IN THE HIGH COURT OF SOUTH AFRICA
KWAZULU-NATAL LOCAL DIVISION, DURBAN

CASE NO: 3079/2015

In the matter between:

N[...] L[...] M[...] Plaintiff

and

THE MEMBER OF THE EXECUTIVE COUNCIL FOR HEALTH, KWAZULU-NATAL Defendant

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JUDGMENT

HENRIQUES J

Introduction

[1] This is the judgment in respect of the remaining issues of quantum for the resumed trial of the matter, specifically past and future medical, hospital and related expenses.

[2] On 13 January 2010, A[...] S[...] K[...] (A[...]) was born at Prince Mshiyeni Memorial Hospital and suffered intrapartum hypoxia and a brain injury. As a consequence of her brain damage she suffers from cerebral palsy and is classified on the Gross Motor Function Classification System at (GMFCS) level 1. She has moderate, to severe, mental and intellectual impairment, severe cognitive delay, a wide range of severe to profound neurological deficits and mild physiological limitations. As a consequence of the neurological deficits and physiological limitations the plaintiff instituted action against the defendant for damages on behalf of A[...].

[3] The defendant conceded liability and pursuant to judicial case management, the issue of general damages and future and past loss of earning capacity was determined and a judgment issued by me on 30 April 2021. At the time, the legal representatives agreed a stated case and agreed the life expectancy of A[...], with a proviso that it would not be bound by such agreement on life expectancy in the determination of the future medical expenses.

[4] The plaintiff's claim for past hospital and medical expenses as well as all future medical expenses was adjourned *sine die* pending the parties obtaining reports from their respective experts.

[5] Since the delivery of the first judgement, the plaintiff obtained an interim payment from the defendant in respect of future medical expenses in the sum of R 4 493 383.00 on 11 October 2021.

[6] In addition, based on the award and A[...]'s condition the defendant had agreed to the creation of a trust and a trustee's fee for administering the trust at the rate of 7.5% per annum of the capital amount awarded.

[7] Pursuant to further judicial case management the matter was re-enrolled for determination of the past hospital and medical expenses as well as the quantification of A[...]'s future hospital, medical and related expenses as well as the costs of modification to her current home.

[8] Additionally, the defendant had in the interim raised what is referred to as "the public healthcare defence" in which the defendant alleges the plaintiff is not entitled to receive monetary compensation in respect of certain future medical treatment and other services and the defendant tenders to provide the plaintiff the required treatment and related necessary services at any one of the public provincial hospitals.

[9] In terms of an amendment to the plaintiff's plea the quantum claimed is as follows:

(a) Future medical expenses R14 000 000.00
(b) Future loss of earnings R5 878 082.00
(c) General damages R2 500 000.00
(d) Acquisition of alterations to a residential dwelling R300 000.00 which totals R22 678 082.00.

[10] Prior to the commencement of the trial, I was advised by Mr McIntosh SC who appeared for the plaintiff, which was confirmed by Mr Van Niekerk SC who appeared for the defendant, that such public healthcare defence had been abandoned *in toto*.

[11] The remaining issues for determination during the re-enrolled trial were the following:

(a) the future medical and hospital expenses to be incurred,
(b) the costs of renovations or modifications to her home which was purchased in July 2022 by the Trust and
(c) the past hospital and medical expenses.

[12] In respect of (c), Mr McIntosh indicated that the attorneys were attempting to resolve this and on finalisation of leading all the evidence will advise the court whether they have reached an agreement on this aspect and in respect of which

no agreement has been reached the court will be asked to issue directives and make a finding thereon.

Preliminary remarks

[13] I do not propose to summarise the evidence of all the witnesses who testified as this is a matter of record and their respective areas of agreement and disagreement have been recorded in the respective joint minutes. In determining the appropriate award to make in respect of the future medical, hospital and related expenses, I have considered the witnesses respective experience in their fields of expertise. I have also borne in mind their specific experience and training involving children with cerebral palsy (CP) like A[...]. In addition, I am mindful that all of them have indicated that there is a window of opportunity available for A[...] to learn and for her condition to improve and thereafter one is concerned with maintaining those levels.

[14] The current position of A[...] which has informed the evaluation of the evidence given by the respective expert witnesses in relation to the cost of future therapies and treatment required. These are the following:

(a) A[...] is presently enrolled at the Swana School and is attended to in the mornings by her caregiver who readies her school;

(b) She attends school as a day scholar leaving in the mornings at approximately 07h30. Whilst she is at school, she is assisted by a teacher's assistant;

(c) She returns home at approximately 14h00 and is attended to by the caregiver who attends to her up until approximately 22h00. Such caregiver is a live-in caregiver who earns a salary of R6000 per month. (This is the salary the caregiver earned 2022 at the time the evidence was presented);

(d) The present caregiver attends to all of A[...]'s needs when she returns home from school in the afternoon until the early evening;

(e) A[...] will attend the Swana School until she turns 21;

(f) Jane van der Merwe has been appointed as A[...]'s case manager and has acted in such capacity since approximately June 2021;

(g) A[...] sleeps well through the night and if she gets up, her mother calms her down and puts her back to sleep;

(h) A[...] is transported to school on the school bus and such arrangements are "reasonably acceptable";

(i) In respect of all therapies awarded, A[...] will be expected to attend such therapies until age 21 outside school hours;

(j) the caregiver's attend therapy sessions with A[...] and are expected to carry out a home exercise routine as a consequence of which they will require training specifically in relation to the care of cerebral palsy children.

[15] I have also borne in mind that A[...] has missed certain windows of opportunity to improve and that she is severely cognitively impaired and that there is no room for improvement in such cognitive impairment. Her cognitive impairment limits her ability to make gains both physically and mentally, although improvements have been noted. I accept, however, that such improvements will be modest and/or limited.

[16] A[...]'s cerebral palsy is classified on the gross motor function classification system (GMFCS) between a level I and a level II and may probably improve to a level I. GMFCS level I do not necessarily deteriorate. She has moderate to severe mental and intellectual impairment, severe cognitive delay, mild physiological

limitations and a wide range of severe to profound neurological deficits.

[17] She has compromised oral and sensory motor impairment and drools a lot. She is classified on the eating and drinking classification system (EDACS system) as a level II to III implying that she eats and drinks with some limitation to safety and is unable to chew her food, has difficulty swallowing, requires her food to be blended and must be supervised during all eating activities.

[18] On the functional communication classification system (FCCS), she is classified as a level IV indicating the need for assistance, specifically, when in situations with unfamiliar people and environments. She is unable to verbally communicate her daily needs and wants with familiar people. She presents with severe limitations in expressive language and communicates with gestures and will require alternative and augmented communication devices and speech therapy to address her feeding and swallowing impairment, AAC and language development.

[19] I have also considered that the respective experts have indicated from the consultations with A[...] that she has developed her own communication system with members of her family and does show some improvement and that there is room for improvement in this regard. So, for example, when she is hungry, she will fetch her bowl, indicating that she is hungry and wants something to eat.

[20] On the GMFCS scale, she is able to mobilise independently and can stand on each foot, one foot at a time for a few seconds, but presents with poor balance, she is able to reach out without taking a step forward but both her right and left side are impaired, with the right side being worse. She has poor dynamic balance, tends to walk in a zig-zag fashion rather than in a straight line, she is able to jump up and down and forwards but not typical of a child of her age. She is unable to jump backwards and is unable to hop. She has weakness of her right upper and lower limbs. As a consequence, on the functional mobility scale she is independent on level surfaces.

[21] She is classified as a level III on the manual ability classification system, which indicates that she handles objects with difficulty and presents with an inability to use her hands functionally, she requires assistance to prepare and modify activities, has less functionality in her right hand than her left, does not handle objects in an age-appropriate way, has poor fine motor function of both hands, requires moderate assistance with bathing, dressing and grooming and is incapable of self-feeding at all and must be fed all her meals.

[22] A[...] will require the assistance of caregivers for the remainder of her life. Whilst the family and her mother have provided such support it cannot be expected that they do so for the reminder of her life[1]. She has suffered an insult and must be appropriately compensated therefore.

The role of experts and the expert witnesses' evidence

[23] In evaluating the evidence of the respective expert witnesses I have borne in mind the value of expert reports in the determination of the quantum of a litigant's damages. Such reports are important not only for litigants but also for the courts in order to discharge their duty to award just compensation.

[24] The general rule is that experts must provide appreciable help to the courts in assessing damages. It is only then that the matter is capable of being decided with due regard to these reports. Trollip JA in *Gentiruco AG v Firestone SA (Pty) Ltd*[2] held that:

> '. . . the true and practical test of the admissibility of the opinion of a skilled witness is whether or not the Court can receive 'appreciable help' from that witness on the particular issue . . .'

[25] The expert opinion does not supplant the court's duty to scrutinise their

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[1] *NH Mtshali v MEC for the Executive Council for Health, KwaZulu Natal* Case No 10460/2015 delivered on 2 May 2023 at paragraph 44

[2] *Gentiruco AG v Firestone SA (Pty) Ltd* 1972 (1) SA 589 (A) at 616H, the court referring to Wigmore on *Principles of Evidence* (3 ed) Vol VII at paragraph 1923.

admissibility and relevance.[3] They are also required to lay a factual basis for their conclusions and explain their reasoning to the court. A court must be satisfied as to the correctness of an expert's reasoning.[4] A court is not bound by the view of an expert and the ultimate decision maker on issues is the court- experts merely provide an opinion.[5] Of vital importance in such determination is that any facts, which an expert witness expresses an opinion on, must be capable of being reconciled with all the other evidence in a matter.

[26] In *Bee*[6] Seriti JA writing a minority judgment held the following:

> 'The facts on which the expert witness expresses an opinion must be capable of being reconciled with all other evidence in the case. For an opinion to be underpinned by proper reasoning, it must be based on correct facts. Incorrect facts militate against proper reasoning and the correct analysis of the facts is paramount for proper reasoning, failing which the court will not be able to properly assess the cogency of that opinion. An expert opinion which lacks proper reasoning is not helpful to the court.'

