

**IN THE HIGH COURT OF SOUTH AFRICA
KWAZULU-NATAL DIVISION, PIETERMARITZBURG**

Case no: 3597/2018P

In the matter between:

M[...] T[...] N[...] M[...]

(obo A[...] M[...])

Plaintiff

and

**MEC FOR HEALTH FOR THE PROVINCE
OF KWAZULU-NATAL**

Defendant

ORDER

The following order is made:

1. The defendant shall pay to the plaintiff's attorneys in favour of the plaintiff a total amount of **R13 159 579.68** which amount is made up as follows:

- 1.1 For past medical and related expenses, the amount of **R674 462.01**;
- 1.2 For loss of earnings, the amount of **R996 512.00**;
- 1.3 For the costs of adaptations to a home for the accommodation of the minor child, A[...], the amount of **R1 025 379.00**;
- 1.4 For transport the amount of **R903 644.00**;
- 1.5 For attendance at a special needs school, the amount of **R918 868.00**;

- 1.6 For caregiving and related expenses, the amount of **R4 788 262.00**;
 - 1.7 For case management, the amount of R491 398.00;
 - 1.8 For general damages, the amount of R2 500 000.00;
 - 1.9 For the costs of the creation and administration of a trust in respect of the award of compensation in terms of this order an amount of R871 054.72
2. The defendant is directed to make payment of the sum of R10 659 579.68, the judgment amount less the interim payment of R2 500 000.00,
- 2.1 To be paid within (thirty) days of the date of the order, failing which the defendant will be liable for interest at the rate of 11.75% per annum, from the date of this order to date of payment, both days inclusive; and
 - 2.2 Into the plaintiff attorney's bank account, with the following details:

Bank:	F[...] N[...] B[...]
Branch:	M[...], D[...]
Trust Account in the name of:	A[...] D[...] S[...] A[...]
Trust Account Number:	6[...]
Branch Code:	2[...]
3. The defendant is directed to pay the plaintiff's reasonable and necessary taxed or agreed party and party costs on the high court scale, such costs to include but not be limited to:
- 3.1 The costs of the plaintiff's attorney attending upon reasonable and necessary consultations with witnesses in preparation for this hearing, including the consultations with the undermentioned expert witnesses;
 - 3.2 The costs of two counsel (senior and junior), with the reasonable and necessary costs of senior counsel up to the maximum rate or part thereof set out in Scale C of Uniform rule 69(7), at the discretion of the taxing master; and the reasonable and necessary costs of junior counsel up to the maximum rate or part thereof as set out in Scale B of Uniform rule 69(7), at the discretion of the taxing master, including the reasonable and necessary costs of their preparation for this hearing (as determined and at the sole discretion of the taxing master), for drafting and preparing heads of argument and for their attendance upon consultations with the under-mentioned expert witnesses and the plaintiff for this

hearing; the qualifying fees of the under-mentioned expert witnesses, including the costs of their reports, supplementary reports and joint minutes, to qualify themselves to testify at this hearing and for any reasonable and necessary consultations with the plaintiff's attorney and counsel for this hearing, as determined by the taxing master namely:

- 3.2.1 **Sue Anderson**, Nursing Sister;
- 3.2.2 **Grace Hughes**, Physiotherapist; (including her reservation fee for 3 and 4 June 2024);
- 3.2.3 **Jane Bainbridge**, Occupational Therapist (including her reservation fee for 3 and 5 June 2024).
- 3.2.4 **Mandy Read**, Dietician;
- 3.2.5 **Dr. R Campbell**, Life Expectancy Expert (including his reservation fee for 6 and 7 June 2024)
- 3.2.6 **Dr. M E Mayat**, Dental Surgeon;
- 3.2.7 **Kasia Hrabar**, Architect;
- 3.2.8 **Sonia Hill**, Industrial Psychologist;
- 3.2.9 **Rochelle Thanjan**, Speech Therapist (including her reservation fee for 4 June 2024)
- 3.2.10 **Maureen Casey**, AAC Expert;
- 3.2.11 **Darryl Grobbelaar**, Orthotist & Prosthetist;
- 3.2.12 **Dr R Fraser**, Orthopaedic Surgeon;
- 3.2.13 **Dr. I Ganie**, Radiologist;
- 3.2.14 **Dawid Marais**, quantity surveyor; and
- 3.2.15 **Mr. G Whittaker**, actuary (report only).

4. The plaintiff's aforesaid attorney of record is hereby directed, upon receipt of the monies being paid to it by the defendant as aforesaid, to:

- 4.1 Hold all monies in trust pending the formation of the Trust as aforesaid;
- 4.2 Pay the trustees remuneration (which shall include the costs of the formation thereof, the costs of administering the Trust, the costs of the trustees furnishing annual security, and obtaining an annual security bond to meet the requirements of the Master of the High Court in terms of

section 6(2)(a) of the Trust Property Act 57 of 1988, in the sum of R871 054.72 directly to the Trust upon it being informed; and

4.3 Pay the net balance of the monies received pursuant to this order to the Trust after all costs, fees, disbursements, and expenses have been deducted therefrom.

5. The trial in respect of all other outstanding claims is adjourned *sine die* for the later determination.

JUDGMENT

Chithi AJ:

Introduction

[1] The plaintiff in this action sues the MEC for Health for the Province of KwaZulu-Natal in her capacity as a mother and natural guardian of her minor child, who was born on 14 July 2015 at Christ the King Hospital in Ixopo, for damages arising from the brain injury the minor child suffered at the time of her birth. For the purposes of this judgment, I shall refer to the minor child as AM. The issue of liability was resolved 100% in favour of the plaintiff on 9 July 2020. The defendant has already paid the plaintiff interim payment in the sum of R2 500 000.00 in terms of Uniform rule 34A.

[2] At the commencement of the trial, the parties agreed that all the issues relating to the public healthcare defence are to stand over for later determination on dates to be arranged with the registrar. Those issues include the following:

(a) whether the defendant is capable of providing the services/interventions/therapies and equipment found to be reasonable and necessary and in respect whereof the plaintiff has not been compensated in terms of paragraph 1 above; and

- (b) Speech therapy including speech therapy equipment, AAC equipment, multidisciplinary meetings, and small group therapy;
- (c) Physiotherapy including multidisciplinary meetings, parent and caregiver training, and home visits;
- (d) Occupational therapy including multidisciplinary meetings and caregiver training;
- (e) Physiotherapy equipment;
- (f) Occupational therapy;
- (g) Equipment recommended by an orthoptist;
- (h) Nursing recommendations for the treatment of pressure sores, and the provisions of equipment, nappies, and related items;
- (i) Dietetic consultations, testing, supplementation, and equipment;
- (j) Orthopaedic related surgical procedures;
- (k) Neurological assessments, medications, serums drug level tests and treatment of chest infections; and
- (l) where the court is not convinced that particular and specific services/interventions/therapies and equipment can be provided by the defendant at a level equivalent or superior to that available in the private sector such costs should be determined by the court.

The issues

- [3] The only issues which this court was called upon to determine are following:
- (a) Life expectancy of AM;
 - (b) General damages;
 - (c) Loss of earnings;
 - (d) Caregiving and related expenses;
 - (e) Case management;
 - (f) The reasonableness of providing cupboards in the house for the live in caregiver and provision for security and backup battery for short term electricity failures. The costs of each of these items was agreed to be a sum totalling R43 466.55 but reasonable requirement of these items was in dispute; the costs of the

adaptation of the plaintiff's home or the costs of the construction of a suitably adapted home have been agreed in the amount of R980 423.79;

(g) Transport requirements of AM;

(h) The costs associated with AM attending Pathways Stimulation Centre ('Pathways').

Heads of damages agreed upon

[4] By the time the parties rendered their closing argument there was agreement between the parties on the following heads of damages:

(a) The plaintiff's past medical and related expenses in the sum of R674 462.01.

(b) The costs of the adaptation of the plaintiff's home in the sum of R980 423.79.

(c) The costs of the creation and administration of a trust at 7.5% of the capital amount awarded.

(d) The general contingency deduction of 15% in respect of the loss of earnings.

Bundles of documents and exhibits

[5] For the purposes of the determination of the issues several experts had assessed AM and compiled the requisite reports. At the outset of the trial, the parties handed in bundles of documents to be admitted in evidence. Bundle A is the Uniform rule 37 documents. Bundle B is the index to the joint minutes of experts. Bundle C is the plaintiff's expert reports comprising 8 volumes. Bundle D is the defendant's expert reports comprising 4 volumes. Bundle E were the therapy and progress reports. Bundle G¹ is the index to literature. In addition, the working notes of Ms Heather Grace Hughes were admitted as Exhibit 1. The memory stick of the videos, which were taken by the plaintiff, was admitted as Exhibit 2. The article by Strauss *et al*, titled: 'Life expectancy in

¹ When the parties labelled the bundles, they inadvertently labelled the next bundle as Bundle G instead of Bundle F.

cerebral palsy: an update'² was admitted as Exhibit 3. The notice in terms of Uniform rule 36(9)(a) and (b), under case number 1113/2014 was admitted as Exhibit 4.

Joint minutes

[6] The joint minutes in Bundle B comprised the joint minutes of:

- (a) The physiotherapists, Ms Heather Grace Hughes, and Ms Pam Dawson;
- (b) The dieticians, Ms Mandy Read and Ms Phumelele Mthembu;
- (c) The industrial psychologists (loss of earnings), Ms Sonia Hill and Mr Gideon de Kock;
- (d) The occupational therapists, Ms Jane Bainbridge, and Ms Helene Prinsloo;
- (e) The dental surgeons, Dr. Mayat and Dr. Singh;
- (f) The orthopaedic surgeons, Dr Fraser, and Dr. Osman;
- (g) The physiotherapists, Ms Heather Grace Hughes, and Dr. Sholena Narain;
- (h) The amended joint minutes of the occupational therapists, Ms Jane Bainbridge, and Ms Helene Prinsloo;
- (i) The updated joint minutes of dieticians, Ms Mandy Read and Ms Phumelele Mthembu;
- (j) The architects, Ms Kasia Hrabar, and Mr Roger Kerr;
- (k) The updated joint minutes of industrial psychologists (loss of earnings) Ms Sonia Hill and Mr Gideon de Kock;
- (l) The orthotists, Messrs Darryl Grobbelaar, and Ugan Chetty;
- (m) The industrial psychologists (caregiver's remuneration), Ms Sonia Hill and Mr Gideon de Kock;
- (n) The life expectancy experts, Dr. R. Campbell, and Dr. A. Botha; and
- (o) The speech and language therapists, Ms Rochelle Thanjan and Ms Fathima Timol.

² D Strauss, J Brooks, L Rosenbloom and R Shavelle 'Life expectancy in cerebral palsy: an update' (2008) 50(7) *Developmental Medicine & Child Neurology* 487-493.

[7] In an effort to prove each of the issues as identified in paragraph 3 above the plaintiff testified in person and called four expert witnesses, namely Ms Heather Grace Hughes, a physiotherapist, Ms Rochelle Thanjan, a speech therapist, Ms Jane Caroline Bainbridge, an occupational therapist and Dr Robert Campbell, a general medical practitioner who testified as a life expectancy expert. On the other hand, to controvert the plaintiff's case on those issues the defendant called two witnesses, namely Dr Andre Stephan Botha, a specialist paediatrician, who testified as a life expectancy expert and Ms. Helene Prinsloo, an occupational therapist. Before venturing into the evidence which was led it would be useful to point out that both occupational therapists, Ms. Bainbridge and Ms Prinsloo agreed in their joint minutes that AM would benefit from attending Pathways for stimulation from now to the age of 18 years. They also agreed on the amount which was payable as the annual costs.

The evidence of the plaintiff

[8] The first witness for the plaintiff was Ms Hughes who assessed AM on 14 May 2020, 2 February 2023, and 27 March 2024. She confirmed having prepared the relevant reports and the joint minutes of the physiotherapists in bundle B. Ms Hughes testified that an objective assessment deals with the individual's physical aspects in relation to movement. The examination deals with whether a person can sit, stand, or whether they can partially stand, or whether they can partially sit, and how do they move their head and legs. This assessment provides a basis from which speech and occupational therapist can work. This assessment would consider the impediments resulting in aspects such as lying, rolling, standing, eating, and walking straight. In relation to the subjective assessment, Ms Hughes testified that the plaintiff had reported that AM suffered from chest infections between 2021 and 2023, which have since resolved after AM relocated from Ixopo to Durban.

[9] Ms Hughes described AM as presenting with Gross Motor Function Classification System (GMFCS) level V cerebral palsy. She testified that while some children with GMFCS level V cerebral palsy have no mobility at all AM has some mobility. AM can interact and loves being given attention. AM was dependent on others for all her

activities of daily living. AM was primarily fed through a percutaneous endoscopic gastrostomy ('PEG'). She emphasised that AM has improved her movements since she returned to Durban in November 2023. Ms Hughes stressed that an individual can improve movements with physiotherapy. However, as soon as physiotherapy has been stopped there was always a potential that movements would be rapidly lost. Ms Hughes testified that AM had grown taller and appeared to be more alert and interactive than when she had previously assessed her in February 2023. Moreover, her gums were still swollen and bruised after undergoing surgery to remove her teeth a few weeks before. While there were still some risks, AM had improved from the chest infection she previously suffered from since Ms Hughes's last assessment of her.

[10] Ms Hughes emphasised that AM can hear and see; she smiles and laughs appropriately and consistently. While she is unable to speak any words, she understands many commands. She sometimes uses eye gaze and infrequently may try to point. The muscle tone in AM's right lower limb and left upper limb appear to be severely affected. Since the previous assessment AM had improved head and trunk control, she was able to sit for a few seconds without support. AM was able to lift her head functionally. She was able to move her upper limbs most consistently and more purposefully. Children at GMFCS level V generally did not have this function. She was able to roll consistently from the supine position to either side and back to the supine position. In order to roll from the supine position to her stomach she needed plus plus encouragement, and AM did so with plus plus difficulty. AM did not have gluteal strength. While standing is good for bone mineral density, AM would never be able to stand on her own. She would benefit from consistent standing in a frame. She can kick the ball sitting and she can swat at objects.

[11] Under cross-examination, Ms Hughes agreed that Ms Prinsloo's classified AM as Manual Ability Classification System (MACS) level V. She further confirmed that according to Dr. Botha, AM functioned at GMFCS level V. When it was put to her that AM had no hand function, she stressed that her function and focus as a physiotherapist was on gross motor function rather than on a fine motor function, which was a sphere

reserved for an occupational therapist. When it was put to her that AM cannot consistently roll over Ms Hughes agreed to this proposition. However, she added that AM rolled from the supine position to either side and back to the supine position consistently. However, AM rolled from her stomach to her side and from supine to the stomach with extreme difficulty. When it was put to her that Dr Narain did not observe AM rolling, Ms Hughes reiterated that she observed AM rolling. Ms Hughes did comment when it was put to her that according to Dr Botha AM could not roll on both occasions that he assessed her.

[12] When it was put to her that AM had a PEG and contractures on the lower limbs, Ms Hughes admitted this. However, she added that with a PEG *in situ* AM most certainly had to be careful when rolling so as not to upset it. The contractures made it further difficult for her to roll easily. When it was drawn to her attention that both life expectancy experts in their joint minutes say AM had a mild scoliosis, Ms Hughes deferred to what the orthopaedic surgeons have stated in their joint minutes, that AM's scoliosis was unlikely to require any orthopaedic management as it was a minor. When it was put to her that Dr Narain had recorded in her report that she did not observe AM being able to turn or roll during her assessment, Ms Hughes testified that AM might have been afraid to fall as she was on a thin plinth from what appears in the photographs of Dr Narain's report.

[13] The next witness for the plaintiff was Ms Thanjan, who assessed AM on 19 May 2020 and 25 March 2024. Ms Thanjan confirmed having prepared the relevant reports and the joint minutes of the speech and language therapists in exhibit B. Ms Thanjan testified that the function of a speech therapist is not to work with the speech but rather to work with communication and swallowing. At the time of the assessment AM was taking 8ml of Epilim twice a day, Baclofen twice a day, a multi-vitamin syrup 5ml once a day, and a Probanthiane tablet once a day. The purpose of Probanthiane was to reduce drooling. AM had a dental extraction in respect of all her teeth in March 2024. In October 2023, AM had been attending weekly speech therapy, physiotherapy, and occupational therapy with different experts. Due to the Covid-19 pandemic the plaintiff

and AM went back home to High Flats and only returned to Durban in 2022. During the assessment, AM was aware of her surroundings and communicative partners.

