REPUBLIC OF SOUTH AFRICA

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

CASE NO: 14/26684

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

24/3/2017
DATE

SIGNATURE

In the matter between:

MODIANANG, N V obo MODIANANG, V K Plaintiff

and

TEMBISA HOSPITAL First Defendant

MEC FOR HEALTH AND SOCIAL DEVELOPMENT, GAUTENG PROVINCE Second Defendant

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J U D G M E N T

KEIGHTLEY, J:

[1] The plaintiff in this matter sues on behalf of her minor child, V, and in her personal capacity. The claim is one for damages arising out of the care and treatment rendered to the plaintiff and V at Tembisa Hospital ("the hospital")

before and during the birth of V, on 4 April 2009. It is common cause that V suffered an acute profound hypoxic ischemic injury to his brain in the latter stages of the plaintiff's labour. V was born with what is commonly referred to as cerebral palsy.

[2] The plaintiff's case is that the nursing and/or medical personnel at the hospital were negligent in a number of respects. Most particularly, her case is that the hospital staff failed to adequately, objectively assess and manage the progress of her labour and the delivery of V. Further they failed to monitor, observe and act swiftly upon signs of foetal distress, in particular the draining of meconium-stained amniotic fluid. They also failed to expedite delivery of the foetus, and to timeously take steps and precautions to prevent foetal hypoxia. They failed further in not following and applying the standard guidelines for maternal care in South Africa. There are various additional grounds of negligence cited in the particulars of claim.

[3] The parties agreed to, and I ordered, a separation between merits and quantum in terms of Rule 33. The hearing before me dealt only with the issue of merits.

[4] The defendants initially defended the action on two material bases: it denied that there was negligence on the part of the relevant hospital staff, and it pleaded that there was no causal connection between any negligence established at trial, and V's cerebral palsy. However, in the defendants' heads of argument they conceded the following:

> "The obstetric experts agree that the inadequate monitoring was sub-standard, more especially because the midwives did not record any

monitoring (of the foetal heart rate) after 03:15, leading to the conclusion that there was no monitoring. Their negligent conduct accordingly consists of an omission." (emphasis added)

[5] In the circumstances, the issue of negligence is no longer in dispute between the parties. The defendants have accepted that the failure to monitor the foetus from 3H15 constituted negligence. As the defendants point out in their heads of argument, the question is whether this negligent conduct caused V's cerebral palsy. In other words, the sole issue is that of causation.

[6] The issue of causation is further narrowed in that there is much that is common cause among the experts. I will deal with the relevant points of agreement between them shortly. First, I set out a broad summary of the facts that are material to the dispute.

[7] According to the hospital records the plaintiff was first examined on the ward at 15H30 on 3 April 2009. She was assessed again at 18H00 hours. By 21H30 the records reflect that she was 2cm dilated, and the foetal heart rate was 144bpm. The nursing care plan noted that the foetal heart rate was to be monitored 4-hourly. It was again monitored at 23H10, and was noted to be 132bpm. The plaintiff was transferred to the labour ward at that stage. In the labour ward, the nursing staff completed a partogram to track the progress of the plaintiff's labour, and of the foetal heart rate. As regards the latter, the first entry on the partogram was at 1H15, when the foetal heart rate was 120bpm. The next entry was at 2H15, when it was 115bpm, and the final entry was at 3H15 when it was 128bpm. It is common cause that no further foetal heart rate monitoring was conducted. As I have already

indicated, the defendants have accepted (based on the views of both sets of obstetric experts) that there was no monitoring of the foetal heart rate after 3H15, and that this constitutes negligence.

[8] According to the doctor's/midwive's notes, at 1H10 on 4 April 2009, there was spontaneous draining of clear liquor, and the plaintiff was in active labour. At 4H45, the records note that the plaintiff was fully dilated. However, the notations entered included those of "caput +++" and "moulding+++". As was explained by Dr Pistorious at the trial (and his evidence in this regard was not contested), moulding is the process by which the foetal head moulds itself to fit through the birth canal. The grading reflects the movement of bones in the skull. A grading of "+++" means the bones in the skull have overlapped to the maximum extent, and there is a concern that the baby could not fit through the birth canal. Indeed, the notes reflect that the doctor or midwife who examined the plaintiff at 4H45 diagnosed "CPD" or cephalic-pelvic disproportion. In ordinary language, it means that the baby's head was too big for the plaintiff's pelvis. The notes go further and show that the plaintiff was booked for a caesarian section at that stage. It is common cause that the caesarian section did not take place. Instead, the plaintiff delivered naturally on the ward at 5H10 in circumstances that I will deal with later.