[27] The duties and responsibilities of expert witnesses specifically in civil matters was dealt with in *National Justice Compania Navier SA v Prudential Assurance Cr Ltd ("the Ikarian Reefer")*[7] where the court held the following:

> 'The duties and responsibilities of expert witnesses in civil cases include the following:
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> 1. Expert evidence presented to the Court should be, and should be seen to be, the independent product of the expert uninfluenced as to form or

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[3] *Seyisi v S* [2012] ZASCA 144; [2012] JOL 29518 (SCA) para 13.
[4] *Bee* para 22.
[5] *Michael and another v Linksfield Park Clinic (Pty) Ltd and another* [2002] 1 All SA 384 (A) para 34 (*Michael*).
[6] *Bee* para 23. See also *Jacobs and another v Transnet Ltd t/a Metrorail and another* [2014] ZASCA 113; 2015 (1) SA 139 (SCA) paras 15-16 (*Jacobs*).
[7] *National Justice Compania Naviera SA v Prudential Assurance Co Ltd ("The Ikarian Reefer")* [1993] 2 Lloyd's Rep 68 at 81.

content by the exigencies of litigation (*Whitehouse v Jordan*, [1981] 1 WLR 246 at p 256, per Lord Wilberforce).

2. An expert witness should provide independent assistance to the Court by way of objective unbiased opinion in relation to matters within his expertise (see *Polivitte Ltd v Commercial Union Assurance Co Plc*, [1987] 1 Lloyd's Rep 379 at p 386 per Mr Justice Garland and *Re J*, [1990] FCR 193 per Mr Justice Cazalet). An expert witness in the High Court should never assume the role of an advocate.

3. An expert witness should state the facts or assumption upon which his opinion is based. He should not omit to consider material facts which could detract from his concluded opinion (*Re J* sup).

4. An expert witness should make it clear when a particular question or issue falls outside his expertise. 5. If an expert's opinion is not properly researched because he considers that insufficient data is available, then this must be stated with an indication that the opinion is no more than a provisional one (*Re J* sup). In cases where an expert witness who has prepared a report could not assert that the report contained the truth, the whole truth and nothing but the truth without some qualification, that qualification should be stated in the report . . .'

[28] Seriti JA (the minority judgment) in *Bee*[8] the Supreme Court of Appeal also considered the role of experts and stated as follows:

'[22] It is trite that an expert witness is required to assist the court and not to usurp the function of the court. Expert witnesses are required to lay a factual basis for their conclusions and explain their reasoning to the court. The court must satisfy itself as to the correctness of the expert's reasoning.

[8] *Bee* paras 22-23, see also *Jacobs* paras 15 and 16 and *Coopers (South Africa) (Pty) Ltd v Deutsche Gesellschaft Für Schädlingsbekämpfung mbH* 1976 (3) SA 352 (A) at 371F-G.

In *Masstores (Pty) Ltd v Pick 'n Pay Retailers (Pty) Ltd* [2015] ZASCA 164; 2016 (2) SA 586 (SCA) para 15, this court said

> "Lastly, the expert evidence lacked any reasoning. An expert's opinion must be underpinned by proper reasoning in order for a court to assess the cogency of that opinion. Absent any reasoning the opinion is inadmissible".

In *Road Accident Appeal Tribunal & others v Gouws & another* [2017] ZASCA 188; [2018] 1 ALL SA 701 (SCA) para 33, this court said

> "Courts are not bound by the view of any expert. They make the ultimate decision on issues on which experts provide an opinion".

(See also *Michael & another v Linksfield Park Clinic (Pty) Ltd & another* [2002] 1 All SA 384 (A) para 34.)

> [23] The facts on which the expert witness expresses an opinion must be capable of being reconciled with all other evidence in the case. For an opinion to be underpinned by proper reasoning, it must be based on correct facts. Incorrect facts militate against proper reasoning and the correct analysis of the facts is paramount for proper reasoning, failing which the court will not be able to properly assess the cogency of that opinion. An expert opinion which lacks proper reasoning is not helpful to the court.'

[29] Ramsbottom J made the following remarks in *R v Jacobs*:[9]

> 'Expert witnesses are witnesses who are allowed to speak as to their opinion, but they are not the judges of the fact in relation to which they express an opinion; the Court . . . is the judge of the fact. . . . In cases of this sort it is of the greatest importance that the value of the opinion should

[9] *Rex v Jacobs* 1940 TPD 142 at 146-147.

be capable of being tested; and unless the expert witness states the grounds upon which he bases his opinion it is not possible to test its correctness, so as to form a proper judgment upon it.'

[30] The role of an expert witness was succinctly summarised by the Supreme Court of Appeal in *Jacobs and another v Transnet Ltd t/a Metrorail and another*[10] as follows:

'It is well established that an expert is required to assist the court, not the party for whom he or she testifies. Objectivity is the central prerequisite for his or her opinions. In assessing an expert's credibility an appellate court can test his or her underlying reasoning and is in no worse a position than a trial court in that respect. Diemont JA put it thus in *Stock v Stock*:

> "An expert . . . must be made to understand that he is there to assist the Court. If he is to be helpful he must be neutral. The evidence of such a witness is of little value where he, or she, is partisan and consistently asserts the cause of the party who calls him. I may add that when it comes to assessing the credibility of such a witness, this Court can test his reasoning and is accordingly to that extent in as good a position as the trial court was."' (footnotes omitted)

[31] In *Schneider NO and others v AA and another*[11] Davis J remarked as follows:

'In short, an expert comes to court to give the court the benefit of his or her expertise. Agreed, an expert is called by a particular party, presumably because the conclusion of the expert, using his or her expertise, is in favour of the line of argument of the particular party. But that does not absolve the expert from providing the court with as objective and unbiased an opinion, based on his or her expertise, as possible. An expert is not a

[10] *Jacobs* para 15.
[11] *Schneider NO and others v AA and another* 2010 (5) SA 203 (WCC) at 211J – 212B.

hired gun who dispenses his or her expertise for the purposes of a particular case. An expert does not assume the role of an advocate, nor gives evidence which goes beyond the logic which is dictated by the scientific knowledge which that expert claims to possess.'

[32] The parties rely on the evidence of expert witnesses to support their divergent contentions. An expert witness' opinion and evidence must be considered holistically during the evaluation of the expert opinion.[12] The evaluation of expert testimony requires a consideration and determination of whether and to what extent the opinions advanced have a logical basis and are premised on logical reasoning.[13]

[33] The limitations to expert opinions are well known and courts are cautious to assess the value of expert opinions without a consideration of the facts upon which it is based. If it is determined that the facts are incorrect then it follows that the expert opinion is flawed.[14] In the case of *S v Mthethwa*[15] the court stated the following:

'The weight attached to the testimony of the psychiatric expert witness is inextricably linked to the reliability of the subject in question. Where the subject is discredited the evidence of the expert witness who had relied on what he was told by the subject would be of no value.'

[34] It is also apposite to mention the English decision of *R v Turner*,[16] which reasoning has been applied with approval by our courts in the evaluation of expert witness opinions. In that matter Lawton LJ stated:

'Before a court can assess the value of an opinion it must know the facts on which it is based. If the expert has been misinformed about the facts or

[12] *Life Healthcare Group (Pty) Ltd v Suliman* [2018] ZASCA 118; 2019 (2) SA 185 (SCA) para 18.
[13] *Michael and another v Linksfield Park Clinic (Pty) Ltd and another* 2001 (3) SA 1188 (SCA) para 36-37.
[14] *Ndlovu v RAF* 2014 (1) SA 415 (GSJ) para 35.
[15] *S v Mthethwa* [2017] ZAWC 28 para 98.
[16] *R v Turner* [1975] 1 ALL ER 70.

has taken irrelevant facts into consideration or has omitted to consider relevant ones, the opinion is likely to be valueless.'

[35] In *Bee*[17] the court quoted from the judgment in *The State v Thomas*,[18] which referred to the expert reports of two psychiatrists and said:

> 'When dealing with expert evidence the court is guided by the expert witness when deciding issues falling outside the knowledge of the court but within the expert's field of expertise; information the court otherwise does not have access to. It is however of great importance that the value of the expert opinion should be capable of being tested. This would only be possible when the grounds on which the opinion is based is stated. It remains ultimately the decision of the court and, although it would pay high regard to the views and opinion of the expert, the court must, by considering all the evidence and circumstances in the particular case, still decide whether the expert opinion is correct and reliable.' (footnotes omitted)

[36] It is also trite that the role of the expert witness is to assist the court in reaching a decision. A court is not bound by, nor obliged to accept the opinion of any expert witness.[19] The facts relied upon by the expert in his evidence must be capable of being reconciled with all the other evidence.[20] In addition, the facts on which the expert witnesses rely must be established during the trial. The exception relates to facts drawn as a conclusion by reason of the expert witness' expertise from other facts that have been admitted or established by admissible evidence.[21]

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[17] *Bee* para 29.
[18] *The State v Thomas* [2016] NAHCMD 320 para 29.
[19] *Road Accident Appeal Tribunal & others v Gouws & another* [2017] ZASCA 188; [2018] 1 ALL SA 701 (SCA) para 33; *Bee* para 22.
[20] *Bee* para 23.
[21] *Mathebula v Road Accident Fund* [2006] ZAGPHC 261 para 13; *PriceWaterhouseCoopers* para 99.

[37] In *Jacobs*,[22] the court held that:

> 'Where experts in a joint minute reach an agreement on an issue, they signify that such an issue need not be adjudicated upon as the initial dispute simply does not exist. Unlike in an expert report where the factual basis upon which the expert opinion hinges is indicated, parties to a joint minute do not indicate such factual basis. They in essence simply agree that a fact or opinion is not in dispute and it will in the normal course of events not be open for a court to cut the veil of such an agreement and question the veracity of the facts or opinion contained therein. By having reached an agreement, they put the dispute beyond the need for adjudication.*'*

[38] It is apparent from the aforementioned exposition on the applicable principles that a distinction can be drawn between the facts upon which an expert's opinion is based and the expert's actual opinion.

[39] In *A M & Another v MEC for Health, Western Cape* 2021 (3) SA 337 (SCA) Wallis JA writing for a full court held the following at 21 'The opinions of expert witnesses involve the drawing of inferences from facts. The inferences must be reasonably capable of being drawn from those facts. If they are tenuous, or far-fetched, they cannot form the foundation for the court to make any finding of fact. Furthermore, in any process of reasoning the drawing of inferences from the facts must be based on admitted or proven facts and not matters of speculation.'

[40] The importance of joint minutes were stressed by the Supreme Court of Appeal in *Hal obo MML v MEC for Health, Free State* 2022 (3) SA 571 SCA at paragraph 49 as follows 'It is trite that where experts agree on a matter of fact in a joint minute, the parties are bound by the agreement and may not, without more, deviate from the agreement, without proper explanation and the consideration of prejudice.'

