



**THE SUPREME COURT OF APPEAL OF SOUTH AFRICA
JUDGMENT**

Reportable

Case no: 863/2024

In the matter between:

**ITOKOLLE-CLINIX PRIVATE HOSPITAL
(PTY) LTD**

APPELLANT

and

M N T obo D O R M

RESPONDENT

Neutral citation: *Itokolle-Clinix Private Hospital (Pty) Ltd v MNT obo DORM*
(863/2024) [2025] ZASCA 153 (16 October 2025)

Coram: DAMBUZA, WEINER, MOLEFE, KEIGHTLEY and COPPIN JJA

Heard: 11 September 2025

Delivered: This judgment was handed down electronically by circulation to the parties' representatives by email, publication on the Supreme Court of Appeal website, and release to SAFLII. The date for hand down is deemed to be 16 October 2025 at 11h00

Summary: Delict – medical negligence – injury to foetal brain – child born suffering from cerebral palsy – admitted negligence by nursing staff in monitoring of foetus and expectant mother – proof of causation – whether admitted negligence was cause of the brain injury.

Compromise – settlement – 'Calderbank offer' by plaintiff – nature of offer – reconsideration of costs in light of offer – effect of offer – reasonableness of rejecting offer – consequences.

ORDER

On appeal from: North West Division of the High Court, Mahikeng (Nobanda AJ, sitting as court of first instance):

The appeal is dismissed with costs.

JUDGMENT

Coppin JA (Dambuza, Weiner, Molefe and Keightley JJA concurring):

[1] The appellant, Itokolle-Clinix Private Hospital (Pty) Ltd (the hospital), was found to be jointly and severally liable, with one Dr Kofi Ofori Amanfo (Dr Ofori), a specialist obstetrician and gynaecologist, by the North West Division of the High Court, Mahikeng (the high court) for all the proved or agreed damages suffered by the respondent (the plaintiff in the high court), in her personal and representative capacities, as a result of her daughter (D) having been born with cerebral palsy.

[2] This is an appeal by the hospital against the decision of the high court declaring it to be jointly and severally liable with Dr Ofori, and against the order of costs, including the costs order the high court made pursuant to an application brought by the respondent for the reconsideration of the costs. The high court granted the hospital leave to appeal to this Court. Dr Ofori did not appeal the high court's decision.

[3] The two issues in this appeal are, first, the liability of the hospital for the respondent's damages (the causation), and second, the liability of the hospital for the respondent's trial costs pursuant to a so-called 'Calderbank offer',¹ made by the

¹ A 'Calderbank offer' is so named with reference to the judgment of the English Court of Appeal in *Calderbank v Calderbank* [1976] Fam. 93; [1975] 3 All ER 333 (EWCA), where it was held that there was no reason in principle why in cases not covered by the rules of court permitting secret offers, a litigant (more particularly, a plaintiff) should not be allowed to make a 'without prejudice' offer to save

respondent to the hospital and Dr Ofori, which was not accepted by them, and was the subject of the application for the reconsideration of the costs order.

Background facts

[4] The respondent, at the time of her pregnancy with D, was a patient of Dr Ofori. Complaining of labour pains, she presented herself, at the instance of Dr Ofori, at the hospital on 29 January 2007, at about 23h00. The hospital staff examined and assessed her and confirmed that she was indeed in labour and admitted her into the maternity ward at the hospital, which is situated in Mahikeng.

[5] On the following day (30 January 2007) at about 08h00, Dr Ofori examined her, and his diagnosis was that she was experiencing a prolonged latent phase of labour and had an unfavourable cervix. At the time, the cervix was 2cm dilated. He prescribed prostaglandins in the form of prostins to be administered to the respondent to induce labour. Dr Ofori then left the hospital to attend to an outreach medical service programme in Lichtenburg, after having arranged with a colleague, Dr Mmutle, to stand in for him, and having requested the midwifery staff in the maternity ward to call him when the respondent's cervix was 8cm dilated.

[6] On the same day, ie, 30 January 2007, at approximately 14h00, Dr Mmutle instructed that the dose of the prostins administered earlier to the respondent be repeated. At the time, the respondent was 4cm dilated. It is accepted that following the repeat dose, the respondent had mild contractions and there was a spontaneous rupture of the membranes.

[7] Between 20h00 and 20h30 of the same day, Dr Ofori was notified by the midwifery staff that the respondent's cervix was 8cm dilated. Dr Ofori arrived at the maternity ward and then proceeded to examine the respondent. The exact detail will be provided in the course of dealing with the first issue. It suffices for now to relate that, after examining the respondent, Dr Ofori prescribed another form of

costs, and to rely on such offer, once judgment has been granted in its favour, in support of claiming indemnifying costs. This principle has been approved and applied by, *inter alia*, South African courts. See, *inter alia*, *AD and Another v MEC for Health and Social Development, Western Cape* 2017 (5) SA 134 (WCC) (*MEC for Health and Social Development*); *Van Reenen v Lewis and Another* [2019] ZAFSHC 55.

prostaglandins, namely syntocinon, to be administered to the respondent intravenously.

