepared by the radiologists, the neonatologists, the nursing specialists and the gynaecologists/obstetricians.

13. In regard to the status of joint minutes, the decision of *Bee v Road Accident Fund* (093/2017) [2018] ZASCA 52; 2018 (4) SA 366 (SCA) (29 March 2018) is instructive, namely:

> '[64] This raises the question as to the effect of an agreement recorded by experts in a 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 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). . . . .

[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.

[66] Facts and opinions on which the litigants' experts agree are not quite the same as admissions by or agreements between the litigants themselves (whether directly or, more commonly, through their legal

representatives) because a witness is not an agent of the litigant who engages him or her. Expert witnesses nevertheless stand on a different footing from other witnesses. A party cannot call an expert witness without furnishing a summary of the expert's opinions and reasons for the opinions. Since it is common for experts to agree on some matters and disagree on others, it is desirable, for efficient case management, that the experts should meet with a view to reaching sensible agreement on as much as possible so that the expert testimony can be confined to matters truly in dispute. . . . If a litigant for any reason does not wish to be bound by the limitation, fair warning must be given. In the absence of repudiation (i.e. fair warning), the other litigant is entitled to run the case on the basis that the matters agreed between the experts are not in issue.

[67] . . . . Whatever may have been the attitude to litigation in former times, it is not in keeping with modern ideas to view it as a game. The object should be just adjudication, achieved as efficiently and inexpensively as reasonably possible. Private funds and stretched judicial resources should only be expended on genuine issues."

14. None of the joint minutes handed in before this Court have been repudiated. Having regard to the above decision, it therefore follows that the facts and opinions agreed to by the experts need not to be proven and enjoy the same status as facts which are common cause on the pleadings or facts

agreed to in a pre-trial conference and the parties are bound by the experts' agreement on matters of opinion.

15. The experts before this court, further agreed that there is a probable causal connection between the negligence alleged and conceded, and the hypoxic ischemic encephalopathy suffered by the minor child.

16. It is further to be noted, that the defendant before this Court had failed to call any witnesses to testify. As such there is no version in rebuttal placed by the defendant that this Court can consider against the evidence placed before this Court by the plaintiff and that of her expert.

17. Absent such evidence, there therefore exists no evidence for this Court to evaluate in determining the absence of negligence and causation on the part of the defendant's employees. Negligence will thus be determined against the evidence presented by the plaintiff and that of her witness.

Evidence

18. The plaintiff testified, that on the 11th April 2012 at around 02h00 she experienced, a rupture of membranes having been at her full term of

pregnancy. At 03h00 she arrived at the Welgevonden Clinic where she experienced painful contractions and was admitted into the clinic. At the time she was attended to by a nurse and her cervix was 3 cm dilated. She was informed by the nurse that based on the dilatation of her cervix she was still far from delivering the baby. The same reading was recorded at 5:00, 7:00, 09:00 and at 12:00. At 08h15 her blood pressure was taken by the nurse on duty both manually and by using an automated blood pressure device. She had an elevated reading. She was again examined at around 10h15 and 12h15 whereafter she was given medication for high blood pressure. As she was very hungry, she was given food but then she vomited, the medication which was given to her and then she lost consciousness. She only woke up the next day, and was then informed by the nursing staff that she had given birth. During cross-examination her evidence remained unchallenged.

19. Professor Anthony testified, that the plaintiff was a primigravid woman who presented with an uncomplicated pregnancy initially assessed as a low risk, pregnancy. He testified that assessed from the hospital records, it appears that she went into spontaneous labour at term on 11 April 2012. On admission to the Welgevonden Clinic and upon assessment at 08h15 she was found to have an elevated blood pressure. He opined that her elevated high blood pressure was seemingly not taken into consideration when planning further management of her labour as the Maternity Guidelines prescribe that

she had to be referred to a hospital immediately on presentation of an elevated blood pressure. He testified that hypertension developing in a primigravida is a sign of potentially life-threatening disease in the form of pre-eclampsia. As the clinic staff had started anti-hypertensive medication at 12h15 already, he opined that this was so, because they had considered the plaintiff to have sufficiently severe hypertension to merit such treatment. It was further for this reason and given the fact that the plaintiff was a primigravida, that the clinic staff must have referred her to a hospital for further management as the development of hypertension in a primigravida must always raise a concern about possible development of pre-eclampsia because the highest incidence of this disease, he testified occurs in first pregnancies. The diagnosis of the plaintiff developing pre-eclampsia, was confirmed by the clear evidence of proteinuria (excessive protein in her urine) as well as two further blood pressure readings taken before 12h15 that day, confirming that she was hypertensive.