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[22] *Jacobs v The Road Accident Fund* [2019] ZAFSHC 4; 22019 JDR 0934 (FB) para 25.

[41] At paragraph 53 the court in relation to uncertainty concerning opinions the court held the following 'When dealing with the evidence of experts in a field where medical certainty is virtually impossible, a court must determine whether and to what extent their opinions advanced are founded on logical reasoning. The court must be satisfied that such opinion has a logical basis, in other words that the expert has considered comparative risks and benefits and has reached "a defensible conclusion."

[42] An opinion expressed without logical foundation can be rejected.' Relying on the status of joint minutes as expressed by the court in *Bee v Road Accident Fund* the court held that where experts in the same field reach agreement a litigant cannot be expected to adduce evidence on the agreed matters. A caution was sounded that unless a trial court was for any reason dissatisfied with the expert's agreement and had alerted the parties to the need to adduce evidence on the agreed material it would be bound to accept the matters as agreed by the experts. *Bee v Road Accident Fund* 2018 (4) SA 366 SCA at paragraph 73.

What then does one do when one has conflicting expert opinions and areas of disagreement in a joint minute

[43] In *AD and another v MEC for Health and Social Development, Western Cape Provincial Government*[23] Rogers J as he then was deals with opinion evidence, where he remarked as follows:

> 'When faced with conflicting expert opinions, the court must determine which, if any, of the opinions to accept, based on the reasoning and reliability of the expert witnesses. The court must determine whether and to what extent an opinion is founded on logical reasoning. An expert's function is to assist the court, not to be partisan. Objectivity is the central prerequisite (see *Michael & Another v Linksfield Park Clinic (Pty) Ltd & Another* 2001 (3) SA 1188 (SCA) paras 37-39; *Jacobs & Another v*

[23] *AD and another v MEC for Health and Social Development, Western Cape Provincial Government* [2016] ZAWCHC 116 para 39 (*AD*).

Transnet Ltd t/a Metrorail & Another 2015 (1) 139 (SCA) paras 14-15). The expert must not assume the role of advocate. If the expert's evidence is to assist the court he or she must be neutral. The expert should state the facts or assumptions from which his or her reasoning proceeds (*PriceWaterhouseCoopers Inc & Others v National Potato Co-Operative Ltd & Another* [2015] 2 All SA 403 (SCA) paras 97-99.) '

[44] Further, in *AD* he held the following:[24]

'The expert must demonstrate to the court that he or she has relevant knowledge and experience to offer opinion evidence. If such knowledge and experience is shown, the expert can draw on the general body of knowledge and understanding of the relevant expertise.'

Contingencies

[45] Some preliminary remarks are warranted in relation to contingencies. I have in this matter been requested to apply a contingency by the defendant in relation to life expectancy, certain of the therapies and equipment as well as to the care giving model.

[46] Contingencies allow for the unknown possibility that the plaintiff may have less than normal expectations of life, that he or she may have experienced periods of unemployment, illness, accident or general economic conditions. These relate to what is often referred to as 'imponderables' and speculation about the future. In addition, age is an important factor in calculating contingencies.

[47] That the calculation of contingencies is not an easy task and is not cast in stone was noted by Willis JA in *NK v MEC for Health*, *Gauteng*[25] as follows:

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[24] *AD* para 42. a
[25] *NK v MEC for Health, Gauteng* 2018 (4) SA 454 (SCA) para 16.

'…[Contingencies are like] the rolling of a dice. A court is not a casino…Conjecture may be required in making a contingency deduction, but it should not be done whimsically.'

[48] In *Buys v MEC for Health and Social Development of the Gauteng Provincial Government*[26] the court summarised the position in regard to contingencies as follows:

'Contingencies are the hazards of life that normally beset the lives and circumstances of ordinary people (AA Mutual Ins Co v Van Jaarsveld (1), The Quantum of Damages, Vol II 360 at 367) and should therefore, by its very nature, be a process of subjective impression or estimation rather than objective calculation (Shield Ins Co Ltd v Booysen 1979 (3) SA 953 (A) at 965 G-H). Contingencies for which allowance should be made, would usually include the following:

- the possibility of errors in the estimation of life expectation;
- the possibility of illness which would have occurred in any event;
- inflation or deflation of the value of money in future; and
- other risks of life, such as accidents or even death, which would have become a reality, sooner or later, in any event.'

[49] Any enquiry into the appropriate contingency to be applied is speculative. Although mentioned in the context of past and future loss of earnings, in *Southern Insurance Association Ltd v Bailey NO*[27] the court held the following:

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[26] *Buys v MEC for Health and Social Development of the Gauteng Provincial Government* [2015] ZAGPPHC 530 para 96.
[27] *Southern Insurance Association Ltd v Bailey NO* 1984 (1) SA 98 (A) 113F-G.

‘Any enquiry into damages for loss of earning capacity is of its nature speculative, because it involves a prediction as to the future, without the benefit of crystal balls, soothsayers, augurs or oracles. All that the Court can do is to make an estimate, which is often a very rough estimate, of the present value of the loss.’

[50] At 114C-E the court further remarked:

‘In a case where the Court has before it material on which an actuarial calculation can usefully be made, I do not think that the first approach offers any advantage over the second. On the contrary, while the result of an actuarial computation may be no more than an “informed guess”, it has the advantage of an attempt to ascertain the value of what was lost on a logical basis; whereas the trial Judge’s “gut feeling” (to use the words of appellant’s counsel) as to what is fair and reasonable is nothing more than a blind guess.’

[51] The amount to be allowed by way of a deduction for contingencies is variable and dependent on the circumstances of a particular case in which a trial judge is asked to exercise his or her discretion. Arbitrary considerations inevitably come to play. This was confirmed by Margot J in *Goodall v President Insurance Co Ltd*:[28]

‘In the assessment of a proper allowance for contingencies, arbitrary considerations must inevitably play a part, for the art or science of foretelling the future, so confidently practised by ancient prophets and soothsayers, and by modern authors of a certain type of almanack, is not numbered among the qualifications for judicial office.’

[52] Both parties accept that this court has a wide discretion to determine what an appropriate contingency deduction ought to be and accept that sometimes arbitrary considerations play a part in the assessment of a contingency

[28] *Goodall v President Insurance Co Ltd* 1978 (1) SA 389 (W) at 392H-393A.

allowance. When the matter was first enrolled for oral and written submissions, the plaintiff submitted that no contingency deduction ought to apply to the calculation of future medical expenses.

[53] These submissions were particularly applicable in light of the following:

(a) every item of expenditure had been meticulously considered by the individual experts concerned and based on their experience and a consideration of A[...]'s condition, each expert recommended what future medical needs would be required for A[...];

(b) in circumstances where the experts reached agreement on individual expenses, an appropriate contingency had already been taken into account, as with for example blood tests where a 50% contingency was agreed;

(c) all duplications had been removed from the calculation of A[...]'s future hospital and medical expenses; and

(d) in relation to the costs of caregivers, the estimation has taken into account what will be paid over A[...]'s life expectancy, and there is no additional surplus that can be trimmed or removed from the calculations and any reduction by way of a contingency will result in a loss to Trust which is responsible for the administration of her needs A[...].

[54] It is for these reasons that the plaintiff submitted that no contingency deduction ought to apply to the calculation of future medical expenses.

[55] The defendant acknowledges that where a court makes assumptions, it is necessary for them to be supported by proven available facts in order to be relevant. To make an assessment of what damages are fair and reasonable, one must have regard to the possibilities that the assumptions may not fully

materialise or will only partially come into future fruition. In determining the nature of the contingency to be considered by a court, one considers the facts and circumstances of a particular matter, subject to the exercise by the court of a discretion.

[56] The defendant submitted that when considering the question of contingencies in this particular matter, this court must take the following into consideration, namely:

(a) that there is a probability that A[...] will not receive all the therapies and utilise all the devices awarded to her;

(b) one must consider the high crime statistics which increase the risk of A[...] being a victim of a serious crime;

(c) the risk of her being involved in a serious motor vehicle accident;

(d) that unknown genetic health conditions will arise which may shorten her life expectancy;

(e) the three aspects which Dr Campbell was unwilling to factor in his calculation will affect negatively on A[...]'s life expectancy, being the fact that she is overweight, the possible incidence of respiratory tract infections and/or chest infections; and

(f) having been awarded funds, the plaintiff ought to have ensured that A[...]'s damages are mitigated by ensuring that her condition is not exacerbated and that she underwent the necessary interventions where there was a window of opportunity.

[57] The defendant proposed that once directives had been given to the actuaries, the court could reconvene and the parties could make submissions on the applicable contingencies to apply.

[58] Given this, the court reconvened to deal inter alia with the aspect of contingencies. A directive was issued to the parties to specifically address this, given that certain contingencies were already taken into account by the experts and the parties in the determination of future medical and hospital expenses and the defendant's stance that a contingency ought to apply to A[...]'s life expectancy. A directive was thus issued to the parties which the parties addressed at a reconvened hearing.

[59] There are two seminal judgments which deal with the appropriate contingency deduction to be applied to future hospital and medical expenses, and where certain factors were considered when applying such a contingency. These are the decisions of Koen J in *Singh and Another v Ebrahim (1)*[29] and that of Rogers J, in *AD and Another v MEC for Health and Social Development, Western Cape Provincial Government*.[30]

[60] In *Singh*, the court initially considered applying an appropriate contingency deduction in respect of each and every item which comprised the future medical costs, however Koen J concluded that such an approach would lead to an impossible varying of the contingency deduction rates in respect of some items which might, when compared with others be difficult to justify.