[14] During the assessment in 2020, AM presented with a V-shaped palate and during the assessment in 2024, she presented a U-V-shaped palate. The impact of a V-shaped palate as opposed to a V-U-shaped palate is that an individual with a V-shaped palate is affected in his ability to speak and feed. When she assessed AM in 2020, AM had a difficulty with nasal breathing and now she has controlled nasal breathing. Although, AM still cannot speak she has however improved and is now able to communicate through vocalisation. Ms Thanjan classified AM's drooling as moderate to severe. Ms Thanjan further testified that on 1 November 2023 AM received a specialised buggy, which plays an important role in her feeding. AM's suck-swallow ratio was delayed. However, with practice, it is likely to improve. During the 2020, assessment AM held the bolus for 3 minutes and since then there has been an improvement. While liquids such as water were difficult for AM to handle due to the swallowing risk, she was able to handle puree, as it was thicker than water. Ms Thanjan classified AM according to the Eating and Drinking Ability Classification System on level VI. Ms Thanjan testified that AM enjoyed tasting juice when she gave it to her. AM was able to follow simple commands such as 'give me your hand', 'close your mouth' or 'open your mouth.' AM presented as a bright child who knew what was happening around her. She was orientated with animals on an Alternative Augmentative Communication Board. She could be able to identify animals such as a dog. Ms Thanjan classified her to be the age equivalent of 9 to 12 months.

[15] Under cross-examination, Ms Thanjan testified that AM was a candidate for combination feeding. She testified that the basis for her to say that is that AM was able to swallow without the food going into the lungs and she expressed joy on being fed. When it was put to her if she knew how long this would last, Ms Thanjan stressed that there would be more progress going forward. In relation to whether there would be no weight plateau, Ms Thanjan stated that that is the reason why the PEG would be left *in situ*. When it was put to her that AM would deteriorate going forward, Ms Thanjan

emphasised that she cannot make that prediction as AM has up to now showed progress. When it was put to her that according to Dr Botha there would be a dramatic change in AM's condition after the age of 4 - 15 years, she testified that AM was now 9 years, she is in between 4 - 15 years, but she has only made progress both in the areas of swallowing and communication.

[16] The next witness was the plaintiff, Ms M[...].The plaintiff testified that she was 38 years of age and the mother of AM. Other than AM she did have other children. While she was no longer in a love relationship with the father of AM, however, AM's father still played a role in his child's life. She further testified that between 2006 – 2016, she was employed as a quality controller at Pandor Paper in Isipingo before she resigned to take care of AM. The plaintiff currently lived with AM in a flat situated at South Beach, Point Road in Durban, since September 2023. They lived in this flat with a care giver who came 3 days a week. The reason why she chose to live at South Beach was to ensure that she was close to the health facilities, which AM is required to attend from time to time for her therapies. Before she moved into this flat, she had lived at her parental home, in the rural outskirts at High Flats in Ixopo, KwaZulu-Natal. She had to go back to live at her parental home in 2020 after her erstwhile attorney had passed away and there was no longer anyone to pay for accommodation in Durban. This area was not easily accessible if one was using a car. The nearest hospital, which is Christ the King Hospital ('CTK Hospital'), is an hour's drive away.

[17] The plaintiff testified that she previously had a caregiver and currently requires one. The reason why she requires a caregiver is because when she went for therapies and to do groceries it was difficult to carry AM as she invariably had to carry AM on her back when she attends to these activities. She has been unable to visit her parental home in High Flats since September 2023 because AM is too heavy to carry on her back. When AM was required to attend therapies, her current attorneys assisted with transporting them to and from the therapies using a private motor vehicle. The plaintiff indicated that she would like to continue to live in Durban after the completion of the

case to be nearer to the health facilities and to find employment for herself. A caregiver would therefore be required to look after AM whenever she was gone to work.

[18] The plaintiff testified that the average day with AM entailed waking up round about 08h00 in the morning, bathing and then thereafter the preparation of breakfast and medication for AM. AM ate every 2 hours with a PEG and she gave her water through the syringe. It took 15 minutes to feed AM. She fed AM by mouth in the morning and in the afternoons round about 15h00. She would feed AM foods such as mash and yogurt. AM enjoyed eating with her mouth and she likes foods which are sweet. AM enjoyed watching television and listening to music. On the television AM usually watched cartoons. AM also liked to play, to go out and to be driven in a motor vehicle. AM can recognize all her family members with their names and voices when she sees the family members. AM communicated by screaming. AM was able to play with toys, puzzles and with a ball. AM was able to turn left and right from her back. However, when she is on her stomach she could not turn to the left or right. She likes to jump when she is lying on her back and she was able to lift her legs up and down. When lying on her back AM was able to lift her head as well as when she was lying on her stomach. AM was only able to sit on her own unassisted for a few seconds.

[19] The plaintiff testified that two weeks before the trial she took videos of AM at the request of her attorneys. The video depicted AM sleeping, turning, sitting, and playing with the ball. On the video AM is also depicted using her hands to scroll on a cellphone, to hold a ball and to play with toys. AM was able to follow instructions when she was instructed to lift her hands or feet or to close her eyes or to open her mouth. The plaintiff testified that while AM had moods, she was a happy child who liked other children and people in general. She further indicated that AM underwent teeth extraction because she was troubled by her gums as they were often swollen and bleeding. Since AM underwent the procedure, her condition has improved. The plaintiff pointed out that every day AM took medication namely Epilim, Baclofen, multi-vitamins and Probanthiane. The plaintiff further pointed out AM suffered from seizures, her last seizure being in March 2024.

[20] Under cross-examination, the plaintiff testified that AM was unable to turn to her back when she was lying on her stomach. When it was put to her if she ever told any expert during the several assessments which AM attended over the years that AM was able to turn to lie on her back when she was lying on her stomach, she said she did not remember ever saying that to any expert. The plaintiff confirmed that AM was not able to turn to her back when lying on her stomach, unless she was assisted with the pulling down of her arm.

[21] The next witness was Ms Bainbridge who assessed AM on 22 May 2020 and 19 March 2024. Ms Bainbridge confirmed having prepared the relevant reports and the joint minutes of the occupational therapists in exhibit B. Ms Bainbridge testified that for the past 10 years she had been working with cerebral palsy cases. She described the condition of AM as level V on the GMFCS and MACS classification systems. She testified that the plaintiff was told for the first time when AM was 8 months that she had cerebral palsy. The plaintiff kept attending CTK Hospital every month for AM to undergo various therapies until AM was referred to Greys Hospital in Pietermaritzburg as she was vomiting copiously. At Greys Hospital, a PEG was inserted on AM. The plaintiff continued to attend the therapies at CTK Hospital monthly and at Greys Hospital on a 6 Monthly basis. The plaintiff stopped attending the respective therapies at CTK Hospital in 2021 because when she took the wheelchair which was issued to AM by the hospital to be fixed, she was told by the nurses to fix it herself.

[22] When the plaintiff enrolled for private therapy from 2023 once a week for AM. The plaintiff found this beneficial. During her assessment of AM in 2024, she found that the AM's left hand was starting to reach for things. The buggy helps AM with posture. AM is now attentive, can engage and is aware of her environment. AM's weight was at 27.8 kilograms. AM's weight is above the recommended lifting for caregivers, which is 15 kilograms. The South African average safe lift weight was between 22 to 25 kilograms. There was a risk of AM falling, due to her weight or being bumped, due to her height, if she was lifted. Ms Bainbridge testified that during the assessment AM was

very engaging and observant of new things. AM was excited with new objects. She was aware when she was left alone. AM was motivated and intentional and does not act randomly. AM laughed appropriately and knew about cause and effect.

[23] Ms Bainbridge confirmed that she and Ms Prinsloo agreed that AM needs to attend at Pathways until the age of 18 years and their disagreement was in relation to the necessity of AM attending Pathways after attaining the age of 18 years. Ms Bainbridge testified that Pathways is a special needs school. It caters for children up to 18 years as well as children from 18 years and over. Pathways is well-run and staffed. In the facility children usually had their meals together, and have sport days and outings. These activities would give AM an opportunity for social interaction in a group. Ms Bainbridge further testified that the reason why Ms Prinsloo was of the view that it would unnecessary for AM to attend Pathways after attaining the age of 18 years was that Ms Prinsloo opined that AM did not have enough cognition and had a low life expectancy.

[24] Ms Bainbridge confirmed having undertaken an anxiety and depression assessment on the plaintiff. She pointed out that the reason why she did so is because those who cared for cerebral palsied children were always at risk. This was because cerebral palsy is unusual and because of its chronicity, it had a sad outcome as children with cerebral palsy did not live their whole life expectancy. She stressed that the people who cared for children with cerebral palsy had very little to no support. The impact on these carers is so severe. There is no facet in their lives, which is not affected. Ms Bainbridge further stressed that the condition in which these children are makes the carers to suffer in their health. As a result, they commonly have anxiety and depression. Socially these carers are stigmatised and ostracised. They become indigent and therefore they become unable to provide for the child. Moreover, she stressed that it was the mothers of these children, who bore the brunt of all of this. Ms Bainbridge testified that the plaintiff's ratings for anxiety and depression were abnormally high. This was because when the plaintiff lived in High Flats, the family did not optimally support her. However, when the plaintiff came to live in Durban those levels became low.

[25] Ms Bainbridge testified that during the assessment AM approached the assessment area with trepidation, reluctant to leave her buggy until she was lifted by the plaintiff and placed on the floor. However, once she was on the floor she calmed down easily. She reached for and thrust and hit out at various toys, which were placed in her reach, she engaged readily and laughed. While there were qualitative changes in AM, she remained profoundly disabled and uneducable. AM's loss of amenities of life were devastating. She responded very well to vestibular and movement stimulation though, which involved the tipping of her wheelchair and the movement of the wheelchair at a fast pace. Since the initial assessment in 2020, and despite minor gains in the motor function, AM still fell on the broader classification of a level V cerebral palsy classification. She cannot move without someone assisting her and will always be dependent on someone to move her. Several scales were used to determine AM's physical developmental capacity including the Chailey Scales for motor development³ and Gross Motor Function Classification System – Expanded & Revised (GMFCS-E+R)⁴ scales. These scales showed that AM's disability is profound and affects all domains of function which meant that she will always be reliant on others to move her about. Lying on her back AM was able to lift her head and arms partially, and lifted her legs into abduction. AM could roll onto her side and then fall into a prone position. Out of a potential 6 points on the Chailey scales AM scored 4 points. AM's age level on development scales was less than a 3-month-old child. She was unable to do reciprocal kicking in the prone position. Her prone position improved from level III in 2020 to level IV. She can lift her head for 3 minutes. She cannot crawl because the trunk and neck does not allow that due to spasticity. She log rolls into prone position gravity assisted. In relation to sitting, she improved from level II in 2020 to level III. AM can tolerate 30 seconds of sitting on her own. In relation to standing, AM cannot weight bear and a standing frame would therefore be useful to her. AM was completely incontinent and was completely dependent on the plaintiff in relation to all her activities of daily living.

³ Chailey Scales are used to measure the motor ability in children and young adults with motor impairments.

⁴ GMFCS-E+R is a widely used method for classifying the movement ability of children with cerebral palsy.

AM cannot grasp or grab. AM does not use her hands together. She is fed every 3 hours. She has no language, but she responds to instruction. AM is mainly PEG fed.

[26] In relation to AM's specialised accommodation, Ms Bainbridge testified that security measures needed in such accommodation included burglar guards, a perimeter fence, a secure gate, and an alarm system as AM was a vulnerable child who lived in a household, which was headed by a woman. In relation to the issue of a backup battery, Ms Bainbridge stressed that in this country the issue of security is critically important for anyone. In relation to the cupboard for a live-in care giver, she emphasised that this would be a necessary addition. Ms Bainbridge testified that a case manager was a medically trained person preferably an occupational therapist or a specially trained nurse who was appointed by a trust. They act as intermediaries between the trustees and the client. A case manager works closely with the mother and the child as the trustees are usually not immediately available to attend to the child's needs. Ms Bainbridge emphasised that the issue of accessing medical care is difficult. While some mothers may be educated, and articulate, others are not. Ms Bainbridge emphasised that while she and Ms Prinsloo agreed, as occupational therapists, about the appointment of a case manager, they disagreed on a fee structure. Ms Bainbridge testified that in respect of the attendance of meetings with trustees and report writing she allocated 6 hours per annum at the rate of R72 000.00, while Ms Prinsloo allocated 3 hours for the attendance of meetings and report writing at the rate of R3 000.00.

[27] Under cross-examination, Ms Bainbridge confirmed that she does case management. She testified that where the mother of the child was actively involved in the sourcing of a caregiver and had a preferred caregiver the case manager got such a caregiver trained. However, the mere fact that the mother was actively involved in the sourcing of a caregiver does not reduce the cost. While AM was generally healthy and had not been admitted to hospital that did not necessarily translate to the reduction in costs of the sourcing of a caregiver as sight should not be lost that AM was only 9 years of age and suffered from epilepsy. While the existence of a database of caregivers was useful and would make it easy to source caregivers, however, there were situations

where the caregiver and the mother might not be compatible or where the caregiver might be moving on in life. These situations would necessitate the sourcing and interviewing of caregivers, hence a provision had to be made to this end at the rate of 5 to 10 hours over 5 years.

[28] Ms Bainbridge testified that there was no logical basis for why provision should not be made for AM to attend Pathways after attaining the age of 18 years. When she was referred to the life expectancy projections by Dr Botha, she testified that AM would exceed the age of 18 years and she will benefit from attending Pathways as that would stimulate her optimally. She emphasised that attendance at Pathways did not amount to an attendance of school program where attendance was required on an everyday basis. A person was charged per his or her attendance with the aim of attendance being to optimise the quality of life. When it was put to her that the fee structure from Pathways made provision for fees to be paid on a monthly, 6 monthly and annual basis, Ms Bainbridge testified that she knew it as a fact that some children at Pathways would be accommodated for less than a week and therefore would be charged per their attendance.

[29] Ms Bainbridge confirmed that AM could execute only partial rolling. She further testified that while AM had significantly improved from her last assessment those improvements were still within the GMFCS level V and MACS level V. However, there was a potential that AM would get to level IV. Ms Bainbridge stressed that therapy improves and retards deterioration. When she was asked the age range in which an improvement can be made, she emphasised that that it was not possible to put a timeline on improvement, as there were a variety of interventions that are useful in effecting changes to a child's development. When it was put to her whether it was not possible that the improvements were due to therapy, Ms Bainbridge was emphatic that the improvements were due to therapy if one considered the considerable improvement AM made 6-months preceding the trial. When it was put to her that according to Dr Botha children with GMFCS level V cerebral palsy deteriorated from the age 7, Ms

Bainbridge pointed out that AM was 9 years of age and at that age she had shown improvement instead of decline.

[30] The next witness for the plaintiff was Dr Robert Duncan Dower Campbell. Dr Campbell had assessed AM on 17 July 2020, 17 May 2022, and 29 April 2024. Before Dr Campbell testified the extracts of the videos, which were taken by the plaintiff were played on the TV monitor, which is fixed in court. The depictions on the footage showed the movements that AM was able to make and from which positions as they are now a matter of record. They also showed that AM was able to follow commands, which were made to her. In relation to his background, qualifications and experience with cerebral palsy and life expectancy, Dr Campbell testified that he was a family practitioner with 25 years of experience in physical rehabilitation medicine. He had worked with children and adults with cerebral palsy on an outpatient basis over an extended period. He had travelled and trained both nationally and internationally in this subject. He had published literature nationally and internationally in relation to rehabilitation medicine in children with cerebral palsy. He had been utilised as an expert witness by plaintiffs and defendants over a period of 25 years in all the provinces in matters which arose both from the private and public sectors regarding the question of life expectancy and future needs of children suffering from cerebral palsy. Dr Campbell confirmed to having prepared the relevant reports including the supplementary report dated 28 May 2024, pursuant to Dr Botha's supplementary report dated 18 May 2024. He further confirmed having prepared the joint minutes in bundle B with Dr Botha.