[9] I should also add that as part of the discovery process the defendants produced a CTG recording purporting to be that of V's foetal heart rate. The timing shows recordings at intervals between 2H01 and 2H20. Although it was not labeled with the plaintiff's name (or any other name). The defendants produced the recording (or a copy thereof) as part of their

discovery. The relevant experts were asked to provide their comments on the assumption that it pertained to the plaintiff and V. I deal with this later.

[10] It is common cause that when V was born his Apgar scores were very low. They were 3 at one minute after birth, 3 at five minutes after birth, and 5 at 10 minutes after birth. Prof Kirsten, the neonatologist who testified for the plaintiff, stated that these scores were very low, with the normal 1 minute Apgar score being 8-9. Such a low score indicated severely compromised respiratory and heart functioning. According to Prof Kirsten, the score of 5 at 10 minutes indicated a sign of intrapartum hypoxia. He testified that this must be why the attending doctor, Dr Nzobo entered the conclusion of "severe birth asyphxia", or suffocation, in his notes.

[11] A cranial ultrasound was performed on V four days after his birth. It showed diffuse intra-cerebral echognic areas suggestive of a hypoxic insult to the brain.

[12] There was very little in dispute between the experts on the basis of the joint minutes agreed upon by them. To the extent that there were any disputes, these were dealt with in the examinations-in-chief of the plaintiff's experts. The defendants did not deal much with these disputes in the cross examination of the plaintiff's experts. Significantly, the defendants elected not to call any of their experts to give evidence at the trial. The court was informed of this election when counsel for the defendants rose to open their defence.

[13] The paediatric neurologists were agreed that:

[13.1] V's injury is global and the pattern is consistent with an acute profound hypoxic ischemic injury of a term brain at a chronic stage of evolution.

[13.2] V's MRI findings are not in keeping with intracranial infection, congenital brain abnormalities, maternal medication, intrauterine growth restriction, intracranial haemorrhage, inborn errors, metabolism or a genetic disorder.

[13.3] V's hypoxic ischemic encephalopathy contributed to his neonatal encephalopathy ("his brain injury").

[13.4] Regarding the timing of V's brain injury he fulfils the criteria necessary for intrapartum asphyxia in terms of ACOG 1999 and 2003.

[14] The obstetric experts agreed that:

[14.1] The recording of foetal observations in the latent phase of labour were insufficient (as compared with the Department of Health Guidelines).

[14.2] It is likely that an acute profound hypoxic event occurred in the time from 03h15 until 04h45 (4 April 2009) where there is no recording of foetal monitoring during active labour.

[14.3] As far as the CTG is concerned, although the recording is of poor quality the foetal heart rate appears to commence at a rate of 180/min (tachycardia), accelerates to 220/min, decelerates to

90/min, and then recovers to a basal heart rate of 130-150/min, with one further possible deceleration to 60/min.

[14.4] Due to the poor quality of the recording it is impossible to be completely certain whether the decelerations are true decelerations or present loss of contact.

[14.5] The appropriate action of the nursing staff should have been to label the CTG appropriately and take steps to improve the quality of the recording, and if the quality was indeed poor in 2009, to determine whether the apparent decelerations were true decelerations or not.

[15] Dr Pistorius testified that the nursing staff should have taken steps to ascertain whether the readings were correct by testing to ensure that the transducer was properly connected and, if necessary, also checking to see whether the machine was giving faulty readings for other reasons. His testimony (which was not materially challenged under cross-examination) was that readings like those reflected on the CTG should never have been accepted without further action on the part of the nursing staff.

[16] The specialist nursing experts agreed that:

[16.1] (If the CTG recordings were of V's foetal heart rate), the foetal heart rate decelerations (vaguely) visible on the tracings reveal patterns with possible signs of foetal compromise.

[16.2] No foetal monitoring was documented between 03h15 to 04h45.

[16.3] Emergency measures by the midwives were not documented in any of the progress reports and it is unknown if this was instituted or communicated to the medical practitioner.

[17] Prof Kirsten, the plaintiff's neonatologist, testified that V suffered an acute profound hypoxial insult. He testified further that with babies it is difficult to pinpoint when the hypoxia started in the absence of a known, traumatic event, like a prolapsed cord or ruptured uterus. This is why monitoring of the heart rate during labour is so important, because it can give an indication of when it commenced. During the active phase of labour the midwife must assess foetal heart rate and response to contractions every 30 minutes so that changes can be identified. The slowing of the foetal heart rate is a sign of hypoxia. Before the onset of the slow foetal heart rate, there will be changes in the pattern on the CTG. In other words, there are warning signs, including meconium in the amniotic fluid. Towards the end of the hypoxic episode, the foetus will have a very slow heart rate and delivery needs to be done quickly. If delivery is soon enough, it is possible to avoid a hypoxic ischemic episode and consequent brain abnormalities. Midwives should also put in place emergency measures to "buy time" for the foetus while preparations are made for urgent delivery. This involves, among others, putting the mother on her left side, and administering oxygen to her. The doctor must be called immediately to assess whether medication should be given to suppress contractions (which affects the flow of oxygen to the foetus). If these measures are introduced, the foetal heart rate can be improved before an emergency caesarian section is performed. Dr Pistorius gave substantially

the same evidence in this regard. Neither of these experts was challenged on their opinions.