[61] He opined that such a determination would 'seek to raise the determination of an appropriate contingency to a level of mathematical precision, to which that exercise does not lend itself, and which is ultimately undesirable'.[31] The approach which Koen J adopted was to apply a contingency once the various rulings on different aspects of the case had been embodied in a schedule and actuarially calculated to take account of amended variables. A ruling on a contingency was only provided in the final judgment once the actuarial calculations had been made

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[29] *Singh and Another v Ebrahim (1)* [2010] 3 All SA 187 (D).
[30] *AD and Another v MEC for Health and Social Development, Western Cape Provincial Government* [2016] ZAWCHC 116.
[31] *Singh and Another v Ebrahim (2)* [2010] 3 All SA 240 (D) para 12.

and submitted to him.[32]

[62] He then applied a 10% contingency deduction. Such contingency deduction appears to have been influenced over concerns he had, that a maximum tariff had been implied in some instances, the effectiveness of some of the therapies, whether all therapies would continue as proposed by the experts, whether some therapies would be carried out with the diligence with which they had been claimed, the possibility that there would be insufficient time to fit in all the therapies claimed, the possibility that some therapies may be discontinued as no benefit was to be gained from continuing with such therapies and also to allow for a rest period each year from such therapies.[33]

[63] Rogers J in the *AD* case did not follow the approach of Koen J and did not apply a general contingency deduction to the calculation of future medical expenses. In declining to follow Koen J's approach, he held the following:

> '[600] The defendant's counsel raised the possibility of applying a contingency deduction to future medical costs. A contingency deduction was made by the court a quo in *Singh*, a discretionary decision in which the SCA did not interfere. A similar approach was followed by Fourie J in *Buys v MEC for Health and Social Development, Gauteng* [2015] ZAGPPHC 530. The deductions in these cases were 10% and 15% respectively. The defendant's counsel said that they did not ask for a global contingency deduction of this kind.
>
> [601] In *Singh* the deduction was made because the judge was doubtful about some of the medical expenses (eg items allowed at the maximum tariff where less might be charged, doubts as to the effectiveness of some of the therapies, whether therapy programs would run their full course, whether they would be diligently carried out, the difficulty of accommodating all of them in the child's schedule and so forth – see para

[32] *Singh and Another v Ebrahim (1)* para 177.
[33] Ibid para 107.

107). While I make no pretence to be able to predict IDT's future expenses precisely, I have attempted in each instance to determine whether the intervention would be reasonable and, if so, its reasonable cost. In regard to time-based interventions, particularly physiotherapy and psychotherapy, I have taken into account what can reasonably be accommodated in IDT's schedule. I do not regard the possibility that the costs will be less than I have assessed them as exceeding the opposite possibility. This includes the possibility that new treatments, not yet dreamt of, may become available which might reduce or increase the overall expenditure on IDT's health.

[602] The factors mentioned in *Buys* in support of the contingency deduction were: (i) the possibility of errors in the estimation of LE; (ii) the possibility of illness which might have occurred in any event; (iii) inflation or deflation; (iv) "other risks of life, such as accidents or even death, which would have become a reality sooner or later, in any event". I do not find these compelling:

- As to (i), I have determined IDT's post-morbid LE on the basis of evidence before me. Things may turn out differently but that could cut both ways. IDT's life might be longer or shorter. One might think intuitively that he is more likely to die in the 48 years from now to age 55 than survive beyond age 55 but that may not be sound. Dr Strauss' life table for IDT's cohort as from age seven reflects slightly fewer death in the group aged 7 – 55 than in the group aged 55 and beyond.

- As to (ii), there is no evidence that the illnesses of which IDT may have been at risk pre-morbidly will not still be a risk for him. He is not being compensated for the cost of treating them. There is no notional saving post-morbidly.

- As to (iii), the parties here have agreed a net discount rate. There is no evidence that medical inflation is more likely to differ from the agreed rate in one direction than the other.

- Factor (iv) seems to be a different way of expressing factor (i).

> [603] Accordingly I do not intend to make a general contingency deduction from medical expenses. This is by no means novel (see, eg, *Van Deventer v Premier Gauteng* [2004 TPD] C & H Vol V E2.1; *De Jongh v Du Pisanie NO* 2005 (5) SA 457 (SCA) paras 48-49; *Lochner v MEC for Health and Social Development, Mpumalanga* supra paras 32, 37 etc). I have borne in mind the possibility of item-specific contingencies but have not considered it appropriate to make deductions save for the psychiatric claims which were advanced and have been allowed on the basis of a percentage risk. (A number of items were settled on the basis of a percentage risk.)'

[64] I have carefully considered the submissions of both parties in respect of applying a contingency deduction. In the portion of the judgment which dealt with the life expectancy and the criticisms of Campbell's calculation thereof, I have declined to apply a contingency as suggested by the defendant. Pillay, the paediatrician, has accounted for the possibility of chest infections which may arise in the latter part of her life. Given the fact that A[...] will be provided with the necessary therapies going forward, optimal care and treatment, I do not foresee a possibility given her GMFSC level as well as any CF level which justify such a contingency deduction and I decline to do so specifically in relation to A[...]'s life expectancy.

[65] If one considers the evidence presented by the various experts and what has been agreed on by the parties largely due to compromises on the part of their respective experts, contingency deductions have already been built into the assessment of the future medical needs and devices required for A[...]. All duplications have been removed from the calculation of the future medical and hospital expenses, and I am mindful of the fact that the fear expressed by Koen J

in that there may be an overstatement of therapy does not apply in this matter.

[66] I also agree with the submission of the plaintiff that, having regard specifically to the cost agreed upon in respect of caregivers, which is in large part a compromise, and what has been provided for her, any further contingency to these costs will result in a loss to the Trust, which is required to make provision for her future needs.

[67] In determining the various therapies to be provided, I have been mindful of the concerns expressed by Koen J in *Singh* specifically whether all therapies will be needed, the effectiveness thereof, that some may not be carried out with the diligence with which they have been claimed, considering the fact that A[...]'s endurance will lessen as she grows older, the difficulties in scheduling all the therapies for her, the possible interruption of certain therapies, but more importantly, the fact that a lot of the therapies towards the latter part of her life are maintenance therapies given the fact that all the experts are in agreement that a maximum benefit stage will be reached over the course of her life and the continued therapy would merely be to maintain her condition and prevent any further deterioration.

The evidence

[68] Several expert witnesses testified for both parties and where there were two experts in a particular field they prepared joint minutes. Only one expert testified in relation to life expectancy. Given that there was no agreement on this a substantial portion of the judgment will be devoted to this aspect. This is also as it will determine the time period for which A[...] will be required to be compensated.

Life Expectancy

[69] Dr Robert Campbell (Campbell) was briefed by the Plaintiff to consult with and prepare a medico-legal report in relation to the estimation of A[...]'s life

expectancy. Although he is a general practitioner he has approximately twenty years of experience as a rehabilitation and life expectancy expert. He had done research and studied the relevant methodology. He has co-written with renowned life expectancy experts such as Strauss, Brooks and the actuary Gregory Whittaker.

[70] His report was prepared and written from a rehabilitation medicine perspective and with a focus on physical rehabilitation. He testified that a rehabilitation medical practitioner bridges the gap between impairment following injury and illness and functionality and independence.

[71] In his initial report, when he interviewed A[...] together with her mother in September 2018 he was advised as follows:

(a) that currently A[...] lives at home and is taken care of by her mother and her grandmother;

(b) A[...] requires care and supervision at all times;

(c) A[...] is likely to start menstruating soon, her mother is concerned as to how this would affect her;

(d) A[...] is only able to tolerate soft food and her mother is unsure whether this would always be the case in the future;

(e) A[...] cannot communicate or express her needs, wants and concerns;

(f) The plaintiff believes that she will need a full time caregiver to assist with A[...]'s care as she is working and not at home during the day and A[...] is cared for by her grandmother who is getting old and who is unable to cope with A[...].

[72] During the early hours of the morning A[...] gets up and wants to watch television. Because she sleeps with her, she calms her down, settles her and puts A[...] back to sleep again. A[...] then wakes up again at around 04:30 a.m. walks around and follows her mother around as she is getting ready for work. When A[...]'s mother leaves for work at 06:00 a.m. A[...]'s grandmother takes over her care and supervision. A[...] plays in and outside the house, chases the chickens and tends to pull the furniture around.

[73] A[...]'s breakfast, usually given to her around 08:00 a.m. is either Weetbix or break soaked in milk or some other type of soft food. A[...] sits on the chair on the floor for her meals and is fed either by her or her grandmother. Although A[...] opens her mouth for food, she cannot take it off the spoon and the food must be poured into her mouth for her. This often results in food spilling from her mouth while she is eating but A[...] rarely coughs or chokes. Meal time lasts for approximately 20 to 40 minutes.

[74] When A[...] is hungry she indicates her hunger by going to fetch her food or a bowl and asks to be fed by showing this to her mother or grandmother. A[...] has water to drink after a meal which must be given to her in a cup which is held whilst the water or liquid is poured into her mouth. A[...] tends to mess the liquid all over herself if she tries to drink independently. During the morning whilst her grandmother is busy with her chores, A[...] plays around the house.

[75] At approximately 11h00 she is bathed and her grandmother fetches water from the communal tap. (This is no longer the position since the family have relocated to Noordsig). A[...] does try to assist her grandmother to help her bath but is supervised and requires assistance to do so. She enjoys bathing and sits independently in the bath water.

[76] Lunch time is around 13:00pm and similarly she fetches the bowl to indicate to her grandmother that she is hungry. A[...] will play and watch television during the course of the afternoon until her mother returns from work in the late afternoon to assist in caring for A[...]. Supper time is between 16:00pm

and 18:00pm and thereafter A[...] settles down around 20:00pm to sleep.

[77] A[...] has had about 4 to 5 episodes of seizures during the course of her life which commenced around about the age of 2. She has not had any seizure episodes in the last two years and has never been put on medication for such problem. A[...] cannot talk, she makes moaning noises and cries and drools excessively and grinds her teeth. A[...] uses nappies to manage her bladder and bowel incontinence but is able to indicate the need to go to the toilet using non-verbal communication during the day. However, she is entirely dependent on nappies during the night.

[78] A[...] has mild to moderate asymmetrical spastic pattern of movement disorder. Her movement is weaker on the right hand side and in her upper limbs when compared to her left hand side and lower limbs. He classified A[...] on GMFCS level 1 which is a reliable tool to assess levels of gross motor function with level 1 representing individuals with the least severe restriction of functioning.

[79] He classified A[...] on GMFCS level 1 as she is between the age of 6 and 12 years as “she can walk at home, school, outdoors and in the community”. She is able to walk up and down kerbs without physical assistance and stairs without the use of a railing. She performs gross motor skills such as running and jumping, but speed, balance and coordination are limited.

[80] With respect to her fine motor skills and upper limb movement, although A[...] is able to pick up and handle light objects and toys she is unable to hold heavier objects. Movement and function is better on the left than on the right side of her body.

[81] In respect of the MACS which organises individuals at different levels of hand function he classifies A[...] on level 4, as she is able to handle a limited selection of easily managed objects in adapted situations, that she performs parts of activities with effort and with limited success. A[...] requires continuous support

and assistance and/or adaptive equipment even for partial achievement of activity.

