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THE HIGH COURT OF SOUTH AFRICA
MPUMALANGA DIVISION, MBOMBELA MAIN SEAT

Case No: 1491/2017

(1) REPORTABLE: YES

(2) OF INTEREST TO OTHER JUDGES: NO

(3) REVISED.

DATE **11 August 2026**

SIGNATURE

In the matter between:

H[...] M[...] obo T[...] **PLAINTIFF**

And

THE MEC FOR HEALTH, MPUMALANGA PROVINCE **DEFENDANT**

JUDGMENT

RATSHIBVUMO AJP:

Delivered: This trial was heard on 04 & 05, 11-13, 25-26 November 2024 & 29-30 April 2025, and judgment was reserved on 14 May 2026 when the final set of the heads of argument was filed. This judgment was delivered by uploading to CaseLines and by transmission via email to the parties' legal representatives on 11 August 2026.

Introduction.

[1] This is a delictual claim in which the Plaintiff, Ms M[...] H[...], sues for a total of approximately R16 million, in her personal and in her representative capacity for her minor child, T[...], who was born on 19 November 2009 at Piet Retief Hospital. The claim alleges medical negligence by hospital staff during labour and delivery, resulting in the child suffering from cerebral palsy, profound intellectual disability, and epilepsy.

[2] The determination of the merits was separated from the quantum pursuant to an order by Mashile J dated 04 March 2024, as provided under Rule 33(4) of the Uniform Rules. As a result, the trial in this court proceeded on the merits only, with quantum to stand over for later determination depending on the outcome *in casu*. The issues in dispute for determination by this Court were whether the child suffered Hypoxic Ischemic Encephalopathy (HIE) and if so, whether this was as a result of the negligence on the part of the medical staff employed by the Defendant.

Summary of evidence presented by the Plaintiff.

[3] Ms M[...] H[...]: She was the only factual (non-expert) witness and the mother of the child, T[...]. She testified that this was her first pregnancy and that her health and the baby's health were reported as perfect throughout her antenatal visits. She was admitted to Piet Retief Hospital on 17 November 2009 with labour pains.

Initially, upon arrival, she was checked every two hours and was encouraged to walk the passages to encourage labour.

[4] In line with the medical records, she was checked at 20h00 on 18 November 2009 and did not recall being checked again until she was in the labour room in the early hours of the morning, around 04h00. She gave birth at approximately 04h15 on 19 November 2009. According to her, the baby did not cry immediately after birth. She saw the nurses slap the baby's feet, but the child still did not cry. The first time she heard her baby cry was at 05:30, and it was only a "squeaking sound," not a normal loud baby cry.

[5] When she tried to breastfeed, the baby could not suckle. She tried both breasts, but the baby struggled. She noticed the baby's head was "squashed" or flat on one side. When she asked the nurse about it, she was told that it might be the forceps. This is how she learned that the forceps had been used during the child's birth. The hospital did not discharge her immediately. She remained in the hospital for about a week, mainly because the hospital wanted to monitor the baby's condition. For the duration of her stay, the child was placed in an incubator and fed through a nasogastric tube because he could not suckle. At the time she gave evidence, the child was 14 years old and had never sat, stood, walked, or spoken. He cannot eat or bathe on his own and is entirely dependent on her. He has had seizures, and as a result, he is on medication (Epilim) treatment.

[6] Professor Regan Shane Solomons (Paediatric Neurologist): He was the Plaintiff's first expert witness. He is qualified as a paediatric neurologist. He holds a PhD and is a full Professor at Stellenbosch University.

[7] He compiled a medico-legal report on the child based on his own history-taking from the mother, an examination of the child, and a review of both the medical records and a neuro-radiology report. He testified that the Magnetic Resonance

Imaging (MRI) scan showed a partial prolonged hypoxic ischemic injury of the brain. This means the brain was deprived of oxygen and blood supply over a prolonged period (typically 2 to 6 hours). He testified that this injury was consistent with a perinatal hypoxic insult (lack of oxygen before, during, or immediately after birth).

[8] He detailed the child's condition after birth, including poor sucking, feeding via a nasogastric tube, and a record of diazepam (anti-seizure medication) being prescribed. The child experienced convulsions/seizures, and the medical records diagnosed HIE. He explained HIE as a brain pathology caused by inadequate oxygen and blood flow. He concluded that the child suffered from a moderate neonatal encephalopathy.