[18] Prof Kirsten's view was that V was delivered very close to the time that he would have died. This is indicated by how long it took to get him back to normal heart rate and respiration.

[19] I should record that while the plaintiff's particulars of claim referred to meconium stained amniotic fluid, this contradicts the hospital records. The plaintiff also testified that she did not give any instructions to her attorneys to the effect that her amniotic fluid was stained with meconium. I accept, for purposes of my judgment, that in the plaintiff's case, no warning sign of this nature (i.e. meconium in the amniotic fluid) occurred.

[20] What is critical for purposes of determining the issue of causation in this case is the acceptance by the defendants that the hospital staff were negligent in failing to monitor the foetal heart rate from 3H15, when the last record of a foetal heart rate was entered. I accept that at that time there was nothing to indicate that V was suffering any foetal distress. However, this does not mean that the defendants are in the clear.

[21] As I noted earlier, according to the neonatal neurologists, no other cause of V's brain injury presents itself other than the acute profound hypoxic injury that he suffered intrapartum (i.e. before or during birth). Further, as the obstetric experts for both sides concluded:

> "It is likely that an acute profound hypoxic event occurred in the time from 03h15 until 04h45 (4 April 2009) where there is no

recording of foetal monitoring during active labour." (emphasis added)

[22] According to the experts, the critical time to assess causation is in this period. From the uncontradicted evidence of Prof Kirsten and Dr Pistorius, it is clear that foetal monitoring every 30 minutes is essential for purposes of detecting warning signs of a possible hypoxic episode. This essential monitoring was not carried out. Inevitably, this means that the nursing staff could not pick up on the warning signs that in all probability would have been evident had they monitored the foetal heart rate as required. Because they failed to monitor the foetal heart rate (and hence were ignorant of any warning signs of foetal distress caused by hypoxia) the plaintiff was denied the correct treatment that would have bought time for V while urgent steps were taken to speed up the birthing process so as to prevent the injury to his brain. From the expert testimony it is evident that had the hospital staff properly monitored V's foetal heart rate in the critical period, it is probable that they would have picked up the warning signs that something was amiss. It is further probable that with the proper emergency measures, V's brain injury would not have occurred.

[23] Counsel for the defendants sought to argue that the hospital records do not contain a diagnosis of foetal distress. As I understand the argument, it was to the effect that the plaintiff's expert witness, Dr Pistorius, had confined his opinion to a diagnosis of foetal distress when he testified that, in those circumstances, the correct monitoring and an emergency caesarian would have had a positive outcome.

[24] There is no merit in the argument. In the first place, it is so that there was no diagnosis of foetal distress in the hospital records. The only diagnosis was for CPD at 4H45. However, this point goes nowhere. If there was no foetal heart rate monitoring (which both parties accept was the case) between 3H15 and the CPD diagnosis, then no foetal distress could have been diagnosed. Thus, in these circumstances, the absence of a foetal distress diagnosis is not evidence of the absence of foetal distress. Furthermore, the diagnosis of CPD, and the recording of moulding +++ and caput+++, together with the direction that a caesarian be performed are all indications that there was some foetal distress.

[25] Furthermore, as counsel for the plaintiff pointed out, the defendants' argument is based on an incorrect understanding of Dr Pistorius' evidence. In his expert summary, Dr Pistorius concluded that

> "There was clearly insufficient monitoring during the latent and active phase of labour. No "sentinel event" was recorded, but a sentinel event would have easily escaped notice, given the insufficient monitoring. The available evidence indicates that there was suboptimal care during labour, resulting in foetal asphyxia and subsequent hypoxic ischemic encephalopathy, which would have been avoided by appropriate monitoring and action."

[26] This opinion is clearly stated, and Dr Pistorius was not challenged on his opinion in this regard during cross-examination.

[27] I conclude that the plaintiff has established the necessary causation to found her claim for damages against the defendants.

