Cerebral palsy claims, negligence and causation

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The patient brought a claim in her representative capacity as the mother and guardian of a minor child, who she alleged suffered harm during birth due to the negligence of staff at a public health institution, which resulted in the child suffering from cerebral palsy. The plaintiff was successful in her claim.

Judgment

The minor child suffered some form of hypoxic ischaemic encephalopathy (HIE) which is lack of oxygen to the brain, which resulted in the child suffering from cerebral palsy. The court had to decide what caused the minor child's cerebral palsy: an acute hypoxic event, a prolonged hypoxic event or a stroke. In determining causation, the court also had to determine whether timeous movement of the patient to another hospital to perform a caesarean section would have made a difference to the outcome.

The hospital contained a midwife-run obstetric unit, without an obstetrician who could carry out caesarean section deliveries. Therefore, the hospital could only deal with low-risk births. High-risk labours were referred to King Edward VII Hospital.

The plaintiff was admitted at 2 am. She gave birth around 7 pm.

The nature of the child's cerebral palsy was important in determining the cause (a prolonged event would lead to different symptoms and markings on the brain, compared to an acute event or a stroke).

Medical practitioners must exercise reasonable skills and diligence, assessed against members of the same profession in similar circumstances. Further, the standard of care in this case was informed by the defendant hospital's Guidelines for Maternity Care.

The hospital records, in relation to a crucial and material portion of the plaintiff's labour, were incomplete. The court noted that these incomplete records impacted on the adjudication of the case. Further, the court said that it is "a disturbing fact" that the defendant has produced incomplete records in more than one of its cases before the court. The inference to be drawn is that no records were kept or, if there is some evidence that records were kept, these were lost or otherwise became unavailable (the court did not accuse the defendant of hiding any records). The defendant claimed the records were lost. However, there were records of initial monitoring of the plaintiff relating to CTG monitoring. The court made an inference that if continuous CTG records were kept as they should have been, the entire CTG record would have been kept together, and therefore it is unlikely that a portion of the CTG record would be lost separately if they existed. Therefore, the court concluded that these records never existed (that is, records were not kept of that portion of the plaintiff's labour). The defendant therefore failed in their duty to properly monitor the plaintiff and to keep records of that monitoring. The lack of monitoring amounted to substandard care.

Furthermore, a combination of factors led to the conclusion that the plaintiff's pregnancy was high risk, and therefore extra care should have been taken to monitor her. These factors were: the patient was one week past her due date, she was a *primigravida* (pregnant for the first time), she smoked and had been treated for syphilis. None of these factors alone constituted a huge risk factor (and, further, they did not cause the child's cerebral palsy) but, together, they warranted closer monitoring of her labour because they made the child more vulnerable to injury. Therefore, her pregnancy should have been viewed as a moderate- to high-risk pregnancy. According to the Guidelines for Maternity Care, the foetal heart rate should have been monitored every two hours at first, and then every half an hour during the active stage of labour. However, according to the evidence, monitoring of the plaintiff was inadequate.

At birth, the baby's symptoms were consistent with prolonged labour and foetal distress. Added to that, the plaintiff's higher risk in pregnancy due to her risk factors also warranted a referral to a hospital with obstetric facilities. Failure to monitor the plaintiff properly – and failure to refer her to an obstetric hospital – constituted substandard care and negligence.

The defendant tried to argue that the labour was not prolonged and that there were no signs of foetal distress. However, proper monitoring of the foetal heart rate in relation to the uterine contractions is vital, particularly during the active phase of labour, in order to diagnose potential foetal distress. This was not disputed. There was no monitoring for the last two hours and forty minutes of the plaintiff's labour.

Further, the evidence of the midwife, who also presented as an expert witness, was viewed with suspicion because the court found it improbable that she would have an independent recollection of the event nine years afterwards. Further, her evidence was in conflict with the other available evidence. Moreover, because her conduct was under scrutiny, the court found her evidence to be probably biased and untruthful. Ultimately, the most probable cause of the baby's injuries was due to prolonged lack of oxygen to the brain. Therefore, the defendant hospital was found to be negligent.

However, even though the lack of monitoring may have been negligent, it does not automatically follow that this *caused* the minor child's cerebral palsy. The defendant would only be liable if, had they monitored the patient properly, they could have picked up a problem and intervened in time to avoid the injury. Therefore, the court had to also decide whether monitoring would have led to a referral to another facility; and whether that referral could have been done in time to change the outcome. Therefore, the court still had to look at whether the injury was in any event unavoidable.

The defendant argued that even if they had monitored the patient properly, a caesarean section could not have been performed in time to avoid the injury. This is because only the monitoring during the last two hours would have shown cause for concern (the portion of labour during which there was no monitoring and no records) and, by that time, transferring the patient to another hospital for a caesarean delivery would not have been possible within the time it took the patient to deliver the baby vaginally.

However, the court rejected this argument because it flowed from the premise that monitoring during the final stages of pregnancy would have alerted the hospital to a distressed baby whereas, according to the evidence, the patient was already experiencing a high-risk labour and therefore should have been transferred to another hospital long before the final stage of labour. Apart from her risk factors mentioned above (regarding smoking, syphilis and *primigravida*), there were also notes of blood-stained liquor (amniotic fluid) and the baby's head being very high. Therefore, transferring the plaintiff to another facility for a caesarean section was indicated earlier that day – at a stage that would have left sufficient time for the plaintiff to have been afforded proper care. The plaintiff was consequently successful in proving both negligence and causation, and her claim succeeded.

This was a judgment of the KwaZulu-Natal High Court in *D v MEC for Health for the Province of KwaZulu Natal* (8700/2013) [2019] ZAKZPHC13 (13 March 2019) at http://www.saflii.org/za/cases/ZAKZPHC/2019/13.pdf.

Legal principles

In assessing conflicting expert opinions, the evidence must be evaluated to see whether they are "reasonably justified as being founded on logical reasoning". Credibility of the expert witness is not as important as the logical reasoning – unless the context of the case calls for assessing credibility. In this case, all of the defendant's expert witnesses were employed by the defendant, leading to the inference that the experts may have loyalty or sympathy for their employer – this inference could not be ignored (expert witnesses are meant to be impartial). Furthermore, the expert midwife was in fact the midwife who attended to the plaintiff during the crucial stages of her labour and delivery; therefore, the court noted that any culpable omissions by her would reflect negatively on her professional proficiency, which also coloured the credibility of her evidence.

With regards to negligence, the court quoted with approval the old judgment of *Van Wyk v Lewis* where it was stated, with reference to *Mitchell v Dixon*, that "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 is bound to employ reasonable skill and care". And, in deciding what is reasonable, the court will have regard to the general level of skill and diligence possessed and exercised at the time by the members of the same profession under the circumstances. The same degree of care and skill is required, regardless of whether the practitioner works in a town or a rural setting.

The mere fact that the medical treatment administered was either unsuccessful or not as successful as it might have been, or that the treatment administered did not have the desired effect, does not on its own necessarily justify the inference of a lack of diligence, skill or care on the part of a healthcare practitioner. The question is whether the care received was substandard. This is determined based on the available evidence.

When the defendant tried to argue (in the form of confession and avoidance) that even if they were negligent, the injury was unavoidable, the court noted that there "is no onus on a plaintiff to adduce evidence to prove, on a balance of probabilities, what the lawful non-negligent conduct of the defendant should have been. All that is required, is the substitution of a hypothetical course of lawful action and posing the question as to whether upon such hypothesis, the plaintiff's loss would have ensued or not".