[9] He excluded other possible causes for the encephalopathy, such as infections, metabolic disorders, or congenital abnormalities. He concluded that on the balance of probabilities, the injury was attributable to the intrapartum period (during labour). As for the current condition of the child, at the age of 14, he was diagnosed with spastic quadriparesis cerebral palsy, microcephaly, profound intellectual disability, and epilepsy.

[10] In conclusion, he testified on a joint minute he prepared with the Defendant's expert, Dr Pais, in which they agreed on the nature of the brain injury, the diagnosis of cerebral palsy, and that evidence pointed towards an intrapartum insult, though the clinical records were "scanty" and inconclusive. He acknowledged there were no major disagreements with the Defendant's expert.

[11] Dr Constant Ndjapa-Ndamkou (Obstetrician and Gynaecologist) (Dr Ndjapa): He is a specialist obstetrician and gynaecologist. He was the Plaintiff's second expert witness and spent three days on the witness stand. He holds a Master's degree and a Fellowship in obstetrics and gynaecology and is a lecturer at the

University of Witwatersrand. He compiled a report on the labour and the child's delivery.

[12] He reviewed the hospital records and the partogram (a graphical record of labour). He testified that the mother was admitted in the latent phase of labour (cervix 1cm dilated). According to the Guidelines, monitoring in this phase should be every 4 hours for the mother and every 2 hours for the foetus. He pointed out that from admission at 20h30 on 17 November, until 06h00 on 18 November 2009, there were no records of the required monitoring, meaning several assessments were missed. The active phase of labour, from 4cm dilatation, started at 20h00 on 18 November 2009. From this point, the Guidelines require the foetal heart rate to be monitored every 30 minutes. He testified there was no evidence that this monitoring was done. He identified a prolonged latent phase of labour, which increases the risk of foetal hypoxia (lack of oxygen).

[13] He testified further that the mother was fully dilated (10cm) at 02h00 on 19 November 2009. The child was delivered by forceps at 04h15. According to him, the period between 02h00 and 04h15, when the child was delivered, was a very critical stage. Unfortunately, the nurses kept no records of foetal monitoring during this 2-hour and 15-minute period. This, he testified, was a significant dereliction of the standard of care.

[14] He also testified that doctors/nurses only use forceps in emergencies, either for foetal distress or maternal exhaustion. He noted that the forceps delivery form was incomplete (missing details on head position, flexion, and maternal consent). He was critical of the forceps procedure, stating that the use of forceps carries a significant risk of injury to the baby's brain (intracranial haemorrhage). He therefore concluded that the standard of care was substandard. The failure to monitor the foetus meant that an evolving hypoxia would have been missed, and

the subsequent use of forceps in that context most likely contributed to the child's current condition.

[15] In conclusion, he testified on a joint minute he prepared with the Defendant's expert, Dr Koll. While they agreed that there was inadequate recording, they disagreed on whether it constituted negligence. His core opinion was that the substandard monitoring and unmonitored second stage of labour were complicated by a birth injury from the forceps application.

[16] Professor Victor Allan Davies (Neonatologist): He is a paediatrician subspecialising in neonatology (the care of newborns). He was the Plaintiff's final witness. He spent over 30 years in academic practice as a neonatologist.

[17] He compiled a report based on the medical records and his experience. He confirmed the brain injury was a "partial prolonged hypoxic ischemic injury," characteristic of repeated episodes of hypoxia over a period. He linked this to the substandard monitoring during labour. While the Apgar scores (8 at 1 min, 10 at 5 min) appeared good, he testified that they cannot be used in isolation to rule out birth asphyxia. He pointed out that the records do not show how the nurses arrived at those specific numbers, which calls their validity into question. He also cited the Medical Guidelines, stating that while a low Apgar score increases the risk of cerebral palsy, a high score (≥7) does not preclude a hypoxic event from playing a role.

[18] He testified further that the child exhibited several key signs of neonatal encephalopathy, including seizures (which can be subtle, like abnormal eye movements), failure to suck (requiring tube feeding), and being described as "weak" and "lethargic" in the medical records. These symptoms are classic signs of a brain injury from hypoxia. He noted the MRI also showed signs of hypoglycaemia (low blood sugar). He explained that hypoglycaemia is often a

consequence of hypoxia, as the brain consumes more glucose when it is starved of oxygen.

[19] He disagreed with the Defendant's expert (Prof. Ballot), who claimed the child had no signs of HIE at birth. He argued that the onset of encephalopathy signs (fits, poor feeding) within the first few days of life is consistent with an intrapartum hypoxic insult. He concluded that the cause of the injury was intrapartum hypoxia. He stated that if the monitoring had been adequate, the foetal distress would likely have been detected, and an earlier delivery (possibly by forceps or caesarean section) could have prevented the injury.

