THE SUPREME COURT OF APPEAL OF SOUTH AFRICA

JUDGMENT

Not Reportable

Case no: 035/2020

In the matter between:

THE MEMBER OF THE EXECUTIVE COUNCIL

DEPARTMENT OF HEALTH,

NORTH WEST PROVINCE **APPELLANT**

and

NAM obo TN **RESPONDENT**

Neutral citation: *The Member of the Executive Council, Department of Health, North West v NAM obo TN* (035/2020) [2021] ZASCA 105 (26 July 2021)

Coram: ZONDI, DAMBUZA and MOCUMIE JJA and GORVEN and EKSTEEN AJJA.

Heard: 10 May 2021

Delivered: This judgment was handed down electronically by circulation to the parties' legal representatives by email, publication on the Supreme Court of Appeal website and release to SAFLII. The date and time for hand-down is deemed to be have been at 09h45 on 26 July 2021.

Summary: Delict – medical negligence – claim for damages based on failure to attend to plaintiff before delivery and foetus after delivery – whether the clinic nursing staff were

negligent in their treatment of the plaintiff and TN – whether negligence caused TN's hypoxic ischemic injury and the resultant cerebral palsy.

ORDER

On appeal from: North West Division of the High Court, Mahikeng (Hendricks ADJP, Gura J and Oosthuizen-Senekal AJ concurring, sitting as court of appeal)

1 Condonation for the late filing of the appeal record is granted.

2 The appeal is upheld.

3 Each party is to pay its own costs.

4 The order of the Full Court is set aside and substituted with an order dismissing the appeal.

JUDGMENT

Mocumie JA (Zondi and Dambuza JJA and Gorven and Eksteen AJJA concurring)

[1] The issue in this appeal is whether the nursing staff at Makgobistad clinic in Kuruman, North West Province were negligent in their management of the plaintiff's delivery and in their treatment of the plaintiff's baby (TN) on 17 December 2003. For convenience, the parties will be referred to as they were in the trial court, plaintiff and the Member of the Executive Council for Health, North West (the MEC).

[2] At the outset, the MEC sought condonation for the late filing of the appeal record on a number of grounds. The factors which a court considers when exercising its discretion whether to grant condonation, include the degree of non-compliance with the rules, the explanation for it, the importance of the case, the respondent's interest in the finality of the judgment of the court below, the convenience of the court and the avoidance of unnecessary delay in the administration of justice.[1] As regards the delay, the MEC

[1] *S v Sayed and Others* [2017] ZASCA 156; 2018 (1) SACR 185 (SCA) paras 21-23 with reference to *Dengetenge Holdings (Pty) Ltd v Southern Sphere Mining and Development Company Ltd and Others* [2013] ZASCA 5; [2013] 2 All SA 251 para 11.

lodged a notice of appeal on 16 April 2020. In terms of rule 8(1) of the Rules of this Court he was obliged to lodge the record within three months of delivery of the notice of appeal. The MEC only lodged the record of proceedings on 10 September 2020, almost five months later. By then the appeal had lapsed. The MEC attributed the delay to the effect of the national lock down, which was imposed in March 2020, under the National Disaster Management Act, 57 of 2002 in an attempt to curb the spread of the Corona virus. During the lockdown the North West High Court operated with skeleton staff to attend only to urgent matters. As a result, service of court processes, including the appeal record of this case, suffered. The attorneys employed by the State Attorney could, initially, not move freely as they were not declared essential workers. They were granted essential work permits on 14 May 2020.

[3] In addition, the transcribers, Digital Audio Recording Transcripts, delayed the transcription of the record within the anticipated period. Ms Ndabeni of the State Attorney, who was responsible for this appeal, instructed Appeals Document Services CC on 20 May 2020 to prepare the record and the documents were sent to them on 3 June 2020. The State Attorney received the draft record from Appeals Document Services on 10 July 2020. On 20 July 2020 the draft record was sent to the plaintiff's attorney for comment. There is no explanation why the draft was not sent sooner, or why it took the State Attorney almost further two months to file the record (10 September 2020).

