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**IN THE HIGH COURT OF SOUTH AFRICA
GAUTENG DIVISION, PRETORIA**

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

17/3/2026

DATE

SIGNATURE

CASE NO.: 45567/2018

In the matter between:-

R[...] A[...] A[...] obo MINOR

Plaintiff

v

Heard on: 21-23 October 2024, 12 May 2025, 15 May 2025, 2-3 February 2026 and 6 March 2026

Delivered: 17 March 2026 - This judgment was handed down electronically by circulation to the parties' representatives by email, by being uploaded to the *CaseLines* system of the GD and by release to SAFLII. The date and time for hand-down is deemed to be 14:00 on 17 March 2026.

ORDER

It is ordered:-

1. The defendant is found to be liable for the damages claimed by the plaintiff.
2. The defendant is ordered to pay costs of the trial on Scale C.

JUDGMENT

KOOVERJIE J

- [1] The plaintiff, Ms R[...] A[...] A[...], the mother of the deceased, instituted a claim against the MEC for Health, Gauteng (the defendant), on the grounds of negligence and breach of duty of care on the part of the hospital doctors and staff in managing her daughter, O[...] J[...] A[...], which resulted in her demise. She claims for loss of support on behalf of the deceased's minor children.

THE ISSUE FOR DETERMINATION

- [2] The merits and quantum have been separated. On the merits question, the main issue for determination are whether the defendant's employees were negligent in the management and treatment of the deceased during both the antenatal and post-natal periods and if so, whether such conduct caused the deceased's death.

BACKGROUND

- [3] The deceased was 23 years old and pregnant with the second child when she was admitted to the Mamelodi Regional Hospital on 25 June 2017. Prior thereto she attended the antenatal care clinic (Phalameng Clinic) between 18 April 2017 to May 2017. Her pre-existing conditions were asthma and anaemia. For her anaemia, she was provided with oral medication, particularly to treat her iron deficiency. On 16 June 2017, the clinic transfused her with two units of blood. The deceased had previously given birth to her first baby by way of a caesarian section procedure in 2012. This was her second caesarian section procedure.

- [4] The clinic advised that she deliver her second baby by way of an elective caesarian procedure at the hospital in order to avoid any risks. Consequently she was booked in at the Mamelodi Regional Hospital for this procedure.
- [5] Upon her admission at the hospital between 25 and 26 June 2017, she was transfused with two units of blood.
- [6] When the caesarian section procedure was performed it was discovered that the patient had placenta accreta. There was heavy bleeding and the doctor administered B-lynch sutures and treated her with oxytocin. The caesarian section procedure was concluded at around 10:30 in the morning. After this procedure she was kept in theatre for a short period and then transferred to a high care unit. It appears that she was wheeled into the high care unit at around 12h00 for acute observation. At 12h15 it was recorded that she had no bleeding on the operated side, the uterus was well contracted, there was vaginal bleeding and the breast was soft and secreting well. Her blood pressure was also recorded as normal.
- [7] Thereafter no entries were made by the staff until 16h33. At that point, the staff discovered that the deceased was bleeding heavily and her linen was soaked with blood. The treating doctor was immediately called to see the deceased.
- [8] A decision was made to perform a relook laparotomy and a total abdominal hysterectomy in order to stop the bleeding. At 17h15 the deceased consented thereto by signing a consent form. After the relook laparotomy and the total

abdominal hysterectomy (TAH) had been performed, she was kept in the intensive care unit (ICU) for observation.

[9] Several hours later, on 28 June 2017, at around 01h00 she was still found to be bleeding excessively. A further relook laparotomy was recommended. She was transfused with red blood cells and fresh frozen plasma and at 03:00 the second relook laparotomy was performed and five large swabs were packed in. The previous 3 swabs packed during the first relook procedure were removed. She was kept in ICU for further management and observation and once more transfused with red cells and fresh frozen plasma.

[10] On 3 July 2017 the third exploratory laparotomy was performed where the five large swabs that were inserted on 28 June 2017, were removed. Unfortunately the deceased did not recover from the procedure and passed on.

[11] There is a dispute as to whether a post mortem was done. No such records have been made available. The plaintiff is of the view that a post mortem had in all probability been performed as it was an anesthetic related death – post mortem was mandatory.

THE PLAINTIFF'S CASE IN ACCORDANCE WITH THE PLEADINGS

[12] The plaintiff's case essentially is that the doctors and the staff who attended to the deceased failed to take proper precautions, care, monitor and manage the deceased during the caesarian section procedure. It was contended that the medical doctors and staff were fully aware that the deceased was a high risk

patient with asthma, anaemia and had undergone a previous caesarian section. As a result of their failure to exercise a degree of skill and expertise, the deceased experienced severe bleeding which could have been prevented had proper care been taken, namely that the total abdominal hysterectomy should have been performed when it was discovered that the deceased had placenta accreta. Under these circumstances her bleeding would have stopped and the deceased's life could have been saved.