[20] With this evidence, the case for the Plaintiff was closed.

Summary of the evidence presented by the Defendant.

[21] Dr Peter Charles Koll (Obstetrician and Gynaecologist): He was the Defendant's first expert witness. He is a specialist obstetrician and gynaecologist with over 40 years of experience.

[22] He compiled a report based on the hospital records. He also participated in a joint minute with the Plaintiff's obstetric expert, Dr Ndjapa. He agreed with Dr Ndjapa on several points, including that the foetal heart rate monitoring was not recorded as frequently as the guidelines prescribe (every 30 minutes) and that the partogram was incomplete as it stopped at 02h00.

[23] He, however, disagreed that the forceps delivery was complicated or contributed to the injury. He testified that the type of forceps used (Wrigley's forceps) is the simplest kind and is designed for easy outlet deliveries. He noted the procedure took 5 minutes (from 04h10 to 04h15), which he argued was quick and uncomplicated. He pointed out that the delivery note indicated the application was easy, the foetal heart was normal, and the liquor was clear.

[24] He further disagreed that the lack of recording necessarily meant that foetal distress was missed. He explained that foetal distress is a progressive condition. The hypoxic (lack of oxygen) threat to the baby increases as labour progresses and is at its absolute maximum just before delivery. Therefore, if the foetal heart was normal when recorded at 02h00 and again when a CTG was applied just before the forceps delivery, it was extremely unlikely that foetal distress occurred in the interim. He made a critical distinction between monitoring and recording, which he argued was the crux of the case. He acknowledged that the recording of the patient's monitoring was substandard. However, he contended that this does not mean the monitoring itself was not done. He testified that in the second stage of labour, it is common practice and practically difficult for nurses to make contemporaneous records while they are scrubbed and attending to the delivery. They listen to the foetal heart, but it is not always written down.

[25] He testified about the six factors that collectively made an intrapartum hypoxic insult extremely unlikely. First, there was no evidence of foetal distress in the recordings (normal baseline, good variability, no decelerations). Second, there was clear liquor (amniotic fluid), which is a reassuring sign of foetal well-being. Third, the Apgar scores were normal (9/10 and 10/10), indicating a vigorous baby at birth. He argued that a hypoxic baby cannot have normal Apgar scores. Fourth, no resuscitation was required at birth. A hypoxic baby would need resuscitation. Fifth, the baby was fit for discharge on day one. The only reason the baby stayed in the hospital was that the mother needed a blood transfusion. Sixth, there were no symptoms of HIE for 50 hours after birth. He argued that if an intrapartum insult had occurred, signs of HIE would appear within hours of birth, not two days later.

[26] Under cross-examination, he conceded that the head's level and position, which are essential for a safe forceps delivery, were not recorded on the forceps

form. He, however, maintained that this omission did not matter in this specific case because the forceps application was easy and quick. He further conceded that while it is theoretically possible for a foetus to suffer an insult within a two-hour window and then appear normal, this possibility was very minimal.

[27] Professor Daynia Elizabeth Ballot (Neonatologist): She was the Defendant's second and final expert witness. She is a Professor of Neonatology at the University of the Witwatersrand. She is a neonatologist, specialising in the care of newborn babies. She reviewed the medical records and prepared a report. She also participated in a joint minute with the Plaintiff's neonatologist, Professor Davies.

[28] Her central and most strongly argued opinion was that the child did not have HIE at birth. She described HIE as a clinical condition that occurs within the first 6 to 12 hours of life. The reasons for her opinion were the following. The baby had Apgar scores of 9 and 10, which is normal and indicates a baby who is pink, vigorous, and well. The baby did not require any resuscitation at birth. The initial physical assessment of the newborn, documented in the records, signified a completely normal newborn. The baby was noted to be crying, breathing, and reacting normally. The baby was not admitted to the Neonatal Intensive Care Unit immediately, but was sent to lie-in with his mother, which would not have happened if he were suspected of having HIE. She focused heavily on the fact that the baby only became sick on 21 of November 2009, some 50 hours after birth. She stated emphatically that HIE from an intrapartum event presents at birth or within the first day of life. A baby cannot be normal for two days and then develop HIE afterwards. She opined that the child’s later illness was a neonatal encephalopathy, but it was not caused by intrapartum hypoxia.