[4] The MEC maintains that he has lodged a notice of appeal which has good prospect of success and that the plaintiff will not suffer prejudice if condonation were to be granted. If condonation is refused, the MEC contends, the appeal will lapse which will severely prejudice him.

[5] It is correct that the delay in filing the record has a direct impact on the plaintiff's interest in the finality of the matter. In my view, although more should have been done in prosecuting the appeal, the delay is not inordinate and it has been satisfactorily explained. Nor can it be said that the plaintiff would suffer any prejudice if condonation was granted. The appeal is very important to both parties as it involves the determination of the cause of the cerebral palsy the plaintiff's minor child suffers from. Having considered all the

circumstances of this case, condonation for the late filing of the appeal record should be granted. I now proceed to deal with the appeal.

[6] The plaintiff instituted a claim for delictual damages in the High Court, North West Division, Mahikeng (the high court), on behalf of her minor child (TN), against the MEC as the employer of the nursing staff at the clinic at the time. The plaintiff's claim against the MEC was brought on the basis that he was vicariously liable for the negligent conduct of the nursing staff that attended to the plaintiff at the clinic during her admission. She claims that this negligence caused and culminated in TN developing cerebral palsy as a consequence of a hypoxic-ischaemic event at birth, and thereafter. She alleged that the nursing staff at the clinic negligently kept the clinic closed the night before her admission (16 December 2003) until after 08h00 on the day on which she gave birth (17 December 2003). Upon her admission, they failed to properly and professionally attend to TN, and, in particular, failed to administer oxygen to TN in circumstances when it was reasonably necessary for them to do so; failed to enlist the services of a gynaecologist, or a qualified doctor or other suitable specialist, to examine and properly treat TN in circumstances when it was reasonably necessary to do so; and failed to adhere to the standard of practice of reasonable sisters or nurses in their respective positions in order to ensure that the plaintiff was attended to without delay, and to prevent TN from suffering from brain and other injuries.

[7] Gutta J in the court of first instance, who, by agreement between the parties, was called upon to decide only the question of liability, dismissed the claim. She found that the plaintiff did not succeed in proving negligence and causation. The plaintiff successfully appealed to the full court (Hendricks ADJP, with Gura J and Oosthuizen-Senekal AJ). Not satisfied with the decision of the full court, the MEC sought and was granted special leave to appeal to this Court.

[8] The facts set out below were either common cause or not seriously disputed. In the morning of 17 December 2003, around 03h00, the plaintiff, who was in her full term of pregnancy, experienced labour pains. She arrived at the clinic not far from where she resided, in a private vehicle, a panel van hired by her father, at about 07h50. The clinic is

a government institution that is supposed to be open to the public on a 24-hour basis. On the day in question, there were two nursing staff on duty, a qualified nursing sister who is a midwife, Sister Moletsane, and an assistant nurse, Ms Motaung. In addition, the clinic has an administration officer who keeps the records and files of the clinic, Ms Jaula, a cleaner, and a security officer. It has a basic obstetric care unit (the labour room) fitted with an incubator for babies after their delivery. The plaintiff was 21 years of age at the time of TN's birth. This was her second birth. Her first child had been born at the same clinic. As in the case of her first pregnancy, she said, she attended antenatal care at the clinic from two months into her pregnancy and had no prenatal complications.[2]

[9] In her particulars of claim, the plaintiff asserted that on 17 December 2003, she gave birth shortly after 08h00 inside the panel van, unmonitored and without the assistance of the nurses at the clinic. It was averred that the harm TN suffered was caused by an acute profound hypoxic ischaemic insult caused by a complete lack of oxygen to the brain for a sustained period as advised by medical experts; which, but-for the nursing staff not attending to her professionally and timeously, would not have occurred.

[10] The antenatal records of the plaintiff, the records from the clinic regarding the day TN was born, as well as the maternity case record relating to the plaintiff's treatment were all missing and subsequently confirmed to have been lost. All that was available was TN's Road to Health Chart (RTHC), which was incomplete. On it, all that was recorded was that TN was born by normal vertex delivery.[3] The weight, length and head circumference were not recorded on the RTHC. No Apgar scores[4] were recorded. TN was diagnosed with cerebral palsy at the age of six months.