[31] Before venturing into the evidence of Dr Campbell, it would be useful to mention that Drs Campbell and Botha agreed, as stated in their joint minute, that it would be reasonable to rely upon Brooks *et al's*⁵ publication on survival patterns and life expectancy in persons with cerebral palsy in estimating life expectancy in respect of AM. In addition, they agreed on the following aspects in respect of AM's condition:

⁵ JC Brooks, DJ Strauss, RM Shavelle, LM Tran, L Rosenbloom and YW Wu 'Recent trends in cerebral palsy survival. Part II: individual survival prognosis' (2014) 56(11) *Developmental Medicine & Child Neurology* 1065-1071.

⁵D Strauss, J Brooks, L Rosenbloom and R Shavelle 'Life expectancy in cerebral palsy: an update' (2008) 50(7) *Developmental Medicine & Child Neurology* 487-493. This publication is marked 'Exhibit C.'.

- (a) She was a 9.4-year-old girl;
- (b) She has severe spastic cerebral palsy leaving her on GMFCS level V and MACS level V;
- (c) She has a severe or profound cognitive impairment;
- (d) She is generally in a good health condition;
- (e) Her weight is satisfactory for her age and severity of her motor impairment;
- (f) She is incontinent of bladder and bowel;
- (g) She has mild contractures around her elbows, wrists, fingers, thumbs, knees and ankles. She has a mild scoliosis;
- (h) She is tube fed;
- (i) She relies on others for assistance with all activities for daily living; and
- (j) She has developed epilepsy.

[32] The fundamental areas of difference between Drs Campbell and Botha were in relation to AM's level of mobility and the methodology, which they each employed to calculate AM's life expectancy. It would also be useful to mention that Dr Campbell provided life expectancy projections when AM was 5 years and 5 months old, again when she was 7 years and 4 months old and then finally for purposes of trial when AM was 9 years and 3 months old.

[33] Dr Campbell referred this court to annexure A attached to his initial report which he prepared in 2020. This is where the summary of the approach he adopted in calculating AM's life expectancy is set out.⁶ Dr Campbell testified with reference to his initial report⁷ and the opinion he expressed in relation to the methodology he used to estimate AM's life expectancy. He stated that he relied on the latest publication from the California based Life Expectancy Project in estimating the impact that AM's condition has had on her life-long survival and life expectancy.

⁶ Bundle C: Vol 2: page 210 - 212.

⁷ Bundle C: Vol 2: page 197.

[34] Dr Campbell stated that he mainly relied on the published information by Brooks *et al* in a paper.⁸ Table II in Brooks *et al*'s paper⁹ provides survival data in the form of probability of survival for a cohort of individuals aged 4 to 30 years in various functional groups, including the 'lifts head and chest in prone position', partial rolling' and 'tube fed' group. Typical 5-year-old girls in this functional group enjoy a 40.5% chance of surviving until the age of 30 years, and have a life expectancy that is 26.3 years compared to 76.1 years in the general population or 34% of general population life expectancy. Dr Campbell testified that it was important to determine the extent to which AM was close to 'typical' in the functional group or was significantly different to the extent that adjustment away from the survival trend for 'typical' girls in the group. According to Dr Campbell, at the time of the assessment, AM presented with severe cognitive impairment, severe feeding difficulties, poor hand function, limited ability to communicate, was incontinent and probably had moderate visual impairment. Dr Campbell testified that these features, while carrying negative implications for survival are typical of the functional group and their impact has already been allowed for in selecting this functional group and at least some may even place AM in an above average place in the functional group. AM, however, did probably have at least some hip instability and this arguably left her somewhat worse off than 'typical girls' in this functional group. He therefore applied an increase of 1.1 to the mortality odds ratio to account for probable instability in the hips.

[35] Dr Campbell stated AM had a history of monthly generalised seizures. Generalised seizures have been shown to be associated with 5/1000 increase in the excess death rate. AM's seizures have remained controlled on medication since she was three years old and Dr Campbell therefore did not increase the excess death rate for them. Dr Campbell testified that he therefore applied these assumptions and calculated that a 5-year-old girl in this functional group, including AM's specific profile of

⁸ JC Brooks, DJ Strauss, RM Shavelle, LM Tran, L Rosenbloom and YW Wu 'Recent trends in cerebral palsy survival. Part II: individual survival prognosis' (2014) 56(11) *Developmental Medicine & Child Neurology* 1065-1071.

⁹ JC Brooks, DJ Strauss, RM Shavelle, LM Tran, L Rosenbloom and YW Wu 'Recent trends in cerebral palsy survival. Part II: individual survival prognosis' (2014) 56(11) *Developmental Medicine & Child Neurology* 1065 at 1068.

additional features, had a 36.9% chance of surviving from five years to 30 years and had a life expectancy that was 24.3 years, compared to 76.1 years in the general population. This is the 32% of general population life expectancy. He pointed out that in his opinion, it would be fair to accept that AM's life expectancy, at the age of 5.5 years, was 32% of that of her general population. Dr Campbell then concluded by saying based on the data he mentioned and making use of Koch's Table 2 as a reference table to adjust to the South African conditions, he estimated that a South African girl in this functional group and with AM's profile of minor factors, AM had a life expectancy, at the age of 5.5 years, of 22.7 additional years (32% of general population life expectancy at age 5.5 years - 71 years).

[36] Dr Campbell stated that the postulated life expectancy figures are for individuals in the study population in California in the United States of America ('USA') and as such cannot be directly applied to individuals in South Africa. It was, however, possible to apply the percentage of general population life expectancy to a South African table. Dr Campbell testified that he had opined that it would be fair to accept that AM's life expectancy at the age of 5.5 years, is 32% of that of her general population peers. Dr Campbell emphasised that the publication upon which he relied on was conducted in the USA where the mortality trends and life expectancy are more favourable than those in South Africa. He applied the results of this research in an appropriate South African life table to adjust for the difference in mortality between the two countries.

[37] Dr Campbell pointed out that since the publication of the 1984/1986 South African Life Tables to his understanding there were truly no reliable and complete South African life tables that have been published. However, there is a strong case for making use of the 1984/1986 South African Life Tables on which Koch's Table 1 and Table 2 is based in the absence of better options, although these are old tables based on old data. He chose to rely on Koch's Table 2 to adjust for the difference in general life expectancy between the USA and South Africa. The reason why Koch's Table 2 was an appropriate table to use as a reference table was because:

- (a) This table is the last available complete official life table from Statistics South Africa that is based on empirical data.
- (b) More recent estimates of life expectancy from birth for persons who do not have HIV/AIDS from Statistics South Africa are not based on any probability study. It has therefore been argued that it would be incorrect to refer to the life tables based on these figures.
- (c) It arguably represents a reasonable reflection of the pattern of survival and mortality for persons not negatively impacted by pre-1994 racist apartheid policy and practice and can neutralise the impact of racial prejudice and bias.
- (d) There is an ongoing support from the South African Actuarial community for the use of this table.
- (e) There was legal precedent in the South African courts for the use of this table.¹⁰
- (f) Further, he recently examined the empirical survival data for 339 South African children with cerebral palsy and that these results suggest that the use of Table 2, is more appropriate in the present case. In brief, the mortality rates for South African children with severe cerebral palsy were 15 - 22 than higher than those for their counterparts in California. The relative increase in mortality rates more closely matches an adjustment using Table 2, than any of the other Koch Tables. The results of this analyse were recently published in the *South African Medical Journal* on an article written by himself, Brooks, and Whitaker.¹¹

[38] Dr Campbell pointed out that as a result, he has at present, continued to make use of Koch's Table 2 for the above reasons but he deferred to the decision of the court and to legal and actuarial input in relation to each point for a final selection of a life table.

¹⁰ *Singh and another v Ebrahim* [2010] ZASCA 145 and *AD and another v MEC for Health and Social Development, Western Cape Provincial Government* [2016] ZAWCHC 181; 2017 (5) SA 134 (WCC).

¹¹ JC Brooks, RDD Campbell, and GA Whittaker 'Survival of South African children with cerebral palsy' (2021) 111(6) *South African Medical Journal* 591-594.

[39] Dr Campbell testified that he further assessed AM on 17 May 2022 when her condition had improved. During this assessment AM was 7.33 years old. When he assessed AM based on the information on the reports, which were available, he assumed that AM was best compared with girls who were in the 'full rolling, does not walk unaided' mobility group and who are in the 'tube fed' feeding group, as per the Brooks *et al* paper.¹² He then considered the pattern of mortality in this functional group between the ages 7 years and 29 years and estimated the life expectancy for typical 7-year-old girls in this functional group. Dr Campbell pointed out that there is a 59.3% probability of a typical girl in this functional group surviving from age 7 to age 30. Typical 7-year-old girls in this functional group have a life expectancy of 30.5 additional years, which is a 41% of general population life expectancy.

[40] Dr Campbell testified that adjustments had to be made for the fact that AM had contractures in her hands and feet, mild scoliosis which arguably placed her somewhat worse off than the typical child in this group. He therefore increased the mortality ratio of AM by 1.1 to adjust for their presence. However, he did not consider as negative factors the fact that AM has severe cognitive impairment, severe feeding difficulties, poor hand function and was incontinent because the impact of these factors have already been allowed for in selecting this functional group. Additionally, he did not consider as a negative factor the fact that AM had active generalised seizures as they remained controlled on medication since AM was three years. Dr Campbell testified that after making these adjustments, 7-year-old girls in this functional group had a life expectancy that was 28.9 additional years, which was 39% of that of her general population.

[41] Dr Campbell then concluded by saying based on the data he mentioned and making use of Koch's Table 2, as a reference table to adjust to the South African conditions, he estimated that a South African girl in this functional group and with AM's profile of minor factors, at the age of 7.33 years, has a life expectancy of 26.9 additional

¹² See JC Brooks, DJ Strauss, RM Shavelle, LM Tran, L Rosenbloom and YW Wu 'Recent trends in cerebral palsy survival. Part II: individual survival prognosis' (2014) 56(11) *Developmental Medicine & Child Neurology* 1065 at 1068.

years, which is 39% of the general population life expectancy at 7.33 years (69.3 years). This is associated with an anticipated total survival time of 34.2 years.

[42] Dr Campbell testified that he further assessed AM on 29 April 2024. During this assessment AM was 9.3 years old. Again, using Brooks *et al*'s paper, when he assessed, he assumed that AM was best compared with girls who were in the 'full rolling, does not walk unaided' mobility group and who are in the 'tube fed' feeding group.¹³ Again, he then considered the pattern of mortality in this functional group between the ages 9 years and 29 years and estimated the life expectancy for typical 9-year-old girls in this functional group. Dr Campbell pointed out that there is a 61.3% probability of a typical girl in this functional group surviving from age 9 to age 30. Dr Campbell stated after making the adjustments for the negative factors specific to AM's condition, as in the previous assessment, 9-year-old girls in this functional group had a life expectancy that was 26.8 additional years, which was 37% of that of her general population.

[43] Dr Campbell then concluded by saying based on the data he mentioned and making use of Koch's Table 2, as a reference table to adjust to the South African conditions, he estimated that a South African girl in this functional group and with AM's profile of minor factors, at the age of 9.3 years, had a life expectancy of 25 additional years, which is 37% of the general population life expectancy at 9.3 years (67.4 years). This is associated with an anticipated total survival time of 34.3 years.

[44] Dr Campbell testified that on 28 May 2024 he further provided a supplementary report in the form of a letter as there remained a lingering question whether AM had a 'full rolling' ability or only had 'partial rolling' ability. To that end he compared AM with girls of her age in the 'lift head and chest and performs partial rolling' functional group.¹⁴

¹³ JC Brooks, DJ Strauss, RM Shavelle, LM Tran, L Rosenbloom and YW Wu 'Recent trends in cerebral palsy survival. Part II: individual survival prognosis' (2014) 56(11) *Developmental Medicine & Child Neurology* 1065 at 1068.

¹⁴ JC Brooks, DJ Strauss, RM Shavelle, LM Tran, L Rosenbloom and YW Wu 'Recent trends in cerebral palsy survival. Part II: individual survival prognosis' (2014) 56(11) *Developmental Medicine & Child Neurology* 1065 at 1068.

Dr Campbell then pointed out that if the court accepted that AM should be appropriately placed in this functional group, the new estimate of life expectancy, at age 9.3 years, is 19.4 additional years (29% of general population life expectancy). This is associated with a total expected survival time to age of 28.7 years.

[45] Dr Campbell accepted that that based on videos, which were played in court, AM could appropriately be placed on the functional group 'lift head and chest and performs partial rolling.' Dr Campbell testified that Table II in Brooks *et al* paper¹⁵ provides probabilities of survival at ages 10, 15, 20, 25, and 30 years in 5 functional groups namely:

- (a) Those who cannot lift their head at all in prone position.
- (b) Those who can lift their head but not chest in prone position.
- (c) Those who can lift their head and chest, and partially roll.
- (d) Those who can fully roll and do not walk unaided.
- (e) Those who can walk unaided.

[46] Dr Campbell pointed out that that Dr Botha used Table III¹⁶ in estimating AM's life expectancy while he relied on Table II, but this did not result in a different outcome if the feeding and mobility approach was used. In his understanding, Table III was applicable to adolescence and adults generally and does not apply to children of younger ages while Table II applied to young children. When Dr Botha's postulation was put to him that AM would not be able to lift her head when she was 15 years, Dr Campbell pointed out that this can only be possible if one was using the none standard approach in estimating life expectancy. In addition, Dr Campbell stressed that in the publications by Strauss *et al*,¹⁷ and Brooks *et al*,¹⁸ upon which their postulations were based, in relation

¹⁵ JC Brooks, DJ Strauss, RM Shavelle, LM Tran, L Rosenbloom and YW Wu 'Recent trends in cerebral palsy survival. Part II: individual survival prognosis' (2014) 56(11) *Developmental Medicine & Child Neurology* 1065 at 1068.

¹⁶ JC Brooks, DJ Strauss, RM Shavelle, LM Tran, L Rosenbloom and YW Wu 'Recent trends in cerebral palsy survival. Part II: individual survival prognosis' (2014) 56(11) *Developmental Medicine & Child Neurology* 1065 at 1069.

¹⁷ D Strauss, J Brooks, L Rosenbloom and R Shavelle 'Life expectancy in cerebral palsy: an update' (2008) 50(7) *Developmental Medicine & Child Neurology* 487-493.

to the development of children to the age of 15 years, they did not observe any notable decline in their ability to lift their heads. Dr Campbell relied on a series of passages in Bundle G and suggested that while there seemed to be a decline, but that decline was variable. Those extracts are the following:

- (a) At page G47 where it is stated: 'Table I shows mean GMFM-66¹⁹ by GMFCS and age. Although this simply uses crude age bands, and does not account for multiple observations per child, it suggests that the nonlinear trend in GMFM-66 over age may differ by GMFCS level. The trend in means shows no evidence of peak and decline for Levels I and II, whereas there is a suggestion of such a decline for Levels IV and V. The trend for level III is not clear.'
- (b) At page G49 it is stated: 'Of course, not all children will experience the average pattern of change for their level. The nonlinear mixed-effects model estimates individual differences in all parameters of change as variance components.'
- (c) At page G50 it is stated: 'Although the average patterns of change in Levels III to V show a decline in GMFM-66, the 50% ranges indicate that the degree of this decline varies considerably among children. William observed that "children with a disability grow into adults with a disability", and has called for more attention to adolescence as a key time of transition and an understudied area of disability research and service.'
- (d) At page G51 it is stated: 'the findings indicate that children and youths within Levels III, IV and V are at risk of losing motor function, with the greatest declines apparent in Level IV.'

[47] Moreover, Dr Campbell pointed out that this article was meant for clinicians to mitigate those risks more than anything else. In the case of AM, she was beyond the age of 4 years and there were no signs of any of the levels of decline postulated in the article instead AM has shown improvement from an early age of 4 years. When Dr

¹⁸ JC Brooks, DJ Strauss, RM Shavelle, LM Tran, L Rosenbloom and YW Wu 'Recent trends in cerebral palsy survival. Part II: individual survival prognosis' (2014) 56(11) *Developmental Medicine & Child Neurology* 1065-1071.

¹⁹ GMFM-66 means the Gross Motor Function Measure 66.

Botha's proposition was put to him that children who can roll onto their sides and are tube fed at the age of 9 years have a significantly better life expectancy compared to those that lift head and chest but cannot roll on their sides and are tubed fed at the age of 9 years as unrealistic, Dr Campbell pointed out that this was inconsistent with the statistical analysis at page G40 of bundle G.