[29] She agreed that the MRI showed a hypoxic brain injury, but she argued that this does not prove that the injury happened during birth. She stated that the MRI

pattern can be caused by an insult occurring between 36 weeks of gestation and about 52 weeks post-conception (i.e., before, during, or shortly after birth). The MRI cannot pinpoint the exact timing. She also acknowledged that other causes, such as genetics and infection, were excluded, but she maintained that this does not necessarily mean the cause was intrapartum hypoxia.

[30] She downplayed the mother's testimony of the baby not crying and having sucking problems, stating that failure to cry and difficulty latching are common in first-time mothers and are not necessarily signs of encephalopathy. She opined that the mother's recollection, given 15 years after the event, was less reliable than the contemporaneous medical records, which showed the baby was normal at birth.

[31] Importantly, she dismissed the later medical record entry that suggested that the child suffered HIE. She stated this was a common error made by junior doctors who see a forceps delivery and seizures and automatically write “query HIE”, but this is not a reliable diagnosis and contradicts the clinical picture of a baby who was well at birth.

[32] Under cross-examination, she was asked about the period of no monitoring (the 2-hour gap), which she deferred to the obstetric expertise. She conceded that the recorded monitoring was substandard. She confirmed that the baby was encephalopathic at 50 hours of age but opined that the timing of the illness was incompatible with HIE, which is a condition of the early neonatal period.

[33] With this evidence, the case for the Defendant was closed.

Plaintiff’s heads of argument.

[34] In the closing argument, counsel for the Plaintiff submitted that the Defendant was liable for the child’s cerebral palsy because the hospital staff were negligent, and this negligence caused the child’s brain injury. The Plaintiff heavily

relied on admissions noted in the Rule 37A joint statement, where the following admissions were noted:

a) The child suffered a watershed (partial prolonged pattern) hypoxic ischaemic brain injury.
b) The child suffered a "moderate neonatal encephalopathy."
c) The antenatal course was normal.
d) The midwives delivered "sub-standard care" by failing to record maternal and foetal observations according to the 2007 Maternity Guidelines.
e) Foetal and maternal observations were not recorded between 20h00 on 18 November and 04h00 on 19 November 2009 (the critical two-hour gap before delivery).
f) The foetal heart rate was only recorded two-hourly during the active phase, not every 30 minutes as required.

[35] It was further submitted that because the brain injury and the substandard care are admitted, the only logical conclusion is that the substandard care caused the injury. The Plaintiff points out that all other potential causes, such as genetic, metabolic, and congenital causes, have been excluded. Therefore, the failure to monitor the foetus during the dangerous second stage of labour meant that foetal distress was missed, and an opportunity to intervene and prevent the injury was lost. It was further submitted that the mother's testimony to the effect that the baby did not cry, could not suckle, had a squashed head, and showed signs of seizures immediately after birth was largely uncontested. This evidence is crucial and proves the injury was present from birth, contradicting the Defendant's experts.

Defendant’s heads of argument.

[36] The Defendant argued that Dr Koll admitted that the monitoring was substandard but claimed it didn't matter. His key argument that the baby was

normal for 50 hours is refuted by the mother's evidence of immediate problems. The Plaintiff also noted that Dr Koll admitted “a small possibility” of an insult occurring in the unmonitored two-hour window. As for Professor Ballot, the Plaintiff argued that her evidence was biased, in that she inappropriately elevated the six-hour window for therapeutic cooling into a rigid diagnostic criterion, ignoring medical literature showing that signs of brain injury can evolve over time. She also relied heavily on incomplete hospital records, which the Plaintiff argued were inadmissible hearsay because the authors were not called to testify.

[37] The Defendant concluded by submitting that the child’s later illness was not a new event but the progression of the existing injury. This view, so it was argued, was supported by medical literature such as *Sato et al* and shows that "parasagittal" injuries often have delayed and progressive clinical manifestations. The hospital records of dehydration and the prescription of hypertonic glucose were evidence that the child was not well from birth and that the injury was evolving. The court was therefore asked to find that the Plaintiff's case was proved on the balance of probabilities and to award her the costs.

[38] The Defendant submitted that, while there were some lapses in record-keeping, they did not cause the child's injury and that the injury was not due to intrapartum hypoxia. The Defendant argued that the child did not suffer from an intrapartum hypoxic insult. The Defendant’s key submission is that the baby was born in good condition in that he had high Apgar scores (9/10 and 10/10), did not require resuscitation, and was clinically well for the first 50 hours of life. The Defendant's expert, Dr Koll, conceded that the monitoring recording was substandard. However, he argued that this does not mean the monitoring itself was also substandard or was not done. He explained that it is common practice not to record every foetal heart rate auscultation in the second stage of labour because it is impractical for nurses to write everything down while attending to the delivery.

