

SOUTH AFRICA / JUDGMENT

NK obo NR v MEC for Health, Free State (4852/2016) [2025] ZAFSHC 225 (31 July 2025)

[2025] ZAFSHC 225

COURT

Free State High Court, Bloemfontein

BEFORE

Chesiwe

CASE / FILE NUMBER

4852/2016

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IN THE HIGH COURT OF
SOUTH AFRICA
FREE STATE DIVISION,
BLOEMFONTEIN

Not reportable

Case number:

4852/2016

In

the matter between:

N[...]

K[...] obo

N[...]

R[...]

Plaintiff

and

MEMBER

OF THE EXECUTIVE COUNCIL

DEPARTMENT

OF HEALTH, FREE STATE PROVINCE

Defendant

Neutral citation: NK

obo NR v MEC for Health, Free State (4852/2016) [2025] ZAFSHC 225
(31 July 2025)

Coram: Chesiwe J
Heard: 14, 15, 17,
21, 22, 24 February 2023. 10,11, 13, 17 September 2024 and 8 October
2024

Delivered:

This judgment was handed down electronically by circulation to the parties' representatives by email and released to SAFLII. The date and time for hand-down is deemed to be 13h00 on 31 July 2025
Summary: Medical negligence – damages claim - liability in respect of a minor child born with brain damage – whether the hospital staff were negligent in their failure to deliver the baby timeously through c/section and whether such negligence caused the damage – if MEC FS is liable.

ORDER

1 The Defendant is liable for payment of 100% of the proven or agreed Plaintiff's damages in her capacity as the mother and guardian of baby NR who was born with cerebral palsy on 26 February 2010;
2 The Defendant to pay the Plaintiff's taxed or agreed party and party costs to date, such costs to include the following

costs:

2.1 The costs of two Counsel, on Scale C;
2.2. Reasonable qualifying preparation and reservation costs of Doctor Jogi and Professor Van Toorn and Professor Anthony, including the costs of their reports, supplementary reports (if any) and involvement in expert joint minutes;
2.3 The costs of obtaining the transcripts, which costs the parties agreed would constitute recoverable party and party costs; and
2.4. The costs of and involved with the drafting of the Heads of Argument;
3 The determination of the Plaintiff's quantum is postponed sine die.

JUDGMENT

Chesiwe, J

- [1] Plaintiff on behalf of her minor child, institute an action against the defendant based on the alleged negligence of the nursing and medical staff who attended to the delivery birth of baby N[...] R[...]. (hereafter, referred to as baby NR) on the 26 February 2010 at Pelonomi Academic Hospital, Bloemfontein Free State. Plaintiff in her representative capacity as the mother of the minor child, alleges that the Defendant is liable to baby NR's conditions in failing to perform c/section timeously.
- [2] Briefly, Plaintiff case is that during the birthing process, the foetus was deprived of oxygen for prolonged periods as a result of the negligence on the part of the hospital staff, which resulted in the new-born suffering hypoxic ischaemic asphyxia, causing brain damage and cerebral palsy. That had the foetal distress been diagnosed timeously with proper medical care, a Cesarean section (hereafter, referred to as C-section) would have been performed. The Defendant denied liability and pleaded that the nursing staff and medical personal did not act negligently and the baby NR's delivery was done within the normal standard operation procedures and in line with the Maternity Guidelines.
- [3] The documents made available and used by the experts to make their findings are the Plaintiff's antenatal card; hospital records relating to Plaintiff's admission on 26 February 2010, Obstetrician clinical/maternity record, management of the labour and neonatal records as well the road to health chart for the child. Parties admitted Bundles A to G that deals with the relevant experts report as well as the CVs and literature.
- [4] It is common cause that the antenatal card had only one page available which confirms the normal foetal growth until the last visit of 25 February 2010 and that Plaintiff is HIV positive and on anti-retroviral treatment since 2008 and baby NR tested negative at birth.
- [5] With regard to the common cause issues in respect of baby NR, the head circumference was 33cm at birth and it was within normal range of a full-term baby; the APGAR score was recorded as 1/10 at one minute and 1/10 at five minutes and that she has mixed cerebral palsy (spastic-dyskinetic) with microcephaly, epilepsy and severe global development delay.
- [1]
- [6] For determination by this Court it is whether there was a failure by the hospital staff in performing a caesarean section (hereafter, referred to as C-section) delivery at 12H25 on the 26th February 2010; whether the failure to deliver by C-section after 12H25 caused the Hypoxic-ischemic (HI) brain injury to the foetus and birth asphyxia; whether the prescription of Oxytocin/Pitocin (herein after used interchangeably) by Dr Mohosho, a consultant obstetrician was negligent and the administration of it caused the HI brain injury.

- [7] In terms of the Rule 37 Minutes, parties had already agreed that the merits and quantum are to be separated and the matter is to proceed only on merits. Plaintiff called the following witnesses Professor Van Toorn (paediatric neurologist), Dr Jogi (specialist radiologist), Professor Anthony (obstetrician and gynaecologist/Obs-Gynae) and the Defendant called Doctor Mohosho (Consultant), Doctor Mosebi (Registrar) and the expert witness Doctor Mbokota (obstetrician and gynaecologist/Obs-Gynae).

Plaintiff's evidence

- [8] Plaintiff testified as follows: She is a domestic worker and is the mother to baby NR. She gave birth on 26 February 2010. She has an older child, and knows about labour pains, as she gave normal birth to her older child who is 22 years old. When she felt mild labour pains, she went to Batho Clinic and was referred to Pelonomi Hospital. She said the pains were strong when she got to the hospital. She remembers a drip was put up and after the drip, the labour pains were extremely painful. She could not recall if the drip was put up on admission or in the labour ward.
- [9] Under cross examination, Plaintiff explained that she could not recall what happened on the day of the delivery. She remembers she was on the bed when she started to push the baby. She does not know what the time was, she only remembers the severe pain and wanting to push.