[13] In the plaintiff's second amended particulars of claim she pleaded essentially that the respondent was negligent in the following manner:

13.1 it failed to employ the services of suitably qualified and an experienced medical practitioner who could manage the patient's labour and perform the caesarian section;

13.2 it failed to have suitably qualified nursing staff who could assess, monitor and manage the deceased and provide post-operative care;

13.3 it failed to ensure that the hospital was suitable and properly equipped to deal with the patient and to ensure the proper performance of the caesarian section;

13.4 it failed to take the necessary steps to ensure proper, timeous, and professional assessment of the patient including monitoring and management of her labour;

- 13.5 with the exercise of reasonable care and diligence it could have avoided the complications;
- 13.6 it failed to timeously give the deceased blood and other blood products and in order to improve the deceased's haemoglobin level and further failed to follow up on the progress within a period of four weeks in preparation of her labour;
- 13.7 it failed to admit the deceased, transfuse her and review her haemoglobin;
- 13.8 it failed to give the deceased a blood transfusion of four units when the deceased was admitted at 32 weeks;
- 13.9 it failed to do a formal assessment of the deceased's haemoglobin to determine whether the deceased was fully resuscitated;
- 13.10 it performed the caesarian section procedure at the inappropriate time. It should have ensured that her haemoglobin count was optimized to at least 10 g/dl ;
- 13.11 the total abdominal hysterectomy (TAH), was performed at the inappropriate time. It should have treated the disseminated intravascular coagulation, hypothermia, and metabolism acidosis (triad of death);
- 13.12 it failed to ensure that there was sufficient abdominal swabs placed in order to compress the bleeding.

[14] With regard to the employees it was pleaded, *inter alia*, that they failed to render the requisite, reasonable, medical, surgical, nursing, and midwifery services with the professional skill and diligence that could reasonably be expected of medical practitioners, nurses and midwives in particular circumstances.

[15] Post the caesarian section the deceased continued to bleed and they failed to timeously notify the doctor of the deceased's continued bleeding. The deceased was only taken to theatre five hours after she had "bled out".

THE DEFENDANT'S CASE

[16] In its plea the defendant essentially denied that:

16.1 there was a breach of duty of care or negligence on the part of the medical staff. It pleaded specifically that the staff, who performed the caesarian section procedure, were qualified to perform the procedure and they did so with reasonable care, diligence and skill that was expected of them under the circumstances;

16.2 after the caesarian procedure was performed, the staff performed various laparotomy procedures to investigate the cause of bleeding and to stop the bleeding;

16.3 when it was discovered that the uterus was atonic, they performed the TAH. They also effected a B-lynch sutures and packed large abdominal swabs in the abdomen to prevent further bleeding;

16.4 they managed the disseminated intravascular coagulopathy (DIC) with plasma and continued to pack her abdomen with swabs to maintain a proper level of haemoglobin. The deceased was kept in the intensive care unit for proper management;

16.5 it was pleaded specifically that the postpartum hemorrhage (PPH) was a sentinel event as the placenta accreta was unforeseeable and could not have been prevented.

[17] In the event the court finds that the defendant was negligent in the management of the deceased's medical complications, it is denied that such conduct was the cause of the deceased's adverse outcome. It further pleaded that the deceased's adverse outcome was unforeseen and consequently unpreventable.

THE EVIDENCE

[18] Both parties appointed experts to opine on the standard of care exercised by the medical staff and further whether the death was caused by their substandard care and negligence. The plaintiff called three witnesses, namely the mother of the deceased, Ms A[...], Dr Songabau, a gynaecologist and obstetrician, and Dr Mkulisi, an anaesthetist.

[19] The evidence of the mother (the plaintiff) remains uncontested. Of significance is her testimony that the deceased had called her on the day that she had given birth (27 June 2017). The deceased informed her that she was not feeling well and she was bleeding excessively. She also asked the plaintiff to come and fetch

the newborn baby. The following day, when the plaintiff went to the hospital to fetch the baby, the deceased was in the ICU and was unable to speak. However on hearing the plaintiff's voice she moved her big toe to show that she could hear what she was saying. Ms A[...] further testified that she then took the child with her, she was advised by the hospital staff that the newborn should be taken to the nearest clinic. She also testified that the deceased's complexion was darker than normal.