[48] Under cross-examination, Dr Campbell accepted that AM can only perform partial rolling. When it was put to him whether in quoting the extracts from exhibit G, he considered Table IV, Dr Campbell pointed out that what is referred to in Table IV were the average trends and AM did not follow those trends. Dr Campbell conceded that the individual trajectories of gross motor capacity scores for GMFCS level V individuals captured by Rosenbaum *et al*²⁰ showed that there is significant variability in the ages of attaining peak gross motor capacity and the ages when gross motor capacity starts declining. When it was put to him that while AM might have improved her gross motor skills between the ages of 6 to 9 years, this improvement did not eliminate the probability of her losing her ability to lift her head in early childhood, Dr Campbell pointed out that he does not accept that children are destined to deteriorate. When it was put to Dr Campbell that Voorman *et al*²¹ documented that the results of his study in respect of cohort cerebral palsied children showed that children with poor selective motor control have showed a less favourable course of gross motor function than those less affected children, he denied that this was applicable to AM. Dr Campbell testified that while AM had severe impairment of gross and fine motor function, she was better than many children in this group.

[49] Dr Campbell denied that AM would lose the ability to lift her head in prone beyond the age of 15 years. When it was put to Dr Campbell that the major reasons

²⁰ PL Rosenbaum, SD Walter, SE Hanna, *et al* 'Prognosis for gross motor function in cerebral palsy: creation of motor development curves' (2002) 288(11) *JAMA* 1357-1363.

²¹ M Voorman, AJ Dallmeijer, DL Knol, GJ Lankhorst and JG Becher 'Prospective longitudinal study of gross motor function in children with cerebral palsy' (2007) 88(7) *Archives of physical medicine and rehabilitation* 871-876.

why the data in Table II in Brooks *et al*²² did not provide realistic life expectancy estimates is because there are no 9-year-old girls in the cohort and all the children in the cohort were 3.5 to 5.0 years old, Dr Campbell maintained that this is incorrect. Dr Campbell emphasised that AM has been in this cohort from the age of 4. When it was put to Dr Campbell that the reason why the cohort approach was unrealistic was because many of those children surviving to age 7 years would no longer be in the same condition, Dr Campbell denied this and pointed out that AM's condition had not changed at the time when she was 5 and a half years up to now. He pointed out that AM had stayed on the same level of function throughout. Dr Campbell agreed when it was put to him that from March 2021 onwards Strauss used the life expectancy estimate from Table III at 15 years in Brooks *et al*²³ as the starting point. He agreed that in some specific matters, Strauss used Table III. When it was put to Dr Campbell that Strauss and Brooks never relied on the data in Table II in Brooks *et al*²⁴ to construct life tables from which life expectancy estimates were derived in opinions, which they provided to the South African cerebral palsy litigants, Dr Campbell pointed out that they used raw data. He added that any assertion that Professor Strauss and Dr Brooks may not have used the standard approach was a misrepresentation. Dr Campbell testified that the life expectancy of children like AM were the same as that of the general population. When it was put to Dr Campbell that although the approach, which he has used has been described in the literature, but it was not the approach that was used by Strauss, Dr Campbell pointed out that this approach was accepted and published in literature that was peer-reviewed. Dr Campbell admitted that poor hand use is associated with increased mortality. However, he added that poor hand use and lack of speech were already accounted for in the model he used. When it was put to Dr

²² JC Brooks, DJ Strauss, RM Shavelle, LM Tran, L Rosenbloom and YW Wu 'Recent trends in cerebral palsy survival. Part II: individual survival prognosis' (2014) 56(11) *Developmental Medicine & Child Neurology* 1065 at 1068.

²³ JC Brooks, DJ Strauss, RM Shavelle, LM Tran, L Rosenbloom and YW Wu 'Recent trends in cerebral palsy survival. Part II: individual survival prognosis' (2014) 56(11) *Developmental Medicine & Child Neurology* 1065 at 1069.

²⁴ JC Brooks, DJ Strauss, RM Shavelle, LM Tran, L Rosenbloom and YW Wu 'Recent trends in cerebral palsy survival. Part II: individual survival prognosis' (2014) 56(11) *Developmental Medicine & Child Neurology* 1065 at 1068.

Campbell that Reid *et al*²⁵ documented that a combination of additional impairments such as severe and profound cognitive impairment, lack of speech, epilepsy, blindness, and deafness have a significant impact on survival probabilities of children with cerebral palsy. Dr Campbell pointed out that the study by Reid *et al* does not have regard to feeding ability. Dr Campbell admitted that Table III²⁶ can be used as a matter of discretion. However, Table II was for young children while Table III was for adolescents and adults. When it was put to him that Strauss was using the same data that Dr Botha relied on and came to the same conclusion namely that Koch's Table III is a more realistic general population life table for South Africa compared to Koch's Table II, Dr Campbell admitted that there was a stage where Strauss relied on Koch's Table III and then he reverted to Koch's Table II. Dr Campbell admitted that he had on an occasion, as a compromise to assist the court, used Koch's Table III as opposed to Koch's Table II. Dr Campbell admitted that all epilepsy cases remit. However, he pointed out that one will not be able to know when will that happen. When he was asked about the possibility of seizure remission at the medium age of 11 years, Dr Campbell pointed out that 3 years was still in the future and that some children do not remit. Dr Campbell further pointed out that while Dr Botha had predicted seizure remission between the age of 3.3 years 6 months and 10 years 4 months AM was close to 10 years, and she has not regressed and therefore the results of the article cannot be applied bluntly. In re-examination, there is nothing, which is of materiality which Dr Campbell raised. This then concluded the case for the plaintiff.

The defendant's evidence

[50] The defendant then opened its case and called Dr Andre Steven Botha. Dr Botha had assessed AM on 17 March 2021 and 18 May 2024. Dr Botha testified that he is a specialist paediatrician with 35 years' experience. He had experience in relation to children suffering from cerebral palsy. He has testified in the high court before and had

²⁵ SM Reid, J McCutcheon and DS Reddihough 'Survival of individuals with cerebral palsy born in Victoria, Australia, between 1970 and 2004' (2012) 54(4) *Developmental Medicine & Child Neurology* 353-360.

²⁶ JC Brooks, DJ Strauss, RM Shavelle, LM Tran, L Rosenbloom and YW Wu 'Recent trends in cerebral palsy survival. Part II: individual survival prognosis' (2014) 56(11) *Developmental Medicine & Child Neurology* 1065 at 1069.

prepared numerous medico-legal reports in matters in which he testified. He was a medical scientist and started researching on the topic of cerebral palsy and analysing the relevant literature in 2006. From then he developed an ability to construct life tables. Dr Botha confirmed having prepared relevant reports and joint minutes of life expectancy experts in bundle B. Dr Botha testified that apart from the disagreement that he and Dr Campbell had about the stratification of the child all the other issues were agreed. He pointed out that his disagreement with Dr Campbell was in relation to the level of movement of AM.

[51] He testified while he agreed with the cohort approach from the general point of view, however, the cohort approach is not appropriate to project life expectancy. The reason being that the difference of motor skills and feeding skills is so big between the ages of 4 and 15 years. He testified that in relation to the method he used to project the life expectancy of AM there is no published data. He had used the period approach, as a cohort approach cannot reasonably be applied in estimating the life expectancy of an individual patient. The cohort approach was used by Dale and Dr Campbell and not by the California Life Expectancy Project. He testified that the period approach is based on the work of Hanna. He testified that according to Hanna *et al*²⁷ at their peak age performance, 52.5% of GMFCS level V children can lift their heads in the prone position but only 17.9% maintain this ability, hence the probability that AM will lose her ability to lift her head in early adulthood is 66%.

[52] Dr Botha further testified that he introduced the research by Voorman *et al*²⁸ in that Voorman *et al* had actively studied a cohort of cerebral palsied children to determine factors that predict gross motor regression with age. The results showed that children with poor selective motor control, tetraplegia, poor muscle strength, mild or moderate limitations in hip and knee extension, spasticity of the hamstrings in both legs,

²⁷ SE Hanna, PL Rosenbaum, DJ Bartlett, *et al* 'Stability and decline in gross motor function among children and youth with cerebral palsy aged 2 to 21 years' (2009) 51(4) *Developmental Medicine & Child Neurology* 295-302.

²⁸ M Voorman, AJ Dallmeijer, DL Knol, GJ Lankhorst and JG Becher 'Prospective longitudinal study of gross motor function in children with cerebral palsy' (2007) 88(7) *Archives of physical medicine and rehabilitation* 871-876.

and children receiving special education, showed a less favourable course of gross motor function than less affected children. Dr Botha asserted that because AM presents with all the factors that are associated with decreasing gross motor function with age as identified by Voorman *et al*,²⁹ therefore, AM has no selective motor control. Dr Botha further asserted that given the probability of AM losing the ability to lift her head in the prone position exceeds 50%. Thus, it is reasonable to assume that it is appropriate to model the estimation of her future survival probabilities on the assumption that she will not maintain the ability to lift her head in prone beyond the age of 15 years.

[53] Dr Botha testified that the extracts from the videos which were taken by the plaintiff do not affect his views. He remarked that from the video extracts AM could only move her entire limb. He remarked that if the probability is more than 50% that is considered as a likely outcome. When it was put to him that Dr Campbell had criticised him that he was not using the standard approach, Dr Botha pointed out that the cohort approach is not a universal standard approach. He testified that according to Hanna as the children grew older, they lost their skills. This will happen regardless of any intervention and from a clinical perspective, cerebral palsied children lose their skills with age. Dr Botha further pointed out that the reason why AM cannot roll is because the muscles are contracted. When it was put to him that it was suggested on behalf of the plaintiff that there was no evidence of decline to AM, Dr Botha remarked that there is no evidence that AM had reached her gross motor capacity peak compared to 2021 when he had initially assessed her. He testified that when he made the downward adjustment in estimating AM's life expectancy, he considered the degree of the cognitive ability AM had as this would affect her going forward. He further testified that the severe the cognitive impairments are, the lower the life expectancy is.

²⁹ M Voorman, AJ Dallmeijer, DL Knol, GJ Lankhorst and JG Becher 'Prospective longitudinal study of gross motor function in children with cerebral palsy' (2007) 88(7) *Archives of physical medicine and rehabilitation* 871-876.

[54] Dr Botha testified that in stratifying AM and estimating her life expectancy he used Table III in Brookes *et al*³⁰ provides for the life expectancy estimates for the Californian Life Expectancy Project defined cohorts. Table III documents that the life expectancy estimates for those children that lift their heads and chest and are tube-fed is for 4 additional years more at 15 years compared to those who cannot lift their heads in the prone position. The life expectancy estimates for tube-fed individuals at the ages of 30; 45; and 60 are not affected by head lifting ability.

[55] Dr Botha pointed out that LT 2: California 2010 for a female who can lift head and is tube fed which accompanied his report provides the life table that yields the life expectancy estimates for this stratification published in Table III in Brookes *et al*.³¹ These are the baseline Californian Life Tables for children with the same best gross motor performance and feeding method that AM has. AM's additional positive factors were the following:

- (a) She is in good health apart from her severe cerebral palsy and associated complications.
- (b) She is well-grown when compared to Californian tube-fed GMFCS level V girls.
- (c) She is a happy and content child that sleeps well at night.
- (d) She has not had any severe chest infections and has good upper airway control for a tube-fed child.
- (e) She does not drool excessively.
- (f) She was noticeably more attentive and interactive at the age of 9 years compared to when she was assessed in 2021 at the age of 6 years.
- (g) The improvement in her socializing skills between 6 and 9 years is an unusual and unexpected finding in a child with GMFCS level V function and profound cognitive impairment.

³⁰ JC Brooks, DJ Strauss, RM Shavelle, LM Tran, L Rosenbloom and YW Wu 'Recent trends in cerebral palsy survival. Part II: individual survival prognosis' (2014) 56(11) *Developmental Medicine & Child Neurology* 1065 at 1069.

³¹ JC Brooks, DJ Strauss, RM Shavelle, LM Tran, L Rosenbloom and YW Wu 'Recent trends in cerebral palsy survival. Part II: individual survival prognosis' (2014) 56(11) *Developmental Medicine & Child Neurology* 1065 at 1069.

[56] Dr Botha testified that although probability favours that AM would lose the ability to lift her head in the prone position before adulthood there remained a chance that she could maintain this ability into adulthood. To allow for this possibility, he constructed life expectancy tables for Californian children like AM who cannot lift their heads in the prone position and who can lift their heads in the prone position and are tube fed. He then made a modest adjustment for the number and extent of additional impairments displaced by AM:

- (a) The scenario where she cannot lift her head in the prone position into adulthood, he increased the yearly probability of dying by 10%.
- (b) In the scenario where she maintains head lifting ability, he increased the yearly probability of dying by 20% from 9 to 30 years and by 10% thereafter.

[57] In both instances, the magnitude of the adjustment is very similar to the impact of adjusting the mortality rate by 5.4 deaths per 1000 person-years for epilepsy. Dr Botha testified that he then adjusted the Californian Life Tables by using the percentage of normal life expectancy in California. In doing this adjustment he specifically used the Californian 2010 general population female life table at 15-; 30-; 45-; and 60- years. He then determined the equivalent life expectancies at these ages for the South African general population female life table, derived from the life expectancy at birth and under 5-year-mortality, published by Statistics South Africa in 2018.

[58] Dr Botha testified that he then selected Life Table 4 of his own constructed life tables, which accompanies his report, as most applicable to AM and hence at 9 years, he estimated AM's life expectancy to be an additional 12 years. Dr Botha further testified that Life Table 5 of his own constructed life tables, which accompanies his report, provides what can be considered the upper bound of AM's life expectancy. based on the assumption that she will maintain her ability to lift her head in prone. It provides a life expectancy estimate of 16 additional years at 9 years of age.

[59] Dr Botha, testifying with reference to his report, he stated that in estimating AM's life expectancy, he considered that AM presented with additional negative factors, including those which are set out as follows:

- (a) She has a profound cognitive impairment.
- (b) Although she is alert and enjoys reciprocal attention, she has not developed any of the cognitive skills that are associated with a neurotypical child that is 18 months old.
- (c) She has an IQ of less than 20.
- (d) She does not use any words and according to Reid *et al*,³² Hillerman and Baird *et al*³³ documented that lack of speech is associated with decreased survival probabilities in cerebral palsy cases.
- (e) AM has no hand use and according to Baird³⁴ there is a dramatic impact on survival probabilities of cerebral palsied children with both lack of speech and no hand use than cerebral palsied children that have either lack of speech but have hand use or lack hand use but have speech.
- (f) Blair *et al*³⁵ documented the dramatic additional negative impact of profound cognitive impairment among cerebral palsied individuals when compared to those with severe cognitive impairment.
- (g) Blair *et al* further documented that by the age of 15 years 50% of cerebral palsied children with severe cognitive impairment have died compared to only 25% of cerebral palsied children with severe cognitive impairment.
- (h) Reid (2021)³⁶ documented that the adjusted hazard ratio of death for severe and profound cognitive impairment was 3%, however, in the analysis of

³² SM Reid, J McCutcheon and DS Reddiough 'Survival of individuals with cerebral palsy born in Victoria, Australia, between 1970 and 2004' (2012) 54(4) *Developmental Medicine & Child Neurology* 353-360.

³³ MW Baird and J Vargus-Adams 'Outcome measures used in studies of botulinum toxin in childhood cerebral palsy: a systematic review' (2010) 25(6) *Journal of Child Neurology* 721-727.

³⁴ MW Baird and J Vargus-Adams 'Outcome measures used in studies of botulinum toxin in childhood cerebral palsy: a systematic review' (2010) 25(6) *Journal of Child Neurology* 721-727.

³⁵ E Blair, L Watson, N Badawi and FJ Stanley 'Life expectancy among people with cerebral palsy in Western Australia' (2001) 43(8) *Developmental Medicine & Child Neurology* 508-515.

³⁶ Dr Botha did not provide the full details of the article and this article was not contained in the literature in Bundle G. I have therefore referred to this article in general terms as referred to by Dr Botha.

Reid *et al*³⁷ the most severe stratification of motor impairment was in the ability to ambulate.