[39] The Defendant placed emphasis on Dr Koll's opinion that foetal distress is a progressive condition. Because the foetal heart rate was normal at 02h00 and again at 04h10 when the CTG was applied just before the forceps delivery, it was extremely unlikely that distress occurred in that two-hour window. He stated that while it is theoretically possible, it was a very low possibility.

[40] It was submitted by the Defendant that, in line with Professor Ballot's evidence, while the MRI shows a brain injury, the timing was unknown. It could have occurred before labour (antepartum) or after birth (postnatal). The fact that the baby showed no signs of HIE at birth proves it did not occur during labour (intrapartum). Professor Ballot testified that HIE must appear within the first six hours of life. According to her, the HIE diagnosis in the hospital records was erroneous. She claimed it was a "query" made by a junior doctor who saw a forceps delivery and seizures and assumed HIE, whereas the clinical evidence contradicts this diagnosis. She argued the child had a neonatal encephalopathy, but its cause was not intrapartum hypoxia.

[41] In conclusion, the Defendant argued that the Plaintiff failed to prove a causal link between the admitted substandard care and the child's cerebral palsy. The Defendant's contention is therefore that the child's injury would have occurred regardless of the monitoring failures. For these reasons, the Court was asked to dismiss the Plaintiff's claim with costs.

[42] **Common cause facts.**

42.1 The Plaintiff's antenatal course was normal**,** with no recognised complications or conditions that could negatively affect the birth of the child.

42.2 At the time, growth parameters for the baby were normal for a term infant. There were, as such, no risk factors, such as intrauterine growth retardation.

42.3 The Plaintiff was admitted to Piet Retief Hospital on 17 November 2009.

42.4 She was fully dilated (10 cm) at 02h00 on 19 November 2009.

42.5 The baby was delivered by forceps due to a delayed second stage of labour at 04h10 on 19 November 2009.

42.6 The recording of the care given by the midwives who cared for the Plaintiff during labour was substandard in that they did not record maternal and foetal observations as prescribed by the 2007 Maternity Guidelines during both the active and latent phases of labour.

42.7 The foetal and maternal observations were not recorded between 20h30 on 17 November 2009, when the Plaintiff was admitted, and 06h00 the next morning, when she was one cm dilated.

42.8 The foetal heart rate was only recorded two-hourly on the partogram during the active phase, instead of the prescribed half-hourly intervals.

42.9 There was no record of blood sugar monitoring and no documented episodes of hypoglycaemia (low blood sugar) during the unmonitored or unrecorded period.

[43] **Facts in dispute.**

43.1 The most critical dispute in the entire trial is with respect to the timing of the brain injury, as to when it happened. According to the Plaintiff, it occurred during labour (intrapartum). The Defendant argued that it could have happened before labour (antepartum) or after birth (postnatal). They argue that because the baby was born with normal Apgar scores and showed no signs of HIE in the first hours of life, the injury could not have occurred during labour.

43.2 Did the child suffer from HIE? The Plaintiff's version is that the child suffered from HIE, whereas the Defendant's version is that he did not.

43.3 The Significance and value of the Apgar Scores. According to the Plaintiff, the Apgar scores (9/10 and 10/10) are unreliable and cannot be used in isolation to prove the baby was healthy. According to the Defendant, the Apgar scores

are highly significant. A baby with such high scores cannot be hypoxic. A hypoxic baby would be "flat" (depressed), have a slow heart rate, and need resuscitation. The fact that the baby had perfect Apgar scores proves he was born in good condition and did not suffer intrapartum asphyxia.

43.4 Causation is also in dispute. Did the Monitoring Failure cause the Injury? According to the Plaintiff, there is a direct causal link. The sub-standard monitoring (failing to check the foetal heart rate every 30 minutes in the active phase, and the complete lack of monitoring in the last two hours) meant that foetal distress was undetected. If the distress had been detected, an emergency delivery (by forceps or caesarean) could have been performed sooner, and the brain injury would have been prevented. According to the Defendant, there is no causal link. Even though the monitoring was substandard, it did not cause the injury. Based on the monitoring readings, from the little that was recorded, the baby was not in distress. Earlier intervention would not have changed the outcome. The injury would have occurred regardless.