The evidence of Dr Songabau

[20] Dr Songabau opined that the deceased was inappropriately treated and that the TAH was delayed. His criticism was the following:

20.1 when placenta accreta was discovered during the caesarian procedure, the doctors treating her should have performed a TAH immediately. This was specifically in accordance with the "Guidelines on Maternity"¹ which guides medical staff on how to treat patients, particularly in life threatening situations. The B-lynch sutures that were effected on the uterus in two layers was substandard. If the TAH was performed during the caesarian section, the complications in managing the bleeding could have been avoided. The uterus was the primary source of the bleeding and had to be removed. No doubt the patient could have been saved;

¹ Guidelines on Maternity Care in South Africa, Fourth Edition 2016, Department of Health

- 20.2 Dr Songabau further criticized the management and care of the deceased. The timing of the caesarian section procedure was ill advised. The treating doctors were obliged to ensure that her haemoglobin count was at least 10 g/dl. The caesarian section could not have been conducted without correcting the haemoglobin post-transfusion with unknown platelet levels;
- 20.3 he further raised issue with the fact that she was not transfused during the caesarian section procedure, in theatre. The blood products, particularly the platelets and the fresh frozen plasma were necessary due to the blood loss. It is a known fact that in caesarian section procedures, patients lose blood. In her circumstances she had anaemia as well;
- 20.4 he further criticized the staff for only performing the TAH later. He noted that after the delayed TAH, she was diagnosed with disseminated intravascular coagulopathy (DIC). Instead of treating the DIC, they incorrectly proceeded to perform a TAH;
- 20.5 thereafter she was inappropriately treated for uterine atony. There was no recordal that uterine drugs were administered. In addition she should have specifically received platelet transfusion;
- 20.6 the management of the anaemia was substandard and blood transfusion was done without identifying the cause of the anaemia. The cause of the anaemia had to be investigated;

20.7 he however commended the staff at the clinic for referring the deceased to the hospital for her caesarian section and treating her for anaemia with blood transfusion;

20.8 there had been no monitoring and management of the deceased after the caesarian procedure which resulted in her continued excessive bleeding;

20.9 her clotting status was also not investigated timeously. It was only done the following day, on 28 June 2017. He alleged there was a misdiagnosis of the triad of death, namely coagulopathy, metabolic acidosis and hypothermia. The condition of uterine atony could have been detected earlier.

[21] Under cross-examination it was put to Dr Songabau that a TAH can only be conducted with the consent of a patient. Therefore, in the circumstances, the staff acted reasonably by not removing her uterus during the caesarian section. There was further no evidence that she was bleeding. His response remained that if placenta accreta was diagnosed, the doctors were obliged to remove the uterus. The bleeding would have stopped if the TAH procedure was performed. This treatment method is endorsed in the Guidelines.

[22] When it was put to him that tests had been conducted in respect of her anaemia and it was found that she was iron deficient, Dr Songabau persisted with his view that they were insufficient. A full investigation of her anaemia had to be undertaken.

The evidence of Dr Mbokota

[23] Dr Mbokota testified, on behalf of the defendant, held a contrary view. His testimony was in effect that:

23.1 the deceased was managed appropriately when the caesarian section procedure was performed;

23.2 placenta accreta cannot be diagnosed antenatally. During the caesarian section there were no abnormalities and complications identified. The bleeding was controlled at the time and there was no need to transfuse her with blood during the surgery;

23.3 moreover an investigation to determine if there was placenta accreta, is not usually performed. It is not standard procedure to investigate whether a patient has placenta accreta prior to the caesarian section;

23.4 the administration of the B-lynch sutures and the packing of the three large abdominal swabs were appropriate treating methods. Her admission to high care, in order that she be monitored every 30 minutes, was also appropriate. The caesarian section procedure lasted 40 minutes;

23.5 when she was brought into the high care unit after the caesarian section, she was found to be stable, her urine was draining well, there was no bleeding on the wound and her uterus was well contracted. All of this was recorded by the staff in their notes;

- 23.6 he further opined that the postpartum haemorrhage (excessive bleeding) was due to the placenta accreta. Since her condition was stable after delivery, there was no need to check the clotting profile before and during the (TAH);
- 23.7 the elective caesarian section procedure was appropriate at the time it was performed. She could not have been induced and she was already at full gestation period.
- 23.8 he further noted that the deceased was transfused with blood 48 hours prior to the caesarian section procedure. The placenta accreta was diagnosed during the performance of the caesarian section procedure which led her to develop postpartum hemorrhage (PPH). In his opinion the placenta accreta and the uterine atony were caused by the postpartum hemorrhage (PPH);
- 23.9 he further opined that although a TAH is one of the acceptable treatments for PPH, as it is lifesaving, the packing of the abdomen with swabs, together with the B-lynch sutures, is also considered an acceptable method to stop bleeding;
- 23.10 according to him, the DIC set in during the first relook laparotomy and total abdominal hysterectomy;