[8] A short while later, the respondent's cervix was fully dilated, and the respondent was taken to the labour room after she expressed an urge to push. At around 21h00, Dr Ofori delivered D with the assistance of a suction device, a ventouse. Upon birth, D's heart rate was zero, and she was not breathing. Dr Ofori attempted resuscitation, and with the help of a paediatrician who arrived and took over the process, D was resuscitated, and she began breathing on her own after about 20 minutes. It is common cause that she suffered a permanent hypoxic ischaemic brain injury during the birth process, causing a debilitating quadriplegic cerebral palsy (the brain injury).

[9] An action was instituted by the respondent, in her capacity as mother and natural guardian of D, and as the executrix of her deceased husband's estate, against Dr Ofori and the hospital for the damages suffered as a result of D's brain injury. The respondent alleged that Dr Ofori and the hospital staff who attended to the birthing process were negligent and that Dr Ofori and the hospital, which is vicariously liable for the negligent conduct of its staff, were jointly and severally liable for the respondent's damages.

[10] The hospital and Dr Ofori defended the matter. In its plea, the hospital denied that the hospital staff were negligent and that it was liable to the respondent. In an alternative plea, the hospital alleged that if its staff were found to have been causally negligent, Dr Ofori was also negligent and caused the brain injury. It is common cause that both the respondent and the hospital engaged expert opinion in support of their respective positions. When the matter was ready for trial, the determination of the issue of liability (merits) was separated from the determination of the damages (quantum), and the trial proceeded first in relation to the liability; the issue of the quantum was postponed indefinitely.

[11] At the hearing of the merits, the respondent (as the plaintiff) testified herself and called various experts, namely Prof Nolte, a midwifery and nursing expert, Dr van Rensburg, a neuro-radiologist, Prof Smith, a neonatologist, Prof Coetzee, a specialist obstetrician and gynaecologist, and Dr Muntingh, a clinical pharmacologist.

[12] Dr Ofori testified himself, personally and as an expert in his field, and did not call other witnesses. The hospital called none of the midwifery staff who attended to the respondent, including Sister Ojeng (Sr Ojeng). The latter played an important role in the management of the birth process and she made many of the progress notes, especially during the shift that started at 19h00 on 30 January 2007. Sr Ojeng noted, for instance, that there were strong contractions at 20h00 and that the cervix was fully dilated at 20h30 (before Dr Ofori's arrival). Dr Ofori's evidence was that the cervix was 8 cm dilated when he examined the respondent at 20h30. Sr Ojeng's evidence was vital, given her crucial role in the saga. The reason the hospital gave for not calling her was that she had relocated to Saudi Arabia. Instead, the hospital called the following experts: Dr Harris, a midwifery expert who is also a medical doctor, Dr Weinstein, a specialist radiologist, and Dr Koll, a specialist obstetrician and gynaecologist. The hospital had also given expert notices and had filed expert summaries in respect of Prof Cooper, a specialist paediatrician, and Prof Louw, a clinical haematologist, but did not call those witnesses to give oral evidence. Other experts who did not give oral evidence are Prof Lombard, an obstetrician and gynaecologist, Prof Viljoen, a specialist geneticist, and Dr Aduc, a paediatric neurologist.

[13] Joint minutes of the following experts were submitted: (a) by the obstetricians Prof Coetzee and Prof Lombard; (b) by the paediatrician, Prof Cooper and the neonatologist Prof Smuts; (c) by the nursing midwifery experts, Prof Nolte and Dr Harris; (d) by the radiologists (in respect of the imagining of D's brain), Dr Weinstein and Dr van Rensburg; and (e) by the obstetricians, Dr Koll and Prof Coetzee.

[14] The correctness of the contents of the hospital's labour and delivery records relating to the birth of D, as well as the neonatal records and neonatal nursing notes of its nursing staff (including laboratory and radiology reports of D, which were combined in the trial bundle), was admitted. In the pre-trial minutes dated 12 February 2020, the parties agreed that the opinions (and the records of those opinions) of Prof Viljoen (geneticist) and Dr van Rensburg (neuro-radiologist), as contained in their expert summaries, would not be disputed. They further agreed that the views of Prof Nolte (nursing expert), Prof Smith (neonatologist), and Prof Coetzee (obstetrician expert) remained in dispute.

[15] Having heard the testimony of the witnesses that were called and the arguments, the high court, in a carefully reasoned judgment, concluded as follows:

'In the result, I find that the plaintiff has failed to establish on a balance of probabilities that Dr Ofori was negligent in administering the syntocinon at 20:45. I however find that the plaintiff has established on a balance of probabilities that Dr Ofori was negligent in failing to monitor the plaintiff's contractions with sufficient frequency or at all, given his manner and timing of augmentation of labour at 20:45 and such negligence casually contributed to the harm suffered by D and accordingly, the plaintiff.

I also find that the plaintiff has established on a balance of probabilities that the second defendant's midwifery staff were negligent in the handling of the plaintiff's labour not only prior to the administration of syntocinon at 20:45 but also after its administration and such negligence caused the harm suffered by D and accordingly the plaintiff. Accordingly, the second defendant is vicariously liable for the actions of its nursing/midwifery staff members.'

[16] Following the determination of liability, the high court was approached by the respondent on an urgent basis to reconsider the costs order it made in that regard, and to effectively award to the respondent against Dr Ofori and the hospital all her costs after the offer she made, as well as the costs of the application for reconsideration. The respondent was largely successful, but the details of this aspect of the matter will be addressed later.