43.5 The Significance of the lack of records. According to the Plaintiff, the absence of records is evidence that the monitoring was not done. The lack of records is in itself evidence of negligence. According to the Defendant, the absence of records does not establish that monitoring was not conducted. It could be evidence that the nurses were monitoring her but were too busy to record the findings.

43.6 The impact of Forceps Delivery. According to the Plaintiff, forceps delivery must have been complicated and risky, and 5 minutes was a long time for a forceps delivery. The forceps form was incomplete and missing information on the position of the child’s head, which increased the risk of injury. According to the Defendant, forceps delivery was uncomplicated and safe. The type of forceps used (Wrigley's forceps) is the simplest, and 5 minutes is a normal duration for the procedure. The delivery note indicated that the application was “easy” and there were no records of injury to the baby from the forceps.

Evaluation.

[44] The Supreme Court of Appeal summarised the approach of a trial court in evaluating evidence by expert witnesses in *Michael and Another v Linksfield Park Clinic PTY LTD and Another*[1] as follows:

> "[36] That being so, what is required in the evaluation of such evidence is to determine whether and to what extent their opinions advanced are founded on logical reasoning. That is the thrust of the decision of the House of Lords in the medical negligence case of *Bolitho v City and Hackney Health Authority* [1998] AC 232 (HL (E)). With the relevant *dicta* in the speech of Lord Browne-Wilkinson we respectfully agree. Summarised, they are to the following effect.
>
> [37] The Court is not bound to absolve a defendant from liability for allegedly negligent medical treatment or diagnosis just because evidence of expert opinion, albeit genuinely held, is that the treatment or diagnosis in issue accorded with sound medical practice. The Court must be satisfied that such opinion has a logical basis, in other words that the expert has considered comparative risks and benefits and has reached 'a defensible conclusion' (at 241G - 242B).
>
> [38] If a body of professional opinion overlooks an obvious risk which could have been guarded against, it will not be reasonable, even if almost universally held (at 242H).
>
> [39] A defendant can properly be held liable, despite the support of a body of professional opinion sanctioning the conduct in issue, if that body of opinion is not capable of withstanding logical analysis and is therefore not reasonable…"

[45] The Defendant's expert witnesses want the court to believe that the fact that nothing was recorded in the file does not mean that there was no monitoring at all. They suggest that there may have been proper monitoring that was just not recorded. Had there been a proper recording, it could have reflected that the child did not suffer HIE during birth or at the hands of the hospital staff. In other words,

[1] 2001 (3) SA 1188 (SCA).

the HIE could have happened long after the child was born and discharged. They align their reasoning with the Apgar score recorded in the file.

[46] The Apgar score and the scant hospital records led the Defendant's expert witness to submit that the baby was "fine" at birth. It should be noted that both Dr Koll and Prof Ballot admit that the hospital's record-keeping and monitoring were undeniably substandard. It is inherently contradictory to champion the absolute reliability of the hospital's Apgar scores and post-natal assessments while simultaneously acknowledging that the very same staff failed spectacularly in their mandatory monitoring and recording duties during labour.

[47] This view should be assessed against the evidence led regarding how the Apgar score is determined. Based on the evidence given by the expert witnesses in this trial, the Apgar score is determined by a standardised scoring system applied to a newborn baby immediately after birth. It is assessed at 1 minute, 5 minutes, and 10 minutes after birth. If the scores are low at 1 and 5 minutes, the test is repeated at 10 minutes. It is performed by the attending midwife, nurse, or doctor who is present at the delivery. The score is calculated by evaluating a baby on five criteria, with each criterion receiving a score of 0, 1, or 2. The total score is out of 10. The five criteria (as described in the trial context) are:

(i) Heart Rate: The baby's pulse.

(ii) Respiratory Effort: The baby's breathing (whether it is normal, slow, or absent).

(iii) Muscle Tone: The baby's activity and movement (whether the limbs are flexed and active, floppy, or limp).

(iv) Reflex Irritability: The baby's response to stimulation (such as a gentle slap on the feet or suctioning the nose). This includes the baby's **cry** or grimace.

(v) Colour**:** The baby's skin colour (whether it is pink, blue in the extremities, or blue/pale all over).

[48] Against this backdrop, it should be remembered that both the Plaintiff's and Defendant's expert witnesses (including Prof Solomons, Dr Ndjapa, and Dr Koll) agreed that the Apgar score cannot be used in isolation to determine if a baby suffered from birth asphyxia (lack of oxygen). It only gives a snapshot of the baby's condition at that exact moment. To truly know if a baby was hypoxic, you need to test the umbilical cord blood for acid-base balance (pH and base deficit). This measures the baby's metabolic state. This test was not done in this case. These sentiments were echoed by the Defendant's expert witness, Dr Koll, who said that the normal Apgar scores were just one part of a larger picture. According to him, the Apgar score was just one of six factors.