[11] In his pleas, the MEC denied all allegations of negligence attributed to the nursing staff at the clinic in relation to the birth of TN. The MEC contended that the nursing staff

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[2] Albeit without the benefit of her medical records which were lost by the clinic.
[3] According to Medterm Medical Dictionary, **a vertex delivery**, means the top of the baby's head comes first. The **vertex** refers to the top of the head.
[4] **Apgar** stands for 'Appearance, Pulse, Grimace, Activity, and Respiration'. In the test, five things are used to check a baby's health. Each is scored on a **scale** of 0 to 2, with 2 being the best score.

were on duty at all relevant times and denied that they arrived after the birth of TN. In the alternative, the MEC contended that the plaintiff was contributorily negligent in that she failed to attend antenatal clinic regularly during her pregnancy; she failed to seek medical assistance during early labour when she should reasonably have done so; she sought medical assistance at the clinic only when her labour had progressed and the head of the unborn child was on the perineum; and she was inappropriately dressed in denim pants during labour which delayed TN's birth.

[12] To discharge the onus which rested on her to prove her case, the plaintiff testified and led the evidence of Mr Lebone - the owner and driver of the van which took her to the clinic, Dr: Moja (a neurosurgeon) and Dr Lewis (a paediatrician). Dr Sevenster, a specialist obstetrician for the plaintiff, was not called although he compiled a report and joint minutes with Dr Malebane. To rebut the case for the plaintiff the MEC led evidence of the clinic nursing staff Sr Moletsane and Ms Motaung, as well as the administration officer Ms Jaula and Dr: Malebane, Dr Marumo, Dr Kganane and Dr Mogashoa, a paediatrician neurologist. There were several other experts who examined the plaintiff and TN and thereafter compiled reports, including radiologists and paediatricians, but who were not called to testify.

[13] The plaintiff's version, which is corroborated by Mr Lebone (although he said the time of arrival was 07h00) must, on all the probabilities, be accepted. She said that she arrived at about 07h50 and at that time the clinic was not open. They found approximately twenty people waiting outside the gate of the clinic. The security officer on duty at the clinic told them to remain outside the premises as the nursing staff were not on duty. They accordingly waited there. Her waters broke at 08h10. At 08h15 she gave birth unmonitored. At 08h20 the cleaner came to assist her by putting a blanket over her and the baby that was already on the seat between her legs. She said, '[the] baby did not cry at birth, was just still for 10 minutes after the nurse arrived'. At 08h25, Ms Motaung, the assistant nurse came to the panel van and took the baby inside the clinic. The plaintiff was also taken into the labour room. TN was taken to another room. Sr Moletsane cleaned and treated her.TN was brought back to her in the labour room and she breastfed her. She was discharged with TN and was home by 14h00. Her grandmother, based on her

observation of the baby's squint eyes, remarked that there was something wrong with the baby. TN did not suckle like her first baby, she said. She took TN to the clinic a week later and neither she nor the clinic staff noticed anything unusual about her. At six months, she went to a different clinic. The clinic referred her to Bophelong hospital which diagnosed TN with cerebral palsy. From the time the plaintiff was discharged on the day of the birth, until six months later, there were no outward manifestations of any injury.

[14] For the plaintiff's experts, in particular Dr Moja, supported by Dr Lewis, were of the view that the hypoxic event was of an acute profound nature which occurs within 6 to 10 minutes at birth. Dr Moja agreed with the radiologists that the MRI showed a mixed pattern with '. . . chronic sequelae secondary to a combination of partial prolonged hypoxic ischemic injury as well as an acute profound hypoxic ischemic injury'. The significance of this is that, Dr Moja said that the acute event would have been at the time of birth (if it had been before, the baby would have been born dead) and lasted 'less than five minutes . . . but there is a second element which is the prolonged element and that to me means that at that point there was lack of oxygen but it was not total lack of oxygen at the point but damage was still occurring because it was suboptimal'. He went on to explain that the acute event occurred at birth and he explained that is why the baby was not breathing or moving initially. But, after she was revived, he believed that ongoing damage would probably have been caused due to poor oxygen supply and that, as he put it '. . . you have an acute profound hypoxia and subsequently also have a prolonged period of hypoxia, you have ongoing damage that may not necessarily be evident subsequently . . .'.