23.11 he further noted that even after the second relook laparotomy the deceased's haemoglobin level improved from 10.6g/dl to 11.8g/dl. This was her reading before the third laparotomy procedure was performed;

23.12 the medical staff utilized appropriate methods of suppressing bleeding of the uterus post caesarian section procedure. When the ordinary method of contracting the uterus and suppressing the bleeding could not achieve the best outcomes, a logical decision was taken to then do a TAH;

[24] Under cross-examination, his evidence was that:

24.1 the medical staff, once becoming aware of the excessive bleeding, had taken correct steps to stop the bleeding, which included the total TAH as well as the laparotomies. It is his view that the deceased's complications were unforeseen;

24.2 when it was put to Dr Mbokota during cross-examination that a full investigation had to be undertaken to determine the cause of the anaemia, he responded that the most common anaemia is iron deficiency and hence unnecessary to do the test. She was treated with iron tablets and folic acid;

24.3 when it was put to him that she was unresponsive to the oral medication, his response was that it could be that she was not taking her iron supplements or not absorbing them. The plaintiff maintained that anaemia had to be fully investigated;

- 24.4 when it was put to him that she should have been transfused in theatre, when the caesarian section procedure was being performed, his response was that since the doctors managed to do the B-lynch suture and the fact that she was not bleeding after the procedure, it was not necessary. Moreover, it was appropriate to give her the transfusion in the ward and not in theatre;
- 24.5 he further opined that there was no evidence that the caesarian section was performed incorrectly or performed by a person who was not incompetent or unqualified to perform such a procedure;
- 24.6 furthermore the patient did not bleed out. It was explained that if she had “bled out”, she would have been unconscious and would have experienced breathing difficulties. In this case, she was still conscious and had no breathing difficulties. She even signed the consent form for the relook laparotomy as well as for the TAH. She was taken to theatre by 18h07;
- 24.7 the period just between 12h00 to 16h33, when the deceased was not monitored, was not the defining moment as the medical staff had, in managing the deceased, immediately taken reasonable steps. The necessary reasonable interventions were undertaken to prevent further complications. She was taken to the ICU, transfused with blood and a TAH was performed immediately.

Dr Mkulisi's evidence

[25] Dr Mkulisi testified in his capacity as an anaesthetist on behalf of the plaintiff and opined that:

25.1 there were no proper pre-anaesthetic assessment notes from the anaesthetist. An elective caesarian section ought to have been delayed until the deceased's haemoglobin count could be corrected. In the joint report, he agreed with Dr Nyoka Mokagalong, that *"the anaesthetic notes are incomplete. The pre-operative management is well documented. The intra operative notes provided by the anaesthetist leave a lot of unanswered questions. The patient did bleed intra operative. The anaesthetic notes do not mention any uterotonics that was used after delivery of the baby"*;

25.2 furthermore the anaesthetist should have determined whether the patient was stable and this had to be investigated through arterial blood gas procedure. This process involves the taking of the blood from the artery and then measure it against certain parameters such as the haemoglobin count and her PH. In his view it was negligent for the anaesthetist to allow the surgeon to conduct the elective caesarian section without making sure that the haemoglobin count was optimized to 10. Moreover there is no formal documentation in the form of hospital/doctors notes setting out how the deceased was treated;

- 25.3 the deceased lost around 1.2 litres of blood during the caesarian section which is a significant amount. There can be no doubt that her haemoglobin count was very low after the procedure;
- 25.4 furthermore without any trace of the relevant notes of the anaesthetist who treated the deceased, it is not known what medication was administered, particularly to contract her uterus;
- 25.5 the supervision by the senior doctors was poor and eventually led to the DIC. An early diagnosis of the deceased's postpartum hemorrhage could have saved her life. According to him, the first anaesthetist, who treated the deceased before her caesarian section, failed to take active measures and ensuring that the patient was doing well post operatively. The second anaesthetist, who treated her before the TAH should have advised the surgeon not to go the theatre and instead treat the triad of death. The delay in performing the TAH most certainly exacerbated her condition.