[82] In addition to primary sensory-motor impairments, A[...] has the following associated impairments, namely moderate to severe cognitive impairment, severe communication impairment, incontinence and mild to moderate visual impairment.

[83] A[...] is fully conscious and aware of her environment and interacts readily with it. She is friendly but becomes irritable if she does not get her way. She initiates contact only with people who are known to her and is able to express her needs and wants through non-verbal communication and cues. Her ability to be attentive and concentrate is impaired. She is able to see and fix her gaze and track movement, but has a variable squint in the right eye with loss of medial deviation. Her hearing is intact and there are no signs of chronic or recurrent pain. A[...] cannot talk and only makes moaning noises and cries. She requires a modified soft textured diet and is dependent on careful feeding by others. She has good facial expression, but tends to keep her mouth in an open position, drools excessively and grinds her teeth.

[84] In September 2018 A[...] weighed 52.4 kg which is above the 95th centile line on an appropriate centile chart placing her well above the zone of concern for an increased risk of morbidity and mortality associated with low weight for age. She still continues to use nappies, especially at night, although she has developed some ability to delay bladder emptying.

[85] She exhibits good head and trunk control in all positions tending to slump her trunk in sitting sometimes. She is able to move all four limbs without any difficulty but movement appears somewhat weaker and of poor quality on the right when compared with the left. Her gross motor function is not obviously impaired but she exhibits poor fine motor function. She is able to pick up and hold objects but with a coarse mass grasp with primitive pincer grip only.

[86] She has no obvious signs of severe impairment of muscle tone but there is

an impression of mildly decreased muscle tone in her trunk and neck. Her resting limb tone is grossly intact. Her sitting and standing balance are good. She walks by holding her arms against her sides with her elbows and wrists flexed in front of her. Although she is awkward she is stable while walking.

[87] She recognised sounds, voices and her own name and understands some simple instructions. Although she is unable to speak at all she can communicate some things like hunger through non-verbal methods of communication. On the communication function classification scale (CFCS), which classifies an individual's ability to engage in receptive and expressive functional communication with level 5 being the lowest level, he classified A[...] on level 4. This means she is limited as both a sender and receiver. Her communication is difficult for most people to understand and she has limited understanding of messages from most people. Communication is seldom effective even with familiar partners.

[88] A[...] is fully independent with respect to all aspects of movement and mobility and she is able to lift her head in all positions, roll over without any difficulty in all directions. She transitions independently from lying to sitting and sitting to standing, can sit and stand without support and can walk and run.

[89] On the eating and drinking classification scale (EADCS), which classifies a person's ability to eat and drink and rates feeding and swallowing ability, A[...] is classified on level 3. People on this level are described as eating and drinking with some limitations to safety and there may be limitations to efficiency.

[90] At the time of his consultation with her and the completion of his report in November 2018, A[...] had been seizure-free for over two years and had never received medication for it and had no history of respiratory problems with no signs of cardiac, respiratory or abdominal problems.

[91] In determining A[...]'s life expectancy he followed the following approach, namely:

(a) he used A[...]'s current age of 8.8 years as a calculation point;

(b) used the relevant life table being life table 2;

(c) the different research groups which have studied survival trends in cerebral palsy;

(d) the research and publications from the researchers working out of California (Strauss and Brooks et al.) provided the most useful and precise framework for use in the estimation;

(e) A[...]'s level of mobility and ability to feed represent the two most important predictors of the impact of cerebral palsy on survival and life expectancy;

(f) accepted that the results of the research performed in California can be applied in a South African context by adjusting for the differences between general population life expectancy in the USA and that in South Africa.

[92] In calculating A[...]'s estimation of life expectancy he took into account the relevant clinical assumptions from the various classifications he has done and compared her with 8.8 year old girls with cerebral palsy who can walk unaided and who are fed orally by others and whose weight is satisfactory. He has also considered the table 2 from Brooks' recent publication from the California Group and the probability of survival of children between the ages of 4 and 30 including in the walks unaided and fed orally by others functional group. He has made use of data from this table and he has calculated that a typical 8 year old girl in A[...]'s functional group has an 88.7% chance of surviving until the age of 30 years.

[93] Secondly, a typical 8 year old girl in the same group has a life expectancy that is 56.1 years compared to 73.2 years in the USA general population.

However, because A[...] has more severe cognitive impairments than any other children in the functional group it was appropriate to make an adjustment for the probable impact of her severe cognitive impairment on mortality. As a consequence he has increased the mortality rates used by 1.35 and when this is applied to 8 year old girls in this customised functional group a life expectancy of an additional 15.7. However, because the research emanates from the USA the life expectancy of the general population is better than in South Africa those results could not be used and applied to A[...] without qualification.

[94] The defendant's cross-examination of Dr Campbell focused on his ability to testify as a life expectancy expert given his qualifications and that the assessment of A[...]'s life expectancy had to be reduced or an appropriate contingency had to be applied due the use of Koch's life table 2, her substantial weight increase, and the risk of epilepsy and respiratory infections in the latter part of her life.

[95] He was challenged on the fact that he is a qualified medical practitioner and not an actuary and in his evidence in this matter and in other matters involving life expectancy, he has relied on the methodology followed by life expectancy experts like David Strauss and Jordan Brooks, that he has referred to papers written by them and has merely collaborated with them on matters and interacted with them.

[96] He has relied on his involvement in the medical field and written papers on life expectancy. He was challenged on the fact that apart from the Singh, matter courts in judgments in which he has testified as an expert have not approved the process of qualification that he has described. It was suggested to him that what he relies on is his expertise as a medical doctor, papers that have been written by others, specifically in California and his interaction with other life expectancy experts and the fact that he has collaborated with Strauss to produce a paper on life expectancy in South Africa.

[97] Campbell's response to this was that he had the knowledge, experience and expertise which has been accepted by both plaintiffs and defendants and he

has testified on life expectancy in courts of law who have accepted the methodology he has used and his experience in the field of rehabilitation medicine.

[98] He indicated that he is the only person in South Africa to research the life expectancy of children with cerebral palsy in which he collaborated with Dr Jordan Brooks and Gregory Whittaker. He collected the data, analysed the data and reported on it. He is also the only published African researcher in the field of life expectancy in cerebral palsy. The assessment of life expectancy falls into an inter-disciplinary field which marries aspects of actuarial science and medical science, and that his knowledge, skills, expertise and experience as a medical practitioner are a strong foundation to provide the opinion.

[99] The second challenge to his evidence was his use of the Koch life table 2 from 1984 for white males. He indicated that there are no South African tables that have been published since the 1984 one and the 1986 that are based on empirical evidence. He indicated that the 1984, 1986 tables are the only four life tables that are available. It was suggested to him that the 1984 life tables pertaining to the white population is an outdated table and that there are other life tables available. He indicated that there is legal precedent for the use of Koch 2 life tables and that if the court was of the view that Koch life table 3 would be more appropriate, it would have the effect of reducing the life expectancy by two years at most.

[100] He was pertinently asked whether he was of the view that the 1984 life table was out of date and he disagreed and indicated that although it is an old table it is still valid. He was requested to look at Koch life table 3 to indicate what difference there would be in A[...]'s life expectancy if such table was used. He was given an opportunity to do so and he did a comparison between Koch life table 2 and Koch life table 3 and he indicated that there was a differential of 1.7 years.

[101] The second aspect dealt with during the course of cross-examination was

the risk of respiratory tract infections in A[...]. He confirmed that there is an increased risk of respiratory tract problems and infections in people with cerebral palsy, but it differs on the severity of the cerebral palsy with which they are diagnosed with. He confirmed that the empirical evidence indicated that the risk of respiratory tract infections which leads to pneumonia and consequently resulting in death is a factor that one has to consider. He confirmed that he had considered this and dealt with it in his report.

[102] He acknowledged that risk factor was taken into account in relation to A[...]. He considered her specific profile and her history of respiratory tract infections. If in her medical history, it demonstrated that she experienced an increase in respiratory tract infections or respiratory tract infections which required specialist care or hospitalisation in the period leading up to his assessments, then he would have assessed her as being worse off than her comparison functional group peers and it would have been appropriate for him to make an adjustment to the estimated life expectancy.

[103] He indicated that as no such risk was reported it was not appropriate to make any adjustments. He acknowledged that the risk of respiratory infections in the future was in line with that of her functional peer group and has been accounted for.

[104] The next aspect dealt with in cross examination was A[...]'s epilepsy. He confirmed that she has had six episodes of epilepsy, the last one being on 13 April 2021 and it is under control given the use of Epilim. There was a risk that A[...] could have further seizures in the future. It was suggested by Mr Van Niekerk that there was an apparent problem with the use of Epilim as since her use thereof it has increased her weight substantially as indicated by Jane Bainbridge.

[105] He indicated that when he first weighed in 2018 her weight was well over the 95th centile line and she weighed 52 kilograms. When he completed his third report she weighed 70.5 kilograms, a variable of approximately 17 kilograms. It

was suggested to him that such an increase in her physical weight was attributable to the use of Epilim. Campbell indicated that the increase in her weight is not remarkable as if one tracks her growth on the chart she has stayed on a similar point on the centile chart above the 95th centile line and A[...]'s increase in weight has therefore been in line with pre-adolescent growth spurts which one would expect.

[106] He indicated that when one compares the increase in her weight against the centile chart and the objective evidence, the weight gain is not unexpected despite evidence of the significant weight increase. When pressed by Mr Van Niekerk he acknowledged that she has gained 17 kilograms. The question for him to be considered in relation to her weight gain is whether it is remarkable, unremarkable and whether it is expected or unexpected. He indicated that such weight gain is not unexpected if one considers the centile chart.

[107] One would have expected an increase in weight in this period and this is based on the empirical evidence being the centile chart. A[...] has gained weight in line with tracking her position on the centile chart. She was overweight when he did his assessment in 2018 and she is at a similar point on the centile chart in 2022 and that there has not been an acceleration of weight after the addition of Epilim. He confirmed that Epilim does have a side effect of increased weight in some people as it stimulates appetite and would contribute to weight gain.

[108] He indicated when asked to comment on the consequence of such weight gain in a child with cerebral palsy he prefaced it by saying that he rejected the contention that there is a connection between Epilim and A[...] and her weight gain. He indicated that there is no empirical evidence as to exactly what the impact and extent of weight gain is. He indicated in answer to the suggestion by Mr Van Niekerk that it may affect the mobility and activity of the child. In other words, A[...] may become less active and less mobile. That was an assumption which has not been borne out by the research, although it may be true in an individual who has excessive weight gain.