Plaintiff's expert evidence

- [10] Professor Van Toorn testified as an expert witness. He testified as follows: He is a specialist in Paediatric Neurology including specialising in the brain of unborn and new-born babies. He compiled two reports. The addendum report of 22 February 2022 was produced to update the first report of 3 August 2018, taking into consideration how medicine advances and develops.[2]
- [11] Professor Van Toorn stated that if there was a problem with the pregnancy, it would have affected the baby NR's growth. He indicated that Baby NR's head circumference was within normal range; the body length was 33cm and the weight at birth was 2,56kg. Thus, baby NR's inter-utero growth was normal. He said according to the hospital records when baby NR was born, her body was lifeless, there was one heartbeat, the Apgar score stayed one for one minute. That had Baby NR sustained an insult during pregnancy, there would not have been brain growth. That Baby NR suffered an injury during labour which resulted in severe hypoxic-ischemic encephalopathy (HIE) during labour. He explained that if contractions are too long and frequent, the baby will need help. And these contractions diminish oxygen to the brain and the purpose is to get the baby out quickly. He further explained that Pitocin administration is a risk factor for brain injury and it does cause the contractions to be frequent. He confirmed the contents of his report and same was admitted as part of Bundle A of the Plaintiff's experts reports. [3]

- [12] Under cross examination, Professor Van Toorn confirmed that he relied on the reports of the Obs-Gynae and the radiologists including the hospital records as he did not examine baby NR at birth. And stated that he stands by his report that the argument that there was no inter-utero growth is incorrect as baby NR's weight, length and head circumference were within normal range.
- [13] Doctor Jogi, an expert radiologist testified that he conducted a Magnetic Resonance Imaging (MRI) scan on baby NR. The MRI scan was done to check the HIE if the imaging was consistent with the hypoxia pattern injury. If the imaging was consistent for the hypocrisy, a pattern injury. He stated that radiology is unable to detect the exact time when an injury occurred. A scan was done in 2017 and there were no other injuries after the birth of the child. He also confirmed that he has done two reports. The second report was to address the Acute Perinatal Sentinel events that are acute and comes without warning and made example of abruption of the placenta. [4]
- [14] Doctor John Anthony, a retired Obs-Gynae specialist registered in foetal medicine testified that: According to the clinical records, there was confusion on gestational age of the Plaintiff, as the birth weight of 2,56kg was not compatible with a foetus of 28 weeks. Further that, Plaintiff was seen at the clinic on 25 February 2010. The clinic staff assumed the Plaintiff was in labour as they had incorrectly measured the height of foetus and the gestational age and

referred her to Pelonomi Hospital. And at the hospital, Plaintiff was seen and labour had commenced with a cephalic presentation and a head that was 3/5ths palpable, which dilation progressed rapidly to 9cm at 11H30. He stated that at that stage, the foetal condition was fine until 11H30 when the midwives recognised that the foetal heart rate was abnormal whereupon they gave the mother oxygen. The clinical records do not reflect whether the oxygen administered improved the foetal heart rate. Doctor Anthony explained that according to the Maternity Guidelines for South Africa 2007, if it is suspected that there is foetal distress, the mother must be put on her side, given oxygen per face mask and that will improve foetal resuscitation. He said the foetus already had bradycardia at 120bpm and that was indicative of hypoxia. When Pitocin was given to induced contractions, it made the contractions intense and that caused baby NR to be at risk of hypoxia. And where there are frequent and continued contractions,

this affects a baby oxygen levels. Doctor Anthony additionally, indicated that usually a baby needs time between the contractions to level up its oxygen. He said the midwives failed to do a cardiotocography (CTG) when Pitocin was administered as the CTG tracing would have indicated the foetal heart rate. Doctor Anthony stated that Pitocin should be used with caution and in this instance, it was contra-indicatory.

- [15] Under-cross examination, Doctor Anthony indicated that Plaintiff received substandard care. That treatment in Plaintiff at the second stage of labour, the medical staff failed to manage the foetal distress, failed to do CTG tracing and failed to manage intra-uterine resuscitation. Moreover, Doctor Anthony stated that, Plaintiff should have been given an expedited delivery and the use of the Pitocin was inappropriate. That was Plaintiff's case.

Defendant's expert evidence

- [16] Defendant proceeded to call Doctor Mohosho. He is a specialist in Obs-Gynae. He works as a consultant for Pelonomi Hospital and as an academic at the University of the Free State. He testified that: On the 26 February 2010 he was on duty in the labour ward doing rounds when he was informed about the labour progression of the Plaintiff and that Plaintiff was already bearing down. He went to the Plaintiff to assess her. He applied the Rules of the 5 P's, that is power, passage, passenger (unborn baby) position and physical wellbeing of the passenger. He identified that there was a prolonged second stage of labour and made a clinical assessment that the contractions were inadequate, but the pelvic outlet was adequate. Further that, the passenger was not the problem 'P', but the power was as the contractions were not strong enough. Doctor Mohosho indicated that is usually addressed with Pitocin administration to assist the contractions.
- [17] Doctor Mohosho indicated that he ordered 5 units of Pitocin to be administered in the drip. He recommended assisted delivery, that is forceps or vacuum delivery, and ruled out any indication of a C-section as Plaintiff had previously given normal birth to her other child. He said baby NR was diagnosed with cerebral palsy

based on the outcome of the birth and that it was an unfortunate situation as he could not have predicted how forceps or vacuum

delivery will go or result in cerebral palsy. He further stated that there was no indication that baby NR was mismanaged during birth.