20. He further opined that on detection of the high blood pressure, she ought to have been monitored closely as any persistent elevation of the blood pressure triggered the immediate referral to hospital as prescribed by the Maternity Guidelines. The nursing staff's failure to action this step, resulted in them having failed to comply with the Maternity Guidelines. It was his further testimony that the Maternity Guidelines prescribes that upon a finding of an

elevated blood pressure reading that the nursing staff ought to have further assessed the plaintiff every 20 to 30 minutes of the initial blood pressure reading. Their failure to have done so, meant that the plaintiff received substandard medical care from the nursing staff in question. Having regard to the medical records assessed, it depicts that the midwives at the clinic gave the plaintiff an oral antihypertensive drug (Aldomet) at 12h15 despite the presence of proteinuria, which is a significant indicator of hypertension due to pre-eclampsia. He testified that the midwives at the clinic failed to appreciate the significance of the findings of proteinuria and three findings of systolic pressures in excess of 140 mmHG and diastolic pressures that ranged from 84 to 90 mmHg.

21. As the nursing staff failed to refer the plaintiff to a hospital that morning, her condition progressed into the development of eclamptic seizures. The expert opined that this was substandard care given to the plaintiff, in that her initial assessment as a low-risk patient, was inappropriate and the evolving evidence of proteinic hypertension was documented without appropriate action being taken such as the reassignment of the plaintiff's risk category and her urgent referral to the hospital. The medical records shows that the plaintiff suffered an eclamptic seizure at 16h00 in circumstances where such seizures could have been pre-empted and the pre-eclampsia could have been managed appropriately. It was also his testimony that eclampsia is a life-

threatening complication with a maternal case fatality rate of one in fifty and is associated with significant morbidity among survivors. In addition, the diagnosis of pre-eclampsia and eclampsia also implies a significant risk for fetus well-being and morbidity due to the effect which pre-eclampsia and eclampsia have on the placenta which is the organ through which the fetus receives blood and oxygen. In addition, impaired placental function increases the risk of the development of hypoxia in the fetus and associated with this, the risk of hypoxic ischemia in the fetus.

22. He therefore opined that when the eclamptic convulsion developed, the midwives administered an inadequate dose of magnesium sulphate, an anti-convulsant, because the clinic did not have sufficient stock. This, in his opinion, was substandard care which directly increased the risk of recurrent eclamptic seizures which did in fact occur while the plaintiff was admitted into the hospital. It was for this reason that he opined that it appears that the monitoring of the fetus was neglected completely.

23. As per the joint minutes prepared by the experts, it is common cause that the readings of the fetal heart rate from 08h15 were not done properly as prescribed by the Maternity Guidelines before, during and after contractions. Furthermore, it is also common cause that after 14h15 on 11 April 2012 there are no recordings of fetal heart rate monitoring or maternal monitoring until

18h30 when there was a retrospective record of maternal monitoring. Furthermore, it is common cause, that the medical records kept, recorded that the plaintiff's cervix was 8cm dilated at around 16h00 at the clinic and also that she was fully dilated while still at the clinic and the same reading was recorded upon her arrival at the hospital. The experts further opined, that this reading is indicative of the failure of the labour to progress at the rate of at least 1cm per hour in the active phase of labour as well as a prolonged active phase of labour, i.e. the dilation of the cervix from 4cm to 10 cm at a rate of at least 1 cm per hour. The experts agreed that the above readings are evident that the failure to properly assess the progress of labour and the failure to adequately document the fetal well-being resulted in substandard care in terms of what is prescribed by the Maternity Guidelines.

24. In addition the Maternity Guidelines also prescribe that the child had to be delivered immediately after a seizure had occurred. It is evident from the hospital records that at 19h40 the Plaintiff suffered a second seizure and had up to this time not been given any further doses of Magnesium sulfate.