[109] When asked to comment that the use of Epilim may be the cause of her weight gain and that other experts are of the view that it may affect her detrimentally in the long run particularly in so far as her level of activity and mobility is concerned, he indicated that in patients he has encountered who have experienced problems with weight gain related to Epilim one then alters the medication to one which does not stimulate weight gain, although he emphasised that he disagreed that her weight gain was due to the Epilim and if it was, he would manage it with changing her medication.

[110] He indicated that it was possible that if she has a weight problem, it would affect her health detrimentally in the future, but it could be managed once A[...] has access to appropriate care. He was then asked to pertinently comment as to whether this would affect her life expectancy. Campbell's response was that when one considers the approach taken by Strauss, Brooks and others there is a possibility that the condition of a person may get better or worse but this was purely speculative. He disagreed with the proposition that A[...]'s condition would worsen. He indicated that he could not discount it. He disagreed with the proposition that the assessment of her life expectancy had to consider A[...]'s ability to climb stairs or slopes or uneven ground.

[111] The test that one uses for life expectancy is whether or not A[...] can walk unaided for 20 feet. The proposition was put to him that her personal situation is not something that can be excluded from the equation of her life expectancy and that her weight gain is a problem and it would have an effect on her mobility in the future. He indicated that the weight gain was not out of keeping with her tracking above the 95th centile line and is unremarkable and that secondly any perceived change in her mobility at this stage is not relevant to the estimation of life expectancy given the methodology that is used, namely that as long as she can walk unaided for 20 steps it does not affect the calculation of life expectancy.

[112] He also indicated that it would be inappropriate for the defendant to argue that the court ought to take these personal factors into account and that a failure to do so would be an incorrect approach. He indicated that he has followed the

approach laid out by researchers and has taken additional factors into account. A[...]'s profile of features fall within those which one could expect inside the functional group and these features are not so grossly outside of typical for this particular functional group for an adjustment to be warranted to the life expectancy in objective scientific terms.

[113] He acknowledged that the estimation of life expectancy based on the literature is a general acceptance and that it was impossible to predict with any degree of certainty how long a person like A[...] would live and he agreed with this submission. He also agreed that although there is no available information on the survival of persons with cerebral palsy in South Africa against whom one can compare A[...], the database that Strauss uses is the life expectancy project conducted in the USA database and that that is what he uses.

[114] He conceded that he is not an actuary or statistician but a general practitioner and relies on the information available in peer reviewed publications. He confirmed that although life expectancy is an inexact science two experts may disagree on calculations and there may be a variance of 3 to 5 years. As there is no expert with a contrary view he has presented his assumptions based on a scientific approach and believe them to be reasonable, fair and unchallenged. He defended the suggestion that his estimate of life expectancy was speculative and he indicated that it provided a fair start point and it is reliable, although imperfect as the methodology used is sufficiently reliable on which to base a computation of damages.

[115] I am of the view that the defendant's criticism of Campbell's expertise to comment and proffer an opinion on A[...]'s life expectancy is unfounded. When he testified he confirmed that since 1999 he has practised exclusively in physical rehabilitation medicine as a clinician and as leader in a group of hospitals providing rehabilitation services to adults and children around the country.

[116] He has published and taught in the field of physical rehabilitation medicine both nationally and internationally. He has published in the Peer Review Press

with Dr Brooks and Greg Whittaker. Together the three of them published the first research paper on the survival of children with cerebral palsy in South Africa. Dr Jordan Brooks is with the Life Expectancy Project in the USA, California and is one of the principal researchers in research dealing with life expectancy in South Africa, along with Professor David Strauss.

[117] He has also been assisting the court as an expert witness in life expectancy for approximately 22 years since late April 2000. He has testified as an expert witness in life expectancy both by plaintiff and defendant's attorneys, including the Medical Protection Society for private claims, the Western Cape Department of Health, the Eastern Cape Department of Health, KwaZulu-Natal Department of Health, Free State, Northern Cape, Mpumalanga, Gauteng and Limpopo.

[118] The defendant did not lead the evidence of or provide any expert report of its own life expectancy expert, to challenge the opinion Campbell, and contented itself with a challenge to his expertise. In the absence of a contrary opinion I accept his evidence of the assessment of her life expectancy. In addition, given his experience in the field, I accept that he is qualified to proffer such opinion.

[119] He confirmed that he completed three reports in the matter and in all three reports her life expectancy remains unchanged, namely that she would live a further 47.2 years and that A[...]'s total expected survival time is 56 years.

[120] In doing so, he considered Koch’s life table 2 and also the most important facets being mobility and feeding. He found that children with cerebral palsy experience a reduction in life expectancy which is predominantly related to the level of mobility and feeding ability. Having regard to the variance relating purely to mobility and feeding ability he arrived at a total expectancy survival time of an additional 47.2 years.

[121] In determining where to place A[...] in the various life tables he followed the following process. He reviewed other available collateral information by way of

medical records and medico-legal reports, conducted a semi-structured interview with A[...]'s mother, family and caregiver and also conducted a careful examination of A[...]. From that he was able to compile an assessment of A[...]'s condition and then identified the relevant factors which would contribute to an estimation of life expectancy. This process was documented in his initial report of November 2018.

[122] When asked to comment on her weight he indicated that her weight was well above the 95 centile line which put her weight at the top of expected weights of children at her age at that point in time with her severity of cerebral palsy. If A[...] was underweight it would warrant an additional downward adjustment of life expectancy. However, such an adjustment was not appropriate in this instance given that her weight was in line with the expected weights for children at her age and with her level of severity of cerebral palsy.

[123] He also testified that although he classified A[...] on the GMFCS level 1 she could also be a level 2 but it would not make a material difference as this does not impact on the estimation of life expectancy. He confirmed that between completion of his first report and the second report, A[...] experienced a single episode of generalised seizures in April 2021.

[124] Concern was expressed that this could possibly affect her life expectancy given the status of epilepsy. He indicated that there is an assumption that the arrival of epilepsy impacts negatively on the life expectancy of a cerebral palsy child. This is based on two published studies which indicated that if one has seizure activity in the last 12 months one must adjust by increasing the excess death rate as one has an increased chance of dying relative to persons who have not had seizures at all in a 12 month period.

[125] At the time of completion of the second report he saw A[...] in April 2022, and he had confirmed with her mother that there had been no seizures in the 12 month period since April 2021 and therefore because she fell outside of the 12 month window, coupled with the fact that she was not placed on anti-epileptic

medication prior to the seizures but has since been well controlled on the medication he did not make any adjustments for epilepsy and thus her life expectancy as it was inappropriate to do so based on the existing empirical evidence.

[126] He confirmed that although the were some changes in A[...]'s condition since the completion of his first report, none of them impacted significantly on her level of mobility or feeding ability nor were there any additional factors which would have influenced him to interfere with the life expectancy either upwards or downwards relative to his first estimation.

[127] Following on the second report he completed a third report dated 8 August 2022, which was intended to clarify certain points raised. He found no significant changes in either her feeding or mobility which would warrant a change in his estimation of her life expectancy. A further reason for the third report emanated from queries raised by the defendant related to the impact of the risk of chest infections either mild or severe in considering A[...]'s life expectancy.

[128] He indicated that children and individuals with cerebral palsy live less longer than the general population and one of the common causes of death relates to respiratory tract infections. Research conducted by him, Strauss, and Shavelle demonstrated that even in people with mild to moderate cerebral palsy there is a significantly increased risk of death due to respiratory tract problems.

[129] As a consequence in A[...]'s instance, her life expectancy is around about 30% less than the general population given one of the factors being the increased risk of respiratory tract infections. A[...]'s functional group was at risk of respiratory tract infections, which is why the life expectancy is poorer. To determine this one would look for a history of recurrent hospitalisations for respiratory tract problems, recurrent chest infections and the need for treatment of chest problems by a specialist medical practitioner.

[130] However, although A[...] has an increased risk relative to the general

population she did not have any of these features, which would warrant him reducing her life expectancy relative to the function group. He was of the view that she is at no higher risk than appears and therefore no further adjustment to her life expectancy was necessary, but provision ought to be made for treatment of chest infections as this would be more common in people who have cerebral palsy than in members of the general population.

[131] The third report was also asked to address the question of whether the impact of epilepsy was considered when estimating her life expectancy. He confirmed that there had been a history of partial seizure activity in 2018, more than two years prior to the date of his assessment and that she had been seizure free and on no treatment for at least two years of him seeing her. At that stage it appeared that her seizure activity seemed to have resolved itself. Her subsequent seizure activity in April 2021 lasted one to two minutes and is classified as a generalised seizure at a time when she was on no treatment.

[132] She was admitted to hospital and seen by a paediatrician and treatment commenced. She had been seizure free between 13 April 2021 and 11 April 2022 and is still seizure free at present. In determining not to make an adjustment to her life expectancy he considered the studies of Strauss and a study by Day which excluded the need to make an adjustment to the life expectancy where one was seizure free in a 12 month period since the last seizure regardless of whether one was receiving treatment or not even if there was a history of epilepsy. These studies concluded that on the basis of objective, empirical evidence it did not increase the risk of death and therefore no adjustment was appropriate to the life expectancy.

[133] He indicated that one would have to make provision for A[...] to deal with respiratory and chest infections even though it does not affect her life expectancy simply because children with cerebral palsy have an increased risk to suffer from them later on in life and is at increased risk of death due to respiratory illness relative to the general population.

[134] Dr Pillay the paediatrician also recommended ongoing treatment for epilepsy and the treatment of respiratory infections. Campbell considered the risk of epilepsy and respiratory infections as well as A[...]'s weight gain and its possible effect on A[...]'s life expectancy. I accept his conclusions in this regard and in the absence of a contrary opinion, accept his assessment that it would not impact on her life expectancy.

[135] Campbell's response to such suggestion warrants mentioning '… I presented my assumptions. I contend that they are based on a scientific approach and as I said they are not challenged and I believe them to be reasonable and fair.'

[136] In the light of this there is no reason to accept the defendant's suggestion of a 3 to 5 year variance in her life expectancy.

[137] I have also considered the defendant's criticism of his use of Koch life table 2. Although questions have been raised concerning the use of these life tables, our courts have consistently endorsed the use thereof in the calculation of life expectancy.