(i) She has an active seizure disorder. Active seizure disorder is associated with decreased survival probabilities. Experts that provide life expectancy estimates for cerebral palsied litigants would usually add 5.3 deaths per 1000 person-years to the yearly mortality rate to reflect the increased risk of death associated with generalised seizures based on the data provided by Strauss (2023).³⁸³⁹

(j) She is incontinent of urine and stool. Strauss (1998)⁴⁰ documented that the proportionate hazard ratio of death for no toileting skills in the 15-year-old cerebral palsy cohort was 2.9 increasing to 3.5 in the 30-year-old cerebral palsy cohort.

(k) AM has clinically apparent scoliosis which did not appear to be clinically severe in May 2024, however, scoliosis communally progresses rapidly during the pubertal growth spurt.

(l) AM contractures in all her four limbs and her contractures worsened during the four years between his assessments as was expected.

[60] Dr Botha further testified that he did not make any specific adjustments for seizures. He stated that the probability of AM losing the ability to lift her head is 66%. Dr Botha disagreed that the use of Table II instead of Table III⁴¹ did not result in a significant difference as Dr Campbell had testified. Dr Botha pointed out that in his view the 7% difference between his life expectancy estimate to that of Dr Campbell made a

³⁷ SM Reid, J McCutcheon and DS Reddiough 'Survival of individuals with cerebral palsy born in Victoria, Australia, between 1970 and 2004' (2012) 54(4) *Developmental Medicine & Child Neurology* 353-360.

³⁸ Dr Botha did not provide the full details of the article and this article was not contained in the literature in Bundle G. I have therefore referred to this article in general terms as referred to by Dr Botha.

³⁹ S Day, D Strauss, R Shavelle, and YW Wu 'Excess Mortality in Remote Symptomatic Epilepsy' (2003) 35 *Journal of Insurance Medicine* 155 - 160, DJ Strauss, SM Day, Rm Shavelle, and YW Wu 'Remote Symptomatic Epilepsy: does seizure severity increase mortality?' (2003) 60 *Neurology* 395 - 399.

⁴⁰ Dr Botha did not provide the full details of the article and this article was not contained in the literature in Bundle G. I have therefore referred to this article in general terms as referred to by Dr Botha.

⁴¹ See JC Brooks, DJ Strauss, RM Shavelle, LM Tran, L Rosenbloom and YW Wu 'Recent trends in cerebral palsy survival. Part II: individual survival prognosis' (2014) 56(11) *Developmental Medicine & Child Neurology* 1065 at 1068-1069.

significant difference. When it was put to him that Dr Campbell criticised him for using Table III, which applies to adolescents and adults and not to children, Dr Botha pointed out that it is not possible to provide for life expectancy at the age of 4 that is why the starting point is 15 years.

[61] Under cross-examination, Dr Botha admitted that he had attached to his report dated 22 November 2021 what he called a working document. He further admitted that in this working document it is recorded that there were 20 editions of it and that this working document kept changing. Moreover, Dr Botha admitted that in his report he has made it clear that he had no formal qualification as a statistician or an actuarial scientist. However, despite his lack of qualifications he stated that 'he has the audacity to interrogate and ultimately discard accepted methodologies commonly used in constructing life tables for cerebral palsy individuals and proffer his own methodologies.'⁴² When it was put to Dr Botha that he was self-qualified and had no formal or objective qualifications, he agreed with this proposition. Dr Botha further stated that he has been criticised for generating a South African life expectancy table in 2018. Dr Botha testified that the reason he generated a South African life expectancy table is because he was not satisfied with the 1986 life expectancy table. When it was put to Dr Botha that he did this because he thought that he was qualified to draw a reliable life table, he agreed with this proposition. Dr Botha conceded that his work has not been published in journals, which are peer-reviewed. He testified that the court must take his word that his methodology was logical. When it was put to him that his expertise was self-taught, Dr Botha conceded to that proposition. Dr Botha admitted to what he recorded in his report that in 2020 Strauss and Dr Campbell accused him of being hostile and implied that he had such a bad attitude that he cannot be an objective expert. Following some introspection, he realised that he had at times been too robust in presenting his arguments and perhaps too outspoken and decided to produce the third edition of his working document with the explicit aim of toning down his statements and demonstrating a less forceful approach.⁴³ Dr Botha, again admitted that he had

⁴² Bundle D: Vol 2: page 186: paragraph 1.19 and 1.20.

⁴³ Bundle D: Vol 2: page 187: paragraph 1.34.

recorded in his report that his intense analysis of life expectancy opinions had led to the discovery that the methods used by respected life expectancy experts to construct life tables for the plaintiffs are sometimes scientifically flawed.

[62] Dr Botha confirmed that when he assessed AM for the first time, she was 6 years and 2 months old. When it was put to him that AM is much better than when he assessed her, Dr Botha contended that the reason why AM may not have fared well during his assessment may have been because the assessment was conducted in the afternoon and AM must have been exhausted at that time. Dr Botha admitted that he recorded in his report that AM lifted her head off the mat twice during her initial assessment. He added that for that period AM took a medical sedative, Ativan and would have calmed down AM. Dr Botha confirmed having recorded in his report that AM was completely inept, she did not respond when called upon and she had very little contractures. When it was put to him that as an expert dealing with AM's life expectancy, he was required to do more than seeing AM once in his rooms, he stated that at the time he was not provided with any expert reports. However, he acknowledged that he did not ask for any reports and that if he had phoned, he could have been told that there were other reports, which had already been compiled. Dr Botha confirmed that when he assessed AM in November 2021, Ms Prinsloo had already assessed AM in July 2020. When it was put to Dr Botha that what he said in his main report in relation to AM being completely inept is markedly different from the objective physiotherapy assessment of Ms Prinsloo's as recorded paragraph 7.1 of her report in relation to AM being able to move, Dr Botha stated that he did not know whether AM was on medication at the time of the assessment. In addition, he stated that if the observations made support those findings there could possibly have been a gross regression when Ms Prinsloo's assessment was made in July 2020, and when he made an assessment in August 2021. When it was pointed out to Dr Botha that Ms Prinsloo in her report, under general observations, did not give a picture of AM being a completely dull and flat child, which Dr Botha reported about in November 2021, his response was that the only defence he could proffer was that at times it is extremely difficult to get reports from the State Attorney's office. Dr Botha suggested that he was

therefore hamstrung by the people who instructed him. Dr Botha admitted that as an expert he was required to give a full picture in his report.

[63] When it was put to him that in 2021, he was firmly of the view that AM had essentially peaked, and she would not do better, Dr Botha admitted this proposition. However, he added that 15 years is not referring to an absolute age, that is why in 2024, he introduced the second scenario. He stressed that in his original report he had said that the chance of AM lifting her head at 15 years was 18%. Dr Botha confirmed that in his report he stated that AM's gross motor skills improved between the age of 6 and 9 years and this improvement does not affect the probability of her losing the ability to lift her head in the prone position in early adulthood. When it was put to him that a child who was 15 years of age cannot possibly be regarded as an adult he replied and stated that adulthood would technically start after 15 years. He added that 15 years is not incompatible with adulthood and a 15-year-old can be referred to as an adult. Dr Botha stated early adulthood is 15 years in females. Dr Botha confirmed that his assessment of AM put her at a lower level than what the extracts from the videos, which were taken by the plaintiff, depicted. Dr Botha testified that in order to estimate AM's life expectancy he took the Californian life table and put it on the RSA life table and then made various adjustments. When it was put to him that when he made the adjustments, he applied 20% and broke down the 20%, Dr Botha testified that he could not specify which of the hazard ratios constituted the 20%. He added that in that 20% there could be positive factors. Dr Botha pointed out that the impact of epilepsy at hazard rates gives 1.2%. Dr Botha confirmed that the estimated life expectancy looks at positive factors such as weight and good health against the negative factors. Dr Botha confirmed that in order to derive a realistic estimate of the increased mortality of profound intellectual impairment, within the stratification of individuals who cannot lift their heads in the prone position, and are tube-fed, he decreased the relative risk of dying to 2.0% associated with profound intellectual impairment compared to severe intellectual impairment between the ages of 5 and 35 by 60%, based on the probable distribution of severe and profound cognitive impairment within this cohort. Dr Botha suggested that this adjustment was his view of how typical AM was. Dr Botha pointed

out that in his view, AM has a profound cognitive impairment and this accounts for the 10% for AM's probability of dying after attaining the age of 30 years. Dr Botha confirmed that he agreed with the statement at page G5 of bundle G that: 'When survival prognoses of an individual patient with CP [cerebral palsy] is of interest one can refer to Tables II and III, which provide estimates based on age, sex, severity of motor disability, and need for feeding assistance.'⁴⁴

[64] Dr Botha admitted that to the proposition that after the choice of a reference table is made one must determine if the factors of each of the tables are typical or atypical group. When it was put to him that AM does not fit neatly in the category of the table, he had chosen, Dr Botha retorted by saying that the only ability that AM had was to roll to the side and partial rolling is not documented anywhere in the article. When it was put to him that life expectancies are age-specific and those in Table III are for adolescents and adults and do not apply to children Dr Botha agreed. Dr Botha admitted that when he assessed AM, she was a child of over 6 years.

[65] In re-examination, Dr Botha introduced exhibit 4, which is life expectancy report, which was prepared by Dr Strauss in the case of *Shange v MEC for Health, KZN*: case no. 1113/2014. There is nothing which turned out of the introduction of this exhibit except the criticism which is recorded in this exhibit in relation to the methodology used by Dr Botha to estimate life expectancy.

[66] The next witness for the defendant was Ms Prinsloo, who assessed AM on 27 July 2020. Ms Prinsloo confirmed having prepared the relevant report and the joint minutes of occupational therapists in bundle B. She testified that Ms Bainbridge and her agreed that AM would benefit from attending Pathways for stimulation to the age of 18 years. However, she and Ms Bainbridge disagreed on AM attending Pathways after she attained the age of 18 years to life expectancy. She was of the view that this was unnecessary while Ms Bainbridge was of the view that it would be beneficial for AM to

⁴⁴ JC Brooks, DJ Strauss, RM Shavelle, LM Tran, L Rosenbloom and YW Wu 'Recent trends in cerebral palsy survival. Part II: individual survival prognosis' (2014) 56(11) *Developmental Medicine & Child Neurology* 1065 at 1069.

attend Pathways to life expectancy. In addition, they further agreed on case management until AM reached the age of 18 years. However, they differed on fee structure and the hours to be allowed for this task. In addition, they differed on whether case management was required after AM attained the age of 18 years to life expectancy. Ms Prinsloo postulated case management from 9 years until AM reached 18 years, while Ms Bainbridge postulated case management to life expectancy. Finally, they agreed on the need for a case manager to attend the meetings of the trust and to the writing of the reports to the trust, but they disagreed on the fee structure and hours to be allowed for these tasks.

[67] Ms Prinsloo testified that AM, after attaining the age of 18 years, would require a rest period because by then she would have reached her potential both cognitively and physically. She would not benefit from being in the stimulation centre. She would rather benefit by being cared for at home. It would rather be prudent for the case manager and the caregiver to take AM out on wheelchair drives and bring her home when she was tired. Home stimulation would be beneficial to AM in that she would be able to rest if she needed to. Ms Prinsloo stated that in relation to case management, the fundamental point of disagreement was in relation to the hours. She pointed out that what informed the hours, which she proposed, is that she looked at AM, her mother, her mother's support system and where they would live. She testified that since the plaintiff had reported to Ms Bainbridge that there is a database of caregivers, which is where they could be sourced, it would be appropriate if the time for the sourcing and interviewing of caregivers would be set at 3 hours every 5 years. Ms Prinsloo testified further that case management should be given from 9 years to when AM attained 18 years for 15 hours at the rate of R15 000. Ms Prinsloo pointed out that the reason for this proposition is that the issues that attended to when AM is aged 10 years would not be different to the issues when AM is aged 18 years. She further pointed out that doctors do not have to be sourced every year. Ms Prinsloo testified that 6 hours for report writing and the attendance at the meeting with the trust is just too long. From her side she was recommending that provision be made for 3 hours at the rate of R3 000.

[68] Under cross-examination, Ms Prinsloo testified that she does not personally give case management and she was merely a practitioner. She admitted that it was a case manager who would attend meetings, including an annual general meeting and write reports. Ms Prinsloo admitted that for the attendance of such meetings and report writing she recommended R3 000 per month. Ms Prinsloo, though, conceded that 6 hours in a year is not excessive. When it was put to her that there was no reason to deprive AM of any benefits as one must treat a patient as far as he or she could go, Ms Prinsloo stated that the child can only be stimulated, but her condition cannot be improved. This then concluded the evidence of the defendant.

The parties' submissions

[69] Mr *Pillemer SC*, who appeared with Ms *Gajoo*, argued that this court should find the life expectancy of 19.4 additional years as fair and reasonable and as such it is the one that should be applied. They then provided actuarial calculations by Mr Whittaker of Algorithm Consultants and Actuaries CC, based on the projected life expectancy of 9.4 additional years. However, they submitted that an actuary would be available on short notice should this court make a different determination on the question of life expectancy to the one they proposed.

[70] Mr *Mthembu SC*, who appeared together with Ms *Takchund*, argued that this court should find the life expectancy of 16 additional years as fair and reasonable and is the one which this court should apply.

[71] Mr *Mthembu SC* requested the court after the conclusion of the argument that the defendant be allowed to instruct an actuary to do actuarial calculations on the scenarios as postulated by the relevant experts. This court granted the defendant that opportunity and the relevant actuarial calculations were delivered on 1 July 2024.

Actuarial calculations

[72] The defendant's actuary, Mr Mavimbela of Manala Actuaries and Consultants, did actuarial calculations on the plaintiff's loss of earnings based on Dr Botha's life

expectancy of 12 additional years as well as Dr Botha's estimated life expectancy of 16 additional years. In addition, he made actuarial calculations on loss of earnings based on Dr Campbell's estimated life expectancy of 19.4 additional years. Further, he made actuarial calculations in respect of future medical expenses based on Dr Campbell's estimated life expectancy of 19.4 additional years. Moreover, they made actuarial calculations on future medical expenses based on Dr Botha's estimated life expectancy of 16 additional years as well as Dr Botha's estimated life expectancy of 12 additional years.

[73] First, it seems that it was unnecessary for any actuarial calculation to be done on Dr Campbell's estimated life expectancy of 25 additional years. Second, that projection was based on the assumption of AM's mobility of 'full rolling and does not walk unaided.' Considering Mr *Mthembu's* submission during argument that this court should find that the life expectancy of 16 additional years is fair and reasonable it was no longer necessary for actuarial calculations to be done on Dr Botha's estimated life expectancy of 12 additional years.

[74] On 2 September 2024, this court through the registrar, enquired from the parties whether do they not consider it necessary to file brief heads of argument consequent upon the defendant having filed their actuarial calculations on 1 July 2024. The parties were then requested to file their heads of argument on or before 9 September 2024, should they consider it necessary. On 9 September 2024, the defendant advised that it would not be filing any further heads of argument. The plaintiff on the other hand requested an indulgence to file further heads by mid-day, 10 September 2024. This court granted this indulgence after the fact as the request came to its attention after the requested timeframe.

[75] In the further heads of argument, which were filed on behalf of the plaintiff, the plaintiff's counsel prepared five tables which set out the differences in the calculations by each actuary. I will revert to these tables later in this judgment. It is argued on behalf of the plaintiff that there is a nominal difference between the total life expectancy

calculations as a result of time difference when the calculations were made. |In summary, there is, a substantial difference between the two calculations in the sum of R893 834.00 in respect of the plaintiff's future medical expenses. Mr Whittaker explained these differences in an email dated 9 September 2024. In essence he stated that the main reason for the differences was due to the adjustment made to the life tables. He pointed out that Mr Mavimbela applies a different method of adjustment to the underlying mortality table that leads to higher capitalized values. In addition, Mr Whittaker, attached to his email an article by Strauss *et al* titled 'Estimation of Future Mortality Rates and Life Expectancy in Chronic Medical Conditions.'⁴⁵ Mr Whittaker explained that, in this article, Professor Strauss *et al* recommends the use of the log-linear declining relative risk (LDR) method for cerebral palsy cases, which is the method he used.