Causation

[17] Essentially, the hospital concedes that its midwifery staff failed to monitor and observe the birthing process adequately, but it denies that this was the cause of D's brain injury. It contends that the high court erred in finding the contrary. It asserts that: the injury occurred after Dr Ofori's return to attend to the respondent at about 20h30 on 30 January 2007; that he was in control from then on, and that the brain injury was entirely due to Dr Ofori's decisions and actions, or lack thereof. The hospital referred essentially to the chronology of events as recorded in the nursing plan and delivery records in support of its argument.

[18] Even though some aspects of the chronology were referred to earlier, it was done in broad brushstrokes to create a context. Since the issue of causation,

specifically, is being dealt with, it is necessary to give a more detailed sequence of events as recorded in the hospital's records. The following chronology is not in dispute:

18.1 On 29 January 2007, the respondent was admitted to the hospital at 23h00 at full-term gestational age. A cardiotocography (CTG) was performed in order to determine the foetal heart rate (FHR). The FHR was 122/136 beats per minute (bpm); the respondent presented with a 1cm dilated cervix and mild contractions.

18.2 On 30 January at 04h00, the FHR was 136/142 bpm. A clinical examination established that there were mild contractions. The cervix was 3cm dilated, and the membranes were still intact. The respondent's blood pressure was 111/59.

18.3 At 08h00, the respondent was seen by Dr Ofori, who administered (by insertion) prostin (to induce/augment labour). The cervix is recorded as being 2cm dilated.

18.4 At 10h00, the FHR was 145 bpm, and mild contractions were recorded. The notes state that the respondent was asleep most of the time.

18.5 At 14h00, the contractions are recorded as 'still mild'. Dr Mmutle (stand-in for Dr Ofori) instructed that the administration of prostin be repeated, and that was done. It is recorded that the cervix was then 4cm dilated, and the membranes that were bulging, 'spontaneously ruptured', and that the liquor was clear, 'mixed slightly with blood'.

18.6 At 16h00-18h30, the following is recorded in the Nursing Care Plan: 'Patient's pains being unbearable, Pethedine 100mg & Aterox 150mg was given. Has strong contractions. PV 8,5 cm dilated well effaced. A well applied drawing clear liquor'.

18.7 At 20h00 (it is recorded by hand by Sr Ojeng under the heading: 'Delivery: Second Stage'), the contractions were strong; the FHR was 128/132 bpm; and the respondent's BP was 117/76, and her pulse rate was 98.

18.8 At 20h30 (as per the delivery records completed by Sr Ojeng), Dr Ofori arrived at the hospital to attend to the patient. The cervix was 'fully dilated'.

18.9 Sr Ojeng recorded Dr Ofori's arrival time as having been at 20h40.

18.10 According to Sr Ojeng's note at 20h45, the patient was still having strong contractions; she was wheeled to the labour ward. According to the note, Dr Ofori reported to the ward where he examined the respondent and instructed that 5 units in 200 ml of saline of another oxytocin (similar to prostin), namely syntocinon, be administered to the respondent.

18.11 It is not clear from the records whether the cervix was 9 or 10 cm dilated at approximately 20h45. The FHR was recorded by Sr Ojeng as 150–152 bpm, and according to the note the cervix was 9cm dilated.

18.12 It is accepted that at 21h10, D was delivered by Dr Ofori using a suction cup (a ventouse) and that upon birth, D had to be resuscitated, having presented with low Apgar scores and being in a compromised state.

18.13 It is noted that at 21h15 blood was drawn from D which showed an elevated NRBC of 34/100 neutrofiles.

[19] The neuroradiologists, Dr van Rensburg and Dr Weinstein, in their joint minutes, agreed, with reference to a Magnetic Resonance Imaging (MRI) examination performed on D, on 3 August 2021, that the abnormalities observed were ‘all consistent with the established stage of perinatal hypoxic ischaemic injury to the brain of a full-term infant . . .’ They disagreed on whether the brain injury was caused by repeated relatively prolonged episodes of asphyxia, or was caused by a single hypoxic ischaemic episode. The MRI described an acute profound brain injury. But they conceded that the timing and cause of the injury cannot be determined radiologically, and they deferred to the experts in obstetrics, neurology, and paediatric neurology concerning that question.

[20] Prof Smith, a specialist neonatologist, opined that the foetus suffered subacute or intermittent hypoxaemia over a long period, which continued undetected due to the failure to properly monitor the FHR. According to Prof Smith, the hypoxic insult started during the first phase of labour and intensified when the prostin was again administered to the respondent at 14h00 (at Dr Mmutle’s behest). The hypoxic injury continued when the respondent reached the active stage of labour. It resulted in the baby having a reduced (or slow) heart rate, below 100 bpm (bradycardia), just before birth. If bradycardia lasts for more than 20 minutes, it results in brain injury because there is little or no blood circulation to the foetal brain. Prof Smith’s view was that D’s Apgar score (that is a combined score given in respect of vital signs, namely, breathing, heart rate, colour, muscle tone, and response to stimuli) was in keeping with her having suffered secondary apnoea, (prolonged bradycardia). Ultimately, his view was that the administration of the syntocinon, on 30 January 2007, at 20h45 ‘was the last straw that broke the camel’s back’.