[138] In *Singh and Another v Ebrahim*[34] Conradie JA writing for the majority agreed with the following passage from Snyders JA judgment:

> 'As with most things in this matter, the appropriate life tables to be applied to the assessment of Nico's life expectancy were also in issue. The high court applied the SA white male tables. The appellant contends for the application of the Koch life tables which adds between 2 to 4 years to the various scenarios calculated by Strauss. Koch's attempt to remove race from the SA life tables is obviously attractive, but the evidence of the assumptions made to compile his life tables does not, in this case, succeed to illustrate their reliability. Although the 1984/1986 SA life tables are out of date, they are still the best available. In the circumstances it

[34] *Singh and Another v Ebrahim* [2010] ZASCA 145 at paragraph 199.

seems eminently reasonable to have used the white male tables to exclude any racial component from the calculation. Consequently the dispute about whether the appellant agreed to the application of the SA life tables only to the actuarial calculation or also to the assessment of life expectancy is irrelevant.'

[139] The use of these life tables was also endorsed by Roger's J in *AD*. I am bound by these decisions and I see no reason to adjust the assessment of A[...]'s life expectancy given the use of such life table. In any event the use of Life table 3 results in a negligible differential of 1,7 years. Dr Campbell's methodology and final assessment are in line with the accepted Strauss practice based on a scientific approach with mathematical certainty and there are no reasons to interfere with his conclusions.

[140] He deals with this principle in cross examination as follows:

"*…The second bit of the question relates to, we are dealing with crystal ball gazing to some extent and we have to acknowledge that there is some uncertainty about what will happen. The model of estimating future life expectancy is the average additional survival rime for a child like this. Now some children will die earlier, some will live as long as predicted and some will live much longer. The estimate of life expectancy provides protection for both the plaintiff and the defendant and provides a fair midpoint. In addition to that, the actuary is going to apply this reduction in life expectancy to a customised life table and then work out what is the probability that the child will be alive at various points in life in the future.*"

Occupational Therapy

[141] The plaintiff's occupational therapist was Jane Bainbridge (Bainbridge). Her expertise was not admitted and consequently *Mr McIntosh* had to qualify her as an expert. The reason for this was not apparent nor did Mr Van Niekerk during the course of his cross-examination challenge her credentials or her expertise

and therefore I am not certain as to why court time was wasted qualifying her. She confirmed having prepared a joint minute with the defendant's expert Prinsloo.

[142] She had last seen A[...] on Friday 26 August at the Swana School in Empangeni to observe her in the classroom and determine how much occupational therapy she was receiving in school. Her enquiries revealed that there were two occupational therapists employed at the school, only one of them was presently at the school as the one who worked with A[...] resigned. The nature of the occupational therapy which A[...] was receiving was not one-on-one occupational therapy and was not focused on her disability or improving her condition and assisting her.

[143] She testified that the area of dispute between herself and Prinsloo was that she classified A[...]'s cerebral palsy as meeting level two in the classification criteria for motor function but falling at a lower scale for other domains of function on various scales of development. She had completed and filed a report and classified A[...] at level one and this was the main area of disagreement. In addition, she was of the view that A[...] suffers from dyspraxia whereas Prinsloo was of the view that she suffers from apraxia.

[144] Bainbridge completed her reports on 25 May 2021 and Prinsloo on 16 September 2021 and again on 9 November 2019. At the time of completion of their reports and specifically the joint minute, both had regard to the findings and recommendations of various other medico-legal experts briefed and which were documented in their respective reports.

[145] They agree that A[...] presents, despite her being 13 years old, with the gross motor skills equating to that of a 24-month old child. The differential between their classifications lies in Bainbridge observing A[...] to require wall support when climbing or descending stairs and her instability walking over uneven terrain and reduced balance ability. There were planning difficulties hence the reason why she classified her as being dyspraxic as she does not know what

to do with her body or how to initiate activity.

[146] She is unable to communicate verbally, has limited vision and hand dysfunction. As a consequence of her hand dysfunction she is rendered dependant on others for feeding, dressing, toileting and bathing. They both agree that A[...] is ineducable and although she is enrolled at Swana Special School she will never be equipped to live alone, work or function in the community. She is extremely vulnerable for the remainder of her life and requires appropriate support, care, equipment, housing, medical and therapeutic intervention.

[147] She confirmed that there was an increase in tone evident in her upper limbs with effort and that the MACS level 4 indicated fine motor control was weak affecting unilateral and bilateral manual control requiring a handover hand approach matching a 2 to 3-year old level of function. Dominance was not established. They both agreed that the feeding is at EDACS level 3. She has limited receptive language, acute communication levels are 0 as she is unable to articulate language. There is a cognitive delay for all basic concepts of less than 24 months and a functional or behavioural delay of between 10 to 24 months.

[148] Both occupational therapists agree that their recommendations are in the context of therapeutic, accommodation, transportation and educational needs secondary to A[...]'s profound developmental, motoric and functional deficits. They agree that A[...] is not a candidate for conventional or even remedial school. Placement in a special school such as Swana is appropriate and continued attendance until she reaches the age of 21 is recommended.

[149] As regards accommodation both occupational therapists agree that although she is mobile A[...] has difficulties with balance and instability. The necessary renovations need to be made to her home to allow for safe and non-slip bathroom fixtures, non-slip flooring and unobstructed walkways, running water and sanitation. Prinsloo commented on the fact that A[...] is taking Epilim which Bainbridge was not aware of. She noticed that cognitively A[...] appeared more suppressed as a consequence of her taking Epilim which has created a

difference in level of alertness and physical tempo and recommended that her doses be monitored and revised if possible to have a better effect on her level of alertness.

[150] As regards accommodation for the caregiver, Prinsloo is of the opinion that she does not need a bed sitter as A[...] sleeps without major difficulties at the school hostel and at home. Bainbridge however recommends bedsitter accommodation to be considered for her caregiver. Both occupational therapists agree that specific training is required for any caregiver appointed to deal with A[...] specifically her cerebral palsy needs and such courses are offered by Nakalala at a cost of R4 180.00

[151] As regards transportation it is reported that A[...] travels quite well on public transport save that she needs to be accompanied by an adult or a caregiver and is very slow.

[152] Prinsloo recommends that she be accompanied on public transport and funds made available for a caregiver or her mother to travel with her. Bainbridge is of the view that difficulties associated with timing for travel, safety of travelling with a disabled person who cannot communicate and who lacks balance and is unstable walking, there is a need for a mobility device for long distances and should be accommodated by either special transportation for disabled persons or the provision of a small sedan. Bainbridge is of the view that A[...] will deteriorate over time making mobility more difficult and placing her at risk especially at increased risk for falling or injuries. At present, both confirm that A[...] is using school transport to travel to and from school and her mother indicates on other occasions she makes use of hired transport.

[153] The defendant's witness Helen Prinsloo's expertise was not accepted by the plaintiff. Prinsloo confirmed she had prepared two reports dated 9 November 2019 and 16 September 2021 and a joint minute with Jane Bainbridge on 27 September 2021. She prepared the joint minute after she had performed a re-assessment of A[...] in September 2021. She confirmed the reports and that she

adhered to the contents thereof specifically her findings and conclusions.

[154] During the course of her assessment in September 2021, she established that A[...] was a day scholar at Swana school and they had moved out of the rural area at Debe to Empangeni. These were the major changes since she had last seen A[...] in 2019. From her reading of the reports she established that Swana School caters for children until age 21.

[155] She testified that despite several attempts made by her telephonically to contact the school and obtain information about the school and the therapy offered, she could not obtain such information. She indicated that when they heard it was her on the phone they refused to provide her with information and she had to rely on what was reported to her. She confirmed that A[...] has balance and stability issues, she cannot feed herself or dress herself and can never be left on her own. She needs constant care-givers for the rest of her life.

[156] Despite this she opined that A[...] could be taken care of by family members and her mother needed to be involved in her development. What was significant since she saw A[...] was that initially during the first two years of her life she suffered five seizures and thereafter in 2021 a major seizure for which she was admitted to hospital. She testified that A[...] is currently on Epilim and her seizures are well controlled. However, one of the side effects of Epilim which is quite common is that she is slower and most importantly is the increased weight gain. This she established from the various reports which show that A[...]'s weight had increased by approximately 17 kilograms over the last two-year period.

[157] When compared to the plaintiff's expert Jane Bainbridge, Bainbridge advocates treatment until life expectancy the reason being she wanted A[...] to be as self-sufficient as possible. However, it is evident that A[...] will never be fully dependant for the daily activities of life given her cognitive deficits and will always be reliant on caregivers 24/7. She acknowledges that despite the extensive therapy which she advocates for A[...] at some stage she will plateau and thereafter some therapy will become maintenance therapy.

[158] The issues in dispute between these experts are as follows:

(a) the amount of occupational therapy that is required by A[...];

(b) the nature and cost of caregiving services required by A[...];

(c) the amount of time required for the sourcing and interviewing of caregivers;

(d) the number of hours required for annual case management;

(e) the number of hours required for report writing or meetings;

(f) the need for an adult hoist;

(g) the need for an advanced anti-decubitus overlay mattress;

(h) the need for a height adjustable bench and table;

(i) the need for a roller/bolster; and

(j) the need for a standard bobath plinth.

[159] In considering the areas of dispute between these two experts I have considered the following:

(a) Caregiving is essential for optimal care for A[...]. Caregivers require to be suitably trained in caring for persons with CP. A[...]'s family if they are appointed to care for her as care givers ought to be remunerated. Accepting that if they are remunerated well they will be less inclined to leave their employment.

(b) Her mother cannot cope with her as she gets older and heavier and will require assistance for her.

(c) If caregivers are appointed to care for her, this will ensure that she will be able to do the exercises and some of the therapy required as she gets older and as reaches the age where only maintenance therapy is required.

(d) Prinsloo has an extremely conservative approach when it relates to the therapy required. She has not case managed CP children and her expertise to speak to their needs in my view is limited.

(e) Bainbridge on the other hand has far more extensive experience in not only case management but has been involved in the actual treatment of CP children like A[...].

(f) Prinsloo in her assessment of A[...]'s needs has indicated that it is better for her to ambulate and walk and this has to a large extent influenced her reluctance to agree to certain of the items recommended by Bainbridge.