[76] This court has considered this article. In one of the passages in this article Strauss *et al* records that proportional life expectancy ('PLE') and LDR models 'are clearly the best methods for the case of cerebral palsy, giving errors of approximately 1 year only.'⁴⁶

[77] I have reproduced below the tables, which I have referred to above, and the argument, which was advanced for the plaintiff in relation to the differences under each of the different heads of damages covered in the relevant tables.

Loss of earnings

<u>REPORT</u>	<u>LIFE EXPECTANCY</u>	<u>CALCULATION</u>
<u>ON THE SAME LIFE EXPECTANCY</u>		
Whittaker (B)	19.4 add. Years at age 9 =	Future loss: R1 172 367

⁴⁵ DJ Strauss, PJ Vachon and RM Shavelle 'Estimation of future mortality rates and life expectancy in chronic medical conditions' (2005) 37(1) *Journal of Insurance Medicine* 20-34.

⁴⁶ DJ Strauss, PJ Vachon and RM Shavelle 'Estimation of future mortality rates and life expectancy in chronic medical conditions' (2005) 37(1) *Journal of Insurance Medicine* 20 at 30.

(Plaintiff)	age 28.4 Total LE	Less 15% contingency (as agreed) R996 511.95
Manala (“C3”)	19.4 add. Years at age 9.3 = 28.7 years Total LE	Future Loss: R1 129 299 Less 15% contingency R959 904.15
<u>OTHER LIFE EXPECTANCIES:</u>		
Manala (defendant) (“C1”)	12.19 add. Years = age 21.19 total LE	Future Loss R516 809 Less 15% contingency R439 287.65
Manala (defendant) (“C2”)	Age 25 total LE	Future Loss: R731 413 Less 15% contingency R621 701.05

[78] In relation to this head of damages, it is argued that on the suggested life expectancy (written ‘LE’ in the table) of 19.4 additional years, and after the application of a 15% contingency, as agreed between the parties, there is only a difference of R36 607.80 in the calculation by the actuaries. It was therefore submitted that it would be reasonable if this court awarded damages under this head in the sum of R996 511.95.

Future medical expenses

[79] Counsel for the plaintiff then made comparisons on the actuarial calculations on the suggested life expectancy of 19.4 additional years at age 9.3 for a total life expectancy of 28.7 years old.

Caregiving

<u>Details</u>	<u>Plaintiff</u>	<u>Defendant</u>
Until age 18:		

Caregiver 1 (12 hour) Caregiver 2(12 hour)	R1 205 352 R1 205 352 = R 2 410 704	R1 254 336
From age 18: Caregiver 1 (24 hour) Caregiver 2 (24 hour)	R1 187 779 R1 187 779 = R2 275 558	R2 538 092
TOTAL	R4 686 262	R3 792 428

[80] In relation to the figures in this table, it is argued that the underlying recommendations are the same and the difference of R893 834.00 is explained by the different methods used by the respective actuaries. It was therefore submitted that it would be reasonable if this court awarded damages under this head in the sum of R4 686 262.00.

Adaptations to home

<u>Details</u>	<u>Plaintiff</u>	<u>Defendant</u>
Total Build Cost	R702 138.00	R701 225.00
Maintenance	R143 956.00	R143 775.00
Architecture Fee	R97 799	R97 676
Appliances	R37 765	R37 718
Furniture for Carer	R8 978	R8 967
Alarm System	R9 212	R9 200
Battery Back Up	R25 532	R25 500

Total	R1 025 379	R1 024 061
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[81] In respect of this table, it was pointed out, on behalf of the plaintiff, that the costs calculated by the actuaries are almost the same and there are no material differences. Once more this court was urged that it would be reasonable to award damages under this head in the sum of R1 025 379.00.

Case management

<u>Details</u>	<u>Plaintiff</u>	<u>Defendant</u>
Initial set up	R15 000	R15 000 (agreed)
Sourcing and Interviewing Caregivers and Domestic Workers	R25 854	R28 783 (on the plaintiff's version)
Sourcing and interviewing Caregivers and Domestic Workers		R10 713 (on the defendant's version)
Case Management until age 18	R169 677	R177 042
Case Management from age 18	R158 645	R143 089 (on the plaintiff's version)
Case Management from age 18		R15 000 (on the defendant's version)
Report writing & meetings	R87 723	R94 716 (on the plaintiff's version)
Report writing & meetings		R47 358 (on the defendant's

		version)
Crisis Management	R34 491	R30 501 (agreed)
TOTAL	R491 398	R295 614 (on the defendant's version)

[82] In relation to this table, it was submitted that once again, the amounts calculated by the different actuaries are not very different. The only differences are the scenarios, which underpin these calculations. It was submitted that it would be reasonable if this court awarded damages under this head in the sum of R491 398.00.

Transportation requirements

<u>Details</u>	<u>Plaintiff</u>	<u>Defendant</u>
VW Caddy (new 1.6l manual) – once off	R509 286	R509 000
VW Caddy (new 1.6l manual) every 8 years	R296 038	R299 420
VW Caddy (used 1.6l) - once off		R389 000
VW Caddy (used 1.6l) – every 8 years		R228 830
Wheelchair Docking System (new) - once off	R87 549	R87 500
Wheelchair Docking System (used) - once off		R65 000
Docking system restraints - once off	R9 806	R9 800
Docking system restraints - age 25	R966	R1 140

TOTAL	<u>R903 644</u> (based on new items)	<u>R693 770</u> (based on used items)
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[83] In relation to this table, it was submitted on behalf of the plaintiff that the provisions of new vehicles and devices are more suitable for AM's needs as they would provide reliability and longevity. In the circumstances, this court should allow an amount of R903 644 be allowed.

Stimulation centre

<u>Details</u>	<u>Plaintiff</u>	<u>Defendant</u>
Pathways until age 18	R431 307	R440 744
Pathways from age 18	R479 561	R393 774
TOTAL	R910 868	R834 518

[84] In relation to this table, it was pointed out that there is a difference of R76 350 between the actuaries' calculations. Once more this court was urged to allow a sum of R910 868.00 for this head of damage.

[85] Mr *Pillemer* and Ms *Gajoo*, in the plaintiff's further heads of argument, argued that Mr Whittaker's actuarial calculations should be followed. I have considered both actuarial calculations and the fundamental reason why there is a substantial difference between the actuarial calculations in respect of future medical expenses. This court accepts Mr Whittaker's explanation for this substantial difference based on his email and the literature, which he had attached to the email as reasonable and logical. In the circumstances and absent any countervailing explanation this court sees no reason why it should not follow the actuarial calculations of Mr Whittaker.

The law

[86] In *Singh v Ebrahim*⁴⁷ this court stated the following:

‘[9] At common law, the basic principle underlying an award of damages of this nature in terms of the *actio legis aquiliae*, is that the compensation should be assessed with a view to place the injured party, as far as it is reasonably possible, in the position he would have been had the injury not occurred (*Union Government (Minister of Railways and Harbours) v Warneke* 1911 (AD) 657 at 665). The principle has been succinctly summarized by the Court of Appeal in *Heil v Rankin and Another and other* [2000] 3 All ER 138 at paragraph 22 as follows:

“ . . . the aim of an award of damages for personal injuries is to provide compensation. The principle is that ‘full compensation’ should be provided . . . this principle of full compensation applies to pecuniary and non-pecuniary damage alike . . . ”

And at paragraph 27:

“ . . . compensation must remain fair, reasonable and just. Fair compensation for the injured person. The level must also not result in injustice to the defendant and it must not be out of accord with what society as a whole would perceive as reasonable.”

[10] Damages include direct positive losses (*damnum emergens*) and also negative losses (*lucrum cessans*) - being that which the injured party is prevented from achieving - insofar as those losses flow from the delict – *Whitfield v Phillips and ano.* 1957(3) SA 318 (A) at 329 and *Guggenheim v Rosenbaum* (2) 1961(4) SA 21 (W) at 34.’

[87] Mr *Mthembu* and Ms *Takchund*, in their heads of argument relying on *Broom v Administrator Natal and Accident Versekerings Maatskappy SA Bpk v Uijs*,⁴⁸ argued that an injured person may, in addition to compensation for medical expenses, recover reasonable damages for items such as costs of transport to and from hospital or

⁴⁷ *Singh and another v Ebrahim* (1) [2010] 3 All SA 187 (D) paras 9-10.

⁴⁸ *Broom and another v The Administrator, Natal* 1966 (3) SA 505 (D) at 526; *Kloppers v Rondalia Assurance Corporation of SA Ltd* 1972 (213) QOD 289 (W); *General Accident Versekeringsmaatskappy SA Bpk v Uijs* NO 1993 (4) SA 228 (A) at 236-237.

doctors; the costs of special transport to and from school; the cost of an attendant for someone who is seriously injured, in the case of a paraplegic. It is conceivable that reasonable expenses in terms of the modification of a motor vehicle or a house of the position of apparatus to render his or her life more comfortable may be recoverable; and the expense of purchasing a vehicle by a paraplegic *vis-à-vis* place of abode and his needs and compensation for accommodation in a specialised institution. In addition, they referred this court to the case of *Medi-Clinic Ltd v Vermeulen*⁴⁹ in relation to the general approach to the assessment of expert evidence where the following was stated: 'the court has to be satisfied that the exponents of the body of opinion relied on can demonstrate that such opinion has a logical basis.' It should be noted that 'An expert is not a hired gun who dispenses his or her expertise for the purposes of a particular case.'⁵⁰

Life expectancy of AM

[88] Mr *Pillemer* submitted that the court should accept Dr Campbell's estimate of the life expectancy of AM of 19.4 additional years as at the age of 9 years and 3 months. He submitted that those projections are based on a methodology that is standard, and set out in peer-reviewed literature, and that this court should reject Dr Botha's estimates of life expectancy, because it was founded on his own uniquely developed approach, which has not been published and/or peer-reviewed. In addition, he criticised Dr Botha for his unbelievable lack of judgment. First, for seeking to rely on exhibit 4, which was an expert opinion rendered in a different case by another expert, which did not only amount to hearsay evidence but also severely criticised the methodology which he used as that of his own devising which was divorced from standard practices. In addition, Strauss who is an eminent expert in the field of life expectancy, unequivocally stated in exhibit 4 that he and his colleagues have not been able to make sense of Dr Botha's methodology. Moreover, he stated if Dr Botha wished to challenge the established statistical/actuarial methodology for life expectancy he was certainly free to do so provided that, he published his methodology in peer-reviewed scientific literature other

⁴⁹ *Medi-Clinic Ltd v Vermeulen* [2014] ZASCA 150; 2015 (1) SA 241 (SCA).

⁵⁰ *Schneider NO and others v AA and another* 2010 (5) SA 203 (WCC) at 212A-B.

than expressing it in litigation regarding individual children. Mr *Pillemer* argued further that when Dr Botha prepared his main report, he did so without having regard to any of the other reports and gave a different picture about AM.

[89] Mr *Mthembu* argued that while Dr Campbell criticised Dr Botha's construction of life tables, suggesting they fell within the domain of a statistician or an actuary, he himself conceded that he too compiled life tables individual to the child. He further argued that in annexure 4 to his report, Dr Campbell had acknowledged that he himself was not a statistician or an actuary. In addition, while he criticised Dr Botha for stratifying AM in terms of Table III of Brooks *et al*,⁵¹ he conceded that Strauss who is one of the authors of the Brooks *et al* publication, on occasion used Table III for the purposes of stratifying a child. Mr *Mthembu* added that Dr Campbell stated that he himself on occasion had used Table III for the purposes of stratifying a child. Mr *Mthembu* therefore urged this court to find Dr Botha's estimates of AM's life expectancy of 16 additional years as fair and reasonable.

[90] Dr Campbell, as has been previously indicated, provided life expectancy projections in this case when AM was 5 years and 5 months old⁵² and when she was 7 years and 4 months old⁵³ and then finally for the purposes of trial when she was 9 years and 3 months old.⁵⁴

[91] Dr Campbell testified that when estimating AM's life expectancy fundamentally he relied on published information contained in the Brooks *et al* publication. It is apposite to quote from Brooks *et al*⁵⁵ the following:

⁵¹ JC Brooks, DJ Strauss, RM Shavelle, LM Tran, L Rosenbloom and YW Wu 'Recent trends in cerebral palsy survival. Part II: individual survival prognosis' (2014) 56(11) *Developmental Medicine & Child Neurology* 1065 at 1069.

⁵² Bundle C: Vol 2: pages 131 - 213.

⁵³ Bundle C: Vol. 5: pages 408 - 519.

⁵⁴ Bundle C: Vol. 7: pages 702 – 776 and Bundle C: Vol. 8 pages 844 - 848.

⁵⁵ JC Brooks, DJ Strauss, RM Shavelle, LM Tran, L Rosenbloom and YW Wu 'Recent trends in cerebral palsy survival. Part II: individual survival prognosis' (2014) 56(11) *Developmental Medicine & Child Neurology* 1065 at 1069-1070.

‘When survival prognosis of an individual patient with CP [cerebral palsy] is of interest one can refer to Tables II and III, which provide estimates based on age, sex, severity of motor disability, and need for feeding assistance. The figures there are appropriate for individuals whose overall condition is typical of the group. To determine whether this is the case, other factors (e.g. activities of daily living, intellectual disability and communication, comorbidities, general health, height and weight, and so on) should also be considered.

. . .

Along these same lines, it should be noted that life expectancies are age specific and those given in Table III for adolescents and adults generally do not apply to children of younger ages. For young children, the survival figures given in Table II may be used, or more detailed calculations may be undertaken.’

[92] Mr *Pillemer* argued that the question of whether the individual’s condition as a whole is typical of a group is particularly important in cases where an individual’s pattern of disability does not fit neatly into one of the categories listed in the article. Moreover, he argued that if the person’s profile with respect to these and other predictive factors is markedly better or worse than the average then some further adjustments to the survival prognosis may be indicated. Mr *Pillemer* pointed out that the article stresses that aside from the other considerations,⁵⁶

‘The most compelling argument for the use of survival prognosis of other countries is the fact that when the severity of disability is taken into account, the survival probabilities for persons with CP [cerebral palsy] in California are markedly similar to those from other countries. If one were to make some adjustments to the life expectancy to reflect the country of residence, the “percentage of normal” method . . . remains a reasonable choice’.

⁵⁶ JC Brooks, DJ Strauss, RM Shavelle, LM Tran, L Rosenbloom and YW Wu ‘Recent trends in cerebral palsy survival. Part II: individual survival prognosis’ (2014) 56(11) *Developmental Medicine & Child Neurology* 1065 at 1070.

[93] It is trite that this method has now found approval in this country and has been approved by our courts.⁵⁷ Dr Campbell had specifically set out the methodology in his original report dated 2 July 2020, and in his supplementary reports dated 26 June 2022 and 19 March 2024⁵⁸ respectively. In the joint minutes, both Drs Campbell and Botha agreed that it is reasonable to rely on Brooks *et al* publication⁵⁹ on survival patterns and life expectancy in persons with cerebral palsy when estimating life expectancy in this matter.⁶⁰ Dr Botha has acknowledged that the methodology, which Dr Campbell used has been described in the literature.⁶¹ During cross-examination, Dr Botha made several concessions in relation to the flaws in the methodology he used. Dr Botha used his own method to construct life tables, which are unique to him and that such tables have not been peer-reviewed in published literature. He attached to his report what he referred to as a working document, which runs into hundreds of pages, which has 20 editions and these keep changing over time. Mr *Pillemer SC* specifically criticised Dr Botha for lack of judgment when Dr Botha insisted and placed before this court exhibit 4. Exhibit 4 does not only amount to inadmissible hearsay evidence it also contains a severe criticism of the very methodology that Dr Botha wants this court to follow. In my view, Mr *Pillemer* correctly criticised Dr Botha that there was no reasonable basis which he advanced to seek this court to rely on his own work as authority for his views. Mr *Pillemer* relied on *Menday v Protea Assurance Company Ltd*⁶² to articulate this point. Dr Botha conceded that in preparing his report he did not consider the reports of the other experts, including reports of the defendant's experts that had already been secured at the time he prepared his report. Consequently, Dr Botha's initial report in relation to AM paints a picture that is in stark contrast to the reports of other experts.

⁵⁷ *Singh and Another v Ebrahim* [2020] ZASCA 145 and *AD and another v MEC for Health and Social Development, Western Cape Provincial Government* [2016] ZAWCHC 181; 2017 (5) SA 134 (WCC).