[21] While agreeing with Prof Smith that the administration of syntocinon at 20h45 was 'the last straw', Prof Coetzee, a specialist obstetrician and gynaecologist, expressed a more nuanced view. He explained that in a normal birth process, contractions by their nature do adversely affect the foetus' heart functions and its perfusion. In a normal process, where there is no augmentation and hyperstimulation, a healthy foetus is able to recover after each contraction and to endure until birth. However, when there is an augmentation, the contractions are stronger, last longer, and are more frequent, which causes the foetus' reserves to be depleted quicker and more profoundly, and reduces the opportunity for the foetus to recover after each episode. According to Prof Coetzee, in this case, where there was augmentation and stimulation with prostins, hypoxaemia was present for some time before delivery, but went undetected because of poor and inadequate monitoring. The administration of the syntocinon at 20h45, indeed, caused the final insult. Prof Coetzee, however, was sceptical of the FHR recordings at 20h30 and 20h45 because there is no CTG available for this period. There was no measurement of the variability of the FHR before, during, and after a contraction, as is required at this stage; consequently, it is not known if there were accelerations or decelerations in the FHR.

[22] Dr Koll, a specialist obstetrician and gynaecologist, essentially agreed with his counterpart, Prof Coetzee, that the foetus must have exhibited bradycardia (a low heart rate) before birth, which was not detected, and must have suffered severe hypoxia prior to birth. However, unlike Prof Coetzee, who was of the view that insidious hypoxia was probably present before the administration of the syntocinon, Dr Koll was of the view that the hypoxic event occurred after 20h45 (after the syntocinon). His views were based on the following:

- (a) the records show that at 20h00 the FHR was 128-132 bpm and the liquor drained was clear; at 20h30 the FHR was 153 bpm, and at 20h45 it was recorded as 150-152 bpm (normal);
- (b) strong contractions are documented at 20h00, 20h30 and 20h45; a high concentration of syntocinon was administered, following (an agreed, injudicious) use of prostaglandins (ie, prostin), which significantly increased the risk of hyperstimulation/tetany;
- (c) the MRI describes an acute profound brain injury. According to Dr Koll, this type of injury is most likely to occur shortly before birth. If it had occurred earlier, the baby

would most likely have been stillborn. According to Dr Koll, if the foetal hypoxia had been severe enough to cause brain injury at the time the monitoring was substandard, a partial, prolonged, or mixed pattern would have been the result.

[23] I should mention that Prof Smith also referred to literature and identified a number of markers that were also evident in this case in support of his view. One of the markers was the fact that the nucleated red blood cell count (NRBC) was significantly elevated at the time of D's birth. She had an NRBC of 34 to 100 white blood cells (WBC) within an hour after birth. Such an elevated NRBC is not found in normal circumstances, and it indicates acute and chronic hypoxia from earlier on in the birth process.

[24] Prof Cooper, a paediatrician/neonatologist, was another expert who had been engaged by the hospital. While he signed a joint minute with Prof J Smith, he was never called to give evidence. His view was that the brain injury was caused by a severe hypoxic ischaemic event that occurred within 10 to 45 minutes prior to the delivery of the baby. However, the experts who were called and gave evidence were all of the view that no single sentinel/catastrophic intrapartum obstetric event caused the brain injury.

[25] Having considered the opinion of the various experts in detail, the high court concluded as follows:

'In the absence of Prof Cooper's untested view to the contrary. . . Prof Smith's evidence and accordingly opinion, supported by numerous literature he referred to for his conclusion that in the absence of a sentinel or catastrophic event, the so called "acute profound injury" developed gradually from subacute and intermittent hypoxic insults that were missed or overlooked over a prolonged period, remains uncontested.'

[26] The high court preferred and accepted Prof Smith's opinion, as being based on logic, supported by expert literature on the topic, and as being consistent with the evidence of the hospital's witnesses. It, however, rejected Dr Koll's theory, because it was not backed by the literature, and did not explain D's elevated NRBC, which was taken one hour after her birth. Prof Smith, on the other hand, was able to explain that elevation, and it was consistent with his opinion about the brain injury.

[27] The high court accordingly concluded, concerning 'the onset of the injury that caused the injury', the following:

'... [T]he plaintiff has established on a balance of probabilities that D suffered a sub-acute or intermittent hypoxic event over a long period of time, more likely beginning from the active phase of labour after the administration of the repeat prostin tablets at 14:00. From the hospital records, about 4 to 4.5 hours later after the prostins were repeated, it is recorded that plaintiff had strong contractions and was 8 to 8.5 cm dilated. As explained by Prof Smith and the obstetricians, the foetus suffers hypoxic events during labour. Due to the augmentation, the contractions were probably more frequent and lasted longer thereby not giving the foetus sufficient time to recover from the interferences. The hypoxic event went undetected for a long period during which time D's oxygen reserves were being consistently depleted. This is supported by the significant increase in the NRBC of 34/100. The administration of syntocinon at 20:45 was the last straw that broke the camel's back as explained by Prof Smith and Prof Coetzee and not the cause of D's injury as postulated by the second defendant.'