Dr Nyoka-Mokagalong's evidence

[26] Dr Nyoka-Mokagalong testified on behalf of the defendant. On the pressing issues she opined:

- 26.1 that the clinical notes provided were incomplete and the anaesthetic reports were lacking. She was therefore unable to determine what medication the deceased received before and after the caesarian section by the anaesthetists;

- 26.2 she indicated that it was acceptable to conduct the caesarian section procedure with a blood count of 9.5 g/dl, but she confirmed that blood must have been ordered and kept on standby. She was further of the view that in her circumstances an elective caesarian section procedure was appropriate before she went into labour. The bleeding was not only the loss of blood but would have included the fluid from the uterus;
- 26.3 the B-lynch sutures was a positive step taken to stop the bleeding. She explained that placenta accreta occurs when the placenta grows deeply into the uterine wall and fails to detach properly after childbirth. This abnormal attachment can cause severe bleeding and can be life threatening and it is a known fact that there would be excessive blood loss during delivery. A caesarian section followed by a hysterectomy is performed in such circumstances;
- 26.4 the deceased's vital signs after the caesarian section procedure was good. She was therefore "hemodynamically stable".² However after the TAH and first relook laparotomy, she fell critically ill and became unstable and she remained in this condition until her demise;
- 26.5 she noted that on 3 July 2017 she was still bleeding. In her opinion, the doctors were treating the DIC aggressively. The DIC set in after the TAH. She opined that the DIC could possibly have been caused by the dilution

² Hemodynamic stability is the maintenance of adequate blood flow, pressure, and oxygen delivery to meet tissue and organ needs

of the clotting factors, due to the massive transfusions and excessive fluid administered during resuscitation;

26.6 metabolic acidosis can only be diagnosed once the blood arterial gas results are made available. Therefore one cannot merely assume that she had this condition;

26.7 she bled excessively but not “bled out”. If she “bled out”, she would have been in hypovolaemic shock, hypotensive and a level of consciousness that would be affected;

26.8 It was also commendable that she was sent to the ICU after the caesarian section procedure for acute monitoring. Although she concluded in her report that the staff did all that was necessary in treating the deceased , under cross examination she conceded the monitoring of the patient in the high care after, that r the caesarian section procedure was substandard;

Under cross-examination she testified

26.9 under cross examination she testified that the Guidelines, although an authoritative guide, the final determination would always be by the treating doctor who clinically assesses a patient;

26.10 she also conceded that if there was timeous monitoring in accordance with the doctor’s direction, early detection of the bleeding and her condition could have assisted the patient’s condition;

- 26.11 she agreed that the anaesthetist's records were lacking, in particular, there is no recordal of what medication was administered on the patient;
- 26.12 she however persisted with her view that there was nothing in the records to lead to the conclusion that "lethal triad" was present;
- 26.13 in response to the proposition put to her that TAH should have been conducted once the doctors diagnosed placenta accreta, she did not deny this fact. She however qualified her response by expressing that the B-lynch procedure was also appropriate. The treatment is ultimately dependent on the assessment of the patient at the time. Hence it is not in every instance when placenta accreta is diagnosed that it should be followed by a TAH;
- 26.14 she explained that the deceased at the time was only 24 years of age and had two children. The removal of a uterus involves ethical considerations. Her consent had to be obtained before the TAH could be performed;
- 26.15 she however accepted that if the TAH was performed with the caesarian section procedure the bleeding could have been prevented;
- 26.16 she confirmed that the postpartum haemorrhage observed at caesarian section stage, led to uterine atony;
- 26.17 lastly she opined that the deceased in all probability passed on due to a heart attack.

ANALYSIS

[27] It is settled law that a party that bears the onus must prove whether its case is more probable than not, on a balance of probabilities. In this case, the onus of proving negligence on a balance of probability rests with the plaintiff. In the ***Mediclinic v Vermeulen*** matter³ the court held that the plaintiff bore the onus of proving that the defendant's nursing staff was negligent. When evaluating the evidence, the evidence must be weighed holistically and a court must distinguish the probabilities and inferences from conjecture and speculation. The inference may be drawn and probabilities considered only in light of objectively proven facts.

[28] The test for negligence is trite. In ***Kruger v Coetzee***⁴ the court held that negligence arises if a reasonable person would foresee the reasonable possibility that his/her conduct would injure another, cause him/her patrimonial loss that reasonable steps would had to be taken to guard against such occurrence and that the defendant failed to take such steps. What steps are reasonable must depend on the particular circumstances of each case.

[29] In ***Meyers v MEC, Department of Health***⁵ the test for negligence was reaffirmed. The court expressed:

"In a case such as this, where specialised skill is involved, the general standard of the reasonable person is adjusted upwards, as it were, to that of the reasonable person

³ Mediclinic Ltd v Vermeulen 2015(1) SA 241 (SCA) at paragraph 16

⁴ Kruger v Coetzee 1966 (2) SA A 430 H

⁵ Meyers v MEC, Department of Health, Eastern Cape (Case 1010/2018) 2020 (3) SA 337 SCA paragraphs 51 and 52

in the field of endeavour involved. In other words, while a person possessed of, or professing to be possessed of, specialised skills is not required to display the ‘highest possible degree of professional skill’, he or she will be held to ‘the general level of skill and diligence possessed and exercised at the time by the members of the branch of the profession to which the practitioner belongs. He or she will be held to a standard of reasonable skill and care within the area of his or her expertise or professed expertise.’”