[15] According to Dr Lewis, 'approximately 10 million babies do not breathe immediately at birth, of which about 6 million require basic neonatal resuscitation'. So what the clinic staff did was basic resuscitation since there is no indication that it took any length of time or special techniques to get the baby to breathe, cry, move and suckle. The evidence concerning monitoring for 12 to 24 hours was that this was the case for babies who require extensive resuscitation. The significance is that Dr Moja testified that the treatment protocol was to administer oxygen and to test for oxygen uptake (which the clinic could not do) and thus to refer to a hospital. He could not say, however, that the nursing staff would have been aware that this was the treatment protocol. This is because

he did not know what training the staff at this level in such a clinic would have received and, therefore, whether such persons could reasonably have known that TN required such treatment. No nursing experts were called to testify on this aspect. Because, after resuscitation, the baby appeared normal, it cannot be said that the clinic staff were negligent in failing to do what the expert neurologist and obstetrician would have done.

[16] In their view, the harm caused by the acute profound hypoxic event occurred at the time the plaintiff gave birth, unmonitored, and TN 'was still, did not cry and was not breathing', before the nursing staff came to assist her. Dr Lewis, however, conceded that if TN was breathing, crying, breastfeeding and was pink in colour there was no need to resuscitate her further after she started breathing. Dr Moja was of the view that, because TN had suffered such an event, the treatment protocol required her to be oxygenated until further tests were done within 24 hours, during which period TN should not have been discharged. This would have involved calling a medical doctor with expertise in resuscitations or referring her to a hospital equipped for such emergencies where she would have been provided with medical treatment immediately to reverse the results, or to minimise them later. Had this been done, he opined that the partial prolonged hypoxia could have been avoided or minimised leading to a better outcome. Dr Lewis was of the opinion that the 12 to 24 hour monitoring protocol was only indicated if extensive initial resuscitation had been necessary. Both experts conceded that they could not testify that the nursing staff would have known that this treatment protocol was indicated. That being the case, no finding of negligence can be supported.

[17] The version of the nursing staff was that Sr Moletsane brought TN back to the plaintiff to establish if TN could breastfeed, which she could do. She monitored TN's progress for 4 hours intermittently, 2 hours apart. She was satisfied that TN was well. She discharged both the plaintiff and TN at approximately 12h00. She said that, although the delivery had been complicated, there was nothing untoward about TN after resuscitation. She was pink in colour, was breathing normally and was breastfed by the plaintiff several times before discharge. Neither of the nursing staff nor the plaintiff saw anything unusual in the state of TN at discharge. It bears reminding that the cerebral palsy was only diagnosed some 6 months later.

[18] Some 7 days after the birth of TN, the plaintiff brought her to the clinic for tuberculosis and Polio vaccination. She was issued with the RTHC. On it she noted the weight to be 2,8kg which was as expected at that stage. She stated that the clinic lost TN's Apgar Scores and the plaintiff's medical records.

[19] In a nutshell, the experts for the MEC agreed with the plaintiff's expert, Dr Moja, as indicated earlier, that '. . . it was impossible to determine with any degree of certainty the precise moment when this injury would have occurred'. Dr Malebane, in particular, stated that in the event that it was accepted that the injury could have occurred in the second stage of labour, it would have been preceded by abnormalities; which was not the case according to the plaintiff's narrative. Dr Kganane stated that the steps taken by Sr Moletsane, namely suction and removal of excessive secretions, wrapping TN and putting her in the incubator (to re-establish the temperature) were normal. The fact that TN was monitored for 4 hours meant that she was conscious and did not need oxygen. The plaintiff told them that she did not pick up any abnormalities as TN was breastfeeding without any difficulty even after they were discharged from the clinic. That, on its own, indicated that despite the injury, there were no apparent problems immediately after birth.