[49] Subjectivity: Both the Plaintiff and Defendant's expert witnesses noted that the Apgar score involves a degree of subjective interpretation. One nurse might score a baby a 6, while another might score the same baby an 8 or a 9. Prof Solomons referenced the guidelines (ACOG - American College of Obstetricians and Gynaecologists), which state that a low Apgar score does not predict individual neonatal mortality or neurological outcome, and a high score does not guarantee the baby is free from brain injury.

[50] The "Not Crying" Dispute: A major point of contention was the baby's cry. Professor Ballot argued that "crying is not part of the Apgar score," claiming the score is about *breathing* and *reflexes*. However, the Plaintiff's Supplementary Heads of Argument strongly contested this, pointing to medical literature (the

"Not Crying After Birth" study)[2] and Volpe's textbook, which state that apnoea (absence of crying/breathing) is part of the respiratory effort and reflex evaluation in the Apgar score. The court will never be certain as to how authoritative this literature is in medical circles, now that the contents were not made available to the expert witnesses at the time they gave evidence. I am, however, mindful of the fact that the Plaintiff's heads of argument were made available to the Defendant. They had all the opportunity to contest the argument if the literature was not authoritative, and they did not. For this reason, there is credence in the Plaintiff's submission in this regard.

[51] Prof Ballot's dismissal of the Plaintiff's direct, uncontroverted observations of the baby's twitching, rolling eyes, and inability to suckle—attributing them merely to the inexperience of a teenage mother—lacks logical merit and is speculative. The mother's evidence was direct and was not disputed by either the staff present or the file records. It cannot be easily rejected based on speculation that is not supported by facts, records, or medical opinion. Her observations align perfectly with the clinical picture of evolving neonatal encephalopathy described by Prof Davies and the medical literature. As Prof. Davies logically explained, an MRI scan confirmed a prolonged partial hypoxic-ischaemic injury, an injury that evolves cumulatively over time.

[52] I am inclined to agree with the submission that the Apgar scores were unreliable for the following reasons: The hospital records do not show *how* the nurses arrived at those numbers (there is no breakdown of the 5 individual criteria). Again, the mother's undisputed evidence was that the baby did not cry at birth and was not breathing normally (the nurses had to pat the baby to try and get a response). This directly contradicts a perfect score, suggesting the Apgar score may have been recorded incorrectly or was a "rough estimation."

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[2] The was referenced in the supplementary heads of arguments as Ashish Kc, et al. *Not Crying After Birth as a Predictor of Not Breathing. Pediatrics* 2020; 145 (6): e20192719. doi: 10.1542/peds.2019-2719

Causation.

[53] On the issue of factual causation, the test remains the "but-for" test. This was applied with the flexibility endorsed by the Constitutional Court in *Lee v Minister for Correctional Services*[3] when it said,

> "With reference to the *onus* resting on the plaintiff, it is sometimes said that the prospect of avoiding the damages through the hypothetical elimination of the wrongful conduct must be more than 50%. This is often followed by the criticism that the resulting all-or-nothing effect of the approach is unsatisfactory and unfair. A plaintiff who can establish a 51% chance, so it is said, gets everything, while a 49% prospect results in total failure. This, however, is not how the process of legal reasoning works. The legal mind enquires: What is more likely? The issue is one of persuasion, which is ill-reflected in formulaic quantification. The question of percentages does not arise (see to this effect Baroness Hale in *Gregg v Scott*). [*Everfresh Market Virginia (Pty) Ltd v Shoprite Checkers (Pty) Ltd* 2012 (1) SA 256 (CC) (2012 (3) BCLR 219; [2011] ZACC 30) (*Everfresh*).] 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 ordinary person's mind works against the background of everyday-life experiences.

[54] In medical negligence cases involving omissions such as the failure to monitor, the court must ask whether, had proper monitoring occurred, the harm would probably have been prevented. In the absence of evidence evincing proper monitoring of the Plaintiff, it can be safely concluded that there was no monitoring for the period not reflected on record. What would have been found if there was proper monitoring remains anyone's guess, and so is the prevention of the intrapartum hypoxic insult.

[55] In *Oppelt v Department of Health, Western Cape*,[4] the Constitutional Court held,

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[3] 2013 (2) SA 144 (CC) para 47-48.
[4] 2016 (1) SA 325 (CC) at para 78-79.