[30] It has also been confirmed that a medical practitioner is not expected to provide the highest possible degree of professional skill but is bound to employ reasonable skill and care.⁶

[31] Insofar as expert witness evidence is concerned, a court is not bound to the expert reports. The court’s determination, at the end of the day, depends on the analysis of the cogency of the reasoning which led to the experts’ conflicting opinions. The court must be satisfied that such opinion has a logical basis. In other words, that the expert is considered a comparative risk, and benefit and has reached defensible conclusions.⁷

[32] If at the conclusion of the case the evidence is evenly balanced, the plaintiff cannot claim a verdict where he will not have discharged the onus resting upon him.⁸

⁶ Mitchell v Dickson 1914 A 519 at 525

⁷ Michael and Another v Linksfield Park Clinic (Pty) Ltd and Another 2001 (3) SA 1188 (SCA) at paragraph 34

⁸ Van Wyk v Lewis 1924 AD 438 at 444

- [33] Before evaluating the experts' evidence, it is apposite to understand the deceased's anaemic history. It cannot be disputed that she suffered from anaemia and had to be constantly managed for this condition.
- [34] The plaintiff highlighted out that the optimal haemoglobin count should be 10g/dl before surgery can be performed. This is in accordance with the Guidelines.⁹
- [35] It is common cause that before the various procedures were performed on the patient, and she was transfused with blood. Her haemoglobin level had never been optimal both during her antenatal and post-natal periods.
- [36] She was provided with iron supplements and folic acid and transfused in order to treat her iron and folic deficiency before she was hospitalized for the caesarian section. She was also transfused with two units of blood a day before the caesarian section procedure was performed;

⁹ Guidelines for Maternity Care in South Africa at chapter 11 which stipulates:

"MEDICAL DISORDERS IN PREGNANCY ANAEMIA

All pregnant women should have an HB measurement at the first antenatal visit. And if less than 10g/dl, it should be repeated between 28 and 32 weeks, and again at 36 weeks. Any HB level of more than 10g/dl should be followed up with more frequent HB measurements after initiating treatment. A haemoglobin Ohm meter should be used so that the result is available at the same visit..

Most cases of anaemia in pregnancy are caused by iron deficiency. The multiple factors that can contribute to iron deficiency in pregnancy, including poor diet and parasitic infestations such as hookworm and bilharzia. The iron deficiency can be pre-existing, or it can occur for the first time in pregnancy due to the increased iron requirements.

MANAGEMENT OF ANAEMIA

In all cases look for an underlying cause and address the cause where possible.

[37] The haemoglobin count, in accordance with the hospital records appeared as follows:

Date	g/dl level	Period
9 May 2017	8.7	Visit to the clinic
6 June 2017	7.9	Visit to the clinic
13 June 2017	9.4	Visit to the clinic
15 June 2017	6.7	Visit to the clinic
16 June 2017	7.2	Visit to the clinic during the blood transfusion
17 June 2017	7.8	After blood transfusion
25 June 2017	8.6	Date of admission to the hospital
27 June 2017	9.5	Reading before caesarian section and after transfusion
27 June 2017	4.4	No formal recordal of her blood count. Experts estimated that it would have been low – 4.4 g/dl
27 June 2017	8.7	Before the first relook laparotomy and TAH procedure and after blood transfusion

28 June 2017	4.6	Before the second relook laparotomy procedure
3 July 2017	10.6	Before the third relook laparotomy procedure after blood transfusion

[38] It is further common cause that a full investigation into the nature of the anaemia as well as the cause of the anaemia was never conducted. Her treatment for the anaemia besides the oral medication was as follows:

38.1 on 16 June 2017 she was transfused with two units of blood;

38.2 on 25 and 26 June 2017 she received a second blood transfusion with two units of blood;

38.3 on 27 June 2017, before the first relook laparotomy and TAH, she was transfused with two units of frozen plasma and two units of packed red blood cells. After the caesarian section she had an estimated blood loss of about 1.2 litres. The medical staff were instructed to monitor her every 30 minutes in high care and transfuse her with two units of blood which they failed to do. She only received blood transfusion later in the evening on 27 June 2017. It was estimated by the experts that before the transfusion, her haemoglobin level could have been around 4.4 g/dl. There was no recordal of the haemoglobin count when she was attended from 16h33 onwards;

38.4 on 28 June 2017 she was further transfused with red blood cells and fresh frozen plasma, which was before the second relook laparotomy procedure.