[28] The high court cannot be faulted for having accepted Prof Smith's opinion, and to the extent that it was consistent with that opinion, that of Prof Coetzee, and for rejecting the opinions that could not account for all the other anomalies present, such as the elevated NRBC at birth.² The so-called FHR recordings, in the absence of a CTG, and evidence of the proper assessment of the FHR are suspect, and are inadequate and unhelpful, for the reasons given by Prof Smith. The hospital's argument that the reliance by the high court on Prof Smith's opinion was not justified is clearly incorrect. The argument is not based on sound reason, and is purely geared to accommodate the hospital's main contention, namely, that the brain injury only occurred when Dr Ofori was present and in control of the birth process.

[29] Dr Ofori is not contesting the finding by the high court that he was negligent, and he is not party to this appeal. The hospital's contention, absolving it from liability, is essentially, that, from the time Dr Ofori arrived at the respondent's side at 20h30 or 20h45 on 30 January 2007, he was in control: he made the decisions, including the decision to administer syntocinon; he examined the respondent and monitored the labour and decided upon the method of delivery and delivered D at about 21h10 using

² Regarding the proper evaluation and acceptance of expert evidence see *Michael and Another v Linksfeld Park Clinic (Pty) Ltd and Another* [2002] 1 All SA 384 (A); 2001 (3) SA 1188 (SCA) paras 36-40.

a ventouse. The hospital's argument further is that the brain injury was solely due to the negligence of Dr Ofori, and that blaming it on the nursing personnel's failure to properly monitor and record the events was unjustified. The hospital argued that even though it is undisputed that the nursing personnel failed to properly monitor the foetal heart rate between 17h00 and 20h30, on the day of the birth, this did not mean that the nursing personnel's negligence caused the hypoxia or the brain injury.

[30] The cogency of the 'sole control' argument of the hospital is thoroughly undermined by the views of the midwifery expert, Prof Nolte, and its own experts, Dr Harris and Dr Koll. These experts were broadly in agreement on the following. The conduct of the attending midwives fell below the standard expected in that they:

- (a) did not monitor and record the FHR at least in two hourly intervals during the latent phase of labour, and half-hourly during the active phase of labour;
- (b) did not monitor the foetal heart rate with a CTG, before and after the prostin tablets and the administration of the syntocinon;
- (c) did not monitor the respondent's contractions at least hourly after the introduction of the prostin tablets;
- (d) wrote up clinical notes that sometimes did not correspond with the partograph, indicating a less than diligent, if not occasionally haphazard, and inaccurate manner of recording key events.

[31] The midwifery experts were also in agreement that professional midwives ought to have been aware, not only of the risk attendant on augmenting labour with prostaglandins, but also of the greater need to be more vigilant in such cases, and to properly monitor the FHR and the contractions of the patient. The midwives in this case ought to have been so aware, but failed to act accordingly. The hospital did not call any of the attending midwives to testify. The reason given for not calling any of them was not justified. The fact that Sr Ojeng had relocated, was not a sufficient reason for not obtaining her testimony. The case against them thus, effectively, remained unanswered. The high court thus correctly concluded that the midwives were negligent.

[32] The high court found that the midwives' negligence was a factual and legal cause of D's brain injury, albeit jointly with the negligence of Dr Ofori. The hospital's

stance is essentially an attack on the finding of factual causation. Counsel for the hospital argued that the respondent did not prove that the admitted negligent conduct of the hospital's attending nursing/midwifery staff was the factual cause of D's brain injury (ie, the harm), and did not address legal causation at all.

[33] It is trite that causation in the law of delict involves two enquiries, namely (i) whether the defendant's wrongful conduct was a cause in fact of the plaintiff's harm or damage (factual causation); and (ii) if so, whether and to what extent the defendant should be held liable for that harm or damage. The second enquiry has been referred to as an enquiry into the remoteness of the damage, or legal causation.³ The appellant only contests the finding of factual causation. Its argument in that regard is the following; 'Although the nursing personnel can be criticised, rightfully so, for failure to record between 17h00 and 20h30 the foetal heartrate on the partogram, in the follow-up thereto it is clear that such failure had no causal effect in that it cannot be disputed, as testified to and emphasised hereinabove, that it is unlikely (meaning improbable) that there would have been a reassuring CTG at 20h30 if there had been prior hypoxic incidents. No causal negligence is proven. This is what will be relied on to be "negligence in the air"'.⁴

[34] The enquiry into factual causation generally involves the application of the so-called 'but-for' test, which is aimed at determining whether a postulated cause can be identified as a *causa sine qua non* of a particular harm or damage.⁵ In order to apply the test, there must be a hypothetical enquiry as to what probably would have happened but for the unlawful conduct of the defendant. This may usually be achieved by 'mentally eliminating' the unlawful conduct, and then asking whether the harm would still have occurred. If the answer is 'yes, the harm would still have occurred', then the unlawful conduct was not a cause of the harm. However, if the answer is 'the harm would not have occurred', then the unlawful conduct was a cause of the harm.⁶

³ *Siman & Co (Pty) Ltd v Barclays National Bank Ltd* 1984 (2) SA 888 (A) (*Siman*) at 914F-G.

⁴ The appellants rely specifically on what the court said concerning 'negligence in the air' in *M v MEC for Health, Eastern Cape* (699/17) [2018] ZASCA 141 (1 October 2018) paras 64-65.

⁵ *Ibid* at 914H-915A.

⁶ *Ibid* at 915A-H. See also *International Shipping Co (Pty) Ltd v Bentley* 1990 (1) SA 680 (A) at 700F-G.