[20] The general rule is that he or she who asserts must prove. Thus, in a case such as this the plaintiff must prove that the damage sustained by her minor child was caused by the defendant's clinic staff's negligence. The failure of a professional person to adhere to the general level of skill and diligence possessed and exercised at the same time by the members of the branch of the profession to which he or she belongs would normally constitute negligence.[5] A medical practitioner 'is not expected to bring to bear upon the case entrusted to him the highest possible degree of professional skill, but he or she is bound to employ reasonable skill and care.' [6]

[5] *Van Wyk v Lewis 1924 AD 438 at 444.*
[6] *Mitchell v Dixon* 1914 AD 519 at 525.

[21] The question that remains is whether any liability can be attached to the nursing staff (and vicariously so, to the MEC), after the plaintiff was admitted into the clinic after TN had already been delivered, unmonitored. Despite the initial vigorous contestation on behalf of the MEC, it became common cause by the end of the trial, as I have already stated, that the cerebral palsy was caused by a mixed pattern with '. . . chronic sequelae secondary to a combination of partial prolonged hypoxic ischemic injury as well as an acute profound hypoxic ischemic injury'. A hypoxic ischaemic event can be described as lack of oxygen and inadequate perfusion of oxygen, through the blood, to the brain which causes damage to the brain.[7] The radiologists produced joint minutes on the imaging features of the Magnetic Resonance Imaging (MRI) brain scan and agreed that 'the scan is indicative of *a hypoxic ischemic injury of a term brain at a chronic stage of evolution* . . . [T]he dominant pattern of injury in this case is acute profound in nature'. In their revised report the radiologists stated that 'a combination of partial prolonged hypoxic ischemic injury as well as an acute profound hypoxic ischemic injury' were features of the MRI. The experts that testified based their evidence on both. The joint report of the radiologists was admitted as evidence by agreement.

[22] It is therefore safe to accept that on everybody's version, including the plaintiff's, nobody thought anything was wrong with TN when she was discharged from the clinic, except what her grandmother said on the first day of TN's arrival at home; namely her squint eyes indicated that there might have been something wrong with her. That TN had squint eyes (without other *sequelae*) is on its own not a manifestation of a brain injury. Furthermore, even when the plaintiff took TN back to the clinic 7 days after her birth for immunisation, according to what is recorded on the RTHC, she reported no abnormality about the baby's behaviour. At that stage, as reasonably expected, she would have told the nursing staff about any abnormality she picked up on her own as the mother or even what her grandmother had said about TN's squint eyes. She did not.

[23] The ineluctable inference must then be drawn that, the fact that the damage was only picked up 6 months later, is an indication that the damage was ongoing after birth.

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[7] *Magqeya v MEC for Health, Eastern Cape* [2018] ZASCA 141 para 8.

As no abnormalities asserted themselves at the clinic, it cannot be said that the nursing staff fell short of the standard of reasonable nursing staff in a position similar to them.

[24] For these reasons, I find that the plaintiff failed to discharge the onus that rested upon her to prove their negligence. There is therefore, no need to consider causation.

[25] What remains to consider, is the issue of costs. Counsel for the MEC did not abandon the costs that follow upon success as in similar cases where the medical records were lost in the hands of the clinic staff to mitigate such loss. It is so that the loss of medical records which recorded the crucial information; in particular, the Apgar Scores, which the plaintiff required in order to prove her claim against the MEC, reflects badly on the clinic and its staff, the MEC and the department. It is conduct which must be deprecated in the strongest terms. In the circumstances, I am of the view that the plaintiff should not be mulcted with costs. I say this because the hospitals and clinics are obliged to keep the records of a minor until they reach majority. They failed to do so.

[26] In the result the following order issues.

1 Condonation for the late filing of the appeal record is granted.

2 The appeal is upheld.

3 Each party is to pay its own costs.

4 The order of the Full Court is set aside and substituted with an order dismissing the appeal.

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B C MOCUMIE

JUDGE OF APPEAL

APPEARANCES

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