[39] Before the caesarian section procedure, and after the transfusions, her blood count was at 9.5 g/dl. It was also recorded from the clinical notes that her haemoglobin level went from 10.6 g/dl to 11.8 g/dl just before the third relook laparotomy, and after she was transfused.

[40] The defendant in argument persisted with the view that negligence or breach of duty of care on the part of the medical staff was not proven, particularly if consideration is given to the following factors:

40.1 the bleeding was caused by placenta accreta and as a result the uterus could not contract. The placenta accreta was unforeseen and unpreventable;

40.2 the hospital staff followed the formal procedures of suppressing the bleeding of the uterus post caesarian section. It is only when that could not be achieved that they took an informed decision to then conduct the TAH;

40.3 moreover the court should take into account that she had unforeseen complications from the postpartum hemorrhage, where she developed atonic uterus and DIC;

40.4 she continued bleeding and the transfusions were not going to stop the bleeding. They do however accept that the treatment of DIC falls within the area of a critical care specialist and is complex;

40.5 moreover there is no causal nexus between the conduct of the medical staff and the death of the deceased. The medical staff were faced with unexpected medical complications relating to the bleeding. They managed the deceased's complex condition according to the accepted practice standard.

[41] I have noted both Dr Mkulisi's and Dr Nyoka-Mokagalong's opinion that a TAH cannot be performed unless the patient's consent is obtained. There are ethical considerations which have to be taken into account. It was also motivated that the B-lynch sutures, packing the abdomen with swabs and directing that she be monitored every 30 minutes in the High Care Unit was not substandard care.

[42] However I took cognizance of the explanation that in emergency circumstances, consent is not required. The medical staff can invoke *inter alia* the relevant provisions of the National Health Act read with the HPCSA guidelines. The motivation would be that the procedure was performed in order to save a patient's life. This submission was not disputed.

[43] Dr Nyoka-Mokagalong, in her report, opined that overall the deceased was appropriately treated at the hospital and that the diagnosis of the atonic uterus and DIC was unforeseeable. However under cross-examination, she conceded that the post caesarian care was substandard when there was a failure to observe her.

[44] I further take cognizance of Dr Songabau's testimony that the deceased had low platelets and since the underlying cause was not investigated she had not been appropriately treated. He testified that thrombocytopenia is a leading cause of blood disorders in pregnancy after iron deficiency anaemia and it causes excessive uncontrolled bleeding. Dr Mbokota, on the other hand, disagreed that the deceased

had thrombocytopenia in her antenatal period as a full blood count was done at the hospital and her platelets were recorded as 196. According to him, the thrombocytopenia developed after the PPH.

[45] According to all three experts, Dr Songabau and Dr Mbokota and Dr Nyoka-Mokagalong, the deceased suffered from postpartum hemorrhage which occurred at the time of the delivery. Generally this is when a mother loses more than half a litre of blood at the time of the delivery. Dr Songabau went further to state that the cause of the postpartum hemorrhage was due to the unsutured bleeders during the caesarian section process, in other words, the round ligament was not sutured. This led to the uterine atony and DIC. Uterine atony is a loss of tone in the uterus muscles. Dr Mbokota, on the other hand, contended that uterine atony developed after the caesarian section.

[46] The plaintiff further pointed out that it was always possible to diagnose placenta accreta with ultrasound techniques which could have been performed before the delivery. I was referred to the text “Clinical Obstetrics”¹⁰ that stated:

“Woman with previous uterine surgery, especially caesarian deliveries with low lying and anterior placenta should receive appropriate imaging (ultrasound) to screen for the presumptive diagnosis of a morbidly adherent placenta during the third trimester.”

[47] Having considered the testimonies of both parties’ experts and the evidence before me, my conclusive findings are:

¹⁰ Cronje Cilliers du Toit (Clinical Obstetrics) South African Perspective, 4th Edition.

- 47.1 although the deceased was anaemic and treated at the clinic and at the hospital for her “iron deficiency”, it is common cause that a full investigation was not conducted to determine the cause of the anaemia. There could have been many factors that could have caused her anaemic condition. Dr Mbokota’s conclusion that the most common anaemia is iron deficiency and that the deceased was possibly not taking her medication is mere speculation. The records show that her haemoglobin count was mostly below the optimal level – 10 g/dl;
- 47.2 I do not take issue with Dr Nyoka Mokagalong’s opinion that although the haemoglobin count of 10.5g/dl was optimal, the count of 9.5g/dl was acceptable to conduct the procedure. Dr Nyoka Mokagalong also expressed that the caesarian section was conducted at the appropriate time if one has regard to the fact that it was her second caesarian procedure. In the circumstances such as the deceased, the chances of the uterus rupturing is very high;
- 47.3 Dr Mkulisi and Dr Nyoka-Mokagalong also agreed that due to the PPH, the deceased had to be observed and managed acutely. It was apparent that due to her having placenta accreta, bleeding was anticipated by the treating doctor, hence his directives for her observation in high care;
- 47.4 she clearly did not receive the management and care that she required after the caesarian procedure and in accordance with the doctor’s instructions. Both Dr Songabau and Dr Nyoka-Mokagalong opined that

there was neglect on the part of the medical staff where she was left unattended for over 4 hours in the high care unit ward;