[35] In *Minister of Safety and Security v Van Duivenboden*,⁷ the following was said regarding the formulation or application of the test:

‘There are conceptual hurdles to be crossed when reasoning along those lines for once the conduct that actually occurred is mentally eliminated and replaced by hypothetical conduct, questions will immediately arise as to the extent to which consequential events would have been influenced by the changed circumstances. Inherent in that form of reasoning is thus considerable scope for speculation which can only broaden as the distance between the wrongful conduct and its effect increases . . . A plaintiff is not required to establish the causal link with certainty but only to establish that the wrongful conduct was probably a cause of the loss, which calls for a sensitive retrospective analysis of what would probably have occurred, based on the evidence and what can be expected to occur in the ordinary course of human affairs rather than an exercise in metaphysics.’⁸

[36] According to the test, the culpable conduct is only a cause of the harm if ‘but for the culpable conduct, the harm would not have occurred. The test, by ‘simple substitution’ yields the rule that in an Aquilian action the plaintiff bears the onus of proving on a balance of probabilities that, ‘but for the culpable conduct in question, the harm in question would not have occurred’.⁹ It is indeed so, that if you can say that the harm would have occurred irrespective of the culpable conduct, then the latter is not the cause of the harm. But it is not a matter of science, mathematics, or philosophy. In cases where the conduct in question constitutes an omission, whether it is a factual cause of the harm, would be a matter of ‘common sense based on the practical way in which the minds of ordinary people work, against the background of everyday-life experiences’.¹⁰

[37] In *ZA v Smith*¹¹ this Court summarised the legal position as follows:

‘The criterion applied by the court a quo for determining factual causation was the well-known but-for test as formulated, eg by Corbett CJ in *International Shipping Co (Pty) Ltd v Bentley* . . . What it essentially lays down is the enquiry – in the case of an omission – as to whether,

⁷ *Minister of Safety and Security v Van Duivenboden* [2002] 3 All SA 741 (SCA); 2002 (6) SA 431 (SCA) (*Duivenboden*).

⁸ *Ibid* para 25.

⁹ That the plaintiff bears such a burden is trite: see, inter alia, *Minister of Police v Skosana* 1977 (1) SA 31 (A) at 45F-G; *Duivenboden* at 449E-F; *Minister of Safety and Security v Carmichele* [2003] 4 All SA 565 (SCA); 2004 (2) BCLR 133 (SCA); 2004 (3) SA 305 (SCA) at 327I-328A.

¹⁰ *ZA v Smith* 2015 (4) SA 574 (SCA); [2015] 3 All SA 288 (SCA) para 30.

¹¹ *Ibid*.

but for the defendant's wrongful and negligent failure to take reasonable steps, the plaintiff's loss would not have ensued. In this regard this court has said on more than one occasion that the application of the 'but-for test' is not based on mathematics, pure science or philosophy. It is a matter of common sense, based on the practical way in which the minds of ordinary people work, against the background of everyday-life experiences. In applying this common sense, practical test, a plaintiff therefore has to establish that it is more likely than not that, but for the defendant's wrongful and negligent conduct, his or her harm would not have ensued. The plaintiff is not required to establish this causal link with certainty (see eg. *Minister of Safety and Security v Van Duivenboden* 2002 (6) SA 431 (SCA) para 25; *Minister of Finance v Gore NO* [2006] ZASCA 98; 2007 (1) SA 111 (SCA) para 33. See also *Lee v Minister of Correctional Services* [2012] ZASCA 30; 2013 (2) SA 144 (CC) para 41).'

[38] Turning to the facts of this case, before the negligent conduct of the attending nurses or midwives could be said to have been a factual cause of D's brain injury (ie, the harm), it must be proved that the injury would not have occurred, but for that conduct. The enquiry may be, what answer the following two questions would yield. First, if they had properly monitored the foetus and the respondent, would D have suffered the injury, in any event? Second, if they did not properly monitor the foetus and the respondent, would D have suffered the injury, in any event? In light of all the evidence, both those questions elicit a negative, common sense, answer, 'probably not'. Those answers are sufficient to find that the respondent discharged her onus.

[39] But for contending that the high court should have accepted Dr Koll's, rather than Prof Smith's thesis, of how and when the brain injury occurred, the hospital has put up nothing of substance, to support its attack on the high court's findings on causation. The experts seem to have been in agreement that if there was proper monitoring, the midwives would have become aware as early as possible of foetal distress, and that this could have been conveyed to Dr Ofori, and that steps could have been taken to prevent irreversible injury to the foetus. Instead, the lack of proper monitoring here seems not only to have been the cause of not becoming aware of any foetal distress and uterine hyperstimulation, which must have been present, but also of the inappropriate further augmentation with prostins and syntocinon, thereby making the birth riskier and increasing the likelihood of injury to the foetal brain, before birth.

[40] The testimony of Prof Smith, Prof Coetzee and Dr Koll was in accord that it was virtually impossible not to have detected an abnormal FHR if it was properly monitored when the syntocinon was being administered. By discontinuing the syntocinon timeously, the brain injury could probably have been averted. Every minute between 20h45 and 21h10 was crucial. According to Prof Smith, had the bradycardia been detected as early as possible, D could have been delivered as quickly as possible with the help of forceps, before the injury occurred. The longer the delay, the greater the risk of the foetus' brain being injured.