- [18] Under cross examination, Doctor Mohosho explained that the Maternity Guidelines are to guide, but as an Obs-Gynae specialist, he can deviate based on his clinical expertise, experience and as a consultant that there is room to modify the guidelines. When questioned about documenting notes, Doctor Mohosho explained that he does not always write notes as he gives advice during ward rounds and expects the junior doctors to note down his advice.
- [19] Doctor Mosebi testified as the gynaecologist on duty on the night in question. He testified that: He is a specialist gynaecologist. He was on duty from 08H00 till 08H00 the next day. He explained that

Doctor Smith is the head of the unit and Doctor Mohosho reports to Doctor Smith. He does not recall the finer details of the case, but recalls that he saw the Plaintiff on 26 February 2010 at around 11H30 and Plaintiff on arrival in the labour ward, had dilated 2cm. When he assessed the Plaintiff, she had dilated to 9cm and was pushing. As he was stationed at theatre, he moved between theatre and the labour ward.

[20] Doctor Mosebi indicates, he was informed by the registered nurse that Plaintiff was transferred to the delivery ward. He called Doctor Mohosho to discuss the Plaintiff's prolonged labour, as he could not perform a C-section without permission from a consultant, who in this instance was Doctor Mohosho himself. He was informed by Doctor Mohosho that Doctor Hanekom will come and do a vacuum delivery. He went to the delivery room, where he found Doctors Smith and Hanekom busy preparing the vacuum instrument as they were going to supervise the vacuum delivery. Doctor Hanekom handed

over the Plaintiff to Doctor Mosebi. Doctor Mosebi indicated that he made his own assessment of the Plaintiff. He was satisfied

with the foetal heart rate, even though Plaintiff was restless. He proceeded to put the vacuum cup around the protruding head of the foetus. The vacuum cup slipped with the first attempt. He tried again the second time to vacuum the foetus' head. The cup slipped for the second time. He proceeded with the forceps delivery. With one pull of the foetus and one contraction from the Plaintiff, baby NR was pulled out. He said baby NR came out flat, was floppy and not crying. Doctor Mosebi stated that the outcome was unexpected as he did everything correctly.

[21] Under cross-examination, Dr Mosebi explained that the whole procedure was done under the supervision of his seniors, Doctors Smith and Hanekom. He also relied on the foetal heart rate and there was no meconium to suspect any distress of the baby. He stated that the outcome of baby NR bothered him as it was not the expected outcome.

He followed the Maternity Guidelines of 2007, what was then called the pink book.

[22] Doctor Mobokota testified as an expert witness, who is a specialist in Obstetrics and Gynecology (Ob-Gyn). He compiled a report which is attached to the papers. [5] He explained that he stands by his report.

[23] The report is based on the information that was made available to him, namely, particulars of claim, the clinical records, which include maternity records (without the antenatal care record) and the radiology report from Doctors Jogi and Ranchod. Doctor Mbokota concludes that the administration of Pitocin could not have caused the insult and that Plaintiff was provided with the care expected according to the standards of the Maternity Guidelines and that there's is nothing they could have done to change the outcome of baby NR.

Submissions

[24] Both Counsel filed substantive written heads of argument and submitted briefly in oral arguments as follows:

Counsel on behalf of the Plaintiff, Advocate Mullins, in oral arguments submitted that baby NR was virtually stillborn. Further that Doctor Mohosho did a wrong thing by prescribing Pitocin and furthermore denied that the contractions were strong. Counsel submitted that the foetal head had not yet descended nor was it even close to the exit to be vacuumed or even close enough for the administration of Pitocin. Counsel said that Doctor Mobokota's evidence was not helpful as he was partisan and that he was unreliable. He submitted that the midwives were concerned and continued to be concerned about baby NR. Further that, in terms of the Maternity guidelines, Pitocin is not to be administered when the mother is bearing down. He stated that Plaintiff's evidence is clear that she had labour pains, but the pains became stronger after the Pitocin drip.

[25] Counsel on behalf the Defendant, Adv Bruinders submitted in oral argument that: Plaintiff's pleaded case was that of foetal bradycardia and that a C-section should have been performed, but has now changed to the theory that there were strong contractions which became stronger after the Pitocin administration. Counsel submitted that even before the Pitocin was administered, Plaintiff was restless and as a result, the nurses could not do tracing for ten minutes. Further that, the increased contractions lead to the insult of the brain injury. Counsel stated that Plaintiff's

evidence is not supported by radiological evidence and that the foetus did not have abnormal heart rate except for one heart rate

that was not normal. Moreover, Counsel submitted that the nursing staff attended to the Plaintiff all the way from 12H00 till 13H00 and were indeed concerned that the foetal head was stuck in the birth canal. Plaintiff according to Counsel received the required care in terms of the Maternity Guidelines and that Pitocin was administered with caution. Counsel concluded that Plaintiff has failed to show that the Defendant was negligent or any causation thereof.

Legal principles of negligence/causation

[26] The test for establishing negligence is trite and rests on two bases, namely reasonable foreseeability and reasonable preventability of damage. It is of great significance that the negligence must be

assessed in light of the relevant circumstances.

[27] For purposes of establishing the existence or otherwise of negligence, the court in *Kruger v Coetzee* [6], the following was articulated:

"For the purposes 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.”

[28] The SCA in the decision of Minister of Safety and Security v Van Duiwenboden [7] said the following:

“Negligence, as it is understood in our law, is not inherently unlawful - it is unlawful, and thus actionable, only if it occurs in circumstances that the law recognises as making it unlawful. Where the negligence manifests itself in a positive act that causes physical harm it is presumed to be unlawful, but that is not so in the case of a negligent omission. A negligent omission is unlawful only if it occurs in circumstances that the law regards as sufficient to give rise to a legal duty to avoid negligently causing harm.”

[29] The issue of negligence involves a twofold inquiry. The first being the harm reasonably foreseeable and the second being, would the diligence paterfamilias take reasonable steps to guard against such occurrence and did the Defendant fail to take those steps. If these steps receive an affirmative answer, then the Defendant has failed to measure up to the standard of a reasonable person and will be judged negligently.