⁵⁸ Bundle C: Vol 2: pages 194 - 199: paras 7.1 - 7.4; Vol 5 pages 451 – 458: paras 4.1 - 4.5; Vol 7: pages 750 – 755: paras 5.1 - 5.4.

⁵⁹ JC Brooks, DJ Strauss, RM Shavelle, LM Tran, L Rosenbloom and YW Wu 'Recent trends in cerebral palsy survival. Part II: individual survival prognosis' (2014) 56(11) *Developmental Medicine & Child Neurology* 1065-1071.

⁶⁰ Bundle B: index to joint minutes page 82: para 2.

⁶¹ Bundle D: Vol 4: page 408: para 4.47.

⁶² *Menday v Protea Assurance Co Ltd* 1976 (1) SA 565 (E) at 569B-E.

[94] Unlike Dr Botha, I find that Dr Campbell's methodology is founded on logical reasoning. It accords with established literature. This court has no hesitation to accept as fair and reasonable the estimated life expectancy of AM of 19.4 additional years as at age 9 years and 3 months for a female child who can lift her head and shoulders in the prone position, can perform partial rolling and is tube-fed, as projected by Dr Campbell. Dr Campbell's downward adjustment for the fact that AM suffers from epilepsy and has contractures is in my view rational. I was not impressed with Dr Botha's testimony as he was a poor witness and made a bad impression to me particularly in relation to his methodology. What I found rather puzzling is that in his initial report Dr Botha severely self-criticised. I have highlighted the relevant pages and paragraphs in his report where he self-criticised, in the footnotes above, when he was under cross-examination by Mr *Pillemer*. Accordingly, I reject Dr Botha's methodology, which by his own admission is of his own devising and has not been published in peer-reviewed articles. However, I am unable to agree with Mr *Mthembu*'s proposition that simply because both Drs Botha and Campbell are neither statisticians, nor actuaries, they are therefore not experts in the projection of life expectancy. I say so because there is a body of authority where both Drs Botha and Campbell testified in this division and other courts in other provinces as experts in this area. In my view, there is no reason why their expertise should be put to question.

[95] In the circumstances, I find that the life expectancy of 19.4 additional years is fair and reasonable, and it is the one that should be applied.

The costs of the adaptation of the plaintiff's home

[96] The only remaining issues under this head is whether the plaintiff's adapted accommodation should include the built-in cupboards for the caregiver and whether it is reasonable to provide an alarm system with an intercom a battery back-up system to cover a maximum of 2 days of no electricity supply. Ms Bainbridge testified as to the reasonable need of these specific items. Ms Bainbridge was not challenged in cross-examination in relation to the necessity for each of these items. In addition, the defendant did not lead any countervailing evidence on any of these items, except for Mr

Mthembu's submission that the caregiver's bed to the extent reasonably required will be from the age 18 to life expectancy. Mr *Mthembu* further submitted that the alarm system is not related to the issue of negligence.

[97] It is undeniably that the issue of security in this country is one of the biggest issues, which has taken a centre stage especially when it relates to women and children. In this case we are not only talking of a household that is headed by a woman, we are also talking about a child who has been rendered vulnerable naturally not only because she was female, but also because of debilitating injuries she suffered at birth. Unlike other children, she would not be able to identify a would-be criminal and run away from him or her. She has been rendered totally defenceless. It is well to remember that in relation to whether a particular item of expenditure is necessary the test is whether it is reasonably required to make a condition or to ameliorate it and the necessity must be established on a balance of probabilities.⁶³ While we have not had loadshedding for a reasonably long period of time the fact is that loadshedding has been with us since 2008 and intermittently it would be gone for a few years before it is reactivated. In view of that, a provision must be made for AM if loadshedding was reactivated. I am therefore satisfied that both the built-in cupboards for a caregiver and an alarm system with an intercom and a battery back-up system are reasonably required and I will allow the costs for their installation.

Case management

[98] Both Ms Bainbridge and Ms Prinsloo are agreed on the need of case management. They agreed on the initial set up costs and the costs of case management at 15 hours at the rate of R1 000.00 per hour to include 4 home visits in the first year at the rate of R15 000.00. However, they disagreed in relation to the hours to be allowed for the performance of this task. Ms Bainbridge recorded the reasons why case management is essential in her report. She stated that it is essential to ensure necessary therapies, medication compliance, appropriate nourishment, stimulation and liaising with caregivers and family members. In her evidence, she stated that a case

⁶³ *Dhlamini v Government of the Republic of South Africa* 1985 (3A3) QOD 554 (W) at 585.

manager was a liaison between the trust, the parent, and caregivers. In relation to the sourcing and interviewing of caregivers and domestic helpers, Ms Bainbridge recommends 5 to 10 hours, every 5 years and R12 000 every 3 years. However, an average of 7½ hours was accepted as reasonable. Ms Prinsloo suggests 3 hours, every 5 years at the cost of R2 400. In relation to case management from 9 years to 18 years Ms Bainbridge proposes 24 hours annually at the cost of R24 000, while Ms Prinsloo proposes 15 hours at the cost of R15 000 from 9 years to life expectancy. In relation to case management from 18 years to life expectancy Ms Bainbridge suggests 18 to 24 hours per annum at the total cost of R18 000. It has however, been accepted that it would be fair to apply the average of that which would be 21 hours per annum. Ms Prinsloo contends that 15 hours from 9 years to life expectancy would be appropriate. In relation to report writing and the attendance of meetings, Ms Bainbridge proposes that 6 hours per annum be accepted, while Ms Prinsloo proposes that 3 hours per annum be accepted. Both Ms Bainbridge and Ms Prinsloo agree to 10 hours every 5 years for the purposes of crisis management at the rate of R10 000.00.

[99] Ms Prinsloo testified that the reasons behind the hours she proposed in relation to case management was that issues that the case manager would deal with when AM is 10 years would not be different to the issues that the case manager would deal with when she was 18 years. Insofar as the issue of the sourcing and the interviewing of caregivers Ms Prinsloo testified that the use of a database would streamline the sourcing of caregivers, which meant this process would be quicker and the hours much less. Ms Prinsloo, under cross-examination for the plaintiff, had however admitted that she was merely a practitioner and did not personally give case management. In addition, she admitted that 6 hours in relation to report writing and attendance of meetings was not excessive.

[100] Mr *Mthembu* suggested that this court should deem Ms Bainbridge to be a witness who was not objective. The reason for this suggestion is because Ms Bainbridge acted as a practitioner and in addition, she ran a case management company. As a result, of that she may well have had an interest in the matter, would

have been lacking objectivity and may well have been biased when she testified. This attack was founded on the basis that Ms Bainbridge personally gave case management. I disagree with Mr *Mthembu*. Ms Bainbridge did not display any interest in the matter, bias for the plaintiff and any lack of objectivity when she testified. When she was under cross-examination, she specifically stressed that she does not case manage cases which are current. Pointedly, she also stressed that she does not inflate the quantum or settle for something that is less. She was not challenged in relation to this pointed contention that she does not inflate the quantum. If any of the amounts, which she referred to were somehow inflated, she could have been challenged on her assertion. The fact that Ms Bainbridge acted as a case manager made her the expert she professed to be. Unlike Ms Prinsloo, who was not a case manager, Ms Bainbridge gave this court the invaluable insight it required on this item based on her experience. In my view, Ms Bainbridge's opinion was founded on logical reasons.

[101] In the circumstances, I find that 7½ hours every 5 years in respect of sourcing and interviewing of caregivers would be fair and reasonable. In relation to case management of AM from 9 years to 18 years, I find that 21 hours annually at the cost of R24 000 is fair and reasonable. In relation to case management from 18 years to life expectancy, I find that 21 hours per annum at the rate of R18 000.00 to be fair and reasonable. Finally, I find that 6 hours per annum at the rate of R7 200.00 for report writing and the attendance of meetings is fair and reasonable.

Transport requirements of AM

[102] Ms Bainbridge and Ms Prinsloo agreed on the provision of a suitably adapted motor vehicle with a docking system for a wheelchair for AM's use. It is proposed that this vehicle would be replaced every 8 years. The only issue in respect of the transport requirements of AM was the determination of life expectancy. To ensure reliability, longevity, and AM's safety, I agree with the plaintiff's counsel that the vehicle and other devices in relation to AM's transportation requirements should be new and not be second hand (or used). Based on the figures as agreed by the parties, the actuarial

calculation by Mr Whittaker on the estimated life expectancy of 19.4 additional years the amount in relation to this head of damages is R903 644.00.

The costs associated with AM attending a stimulation centre post 18 years

[103] Ms Bainbridge and Ms Prinsloo are agreed on the requisite need for AM to attend Pathways until she reaches the age of 18 years. The only dispute between the two of them is in relation to the need for AM to attend Pathways from 18 years until life expectancy. Ms Bainbridge testified that the attendance at Pathways by AM will provide her with an opportunity of stimulation and socialisation. Ms Prinsloo on the other hand disagreed and suggested that AM would not benefit from such attendance instead she would benefit if she received care at home wherein the case manager and caregiver would take her out on wheelchair rides and whenever she was tired bring her home to rest.

[104] In the determination of this issue, it is also relevant to consider the other dimensions of what the plaintiff attested to when she described AM. She described AM as a happy child who likes other children. She stated that, although at times she was moody, she liked people. This evidence also spoke directly to the issue of stimulation and socialisation. From this context it is apparent that AM would benefit from the attendance of Pathways post 18 years.

[105] In the circumstances, I find that it is fair and reasonable that I allow costs for the attendance of AM at Pathways post 18 years to life expectancy.

Loss of earnings

[106] The industrial psychologists, Ms Sonia Hill and Mr Gideon De Kock, in their joint minutes agreed on the career projection⁶⁴ of AM and based on the scenario they postulated Mr Whittaker made actuarial calculations based on future life expectancy of 19.4 additional years, which I have already accepted. Mr Whittaker valued the loss of

⁶⁴ Bundle B: Index to Joint Minutes: pages 18 - 21.

income at R1 172 367.00. I have also already accepted the actuarial calculation by Mr Whittaker.

[107] The parties have agreed on the general contingency deduction of 15%. After the deduction of the contingency of 15% the value of the loss of income under this head of damages is R996 511.95

Caregiving and related expenses

[108] In their joint minutes,⁶⁵ Ms Bainbridge and Ms Prinsloo agree that AM whether she was resident in Durban or High Flats, from 9 to 18 years, would require two caregivers, working 12-hour shifts on a 1 week on / 1 week off rotational basis while the plaintiff would assume a night time oversight. In adulthood that is from 18 years to life expectancy they agreed that as AM's disability was profound and it is anticipated that over time she would deteriorate, AM would require access to 24-hour care. However, Ms Bainbridge and Ms Prinsloo deferred to the industrial psychologists on the caregiver's rates.

[109] The industrial psychologists, Ms Hill, and Mr De Kock, in their joint minutes agreed to the rate of R31,05 per hour.⁶⁶ The parties were agreed to this rate and the actuarial calculation had to be done on that rate. The only issue that was in dispute was the estimation of life expectancy. Both parties have done actuarial calculations based on this rate. I have already dealt with the issue of actuarial calculations above and advanced the reasons why I preferred the actuarial calculations by Mr Whittaker and not those of Mr Mavimbela. I have also determined that the fair and reasonable estimation of life expectancy is 19.4 additional years. Consequently, on a life expectancy of 19.4 additional years, Mr Whittaker's actuarial computation is a sum of R4 788 262.

General damages

⁶⁵ Bundle B: Index to Joint Minutes: pages 54 - 60.

⁶⁶ Bundle B: Index to Joint Minutes: pages 68 - 70.

[110] Mr *Pillemer* argued that based on the recent cases it would be fair and just if this court awarded AM general damages in the sum of R2.5 million. Mr *Mthembu* on the other hand submitted that cases upon which the plaintiff relied on emanated from other divisions. He therefore submitted that in his view an appropriate amount for general damages would be between R2 million to R2.2 million. Both parties referred me to several cases. All the cases, which the parties referred to, were similar except for one case.

[111] As a starting point, the cautionary injunctions in the assessment of general damages are perhaps apposite. It has been said that in assessing damages, the court must take care to see that its 'award is fair to both sides - it must give just compensation to the plaintiff, but must not pour our largesse from the horn of plenty at the defendant's expense.'⁶⁷

[112] Mr *Pillemer* identified the following as the main aspects of comparison between the cases he referred to and the impact the injury has on AM:

- (a) Has a severe cerebral palsy.
- (b) Presented with gross motor function classification scale level V characterised by spastic quadriplegia with elevated muscle tone, as well as diminished proximal muscle tone.
- (c) Takes medication for epilepsy, spasticity and drooling as well as multi-vitamins.
- (d) Can probably see and hear without impairment.
- (e) Has a PEG *in situ* and receives most of her meals and liquids through the PEG.
- (f) Has a number of contractures.
- (g) Appears to be in pain when some of her passive movements are done, particularly where she has more severe contractures in her left wrist and both ankles and feet with the contracture being greater in the right ankle than in the left ankle.

⁶⁷ *Pitt v Economic Insurance Co Ltd* 1957 (3) SA 284 (N) at 287E-F.

- (h) Has a mild scoliosis.
- (i) Before moving to Durban in September 2019 she suffered infections approximately monthly which have since decreased.
- (j) Has difficulty swallowing.
- (k) Can lift her head and shoulder in supine.
- (l) Can attain upright/sitting from a forward flexion position over her legs, but she is unable to maintain sitting for any length of time.
- (m) Can effect some purposeful rolling.
- (n) Engages readily and enthusiastically with those around her.
- (o) Presents with profound permanent disability, associated with her mixed type of level V cerebral palsy.
- (p) Remains profoundly disabled and is completely reliant on her mother and caregiver for every aspect of her activities of daily living and survival.
- (q) Has cognitive and physical delays, which are compounded by epilepsy, which is medically managed.
- (r) Requires reasonable stimulation, specialised equipment, transportation, therapeutic and medical intervention and care lifelong.

[113] In determining the issue of general damages, I have had regard to the following cases as were referred to by the parties.

[114] In *KTP obo OP v Minister of Health*⁶⁸ an award of compensation of R2.5 million was made in May 2024 in respect of a child with GMFCS level V of disability. The child in this case suffered from spastic quadriplegic cerebral palsy and microcephaly. He suffered spasticity in all four limbs, with his upper limbs being more severely spastic than his lower. He could not sit unsupported, was mentally disabled and had no ability to communicate verbally or non-verbally. He would only express himself with joyful sounds when touched or picked up and could roll from side to side. He needed high levels of care and comfort for the rest of his life. The award is very recent and highly comparable to the damages claimed in respect of AM.

⁶⁸ *KTP obo OP v Minister of Health of the National Department of Health and others* [2024] ZANWHC 120

[115] In case of *MEC for the Department of Health: Free State Province v GAK obo MAK*⁶⁹ Hefer AJ, on appeal upheld an award of R2.4 million as a fair and reasonable amount for compensation for the minor child who suffered from cerebral palsy for general damages. Although the specific details pertaining to the condition of the child were not discussed in the judgment, but the court found that the diminished life expectancy of the child was to be taken into account, but did not play a role in determining the amount of general damages to be awarded.

[116] In *MSM obo KBM v MEC for Health, Gauteng*⁷⁰ the minor was seven years old at the time of judgment and had reduced life expectancy of 24.6 years. Although the judgement did not set out a list of disabilities and deficits suffered by the minor child, she was awarded R2 million as damages. (The current value of which is R2.552 million).

[117] In *Booyse and another v MEC, For Health, Gauteng Province*⁷¹ the court awarded R1.5 million as general damages (the current value of which is R1.914million). However, the child in this case passed away during the litigation at the age of nine. Prior to his passing, the child was almost in a permanent vegetative state. He had epilepsy, which was becoming increasingly difficult to control. His ability to interact had deteriorated over time, and he could no longer respond to a voice or even smile. The child's gross motor function and manual ability classification were of the most severe.

[118] In *PM obo TM v MEC for Health, Gauteng Provincial Government*⁷² the court awarded compensation of R1.8 million (the current value of which is R2.53 million) in respect of a child with a GMFCS level 5. The child in this case although she was not able to communicate verbally, she was aware of her surroundings. She was capable of understanding English, Southern Sotho and isiZulu and she could make sounds. She

⁶⁹ *MEC for the Department of Health Free State Province v GAK obo MAK* [2024] ZAFSHC 142.