[28] One of the issues dealt with at the trial was the plaintiff's evidence that the nursing sister who assisted her in the birth of V applied extreme fundal pressure to her abdomen to force the baby through her pelvis. This issue is not material to the question of V's injuries. However, as the plaintiff has claimed in her personal capacity for damages, I need to resolve this issue.

[29] The plaintiff testified that after she was booked for a caesarian, a nursing sister came to her and put a hospital blanket on her, covering her breasts. The plaintiff was lying on her back on the hospital bed. The curtain was drawn around the bed. The sister positioned herself at the curtain and then came towards the bed, walking very quickly. She pressed very hard under the plaintiff's breasts, holding her one hand over the other and pressing down. The plaintiff testified that the baby came out immediately after the nurse pushed.

[30] It is so that there was some discrepancies in what Dr Pearce said in her testimony that the plaintiff had told her when she reported the incident. Dr Pearce was adamant that the plaintiff had told her that the nursing sister had run up to the plaintiff and pushed down. A similar description was contained in the report of Dr Pearce's counterpart. However, the latter did not testify in the proceedings. In my view this is not a discrepancy that ought to lead me to reject the plaintiff's evidence in this regard. The plaintiff was clear on the nursing sister applying her body-weight pressure to the area of her abdomen under her breasts to expel the baby. Whether she ran or walked quickly in the lead-up to this is not material in my view. The plaintiff was a good witness on this aspect. It would have served her case more had she repeated what was said in the reports, i.e. that the nurse had run up to her.

Instead, she was clear that this was not the case. Moreover, it is common cause that the moulding and caput were at the extreme grades, as reflected in the progress report. The doctor had diagnosed the plaintiff with CPD and ordered a caesarian. In these circumstances, it is probable that the plaintiff would not have given birth naturally without some third party assistance. The diagnosis of CPD, and the recording of the degrees of moulding and caput add corroboration to the plaintiff's case that a nurse applied pressure to her abdomen that caused the baby to emerge. In the circumstances, I accept the plaintiff's evidence in this regard. I find that V was born vaginally as a result of one of the nursing staff applying fundal pressure to the plaintiff. All the experts were agreed that this procedure is not sanctioned, and that had there been any practical reason for delaying the caesarian (for example, the theatre being unavailable) the proper procedure for nursing staff to follow would have been to consult with the doctor. The nursing sister's conduct was clearly unlawful.

[31] The only remaining issue is that of costs. The plaintiff submitted that it would be appropriate for me to make a special costs order. More particularly, counsel or the plaintiff submitted that at the end of the day the defendants had not presented any real defence to the case. They had not called any witnesses to rebut those called by the plaintiff, nor had they really made out a case for the defendants in the cross-examination of the plaintiff's witnesses. In effect, the plaintiff argues that the first four days of the trial were unnecessary. The plaintiff seeks an order that the defendants should pay the plaintiff's costs on an attorney and client scale in respect of the first four days of the trial.

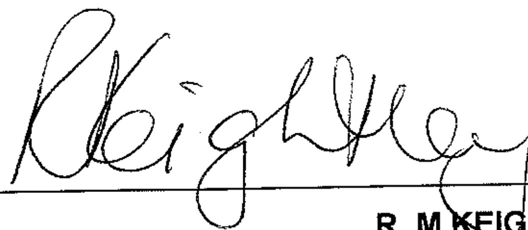
[32] In my view, such an order is not warranted. It is so that the defendants ultimately did not call any witnesses in their defence. However, they were entitled to argue for a defence based on the common cause facts and opinions of the experts. As far as the plaintiff is concerned, she was cross-examined on her evidence regarding fundal pressure and it was put to her that her testimony in this regard was false. The lack of clarity surrounding the CTG evidence that occurred on the first day of the trial also introduced a spanner into the works and necessitated additional expert reports and evidence. This contributed to the necessity for the trial to run.

[33] In the circumstances, in my view, costs on the ordinary scale are appropriate.

[34] I make the following order:

1. The second defendant is liable to the plaintiff, both in her personal and representative capacities, for her damages consequent upon the negligence of the first defendant's medical and nursing personnel on the 3rd and 4th of April 2009, resulting in the minor child, Victor Kwena Modianang's cerebral palsy and accompanied deficits.

2. The second defendant is ordered to pay the plaintiffs costs on the ordinary scale.



R M KEIGHTLEY
JUDGE OF THE HIGH COURT OF SOUTH AFRICA
GAUTENG LOCAL DIVISION, JOHANNESBURG

Date Heard: 13 February 2017

Date of Judgment: 24 March 2017

Counsel for the Plaintiff : Adv G J Strydom SC

Instructed by: Edeling Van Niekerk Incorporated

Counsel for defendant: Adv V Soni SC and B Shabalala

Instructed by: State Attorney