25. In the joint minutes, the experts further opined the doctor's retrospective notes indicate that the plaintiff suffered the second seizure while she was in labour bearing down in the second stage of labour with delivery following the seizure 55 minutes later at 20h35. They further agreed that fetal monitoring

in the active phase of labour and in the second stage of active labour is vital in determining fetal well-being and the occurrence of fetal hypoxia. They also agreed that in the absence of fetal monitoring it would have been impossible to detect the occurrence of hypoxic ischemic insults timeously in order to intervene in the labour process to avert the insult and mitigate the consequent injury. In addition, they also agreed that in this case the labour was not adequately monitored during the first and second stages of labour and that it is probable that the Plaintiff developed slowly progressive hypoxia during the first stage of labour which was prolonged and remained unrecognized for some time. The experts were further in agreement that the second stage of labour also went unmonitored and also had the occurrence of a second eclamptic seizure which occurred at the time when the fetus was most vulnerable to hypoxic injury.

26. In their joint minute they as a result concluded that therefore it is likely that the pattern of neurological injury observed represents the slowly progressive development of intrapartum hypoxia during the first stage of labour (which went undetected because of inadequate monitoring of the fetal heart rate) followed by acute severe injury occurring during the second stage of labour when the plaintiff suffered a seizure leading to maternal and fetal hypoxaemia (abnormally low levels of oxygen in the blood). They were also of the opinion, that the management of the labour was substandard especially

from the period when she suffered the eclamptic seizure. It is on this basis that they concluded that the adverse outcome in the hypoxic ischemic brain injury would have been less likely to have occurred, if substandard care associated with the monitoring of fetal well-being in labour and mostly if substandard care associated with the management of eclampsia had been avoided. They ultimately agree that the management of the plaintiff's labour and the delivery of the baby was substandard and therefore negligent and that this substandard care is the most probable cause of the child's injury.

27. In addition to the joint minute prepared by the obstetricians, the radiologists also prepared a joint minute which was accepted into evidence. In their joint so prepared, the Radiologists – Dr Alheit and Dr Westgarth-Taylor agreed that the MRI images depict that the dominant injury seen on the MRI is hypoxic ischemic injury. Further, that the findings of the MRI study suggests that genetic disorders as a cause of the child's brain damage is unlikely. In addition, that the MRI findings suggests, that inflammatory or infective causes are unlikely as causes of the child's brain damage.

28. The Neonatologists, Professor VA Davies and Professor PA Cooper also prepared a joint minute and recorded the following agreements upon their meeting, namely that the antenatal course of the plaintiff's pregnancy was normal with no recognized complications or conditions which could have

affected the outcome. Further, that moderately severe neonatal encephalopathy (NE) Grade 2 with seizures was present after birth. The experts opined that the most probable cause of P[redacted]'s neonatal encephalopathy, is hypoxia ischemia and in South Africa Hypoxic Ischemic Encephalopathy should be considered preventable in the majority of cases. Having regard to the features present in P[redacted], an intrapartum hypoxic-ischemic event emerges as the most probable cause of the child's injury. Furthermore, that Eclamptic seizures are a probable cause of fetal hypoxia in this case. The experts were further in agreement that suboptimal intrapartum obstetric care emerges as a probable causal factor.

29. The Paediatric Neurologists, namely Professor Regan Solomons and Dr V Mogashoa also prepared a joint minute and agreed on the following namely that P[redacted]'s brain MRI changes are diagnostic of chronic sequelae of partial prolonged hypoxic ischaemia. Further that P[redacted] has asymmetric mixed cerebral palsy, microcephaly, profound intellectual disability, ADHD and behavioural abnormality. The experts agreed that there exists a good correlation between P[redacted]'s MRI brain abnormalities and the type of cerebral palsy. Further that P[redacted]'s motor disability is moderate to severe; Gross Motor Function Classification System IV. They further had consensus that P[redacted] suffers from moderate neonatal encephalopathy. The experts also agree that there is evidence for timing of the partial prolonged hypoxic

ischemia to the intrapartum period, predisposed by severe eclampsia. In addition, that P[redacted]'s head circumference was within normal limits at the time of delivery and that the normal head circumference at birth suggests that the insult occurred late in gestation, close to delivery or during the intrapartum period. The experts concluded that there is no recorded evidence for hypoxic ischemic injury in the postpartum period.