Factual Matrix

[30] I will first deal with the evidence that emanates from the Plaintiff’s clinical, hospital and labour/delivery records up until her discharge with baby NR. [8] Plaintiff was a 37-year-old who was referred from Batho Clinic at around 06h45 on 26 February 2010, with a history of pre-term labour; dilated at 2cm and gestational term of 28 weeks. Plaintiff was a multigravida and a para 1 (pregnancy beyond 24 weeks). The reason for the referral was due to abdominal pains. On arrival in the labour ward at Pelonomi Hospital, Plaintiff’s initial assessment reflected the following: Plaintiff was unsure about her gestational age; on palpation she was 37 weeks; 9cm dilated, with inadequate pelvic outlet and foetal heart rate at 140 beats per minute.

[31] At the second stage of labour, the summary of labour clinical notes reflected the following: At 12H00, Plaintiff was fully dilated and begun bearing down at 12H20. The pelvic outlet was not enough to deliver the baby. Plaintiff was administered with 5 units Pitocin and another 5 units at one minute apart. A forceps delivery was done. Baby NR’s time of delivery is noted as 13H35. Baby NR’s Apgar score at one minute was 1/10 and at five minutes was 1/10. [9]

[32] On the same date at around 14H03, Plaintiff was assessed by nursing sisters Teleka and Mosupi. Plaintiff was already bearing down. According to the nursing sisters, Plaintiff’s outlet was inadequate. Plaintiff was already restless when Sister Mosupi attempted to monitor the foetal heart rate which was ranging between 98 – 120b/m. Oxygen was

administered to the Plaintiff per face mask, at the same time the nurses supported the Plaintiff's perineum and the foetal heart improved to 125 – 138 b/m. The nurses called Doctor Mohosho, informing that the Plaintiff was bearing down. Doctor Mohosho ordered a ringer's lactate drip and 5 units Pitocin as the contractions were not enough. Plaintiff continued to be restless and pushing. Sister Jacobs also made an assessment of the Plaintiff and noted that the pelvis is inadequate and that it is a Cephalopelvic disproportion (CPD). The nurse that wrote the report dated 26 February 2010 at 14H03,[10] remarked to Doctor Mosebi that they are going to have a problem with baby NR as it has been an hour that the Plaintiff was bearing down, and that a caesarean section be done.

Labour and Delivery

[33] According to Doctor Mosebi, Plaintiff was handed over to him by Doctor Hanekom at around 13H25. Plaintiff was in advance labour at 9cm dilated. It was already discussed with Doctors Mohosho and Hanekom that an assisted delivery be performed, that is either vacuum (ventouse) delivery or forceps delivery. Doctor Mosebi chose the vacuum delivery. The ventouse machine was already prepared. He proceeded to assess the Plaintiff again to rule out any contraindications to the above and the foetal head was at the brim and that this meant there was good application of the cup to the foetal head for a ventouse delivery. He noted that a fifth of the foetal head was palpable and the cervix was fully dilated. There was no meconium-stained liquor (MSL) and the foetal heart was ranging between 125 -140 bpm. He applied the cup to the foetal head and when there was a contraction, he vacuumed baby NR. The cup slipped but, baby NR came down.[11] He waited for the second contraction and vacuumed again. Baby NR made little progress and the cup slipped again. He could not repeat the vacuum for a third time. He then proceeded with a forceps delivery. The foetal head was at the brim and with one pull, baby NR was out. After the birth, Doctor Mosebi said he observed as follows: "... The baby came out flat because it was a surprise to me that the baby was flat, at least there should have been a sign that this baby is in distress... meconium stained. At least there should have been a bradycardia which I did not see on this patient. So, it really came out as a surprise to me that we have this outcome." [12]

Baby NR's outcome and neonatal period

[34] A hand written entry in the clinical notes dated 26 February 2010 at 14H00, the paediatrician that examined baby NR after birth, made the following observations [13]: "Called to assess the baby, Apgar on delivery was 1/10. On examination, unresponsive heart rate less than 60 minutes, no

respiratory efforts. Baby was intubated, Adrenalin of 3ml given via ETT and chest compressions was started. Heart rate improved to 100 b/m. Second dose of Adrenalin also chest compressions and heart rate improved. ETT was removed from baby, no respiratory effort and baby was gasping." [14] The baby was thereafter admitted in neonatal ICU.

[35] Doctor Gericke, a Specialist Medical Geneticist stated in the conclusion of the report [15] as follows:

“All of the current findings and most likely indirectly derived conclusions comply with the baby having suffered intrapartum birth asphyxia and a severe neonatal encephalopathy. In the present matter, as indicated, a chain of events can be indirectly reconstructed with the most logical pathway leading to [sic] a injury on neuroimaging and a characteristic clinical cerebral palsy outcome. The leading pathogenetic mechanisms for newborn HIE remain hypoxia and/or ischemia, as a result of perinatal asphyxia. Neonatal hypoxic-ischemic brain injury leads to serious long-term morbidities.”

[36] Doctor Anthony, concluded in his reports [16], as follows:

“... the baby delivered with severe asphyxia and acidosis, developed early onset encephalopathy leading to spastic cerebral palsy. This is consistent with intrapartum injury. The management in the second stage of labour was characterised by substandard care as already described and given the normal tracings evident prior to the onset of the second stage of labour, it is likely that the injury develop from 12h25 onwards and the substandard care (in particular: the failure to diagnose foetal distress, the inappropriate use of oxytocin and the failure to intervene earlier in the second stage of labour because of fetal distress as well as the sequential use of vacuum and forceps) led to the development of fetal hypoxia, leading to the acidosis evident at birth.”

[37] Doctor Anthony in his supplemented report [17], states as follows:

“In this case, the hypoxic injury did not occur solely as a result of the delivery that took place at 13h25, but as a result of the overall inadequate and insufficient response to the fetal distress that was present which was then perpetuated and worsened by the administration of oxytocin. ... Thus, if the bradycardia and foetal distress that the staff were aware of from at least 12h25 onwards were managed in accordance with the Maternity Guidelines as discussed above and oxytocin was not administered, the hypoxic ischemic injury would probably not have occurred, even in event that the baby was only delivered by caesarean section at 13h25.”