47.5 In this time, she bled excessively that even the bed was soaked in blood. It was only after 16h33 that a diagnosis was made that she had uterine atony. The deceased was not in an optimal condition. This was confirmed by the plaintiff who visited the deceased before she went into theatre for the first relook laparotomy and TAH. She testified that the deceased was not responding and that her complexion was darker than usual.

47.6 In my view, the lack of observing and managing the deceased during the most critical period, caused her condition to deteriorate drastically. She bled heavily and was not transfused after the caesarian section. The records reflected that after the TAH she was hemodynamically unstable. She remained in this condition until her death. Clearly, she was treated “a little too late”.

47.7 Dr Nyoka-Mokagalong also opined that the continuous transfusion could have resulted in DIC. According to her, the DIC developed after the TAH. She continued bleeding even after the TAH. Despite her haemoglobin count being above 10g/dl before the third relook laparotomy, the records show that she was unstable.

47.8 Even though Dr Nyoka-Mokagalong opined that the B-lynch suture was appropriate in circumstances where a patient has placenta accreta, in my view, with the deceased’s history of anaemia, the appropriate decision that

had to be taken was to perform the TAH at the earliest. The medical doctors are well versed that placenta accreta causes more bleeding than normal.

47.9 Furthermore when she underwent the caesarian procedure, her haemoglobin count was 9.5g/dl. She however had lost over 1.5 litres of blood/fluid during the caesarian procedure. It was critical for her to receive blood, at the earliest in order to raise her haemoglobin count. It was also not disputed that at around 16h33 her haemoglobin level was very low. She was only transfused before the relook and TAH procedure in the evening of 27 June 2017.

47.10 The extensive bleeding could have been prevented if she was timeously monitored. Bleeding was anticipated because of placenta accreta. Clearly the post caesarian section care and management was substandard. The staff neglected to treat the deceased with the reasonable care expected of them.

47.11 Furthermore even if the ultrasound test for placenta accreta was not performed, doctors and staff upon discovering this condition, were required to take reasonable steps in treating, managing and observing the deceased.

47.12 More significantly, both anaesthetists, Dr Mkulisi and Dr Nyoka-Mokagalong, testified that there were inadequate records of the anaesthetists' management of the deceased. It could not be established

what medication was administered before and after the caesarian section, particular in aiding the uterus to contract.

47.13 The records reflected that after the TAH was performed, she was critically ill, haemodynamically unstable, still bleeding, and was on mechanical ventilation. After the TAH, the deceased was unstable and unresponsive and remained in that state until her demise.

47.14 In my view, under the circumstances, the subsequent conditions that arose could have been averted if she was monitored continuously and received transfusion immediately after the caesarian procedure.

[48] I therefore find that the plaintiff has proven that the medical doctors and staff did not attend to the patient with the reasonable care and skill required of them. The lack of monitoring the patient post caesarian clearly constituted negligent conduct. The monitoring was critical. There is no doubt the surgeon who performed the caesarian section procedure requested acute observation as he was alive to the fact that there could be bleeding due to the placenta accreta.

[49] Consequently the plaintiff therefore succeeds on the merits. Liability on the part of the defendant has been proven.

COSTS

[50] The general principle that costs follow the result is applied. The plaintiff as the successful party is entitled to her costs. I therefore order that the defendant pay

the costs of the trial on Scale C, for costs of two counsel, which would include the costs of 13 and 14 May 2025 due to wasted costs as a result of the unavailability of the defendant's experts.

H. KOOVERJIE
JUDGE OF THE HIGH COURT
GAUTENG DIVISION, PRETORIA

Appearances:

Counsel for the applicants: Adv.P Loselo and Adv. Z Nkwane

Instructed by: R Loselo Inc.

Counsel for the respondents: Adv. Phaswane SC and Adv. E Snyman

Instructed by: The State Attorney

Date heard: 21-23 October 2024, 12 May 2025, 15 May 2025, 2-3

February 2026, 6 March 2026

Date of Judgment: 17 March 2026