> [78] Crucial to the determination of negligence was the four-hour period calculated from the time of the injury, approximately 14h15. Although there is evidence showing that the closed reduction procedure was sometimes performed at Groote Schuur, for all practical purposes the arrival of the applicant at Groote Schuur at 17h40 followed by his medical examination at 18h00 lessened the probability of a closed reduction procedure being concluded within four hours, and thus prevented the probability of recovery by treatment there.
>
> [79] The applicant arrived at Wesfleur Hospital at 15h15. He could have been transferred directly to Conradie and treated there with closed reduction within the four-hour period. Was the failure to do this negligent? The first part of the negligence enquiry, foreseeability of the possibility of harm, has clearly been established. It is the general foreseeability of the possibility that must be established, which is not dependent on specific knowledge of Dr Newton's four-hour theory. And that was common cause on the evidence. The second part, preventability, is somewhat trickier. The minority judgment holds that the applicant failed to discharge the onus of proving this requirement. As I understand the underlying reasoning, it is based primarily on two considerations.

[56] The Defendant's staff had a legal duty to monitor the foetal heart rate every 30 minutes during the active phase, and more frequently during the second stage of labour. Dr Koll conceded that the purpose of such monitoring is the early detection of foetal distress. He conceded that an umbilical cord occlusion could cause distress. By failing to monitor the foetus for several hours—most critically during the delayed second stage between 02:00 and 04:10—the staff closed their eyes to the foetus’s condition.

[57] The argument that a single “normal” CTG reading before the forceps delivery absolves the Defendant is rejected. As Dr Ndjapa correctly stated, a single reading without the context of continuous monitoring cannot establish foetal well-being over the preceding hours. Had the staff monitored the plaintiff properly, the evolving hypoxia would have been detected, and interventions (such as an earlier

forceps delivery or an emergency caesarean section) would have been implemented, thereby preventing the prolonged partial hypoxic injury.

[58] I am satisfied that the Plaintiff's expert witnesses provided a logical, coherent, and medically sound sequence of events: the failure to monitor led to undetected foetal distress during a prolonged second stage of labour, resulting in a hypoxic-ischaemic brain injury, which manifested in neonatal encephalopathy and culminated in cerebral palsy.

Conclusion.

[59] The Plaintiff has discharged the onus of proving, on a balance of probabilities, that the Defendant's employees were negligent in their care and monitoring of the Plaintiff and her unborn child. Furthermore, this negligence was the cause of the hypoxic-ischaemic injury and resultant cerebral palsy suffered by the Plaintiff's child.

Order.

[60] For the reasons above, I make the following order:

60.1 The Defendant is liable for 100% of the Plaintiff's agreed or proven damages arising from the hypoxic-ischaemic brain injury and resultant cerebral palsy sustained by the minor child, T[...].

60.2 The Defendant is ordered to pay the Plaintiff's costs in respect of the merits of the claim, such costs to include the qualifying, preparation, and attendance fees of the Plaintiff's expert witnesses.

60.3 The determination of the quantum of damages is postponed *sine die*.

TV RATSHIBVUMO
ACTING JUDGE PRESIDENT
MPUMALANGA DIVISION OF THE HIGH COURT

APPEARANCES:

FOR THE APPLICANT:	**ADV. D BROWN**
INSTRUCTED BY:	**DU PLESSIS ATTORNEYS**
C/O:	**DU TOIT SMUTS & PARTNERS** **NELSPRUIT**
FOR THE RESPONDENT:	**ADV. MS NGOMANE AND *POSTEA*** **ADV. LA SHIVITI**
INSTRUCTED BY:	**STATE ATTORNEY** **MBOMBELA**
C/O:	**TH MATHEBULA INC** **MBOMBELA**
DATES HEARD:	**04 & 05, 11-13, 25-26 NOVEMBER 2024 &** **29-30 APRIL 2025**

JUDGMENT RESERVED ON: **14 MAY 2026**[5]

JUDGMENT DELIVERED ON: **11 AUGUST 2026**

[5] Following the closure of the Defendant's case on 30 April 2025, the matter was postponed to allow the filing of the heads of argument. These were only filed by the Plaintiff on 07 October 2025 and by the Defendant on 06 March 2026, with the Plaintiff's supplementary heads being filed on 14 May 2026. While awaiting the heads, further development occurred, including the termination of the Defendant's attorneys' mandate, resulting in further delays in filing them.