[38] Professor R Van Toorn a Paediatric Neurologist, in his first and second reports [18], concludes as follows:

“... I concur with the radiology opinion that she suffered brain injury as a result of a combined pattern of hypoxic ischemic injury.”

The reported fetal distress, the depression at birth (poor 1 minute Apgar and score) the prolonged need to resuscitate, the presence of at least a moderate (possibility severe neonatal encephalopathy) with early onset neonatal seizures, the prolonged period of hospitalization and the type of cerebral palsy is all supportive of an intrapartum hypoxic ischemic insult.”

It is noted that the conclusion in the second report is similar to the conclusion in the first report.

[39] As per Defendants' expert supplemented bundle [19], Dr Malebane, stated that:

“222. There is unequivocal and objective evidence of the poor neonatal condition at birth.”

223. The results of the post-delivery blood gas indicate that the foetus suffered severe hypoxia, most likely during labour.

224 ...

225. Given the fact that the results of foetal monitoring prior to delivery suggested optimal foetal condition, it seems unlikely that the poor outcome would have been foreseen and prevented.”

[40] Doctor Mogashoa in his report [20], summarised as follows:

“The available neonatal records are incomplete, however, I am able to conclude that N[...]’s impairments were caused by intrapartum hypoxia, Identifiable risk factors were maternal HIV infection and a complicated second stage of labour.

The MRI findings and predominance of dyskinesia are in keeping with acute profound hypoxia.”

[41] Professor Cooper in his report [21], opined as follows:

“N[...] was born with a slow heart rate (score of ½ recorded for the 1-minute Apgar) and no signs of life and he made no attempt at spontaneous respiration for at least 20 minutes. This was compatible with a state of secondary apnoea which follows a severe hypoxic ischaemic episode, preceding the delivery of the infant leading to bradycardia.”

[42] Doctor M Mbokota in his report [22], concluded as follows:

“7.8 The AVD was implemented and executed correctly as per acceptable norms and guidelines.

7.9 The staff at Pelonomi, both nursing and medical provided care to Ms K[...] that was expected of them and largely according to standards; their concern and attention to her is evident throughout the clinical notes. There was nothing they could have done to change the current outcome of the child.

7.10 This injury was thus not preventable.”

Joint minutes of the experts

[43] Between Prof R Van Toorn and Dr Mogashoa, the experts are in agreement with each other on most of the issues except in their conclusions. Prof Van Toorn stated in the joint minutes [23] that: “The obstetrician report that the oxytocin was administered despite being contraindicated. It is my opinion that this represents a risk factor for fetal brain injury... . Dr Mogashoa “defers to obstetricians for expert opinion on the management of the intrapartum period.”

[44] In Conclusion [24], Professor Van Toorn stated that: “.... N[...] has a mixed type cerebral palsy (GMFCS V) with severe global development delay and postnatal microcephaly. I concur with the radiology opinion that she suffered a hypoxic ischemic brain injury (cerebral-deep nuclear neuronal pattern). The reported fetal distress, the depression at birth (poor 1 minute Apgar score), the need for active resuscitation, the severe acidemia and

hyperlactatemia shortly after birth, the presence of at least a moderate (possibly severe neonatal encephalopathy) with early onset neonatal seizures, the prolonged period of hospitalization and the type of cerebral palsy is all supportive of an intrapartum hypoxic ischemic insult.”

Doctor Mogashoa “agrees, however she defers to radiologists to discuss the MRI findings because she did not have access to the MRI.”

[45] Between Professor Anthony, Doctor Mbokota and Doctor Malebane, these experts in the joint minutes [25] under the topic summary and assessment of avoidable injury agreed as follows:

“6. It is likely that the fetus developed acutely worsening hypoxia during the second stage of labour following the introduction of oxytocic drugs

7....

8. Substandard care directly linked to an increased probability of adverse outcome was evident in relationship to the inadequate fetal heart rate monitoring combined with inadequate intrapartum intrauterine fetal resuscitation, the inappropriate use of oxytocin leading to aggravated fetal hypoxia during the second stage of labour and the contraindicated sequential use of instruments to effect vaginal delivery.”

Experts’ evidence

[46] In *Stocks v Stock* [26], the SCA held that an expert must be made to understand he or she is there to assist the Court and, if the expert is to be helpful, he or she must be neutral. “The evidence of such a witness will be of little value where he or she is partisan and consistently promotes the cause of the instructing party.”

[47] In *Schneider NO and Others v AA and Another* [27], where the Court emphasised the duty of “an expert witness as someone who ‘comes to court’ to give the Court the benefit of his or her expertise.” Moreover, “an expert should not be a hired gun who dispenses his or her expertise for purposes of a particular case.” (See *Jacobs and Another v Transnet Ltd t/a Metrorail and Another* 2015 (1) SA 139 SCA)

[48] The experts in the joint minutes basically agreed on the injury, though they could not agree as to when the injury occurred. According to Professor Van Toorn, the administration of the pitocin was contraindicated, and it represented a risk factor for foetal brain injury. Doctor Mogashoa preferred to defer to obstetricians. On the other hand, according to Doctors Mohosho and Mbokota, everything was done correctly and that it was unavoidable for baby NR to have merged with severe hypoxic brain damage. Doctors Mohosho and Mbokota disagreed with Professor Van Toorn that the foetus suffered the hypoxic injury due to the administration of pitocin.

[49] It is a settled principle that in order to evaluate expert evidence, the Court must be apprised of and analyse the process of reasoning which led to the expert's conclusion, including the premises from which that reasoning proceeds.[28]

[50] In an SCA matter, the Court held as follows [29]:

“The Court must be satisfied that the opinion is based on facts and that the expert has reached a defensible conclusion on the matter. The purported admission by the Defendant cannot, and does not, absolve the Court from this duty. Even if experts agree on a matter within their joint expertise, that is merely part of the total body of evidence. The Court must still assess the joint opinion and decide whether to accept it.”