30.The Nursing Specialists, namely Professor DW Du Plessis and Professor A Nolte likewise prepared a joint minute. In their meeting held the experts opined that Ms. L[redacted]'s pregnancy progressed normally. Further, that the fetal development was within normal parameters according to the palpitations and symphysis fundal height on the SFH graph. The experts agree that there was no record of any maternal diseases or complications but for maternal anemia which was treated according to protocol. Further that the midwives who cared for Ms. L[redacted] during her labour did not timeously refer a patient presenting with hypertension and proteinuria from a clinic to a hospital nor were they remiss to make sure that they have enough stock of emergency medication available. In addition, they failed to timeously administered the correct emergency treatment for hypertension and also failed to timeously diagnose fetal compromise. The experts also concluded that the nursing staff failed to monitor the fetal heart continuously with a CTG according to existing protocol.

Negligence

31. In order for the plaintiff to succeed with her claim as against the defendant the plaintiff must establish negligent conduct on the part of the defendants' employees and in the circumstances of this case a court must determine, whether such conduct falls short of that of a reasonable man. Holmes JA in Kruger v Coetzee set out the test for negligence to be the following:

> 'For the purpose 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.'

32. In the decision of Standard Chartered Bank of Canada v Nedperm Bank Limited[2] the principle was further stated as follows:

[2] 1994(4) SA 747 (A), at 65

'In delict, the reasonable foreseeability test does not require that the precise nature or the exact extent of loss suffered, or the precise manner of the harm occurred and should have been reasonably foreseeable for liability to result. It is sufficient if the general nature of the harm suffered by the plaintiff and the general manner of the harm occurring was reasonably foreseeable.'

33. In *casu* the case of the plaintiff is largely reliant on the evidence of the plaintiff and circumstantial evidence in deciding whether any clinic and / or Hospital personnel acted negligently as a result of which P[redacted] suffered cerebral palsy. As mentioned, the direct evidence of the plaintiff is largely clear and undisputed.

34. The Plaintiff's evidence is the only factual evidence on which the matter is to be decided. When an inference of negligence would be justified and to what extent expert evidence would be necessary would depend on the facts of the particular case. A court is further not called upon to decide the issue of negligence until all of the evidence is concluded.

35. It thus follows, that any such explanation as may be advanced by a defendant forms part of the evidential material to be considered in deciding

whether a plaintiff has proved the allegation that the damage was caused by the negligence of the defendant.[3]

36. In order to succeed it will suffice for plaintiff to convince the court that the inference that he or she advocates is the most readily apparent and acceptable inference from a number of possible inferences.[4]

37. Before this Court in essence, it is the defendants' case, that the standards that were applicable to the matter at hand are set out in the National Maternal Guidelines published in 2007. The foreword to the guidelines states that they were reviewed by many experts and were updated following a vast literature review. The guidelines are applicable to clinics, community health centres and district hospitals in South Africa and these Guidelines for Maternity Care in South Africa (2007 Edition) ('GMC') were the applicable standard when the plaintiff gave birth at the Hospital.

38. In terms of these guidelines "Labour" is diagnosed if there are persistent painful uterine contractions accompanied by at least one of the following: cervical effacement and dilatation, rupture of the membrane or show.

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[3] Goliath v Member of the Executive Council for Health, Eastern Cape (085/2014) [2014] ZASCA 182; 2015 (2) SA 97 (SCA) (25 November 2014).
13AA Onderlinge Assuransie-Assosiasie Bpk v De Beer 1982 (2) SA 603 (A);
See also Cooper & Another NNO v Merchant Trade Finance Ltd 2000 (3) SA 1009 (SCA).

39. Labour is divided into four stages. The first stage is divided into two phases, i.e. the latent phase and the active phase. A woman is in the latent phase of labour if her cervix is less than 4 cm dilated and more than 1 cm long. In the latent phase the blood pressure must be taken 4 hourly. (GMC 36). The latent phase is prolonged when it exceeds 8 hours. (GMC 44).

40. The Guidelines further stipulates that a woman is in the active phase of labour if her cervix is greater or equal to 4 cm dilated and less than 1 cm long. (GMC page 34). The labour is prolonged in the active phase of labour if the cervix dilates at a rate of less than 1 cm/h (cross the alert line). (GMC page 34). In the active phase of labour the blood pressure must be taken hourly. (GMC 36).

41. In terms of the Guidelines, the next stage is the second stage which commences when the cervix reaches full dilation (10 cm). From the time that full dilation of the cervix is first noticed, up to 2 hours may pass before the mother starts to bear down. (GMC 40).

42. The third stage starts immediately after the delivery of the infant and ends with the delivery of the placenta. What follows is then the fourth stage, which is the first hour after delivery of the placenta. (GMC 41).