⁷⁰ *MSM obo KBM v MEC for Health, Gauteng* 2020 (2) SA 567 (GJ).

⁷¹ *Booyse and another v MEC, For Health, Gauteng Province* [2019] ZAGPPHC 363.

⁷² *PM obo TM v MEC for Health, Gauteng Provincial Government* [2017] ZAGPJHC 346.

would smile, laugh out loud and become excited. Despite her disabilities, she was alert and able to recognize some objects and pictures. She cried when upset and enjoyed various activities including horse riding and swimming. She did, however, have very little voluntary functional movement and was dependent on others for all activities of daily living. She had profound mental retardation and required constant and permanent care.

[119] In *N Mngomeni obo EN Zangwe v MEC for Health, Eastern Cape Province*⁷³ the child suffered from spastic quadriplegic cerebral palsy, was severely mentally and physically retarded, and permanently disabled. He had been rendered unemployable in the open market and suffered a catastrophic loss of amenities of life and was dependent on assistance in all personal care and activities of daily living, requiring 24-hour care and supervision. The minor child would need continuous medical care and treatment as well as specialised equipment, devices, accommodation, and services to accommodate his special needs for the remainder of his life. He was awarded general damages of R2 million (the current value of which is R2.812 million).

[120] In *Matlakala v MEC for Health, Gauteng Provincial Government*⁷⁴ the minor child suffered from spastic dystonic cerebral palsy, which was irreversible, as a result of incorrect resuscitation procedures at a provincial hospital. The minor child was totally incommunicative and had never learned to sit, stand, or walk and was regarded as ineducable, had the lowest level of gross motor function classification and only produced sounds, no words and was incapable of social activity. The minor child needed constant care for his most basic functions. He was awarded general damages in the sum of R1.5 million (the current value of which is R2.344 million).

[121] In the matter of *CS obo TGS*⁷⁵ Louw J awarded a sum of R1.8 million (the current value of which is R2.183 million). In this case, the minor child suffered from severe motor and cognitive impairment in the form of quadriplegia complicated by

⁷³ *N Mngomeni obo EN Zangwe v MEC for Health, Eastern Cape Province* 2018 (7A4) QOD 94 (ECM).

⁷⁴ *Matlakala v MEC for Health, Gauteng Provincial Government* [2015] ZAGPJHC 223; 2015 (7A4) QOD 22 (GJ).

⁷⁵ *CS (obo TGS) v MEC for Health, Gauteng* [2015] ZAGPPHC 605; 2018 (7A4) QOD 104 (GNP).

contractures leaving him permanently disabled and disfigured. The child required scoliosis surgery, had a disfigured claw-like right hand, could not walk or talk and his hearing and vision had been severally reduced. The child was considered not to have insight into his condition but did suffer pain, discomfort, and frustration.

[122] In *Singh and another v Ebrahim*,⁷⁶ Koen J awarded R1.2 million as general damages, the current value of which is R2.9. In this case the child, Nico who was 6½ at the time of judgement, and whom the trial judge found to have a life expectancy of 30 years, was unable to walk and lacked self-feeding ability. Nico had no loss of hearing and did not have expressive speech.

[123] In *ME obo NPM v MEC for Health, Gauteng*⁷⁷ the court awarded R2 million as of compensation (the current value of which is R2.254 million) in respect of a child with a GMFCS level IV level of disability. The child was toilet trained, and able to communicate her toileting needs but needed assistance to use the toilet. The child was able to see and hear. She could communicate with limited sentences, but her speech was dysarthric and difficult to understand. She had good receptive language. She had severe mixed-type cerebral palsy, predominantly dystonic, with superimposed right hemiplegia. She also had compensatory scoliosis, microcephaly, contractures and severe developmental delay.

[124] In *Madela v MEC for Health, Kwazulu-Natal*⁷⁸ this court awarded compensation of R1.6 million (the current value of which is R1.9 million) in respect of a child with a GMFCS level I disability. This award stands in stark contrast to the pattern of other awards in similar case the current value of which in many cases exceed R2,5m.

⁷⁶ *Singh and another v Ebrahim (1)* [2010] 3 All SA 187 (D) para 13. The Supreme Court of Appeal subsequently confirmed the award of R1.2 million for general damages, see *Singh and another v Ebrahim* [2010] ZASCA 145 para 116.

⁷⁷ *ME obo NPM v MEC for Health, Gauteng* [2022] ZAGPJHC 29.

⁷⁸ *Madela v MEC for Health, Kwazulu-Natal* [2021] ZAKZDHC 18.

[125] In *Kriel NO obo S v Member of the Executive Council for Health, Gauteng*⁷⁹ an award of R2 million (the current value of which is R2.45 million) in respect of a child who was GMFCS level II. The child walked with limitations. Her motor impairment was associated with global developmental delay, congenital microcephaly, intellectual disability, excessive drooling of saliva, communication problems and bladder and bowel control problems. She was however, capable of independent mobility but could not manage long distances.

[126] In *MP obo SP v Member of the Executive Council for Health, Eastern Cape, Province*⁸⁰ the child suffered from cerebral palsy as a consequence of hypoxic ischaemic injury to the brain, which resulted in him becoming a quadriplegic involving the trunk of his body. He was unable to stand without assistance and was only able to roll, scoot or crawl in order to move. He was unable to feed himself or perform his personal hygiene. His speech had been severely affected. His brain functions however, were at a much higher level than his body, and enabled him to express himself, which was found to be a factor aggravating his suffering. There had been devastating loss of enjoyment of ordinary amenities of life, although he would be able to attend to a school and operate an iPad. Full time care was required. An award of R2 million (the current value of which is R2.672 million) was made for general damages.

[127] In *NK v MEC for Health of the Gauteng Provincial Government*⁸¹ a boy suffered a hypoxic-ischaemic incident during birth and suffered severe brain damage which manifested itself in spastic cerebral palsy, quadriplegia, mental retardation, epilepsy, marked delays in development, speech deficits, general spasticity, compromised respiratory function, subluxation of the hips, scoliosis of the spine and behavioral problems. The little boy would be incontinent for his entire life, would have to use nappies and would have to be changed constantly by caregivers. He experienced pain and

⁷⁹ *Kriel NO obo S v Member of the Executive Council for Health, Gauteng Provincial Government* [2020] ZAGPJHC 273.

⁸⁰ *MP obo SP v Member of the Executive Council for Health, Eastern Cape, Province* [2018] ZAECHC 28.

⁸¹ *NK v MEC for Health of the Gauteng Provincial Government* [2018] ZASCA 13; 2018 (4) SA 454 (SCA); 2018 (7A4) QOD 80 (SCA).

discomfort and would have to undergo physiotherapy requiring the regular use of a hoist in later years. He had difficulty eating, had to be force-fed, and was not in a state of 'unconscious suffering.' An award of R1.8 million (the current value of which is R2.404 million) was made for general damages.

[128] In *AD and another v MEC for Health and Social Development, Western Cape Provincial Government*⁸² the court made an award of R1.8 million (the current value of which is R2.813 million) for general damages. The level of disability of the child was GMFSC level II. He suffered from athetoid movements, which would cause him muscle fatigue and stress for his life. He could self-feed, although messily, was still incontinent of bowel and bladder, but was seen to be toilet trained. He had hearing loss, which resulted in communication being a major challenge in his life. The court found that the child had some insight into his condition and had a life expectancy of 48 additional years with his expected death age being his 55th birthday.

[129] I am conscious that the previous awards of damages in comparative cases are not straightjackets. They merely serve as a useful guide and are not decisive. It is common cause that AM presents with profound permanent disability, associated with her mixed type of level V cerebral palsy. AM is predominantly tube fed. She is unable to communicate. She has severe contractures, mild scoliosis. She has had they were painful with gums constantly bleeding. AM is unable to attend to the activities of daily living will for the rest of her life be dependent on others including her mother and caregivers. I have considered the several comparative cases, which were referred to by the parties. I am of the view it would be reasonable, fair, and appropriate to award a sum of R2.5 million as and for general damages in this case.

Costs

[130] Mr *Pillemer* submitted that it was reasonable that in granting costs, this court should grant costs consequent upon the employment of two counsel and the qualifying

⁸² *AD and another v MEC for Health and Social Development, Western Cape Provincial Government* [2016] ZAWCHC 181; 2017 (5) SA 134 (WCC).

costs and other associated costs of the witnesses employed by the plaintiff. He submitted that this matter was complex and involved vast documentation and expert opinion. Consequently, the costs consequent upon the employment of two counsel were warranted, with costs of senior counsel to be awarded at scale C while those of junior counsel were to be awarded at scale B. Mr *Mthembu* did not make any submissions on the issue of costs. However, the issue of costs is pre-eminently in the discretion of the court which discretion must be exercised judicially.

[131] Above and beyond the general discretion which this court has regarding costs generally, additionally, the court has a discretion whether to allow the costs consequent upon the employment of more than one counsel. In relation thereto, it must consider whether it was a 'wise and reasonable precaution' to employ such advocate.⁸³ In addition, the court will also have regard to the amount involved in the action,⁸⁴ the nature of the issues in dispute between the parties, the number of legal authorities quoted.⁸⁵ The general rule is that the costs follow the event. I do not see any reason why I should deviate from this general rule.

[132] In this case both parties had instructed senior and junior counsel. Counsel from both sides during the trial had to marshal several bundles of documents comprising various volumes which they meticulously had to go through with their respective witnesses. These documents comprise among others pleadings, various expert reports, joint minutes of experts and the relevant literature on life expectancy. In addition, counsel from both sides apart from providing invaluable heads of arguments they also provided to the court separate bundles of case authorities on general damages which ran to 253 pages and 68 pages respectively. This case was not only undoubtedly complex but it was also important to both sides. According to the prayer to the particulars of claim the total amount of the claim is a sum R22 374 462.01. This is quite a substantial quantum claim. The mere fact that I separated all the issues relating to the public healthcare defence for later determination has not made the claim insubstantial

⁸³ *Steenkamp v Steenkamp* 1966 (3) SA 294 (T) at 297G.

⁸⁴ *Barlow Motors Investments Ltd v Smart* 1993(1) SA 347 (W) at 352.

⁸⁵ *De Naamloze Vennootschap Allintex v Van Gerlach* 1958 (1) SA 13 (T).

either. This will be apparent from the order which I grant. Without extra pair of hands, it would have been challenging for senior counsel from both sides to marshal the bundle of documents involved as efficiently as they did. Not to mention the well-known phrase ‘two heads are better than one.’

[133] In the circumstances, I am therefore satisfied that the complexity of the matter, the value of the claim and the importance of the case warranted the employment of two counsel. I am conscious that the scale of fees contemplated by Uniform rule 67A(3) and Uniform rule 69(7) apply to all counsel alike irrespective of seniority. However, an appropriate scale is left to the discretion of the court. There is authority where different scales were applied.⁸⁶ For these reasons I do not see why in this case I should not award costs of counsel on scale B and C respectively. Accordingly, for the reasons I have alluded to above, I am satisfied that it is fair and reasonable to award costs consequent upon the employment of two counsel with costs of junior counsel at scale B and costs of senior counsel at scale C.

Order

[134] In the result, I make the following order:

1. The defendant shall pay to the plaintiff’s attorneys in favour of the plaintiff a total amount of **R13 159 579.68** which amount is made up as follows:

- 1.1 For past medical and related expenses, the amount of **R674 462.01**;
- 1.2 For loss of earnings, the amount of **R996 512.00**;
- 1.3 For the costs of adaptations to a home for the accommodation of the minor child, A[...], the amount of **R1 025 379.00**;
- 1.4 For transport the amount of **R903 644.00**;
- 1.5 For attendance at a special needs school, the amount of **R918 868.00**;
- 1.6 For caregiving and related expenses, the amount of **R4 788 262.00**;
- 1.7 For case management, the amount of **R491 398.00**;
- 1.8 For general damages, the amount of **R2 500 000.00**;

⁸⁶ *Buhle Waste (Pty) Ltd v MEC of Health, Gauteng Province and Others* (2023/102560) [2024] ZAGPJHC 493 (22 May 2024).

1.9 For the costs of the creation and administration of a trust in respect of the award of compensation in terms of this order an amount of R871 054.72

2. The defendant is directed to make payment of the sum of R10 659 579.68, the judgment amount less the interim payment of R2 500 000.00,

2.1 To be paid within (thirty) days of the date of the order, failing which the defendant will be liable for interest at the rate of 11.75% per annum, from the date of this order to date of payment, both days inclusive; and

2.2 Into the plaintiff attorney's bank account, with the following details:

Bank: F[...] N[...] B[...]

Branch: M[...], D[...]

Trust Account in the name of: A[...] D[...] S[...] A[...]

Trust Account Number: 6[...]

Branch Code: 2[...]

3. The defendant is directed to pay the plaintiff's reasonable and necessary taxed or agreed party and party costs on the High Court Scale, such costs to include but not be limited to:

3.1 The costs of the plaintiff's attorney attending upon reasonable and necessary consultations with witnesses in preparation for this hearing, including the consultations with the undermentioned expert witnesses;

3.2 The costs of two counsel (senior and junior), with the reasonable and necessary costs of senior counsel up to the maximum rate or part thereof set out in Scale C of Uniform rule 69(7), at the discretion of the taxing master; and the reasonable and necessary costs of junior counsel up to the maximum rate or part thereof as set out in Scale B of Uniform Rule 69(7), at the discretion of the taxing master, including the reasonable and necessary costs of their preparation for this hearing (as determined and at the sole discretion of the taxing master), for drafting and preparing heads of argument and for their attendance upon consultations with the under-mentioned expert witnesses and the plaintiff for this hearing; the qualifying fees of the under-mentioned expert witnesses, including the costs of their reports, supplementary reports and joint minutes, to qualify themselves to testify at this hearing and for any reasonable and necessary

consultations with the Plaintiff's attorney and counsel for this hearing, as determined by the Taxing Master namely:

- 3.2.1 **Sue Anderson**, Nursing Sister;
- 3.2.2 **Grace Hughes**, Physiotherapist; (including her reservation fee for 3 and 4 June 2024);
- 3.2.3 **Jane Bainbridge**, Occupational Therapist (including her reservation fee for 3 and 5 June 2024).
- 3.2.4 **Mandy Read**, Dietician;
- 3.2.5 **Dr. R Campbell**, Life Expectancy Expert (including his reservation fee for 6 and 7 June 2024)
- 3.2.6 **Dr. M E Mayat**, Dental Surgeon;
- 3.2.7 **Kasia Hrabar**, Architect;
- 3.2.8 **Sonia Hill**, Industrial Psychologist;
- 3.2.9 **Rochelle Thanjan**, Speech Therapist (including her reservation fee for 4 June 2024)
- 3.2.10 **Maureen Casey**, AAC Expert;
- 3.2.11 **Darryl Grobbelaar**, Orthotist & Prosthetist;
- 3.2.12 **Dr R Fraser**, Orthopaedic Surgeon;
- 3.2.13 **Dr. I Ganie**, Radiologist;
- 3.2.14 **Dawid Marais**, quantity surveyor; and
- 3.2.15 **Mr. G Whittaker**, actuary (report only).

4. The plaintiff's aforesaid attorney of record is hereby directed, upon receipt of the monies being paid to it by the defendant as aforesaid, to:

- 4.1 Hold all monies in trust pending the formation of the Trust as aforesaid;
- 4.2 Pay the trustees remuneration (which shall include the costs of the formation thereof, the costs of administering the Trust, the costs of the trustees furnishing annual security, and obtaining an annual security bond to meet the requirements of the Master of the High Court in terms of section 6(2)(a) of the Trust Property Act 57 of 1988, in the sum of R871 054.72 directly to the trust upon it being informed; and

- 4.3 Pay the net balance of the monies received pursuant to this Order to the Trust after all costs, fees, disbursements, and expenses have been deducted therefrom.
5. The trial in respect of all other outstanding claims is adjourned *sine die* for the later determination.

CHITHI AJ

APPEARANCES

Counsel for the Plaintiff:	M. Pillemer SC with C. Gajoo
Instructed by:	AC De Sousa Attorneys Durban
Counsel for the Defendant:	T.S.I. Mthembu SC with S. Takchund
Instructed by:	State Attorney (Durban)
Heard:	3, 4, 5, 6, 7, 10, 12 June 2024
Date of Judgment:	30 September 2024