[41] The respondent as plaintiff, succeeded in proving, on a balance of probabilities, that the midwifery staff, in attendance at the birth of D, were not only negligent, but that their negligence probably caused D to be born suffering from cerebral palsy. The staff ought to have known of the attendant risks, where the contractions are augmented with oxytocins such as prostin and syntocinon; and they ought to have appreciated the need, in this instance, where there was such augmentation, to properly monitor the foetus and the respondent, by for example using the CTG, and establishing whether there were variations in the FHR, before, during and after a contraction; in so doing, they would have detected foetal distress as soon as it occurred, and the necessary steps could have been taken to reduce the risk of a compromised birth. The CTG reading recorded at 20h30, which the appellant relies on as indicating that there were no prior hypoxic incidents, given the circumstances, could not have been reassuring; and certainly, on its own does not indicate that there were no prior hypoxic events.

[42] The fact that Dr Ofori was present, from about 20h45, until D was born, did not reduce the midwives' responsibility to properly monitor; and keep the attending doctor informed of, inter alia: the condition of the foetus and the respondent at all times during the labour; the nature of the contractions, the FHR; the extent of the dilation of the cervix over the time; and the contra-indication of further augmentation. It was also proved that the midwives ought to have foreseen the debilitating consequences of not monitoring, or properly monitoring, the foetus and the respondent during the labour and birth process before and after Dr Ofori returned.

[43] The high court's findings in the following respects cannot be faulted: that the hospital's attending midwifery staff were causally negligent in the handling of the respondent's labour, not only prior to the administration of the syntocinon at 20h45, but also thereafter; and that their negligence caused the harm suffered by D, and accordingly by the respondent; that the hospital was vicariously liable for the conduct of its midwifery staff; and that the hospital was jointly and severally liable, with Dr Ofori, for the full amount of damages agreed to, or proven by the respondent to result from D's brain injury.

The reconsideration of the costs order

[44] After the high court gave an order in respect of the liability (including costs) on 3 August 2023, the respondent brought an application for the high court to reconsider the costs order that was made. The essence of the application was that two days before the trial commenced, on 17 March 2020, the respondent had made a so-called 'Calderbank offer'¹² to both the hospital and Dr Ofori in terms of which she indicated a willingness to settle if they admitted that they were liable for 85% of her agreed or proven damages.

[45] It is undisputed that both the hospital and Dr Ofori rejected the respondent's offer and that they made counter-offers. The hospital was prepared to settle on the basis, initially, that it was 20% liable, and subsequently increased this to 50%. It is also not disputed that on 3 August 2023, the high court found that the hospital (and Dr Ofori) was liable for 100% of the respondent's proven or agreed damages.

[46] In terms of the 'Calderbank' principle, an offer made by a plaintiff to settle a matter is given the same recognition as an offer made by a defendant to settle a matter, in terms of, for example, rule 34 of the Uniform Rules. And the failure by a defendant to act reasonably in rejecting the plaintiff's offer, may result in the defendant being ordered to pay all the costs (not merely the party and party costs) of the plaintiff from the date of the offer.

¹² See fn 1 above.

[47] In the reconsideration application, the respondent wanted the high court's order of 3 August 2023, dealing with the costs aspect (ie, paragraphs (b) and (b)(v)), to be amended to the effect that the hospital and Dr Ofori, jointly and severally pay, the one paying the other to be absolved, the following:

'(b) . . . [T]he plaintiff's taxed or agreed party and party costs on the High Court scale up to and including 11 March 2023, and from 12 March 2023 the plaintiff's taxed or agreed attorney and own client costs on the High court scale, such costs to include . . .

(v) The costs of the postponement of 18 March 2020.'

[48] In addition, the respondent wanted the hospital and Dr Ofori to pay the costs of the reconsideration application, jointly and severally, on an attorney and own client scale; and the hospital to pay the costs of a semi-urgent application that it had brought to seek directions from the court. The hospital opposed the reconsideration application. After hearing the parties, the high court, in essence, granted the amendment order sought by the respondent, and awarded the costs of the reconsideration application on the scale sought by the respondent, but refused to grant the costs sought in respect of the semi-urgent application. The high court's order, insofar as is relevant, reads as follows:

'72. In the result, I make an order in the following terms:

1. The plaintiff's application for reconsideration of costs granted on 3 August 2023 is granted;
2. Paragraph (b) of the Order of 3 August 2023 is amended to read as follows:

"(b) The defendants are ordered to pay, jointly and severally the one paying the other to be absolved, the plaintiff's taxed or agreed party and party costs on the High Court's scale up to and including 11 March 2020, and from 12 March 2020, the plaintiff's taxed or agreed attorney and own client costs on the High Court's scale, such costs to include:

. . .

(v) The costs of the postponement on 18 March 2020."

3. The defendants are ordered to pay, jointly and severally the one paying the other to be absolved, the costs of this application on the scale as between attorney and own client scale, such costs to include:

3.1 full day fees of Senior Counsel for the duration of the argument of this application; and

3.2 the costs of drafting heads of argument.