43. The Guidelines also deals with Hypertensive disorders in pregnancy. In terms of the GMC hypertension is defined as a blood pressure of 140/90 mmHg or more on two occasions at least 2–4 hours apart. Mild pre-eclampsia is defined as a diastolic blood pressure of 90–109 mmHg with 1 + or 2+ proteinuria. Symptoms of imminent eclampsia that develop in pre-eclamptic women are severe headaches, visual disturbances, epigastric pain, hyperreflexia, dizziness, fainting and vomiting. (GMC 79).

44. The management of mild pre-eclampsia at the clinic is the prescription of a loading dose of 1g methyldopa orally and to refer the woman to the hospital on the same day. The woman does not have to be referred to the hospital immediately as in the case of severe pre-eclampsia. (GMC 81).

Arguments advanced by the Defendant

45. With regards to the GMC, the defendant had argued that there was no negligence on the part of the staff at the clinic, despite the evidence presented by Professor Anthony.

46. On the question as to whether the clinic and hospital nursing staff in the position of the staff member(s) at either the clinic or hospital would have realized, that a serious condition was developing or threatening to develop

and, if so, when such a staff member would reasonably have come to realize, the argument advanced, was that the staff in question upon the plaintiff first presenting at the hospital at 8:15 at most had a borderline high blood pressure (140/90 or 146/95 without proteinuria).

47. At this point there was thus no signs of pre-eclampsia on her admission as per the GMC. Later at around 10:15 the plaintiff's blood pressure was recorded as 140/85 with a trace of protein in her urine. This does not equate to pre-eclampsia according to the GMC.

48. Thereafter at 12:15 her blood pressure was measured at 170/84 with a trace of protein in her urine. The patient was given 500g of Aldomet. This counsel submitted, likewise, does not equate to pre-eclampsia according to the GMC. At around 14:15 the blood pressure was measured at 150/90 with a proteinuria of 2+.

49. The reading taken at 14;15 was the first time that mild pre-eclampsia was detected. According to the GMC the treatment of mild pre-eclampsia consists of the following: a dose of 1g methyldopa orally and the referral of the patient to the hospital on the same day. There is nothing in the clinical records that indicate that the plaintiff had symptoms of imminent eclampsia. Plaintiff’s eclamptic fit occurred at 16:00, i.e. 1 hours and 45 minutes after mild pre-

eclampsia was noted. When the patient had the seizure, she was immediately treated with 2mg Magnesium Sulphate, which treatment was effective since the patient's blood pressure at 16:55 was 126/67 mmHg. Hereafter the patient was transferred to the hospital.

50. The treatment administered to the plaintiff, the defendant had argued, was in line with what was set out in the Guidelines for Maternity Care and it is for this reason that counsel had submitted that the notional reasonable staff member would not have realized that a serious condition in the form of a seizure was developing prior to the first fit. As in line with what the Guidelines dictated, the plaintiff nevertheless was transported to a hospital on the same day after the patient had her first fit and it is on this basis that counsel contended the defendant nursing staff acted reasonably.

51. Upon arrival at the hospital at around 17:45 the patient’s history recorded, a fit at the clinic around 16:00 hours and with a measured blood pressure at 16:55 of 126/65. It is on this basis that counsel submitted that given the readings so recorded the patient arrived with no current symptoms of pre-eclampsia. On arrival at the hospital no fits were also observed. The cervix was 8 cm dilated and the blood pressure was 135/85. (See L51), thus per the GMC the patient was not diagnostic of pre-eclampsia.

52. The GMC further prescribed how the management of eclampsia after fits should be controlled. In this regard it sets as guidelines that the baby should be delivered as soon as possible after the first fit by Caesarean section if there is foetal distress or if the cervix is unfavourable or if there is any other obstetric indication and vaginally if the mother is in labour or if the cervix is favourable for induction. The hospital records show no signs of foetal distress nor does it contain any indication that the patient's cervix was unfavourable for induction. Patient was in labour as a vaginal birth was indicated on her profile to be the preference. It is further for this reason that counsel had argued that no negligence on the part of the hospital staff can be attributed.

Arguments Advanced by the Plaintiff.