Otherwise viewed, it would mean that when a party admits the correctness of an expert's opinion and the reasons for it, as the Defendant purported to do in this case, both the opposing party and the Court are bound by that admission. Despite being the arbiter of the dispute, the Court may then not reject the expert's opinion, even if it is wholly indefensible. Such an approach is untenable, and at odds with the rule that experts have a principal and overriding duty to the Court.”

[51] Thus, in the case of an expert such as an obstetrician or gynaecologist, the test for negligence is about the exercise of the expert's area of expertise, the so-called reasonable obstetrician and reasonable gynaecologist, etcetera. The negligence of an expert is sometimes referred to as professional negligence [30]. This applies equally to professional nurses whose conduct is also judged according to their rank and experience. A nurse who has progressed to the rank of a sister, in certain circumstances, will be judged according to the reasonableness of a nursing sister and not that of a student nurse. The same holds true in the case of a registrar practitioner who should exercise the same degree of skill and care as that of a reasonable medical practitioner. He or she is in fact not a specialist but a medical practitioner. In *Louwrens v Oldwage* [31], *Mthiyane JA* with approval [32], the following is noted:

“A specialist is required to employ a higher degree of care and skill concerning matters within the field of his speciality than a general practitioner. The objective ‘reasonable physician test’ is subjectified to the particular branch of medicine to which the specialist belongs. This means that it is expected from a specialist in the treatment of his patients to act as a reasonable specialist would have done under the circumstances.”

[52] The experts, to an extent, agreed that Plaintiff was given substandard care and that the administration of pitocin was contraindicated, nor were the Maternity Guidelines followed when the pitocin was administered, but they cannot agree that it was the contributory factor that caused baby NR's brain injury. The experts also disagree as to the correct gestational period and when the brain injury occurred.

- [53] The evidence of the experts was to assist this Court, in order for the it to have full and balanced evidence from both sides. It should not be a case of the expert who is used by a certain party, that he or she gives evidence on behalf of the concerned party. Professor Van Toorn's evidence was balance, and he believed that the baby NR suffered a hypoxic injury in the second stage of labour caused by the administration of the pitocin injection. Doctor Mbokota with regret advocated for the party that called him to testify. Doctor Mobokota furthermore defended the conduct of Doctor Mohosho based on the fact that Doctor Mohosho was a consultant and knew what he was doing, the same Doctor Mohosho who testified that the outcome of the baby was unexpected. Both medical Doctors Mohosho and Mbokota dispute that the foetus was in distress when pitocin was administered and that the foetal heart rate was within normal range.
- [54] The clinical notes give a clear picture that on admission at 10H30 on 26 February 2010, Plaintiff a 37 year old female, who was a multiparous mother already had ruptured membrane with spontaneous draining of clear fluids and was dilated at 2cm. At 11H30, Plaintiff, during the labour assessment by Doctor Mosebi, had dilated to 9cm. This raises the question of whether the entries are correct, as within an hour she dilated from 2cm to 9cm. At 12H25 the first abnormality was recorded as bradycardia documented under risk factors on the Labour Initial Assessment document. [33] The duration of this bradycardia was not documented nor its reading. At 13H25, the pelvic outlet was still not adequate for normal delivery, and at that stage, the foetal heart rate was recorded as normal ranging between 125 -140 b/m. At 14H05, Plaintiff was restless and had started bearing down at 14H30. The midwives assessed the Plaintiff and made an inadequate pelvic output assessment. They attempted to monitor the foetal heart rate at this stage, which was ranging between 98 – 120 b/m. Plaintiff was given oxygen per facemask, and her perineum was supported. The foetal heart rate improved to 125 -138 b/m.
- [55] It was then reported to Doctor Mohosho that it, had been 20 minutes since Plaintiff was in the second stage of labour. Doctor Mohosho also examined the pelvis and indicated that there was enough outlet for the head to come out. However, an hour later the Nursing Sister raised a concern that Plaintiff has been bearing down and pushing Baby NR out. Dr Mohosho was contacted again, and he indicated that Dr Mosebi will do a vacuum delivery. Dr Mohosho prescribed Pitocin at 12H55, without having done another assessment of the Plaintiff, and this after the midwives informed him that they are going to have a problem with Baby NR. The midwife's narrative is that after the administration of pitocin they were unable to provide CTG monitoring as the mother was restless, but were able to document a foetal heart rate between 100 – 125 b/m. The midwives' attempt to undertake an intrauterine foetal resuscitation at that stage, was already an indication of foetal distress.
- [56] The Maternity Guidelines applicable on the management of labour and delivery,[34] states as follows:

'Management of Foetal Distress

1. Explain the problem to the mother;
2. Lie the mother in a left lateral position;
3. Give oxygen by face mask at 6 litres/minute;
4. Start an intravenous infusion of Ringers Lactate to run at 240ml/hour.'

[57] The midwives partially attempted to do the above. However, the attempt of the above simultaneously with the augmentation of the contractions with the administration of pitocin to expedite the delivery even though with the knowledge that the foetus was in distress, affected the outcome. It is noted that the administration of pitocin was done in order induce and strengthen uterine contractions. Nevertheless, there has to be an assessment of the mother and foetus before pitocin is administered as well as continuous foetal heart rate monitoring once the pitocin has been administered.[35] The Maternity Guidelines clearly distinguish between the use of pitocin to augment labour due to slow progression and when bearing

down has not yet commenced. According to Odendaal,[36] Oxytocin has been implicated as a major cause of adverse outcome of newborn babies.