4. The application for the urgent application costs is dismissed.

5. The plaintiff is ordered to pay the second defendant's costs occasioned by such opposition.'

[49] The commonwealth cases from which the ‘Calderbank principle’ was derived, emphasise that a plaintiff, who made an offer that turns out to be more generous to the defendant than the subsequent award by the court, is not automatically entitled to attorney/client costs because of its offer. But for such an award, the plaintiff is required to show that the defendant acted unreasonably in not accepting the plaintiff’s offer.¹³ Factors that the court may take into account are not confined to a closed list, and it all depends on the circumstances of each case. ‘Calderbank offers’ serve an important public interest. It is in the wider public interest to conserve and not waste public resources on litigation that could be curtailed or avoided by settlement.¹⁴

[50] In this appeal, the hospital does not dispute the applicability of the ‘Calderbank principle’, but seeks to substitute the high court’s order with an order that the application for reconsideration granted on 3 August 2023 is dismissed with costs. Ultimately, the hospital is contending that the high court erred in making the order it made in that application. It argues, as it contended before the high court, that the conduct of the hospital, in not accepting the respondent’s offer, was ‘throughout reasonable’. One leg of that argument is that the time given by the respondent to the hospital to consider her offer (the *spatium deliberandi*) was too short. The other leg, was that the hospital’s refusal of the offer and its counter-offers of 20% and 50%, respectively, were reasonable.

[51] In coming to its carefully reasoned conclusion, the high court had also considered the conduct of the hospital with regard to the Calderbank offer, and concluded with reference to this Court’s decision, in *Singh and Another v Ebrahim*,¹⁵ that the time for consideration of the offer (the *spatium deliberandi*) only becomes relevant if the party to whom the offer is made accepts the offer, or attempts to accept it, after the expiry date. This was not the case here. The hospital did not complain that it needed more time to consider the offer; it simply rejected the offer, therefore the reasonableness of the *spatium deliberandi* was and is irrelevant.

¹³ *MEC for Health and Social Development* para 61.

¹⁴ See, *inter alia*, *MEC for Health and Social Development; Du Toit NO obo Nkuna v Road Accident Fund* [2024] 4 ALL SA 476 (NCK) para 9.

¹⁵ *Singh and Another v Ebrahim* [2010] ZASCA 145 para 88.

[52] The high court also dealt with the issue of the conduct of the hospital in refusing to accept the offer and concluded that the respondent had made out a proper case for the relief that she sought. The high court, being at the 'coal face' and steeped in the atmosphere of the trial, essentially found that the conduct of the hospital, in the circumstances, was shown not to have been reasonable. The high court pointed out objective factors that should have alerted the hospital to the high risk it was taking in continuing with the litigation.

[53] The high court, in effect, found that the hospital would have known from the joint minutes of the various experts that the midwives' failure to properly monitor the foetus and the respondent played a major role in the unfolding of events. The midwifery experts agreed on the hospital staff's failures in that regard. The high court found that much information, other than the testimony of the witnesses, was available to the hospital by the time the respondent made the offer, to alert the hospital 'to the high risk of continuing with the trial, especially considering the nature of the action and the level of proof that the plaintiff required to succeed'. It was incumbent upon the hospital to properly assess its case and the risk inherent in running a trial. It held that the fact that the hospital and Dr Ofori attributed fault to each other in the pleadings was another factor that ought to have alerted the hospital to the risk it faced.

[54] In deciding whether the costs ought to be on an attorney and own client scale, the high court embarked on a careful balancing of various factors, including D and the respondent's financial position in comparison to that of the hospital. Awarding the respondent anything less than attorney and client costs would mean that the respondent would still have to bear some part of the costs, thus significantly eroding the capital amount that the respondent would be awarded as damages. The high court concluded that the purpose of awarding the costs claimed by the respondent was justified. Its purpose was to 'indemnify' the plaintiff in respect of those costs unjustly incurred as a result of the defendant's unreasonable rejection of the plaintiff's reasonable offer. Those consequences flow naturally from 'Calderbank offers'.

[55] In reconsidering the issue of the costs, the high court exercised a discretion. It is trite that an appeal court will only interfere with the exercise of that kind of discretion if it concludes that the high court has not exercised that discretion judicially, ie, it has

exercised its discretion capriciously, or upon a wrong principle and did not apply its unbiased judgment to the issues raised, etc.¹⁶ It is the task of the hospital to convince this Court that the high court did not exercise its discretion judicially.¹⁷ Unfortunately, the hospital did not discharge that onus. It has not shown any basis upon which this Court could interfere with the high court's discretion regarding the costs. The mere fact that this Court might have made an order that is different from the high court's costs order is not a basis to interfere with the exercise of that court's discretion. The appeal should therefore fail.

[56] The respondent argued that in the event of the appeal being dismissed, the hospital should also be ordered to pay the costs of the appeal on the attorney and own client scale, in light of the offer that she made. Despite the fact of that offer, this Court retains a discretion in respect of costs orders in appeals before it. Having considered all of the facts, it is fair that the costs of the appeal should be on the ordinary scale.

[57] In the result, the following order is made:
The appeal is dismissed with costs.

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JUDGE OF APPEAL

¹⁶ *Merber v Merber* 1948 (1) SA 446 (A) at 452-453; *Levin v Felt & Tweeds Ltd* 1951 (2) SA 401 (A) at 416D-E.

¹⁷ See *Cronje v Pelser* 1967 (2) SA 589 (A) at 593.

Appearances

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