53. On behalf of the plaintiff, the strongest argument advanced was that of the evidence presented by Prof Anthony together with the Joint Minute prepared with his counterpart. In this regard counsel had submitted that the defendant’s plea did not disclose with any particularity the basis of its defense. It however emerged from the Joint Minutes of the plaintiff and defendant’s experts that the defendant conceded that the care given to the plaintiff, the management of the plaintiff’s labour and the delivery of the child was substandard.

54. On this basis, counsel for the plaintiff had argued that Prof Anthony was of the view that remedial action should have been taken and that the failure to take remedial action is causally connected to the damages suffered by the patient.

55. Based on the evidence of the plaintiff and that of the plaintiff's expert witnesses, counsel had argued that the neo-natal signs were consistent with an intrapartum event with features associated with a prolonged hypoxic ischemic insult.

56.This insult and injury resulted from a failure properly monitor the plaintiff's labour, to detect foetal distress, to intervene timeously and to assist, appropriately with the delivery of the child. If the birth was properly managed the harmful situation the fetas experienced should have been recognized and timeously reacted upon.

57. On this basis counsel submitted that there is therefore a direct causal link between the negligence of the defendant in not monitoring the plaintiff appropriately during the process of labour, the inappropriate treatment which the plaintiff received when the hypertension which she suffered, progressed to pre-eclampsia and eventually life-threatening eclampsia and the injury suffered by the plaintiff's child.

58. In addition counsel had argued, that if there was proper monitoring and assistance, foetal distress would have been detected, assistance would been given with the delivery either by expediting the delivery or by referring the plaintiff to a hospital for a caesarean section timeously to prevent the hypoxic ischemic insult which resulted in the cerebral palsy.

Findings

59. The defendants' case is primarily premised on the Guidelines for Maternity Care. At the outset it should be noted that the Guideline for Maternity Care, is just that, namely guidelines. It is by no means cast in stone and it cannot be said that it takes away the discretion of any professional when making observations of a patient.

60. Thus, when in doubt the nursing staff should have called for the opinion of other professionals who could have assisted them in making a diagnosis of the plaintiff and formulating an appropriate protocol for treatment.

61. Before this Court, there exists no evidence that the nursing staff who treated the plaintiff was prevented from deviating from the set Guidelines and

that they were prevented from taking different remedial action, given the symptoms that the plaintiff presented with.

62. Absent, such direct evidence, this court is unable to deduce what informed the nursing staff to strictly comply with the Guidelines in question and why no deviation from such Guidelines was either permissible or even considered and subsequently rejected.

63. Counsel for the defendant had argued the plaintiff has failed to prove the time of the hypoxic insult. This resulted in the plaintiff failing to prove when the need for remedial action would have been realized by the notional reasonable staff member and that there by then would have been sufficient time left to avoid the damages suffered by taking the indicated remedial steps.

64. This argument advanced by counsel for the defendant, this court cannot find favour with. It is not for the plaintiff to have established the exact time when the hypoxic insult did occur. In any event, this information falls within the exclusive knowledge of the defendant and or its staff and any records kept by them in relation to the treatment meted out to the plaintiff. Only the defendant would thus have been able to shed light on this crucial aspect.

65. What is common cause, is that the hypoxic insult indeed occurred, resulting in the challenges the patient now presents with.

66. It is noteworthy that all experts who filed joint minutes agreed that the nursing staff should have taken appropriate emergency steps in order to diagnose timeously fetal compromise and had such appropriate steps been taken, the injury to the patient could have been prevented or mitigated.

67. For the reasons alluded to above, I therefore conclude that the defendants' staff was negligent in their treatment of the plaintiff and therefore should be held liable for the injury inflicted upon the patient.

68. It is therefore a finding of this Court that their conduct fell short of the conduct expected of a notional reasonable staff member. As such, it follows, that the Plaintiff has succeeded in proving her claim on a balance of probabilities. Judgment on the merits is as a result granted in favour of the Plaintiff against the Defendant.

Order

69. In the result, judgment on the merits is granted in favour of the Plaintiff against the Defendant with costs.

C.J. COLLIS
JUDGE OF THE HIGH COURT
GAUTENG DIVISION, PRETORIA

APPEARANCES

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Instructed by:	MARTIN Du PLESSIS ATTORNEYS
Counsel for Defendant:	ADV.A B. ROSSOUW SC assisted by ADV L. PRETORIUS
Instructed by:	OFFICE OF THE STATE ATTORNEY
Date of hearing:	22 February 2023
Date of judgment:	07 February 2024