[58] The concern raised by the midwives, in my view, was very valid and crucial. As the foetal heart rate was not stable, be it the early bearing down or the mother's restlessness, there was already an indication of foetal distress with a foetal heart rate of 98 – 120 b/m. The midwives in giving oxygen and attempting

intrauterine foetal resuscitation was due to the presence of foetal distress. Even though Doctors Mobokota and Mohosho are of the view that the midwives may have been incorrect by assessing the Plaintiff to have inadequate pelvic outlet, the labour records

provided evidence that the foetus had repeated abnormal foetal heart rate from 12H25. From there onwards this remained a major concern for the midwives. The midwives documented that at 14H03 they informed Doctor Mosebi that, It had almost been an hour then, and thought that they was going to be a problem with the baby NR. The foetal heart rate was already ranging between 100 - 125b/m. The timeline indicated that the time pitocin was administered, there was already a concern of the foetus by the midwives. Pitocin may have been given without adequate monitoring of the second stage of labour. The midwives would not have given the Doctors incorrect information. The midwives work daily with patients that in labour. Even if they may have been incorrect on the issue of inadequate pelvic outlet, they had been correct about the foetal distress.

[59] The Maternity Guidelines give further directives in respect of the administration of pitocin as follows:

‘Exclude foetal distress (late decelerations, thick meconium): If the Foetus is in distress, do immediate caesarean section delivery or transfer from CHC to hospital urgently. If progress crosses the two-hour action: Transfer to CHC hospital; If no CPD in a primigravida and no evidence of foetal distress, start oxytocin infusion.

“Oxytocin Precautions: Only use intrapartum oxytocin in facilities with a 24 -hour caesarean delivery facilities; There must be no evidence of foetal distress: use oxytocin with great caution in multiparas, after excluding CPD; Do not use in women with parity less than 5 or with previous caesarean delivery; use CTG for foetal monitoring.’

[60] Doctor Mosebi who was the registrar on the day in question, had consulted with Doctor Mohosho that Plaintiff was 9cm dilated. On assessment Doctor Mosebi satisfied himself that the foetal heart rate was present even though Plaintiff was restless and a CTG was not done due to the volume of patients that were to be assisted. The maternity register attached to Bundle “G”, reflects a total number of patients admitted on 26 February 2010 was 30 and 16 of those patients, C-sections were performed. There is no acceptable excuse or even evidence as to why a C-section was not performed on the Plaintiff, nor as to why Plaintiff was not properly managed or even why there was neglect to monitor the foetal heart rate, despite the midwives’ concerns raised about the problem they were going to have regarding the foetus. Doctor Mosebi in proceeding with a vacuum extraction of a foetus that was already in distress, in my view was negligent.

[61] The Maternity Guidelines [37] state explicitly that “a failed vacuum extraction necessitates a caesarean.” The importance of the recording and monitoring of the CTG in pregnant woman in the labour ward is very important as this is where any changes to the foetal heart rate can be picked up. This was not done and ought to have been done. Even though Doctor Mosebi explained that there were too many patients that had to be monitored, the clinical records reflect that on the day in questions, there were more than three medical officers (Doctors Smith, Hanekom, Mohosho, Mosebi and Lee). Even if some of the medical doctors were consultants, when there is an emergency in any medical situation, medical personnel ought to come to the assistance of the patients. In this instance it was the unborn baby and the mother. The performance of an expedited C-section would have prevented any injuries to the foetus. Instead, labour was augmented with the administration of oxytocin, whereby its administration was contraindicated.

[62] Professor Anthony and Doctors Mobokota and Mohosho all relied on the authoritative book of Munro Kerr’s Operative Obstetrics that states as follows: “oxytocin to accelerate (augment) labour at full dilatation in multiparous labour is not recommended.”

Plaintiff in this instance was a multipara and in her evidence, indicated that she was already experiencing strong contractions.

There was concern by the midwives about the foetal distress as well as the concern of Cephalopelvic disproportion (CPD). Doctor Mohosho’s assessment of the Plaintiff was that the contractions were not enough and that was the main reason for the administration of the pitocin.

However, in his oral evidence Doctor Mohosho conceded that he did not make any notes as consultants do not make notes, but expect the registrar to take instructions and make the notes. Doctor Mohosho did not satisfy himself whether there was foetal distress before resorting to prescribe pitocin. The decision to prescribed pitocin was given telephonically to the midwives and this is noted in their notes.[38] Thus, the use of oxytocin under these circumstances was indeed contraindicated. According to Professor Van Toorn, the administration of pitocin despite it being contraindicated when it was administered, represented a risk factor for foetal brain injury.

[63] Baby NR was born with compromised health. According to clinical records as well as labour records, baby NR was virtually stillborn. The following is noted [39] “No pulse and peripheral circulation, central cyanosis; Apgar score at 1 min: 0 and at 5min: 2. No breathing no pulse at birth, Baby intubated and ventilated.” The evidence from the clinical records reflects that the foetus during antenatal was fine and the growth was normal. This can be seen in the weight of the baby NR at 2,5 kg, head circumference of 33 cm and length of 49 cm. Had the foetus suffered a hypoxic injury during antenatal period, foetal growth would have been affected. Immediately after birth, baby NR was born lifeless, with no pulse, not breathing and zero Apgar score at one minute and at one stage was gasping and had to be intubated.

[64] According to Doctor Murray, Professor Anthony and Doctor Malebane in their Joint Minutes agreed that: “it is likely that intrapartum

hypoxia developed during the second stage of labour during which abnormal foetal heart rate patterns were repeatedly documented and when evolving hypoxia would have been aggravated by the use of oxytocin.”[40] According to Professor Anthony, the administration of pitocin was similar to adding fuel to fire.

[65] Therefore, in my view and taking into consideration the evidence from the witnesses on behalf of the Plaintiff, there were several warning signs that the foetus was in distress, including the deceleration of the heart rate, which was worsened by the administration of the pitocin.

[66] Furthermore, the Defendant did not call any of the midwives that were on duty and specifically the midwife who raised the concern that there is going to be a problem with the foetus. It is settled that if a witness is not called an adverse inference should be drawn.[41] During the Plaintiff’s evidence including the evidence from the clinical records it is clear that the evidence of the midwives was important and they should have been called to testify, in order for them to rebut the Plaintiff’s evidence or confirm the clinical notes that they made.

[67] The evidence from Doctor Mbokota was not convincing and the court expected of him not to be partisan as he testified as an expert and to assist the court. Doctor Mbokota cannot overlook the opinion of the other experts that the administration of the pitocin caused an obvious risk that caused the injury. However, I am hesitant of being critical of a person of

his stature, qualifications and experience. Nor is it fair and just to make credibility findings against him as he is a professional person, in the medical field and practising in his own right.

[68] In my view, Plaintiff's evidence as well as the expert witnesses' evidence was clear and concise and explained how the negligence occurred that caused the hypoxic injury. This Court has no reason to doubt the evidence of the Plaintiff. Plaintiff is indeed having a child with serious birth defect (severe brain

damage) that occurred during the second stage of the prolonged labour.

[69] In the circumstances, having regard to the evidence rendered before me, the antenatal, clinical records, labour records as well as the experts evidence and the joint minutes presented in support of the Plaintiff, I find that Plaintiff has established on a balance of probabilities that the Defendant acted negligently in failing to

treat Plaintiff and her unborn child with the required level of care and skill required of them during the preparation for Plaintiff's

delivery on 26 February 2010. This negligence resulted in the foetus being born with cerebral palsy.

Conclusion

[70] For the reasons stated above, the Defendant failed to properly monitor the Plaintiff and the unborn baby and failed to follow the Maternity Guidelines. Had these being followed and Baby NR delivered earlier by C-section, the harm could have been prevented and the injury would have been averted. I am inclined to agree with the experts that Plaintiff received substandard care.

Order

[71] In the premises the following order is made:

CHESIWE, J

Appearances For the Plaintiff: Adv. J F Mullins SC with Adv. F Pauer Instructed by: Green
Attorneys For the Respondent: Adv. T J Bruinders SC with Adv. L Mtukushe Instructed by: State Attorney

[1] Index to Supplemented Bundle of Documents: Medical and Hospital Records, Summary of Labour, page 8.

[2] Bundle A, pp. 33 to 46 and pp. 51 to 56

[3] (See pp. 33 - 46)

[4] Bundle A of the Plaintiff's expert reports (first report pages 47 - 48 and second report 49 - 50).

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- [5] Index to Bundle of Documents: Supplemented Defendant's Expert Reports - Bundle B, pp. 72 – 103.
- [6] 1966 (2) SA 428 (A) 430 E-G
- [7] 2002 (6) SA 431(SCA) 2002 3 All SA 741; [2002] 2ASCA 79 para 12
- [8] Index to Supplemented Bundle of Documents, Bundle 'G'.
- [9] Index to Supplemented Bundle of Documents, Bundle 'G', p8.
- [10] Bundle G page 15 of the Clinical Notes.
- [11] Transcribed record line 25 pp. 32, 10 - 11 September 2024.
- [12] Transcribed record line 11–20 p36, 10 – 11 September 2024, see also Summary of Labour, Bundle G p8
- [13] Index to Supplemented Bundle of Documents, Bundle "G" p16.
- [14] See also Index to Supplemented Bundle of Documents, Bundle G p43.
- [15] Index to Supplemented Bundle of Documents: Plaintiff's Expert Reports, Bundle "A", p 12
- [16] Index to Supplemented Bundle of Documents: Plaintiff's Expert Reports, Bundle "A", pp 31 to 32.
- [17] Index to Supplemented Bundle of Documents, Plaintiff's Expert Reports, Bundle "A" p 89.
- [18](page 46 and 56 Bundle A)
- [19] Bundle B, p41.
- [20] Bundle "B", p60.
- [21] Bundle "B", p70.
- [22] Bundle "B", p101.
- [23] Index to Bundle of Documents: Joint Minutes, p 3.
- [24] Ibid, p 4.
- [25] Ibid, pp 53
- [26] 1981 (3) SA 1280 (A)
- [27] 2010 (5) SA 203 (WCC) 211J – 212B
- [28] *Coopers (South Africa) (Pty) Ltd v Deutsche Gesellschaft Für Schädlingbekämpfung MBH* 1976 (3) SA 352 (A) at 371F-G.
- [29] *NSS obo AS v MEC for Health, Eastern Cape Province* (017/22) [2023] ZASCA 41; 2023 (6) SA 408 (SCA) (31 March 2023).

- [30] Van Wyk v Lewis 1924 AD 438 at 444F.
- [31] 2006 (2) SA 161 (SCA) at 171C
- [32] Classen and Verchoor – Medical Negligence in South Africa (1992) at 15
- [33] Page 4 of Bundle “G” Medical and Hospital records
- [34] Guidelines for Maternity Care in South Africa, A Manual for clinics, community health centers and district hospitals Third Edition 2007.
- [35] Ibid, p 50.
- [36] Odendaal, Howarth Pattison. 2011. Obstetric litigation – time to reflect? Editorial. Obstetrics & Gynaecology Forum. “In South Africa, inappropriate management of fetal distress during labour resulting in hypoxic ischaemic encephalopathy, followed by cerebral palsy is one of the major reasons for successful obstetric litigation.” (See Odendaal HJ. Is the unsafe use of oxytocin in South Africa contributing to our high prevalence of perinatal asphyxia? Obstet Gynaecol Forum 2002;12:1).
- [37] Ibid, p 48
- [38] Clinical Notes, Bundle “G”, pp 15 - 17
- [39] Ibid, p 44.
- [40] Bundle “C”, Joint Minutes p 48.
- [41] See Munster Estates (Pty) Ltd v Killarney Hills (Pty) Ltd 1979 (1) SA 621 (A) 624 -625.
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Prepared on 8 October 2026 · Esheria