[160] I agree with Bainbridge's suggestion of the adult hoist. As A[...] grows older and if her condition deteriorates it will be difficult for her care givers to move her around like for example transferring her off the bed, into the shower or onto a commode. This would be contingent on her condition deteriorating and bearing in mind the therapies advocated together with her being given optimal care I believe a contingency ought to apply of 50 %. The same would apply to the advanced anti-decubitus overlay mattress as this would be needed to prevent pressure sores if her mobility drastically decreases and she becomes immobile and bed ridden.

[161] The height adjustable bench and table Bainbridge conceded was "nice to have" but not a necessity. The roller/bolster is necessary for her therapies to

provide her with good proximal support or stimulation. I agree that the standard bobath plinth can assist with her therapy and ought to be allowed.

Case Management, Crisis Management, Report Writing

[162] Bainbridge advocated 24 hours per annum and indicated that this was a conservative estimate based on her experience. This would involve inter *alia* arranging doctor's visits, new prescriptions, medication, interaction with the various therapists. In relation to caregivers, she indicated that they would need to be trained in CP care and has made allowance for training to be repeated every five years. Her allowance for 10 hours every five years is a reasonable estimate having regard to what is involved namely conducting intensive interview with prospective candidates, doing background checks and any aspects incidental to the appointment of caregivers. This is based on her extensive experience as case manager. She has also indicated that a conservative estimate of 6 hours per annum will be required.

[163] In respect of crisis management, her and Prinsloo part ways. Her suggestion that the plaintiff deal with any potential crisis which may arise, I agree illustrates a lack of empathy and a detachment from the circumstances mothers of CP children must negotiate. Her lack of experience as a case manager renders her oblivious to the hardships mothers of CP children endure. Bainbridge testified that 10 hours every five years is required. Her reasoning for this is the following:

> "*Well my view and the view generally in the global body of this is that disability of this nature places an inordinate strain on caregivers but the matter in particular and the enormity of the responsibility that goes with this and there is no end in sight really. That this is never going to get better is exhausting and it is exhausting on many levels. It is extremely exhausting, it is physically draining and financially bankrupting and from a social point of view isolating.*"

[164] Bainbridge further recommends 6 hours per annum.

[165] Prinsloo admitted that she has never done work with cerebral palsy children and has never been a case manager. This in my view renders any opinion she proffers in regard to case management unreliable as such opinion is not based on any practical experience. Consequently, Bainbridge's recommendations in this regard must be preferred.

Caregivers

The remuneration of caregivers

[166] Two industrial psychologists prepared reports relating to the remuneration for the caregivers and facilitators to be appointed. The plaintiff's expert, Sonia Hill, and the defendant's expert, Gideon De Kock, prepared remuneration reports and then subsequently as a consequence, a joint minute.

[167] Pursuant to the preparation of the joint minute they agreed after consideration of the various medical legal reports that her life expectancy is reduced and any calculation in relation to the remuneration of caregivers would have to bear this in mind to A[...]'s expected survival time to age 56. They agree, having regard to A[...]'s disabilities and to the reports of the experts that A[...]'s disability comprises of severe functional limitations in all spheres of development and will preclude her from living a normal life. She is dependant on her mother and her caregiver for all her basic needs, security and they agree that this will be lifelong warranting appropriate provision of care, schooling and therapeutic and medical interventions.

[168] They agreed that given the complexity of dealing with a cerebral palsy child it is necessary for a caregiver to obtain a relevant qualification and a certified trained caregiver should be appointed. In addition, they agreed that the number and type of caregivers, hours of work, shift work as well as relief workers would be determined by the respective occupational therapists and they agree to

the recommendations of such therapists.

[169] In addition, a signed contract of employment as containing the appointment and benefits for caregivers should incorporate the terms and conditions of the Basic Conditions of Employment Act. As per the BCEA, the following would apply to such remuneration package, namely a basic salary, overtime (limited to a maximum of 10 hours per week), shift work, fifteen days annual leave, ten days sick leave per annum, family responsibility leave of 3 days per annum and the caregiver, relief worker or shift worker ought to be registered with the Unemployment Insurance Fund (UIF).

[170] Meals may be provided at the discretion of the employer as well as bonuses. Other benefits may also be paid at the discretion of the employer and caregivers ought to benefit from an annual inflationary linked increase for the duration of their employment.

[171] They note that A[...] has currently one caregiver, Miss Ngxongo, whose working hours are from 05h00 to 09h00, 15h00 to 21h00 from Monday to Friday. She earns at a rate within the region of R30.78 per hour working a 45-hour week and a basic salary of R6000 a month. She lives in and benefits from accommodation and meals calculated at approximately 10% per day in the region of R60 plus annual leave and a total income of R7 654.84 per month.

[172] In relation to the appointment of a suitable caregiver Miss Hill has done extensive research which she testified about. In addition, in preparing tables to be used for remuneration of caregivers, facilitators and attendants she has had extensive consultations with therapists, parents, facilitators, caregivers as well as the Head of Wizkids, Pathways and Nakalala. She drafted a relevant job description specifically in relation to the care of a cerebral palsy child. Included in the job description includes in summary an understanding of a cerebral palsy child, handling of a disabled child, the administration of medication, understanding seizures, stimulation and application of therapeutical intervention and keeping notes. The provision of pension or a provident fund and a medical

aid are not compulsory benefits payable to the employee and does not form part of the basic conditions of employment. However, it is compulsory for an employer to register an employee and it is compulsory for the employer and the employee to contribute to the Unemployment Insurance Fund.

[173] n her report she has prepared three tables for salaries for a caregiver and facilitators working a 40-hour normal week, an eight-hour shift system and caregiver rates as provided to her by Nursing SA. Essentially the total cost to an employer of a general caregiver amounts to R6 872.98 per month, a facilitator to R9 482.81 per month and an assistant to R5 093.84 per month. In respect of shift workers, the total cost to employer of a general caregiver amounts to R7 690.72 a month and the cost of an attendant to R5 699.90 a month.

[174] Essentially, in respect of those caregiver rates provided by Nursing SA the hourly rates have been provided for a weekday, weeknight, Saturday, Sunday and public holidays. It must be borne in mind that caregivers from Nursing SA have a nursing qualification and in addition from the hourly rate is deducted a commission and less is paid to a caregiver and a specialised caregiver.

[175] Miss Hill refers to the opinion of Sue Anderson that A[...] requires two caregivers as well as a night assistant.

[176] There is disagreement between her and Gideon De Kock as he is of the view that A[...] is cared for by her mother and her mother's sister Ms Biyela. In addition, she is cared for by Ms Ngxongo whose qualifications and experience are not known. He is of the view that in the final analysis a caregiver is a general worker which if cerebral palsy (CP) trained receives a week's formal training. Caregivers often get involved in domestic work but do not work as domestic workers and he is of the view that it would be appropriate that the remuneration for caregivers fall within the rage of the general worker category. He opines that there is an overlap in duties between domestic workers and caregivers. He has applied the national minimum wage as an appropriate wage rate for CP caregivers. He compares the national minimum wage with the wage payable to

farm workers, domestic workers, gardeners and community health workers.

[177] In addition, he has relied on a search engine Payscale.com for the various rates paid to caregivers. These rates are much lower than the rates advocated by Miss Hill.

[178] In the final analysis he is of the view that a rate of R23.91 per hour be used in all calculations and permutations as a basic remuneration rate of a trained CP caregiver. In addition to this the statutory required payments must be proportionally added and the appropriate support care system must be agreed by the occupational therapists.

[179] In addition, he is of the view that A[...]'s mother consider a suitable family member to be trained to be appointed to look after A[...] and that the contract of employment concluded with any person appointed to take care of her must comply with the BCEA. Any caregiver appointed must undergo a refresher training course every five years.

[180] The parties subsequently agreed the model of costing for caregivers' subject to the court's directive in relation to the caregiving model the agreed rate of remuneration is R 27.00 per hour.

[181] For similar reasons, Bainbridge's model for the appointment of caregivers is to be preferred. I do not agree with Prinsloo's suggestion that her mother and family members ought to be responsible for A[...]'s care. In the event that a family member is appointed as a caregiver, they ought to be renumerated. I accept Bainbridge's recommendation on the following in relation to caregivers:

(a) two caregivers be appointed working 8-hour shifts until A[...] turns 18 years of age;

(b) thereafter A[...] will require 24-hour care with three 8-hour shifts. The costing of caregivers was agreed as per the table below subject to the UIF contribution being halved.

Description	**Unit**	**Caregiver**
Hourly Rate	1 hour	R 27.00
Overtime (x 1.5)		R 40.50
Sunday (x 2)		R 54.00
Public Holidays (x 2)		R 54.00
Weekday	8 hours	R 216.00
Saturday		R 324.00
Sunday		R 432.00
Week	5 days	R 1080.00
Saturday	1 day	R 324.00
Sunday	1 day	R 432.00
Total weekly	7 days	R 1836.00
Monthly Total (x 4,333 weeks)		R 7 955.39
Annual leave (15 days per year)	(27x8x15)/12	R 270.00
UIF		R 46.80
12 Public Holiday per year	*1 day/4,333*	*(R99.70)*
Total		R 8 418.68
Additional Discretionary benefits		
Bonus (2 weeks' pay)	(27x80)/12	R 180.00
Food and Accommodation (10% of basic wage)		R 180.00
Total monthly		R 8 778.68
Relief caregiver cost (8 hours at R 27 and 8 hours at R 40.50)		R 540.00

(c) The additional discretionary benefits recommended should be included in the calculation to eliminate the likelihood of a high turnover of caregivers. The contribution to a provident fund or pension fund should the plaintiff decide to pay is a cost the Trust must bear.

Physiotherapy

[182] The plaintiff instructed Surekha Somaroo (Somaroo) and the defendant Sholena Narain (Narain). They prepared a joint minute from which it is apparent there are wide discrepancies in relation to the nature of therapy A[...] will require. Somaroo testified in detail advocating the therapies she recommends and envisages intensive therapy to begin with and therapy to life expectancy. Narain is of the view that following the intensive period of therapy, what is required by A[...] is maintenance therapy.

[183] Rogers J in *A.D.* held the following when faced with discrepancies in the recommendations and evidence of physiotherapists.

> "*451. However I cannot but think that subconscious pro-client bias has caused the one expert to make recommendations at the top end of what might be defendable and the other to do the opposite.*
>
> *452. An appropriate amount lies somewhere between the two sets of recommendations. In determining the appropriate allowance one must not only consider the incremental benefit from more physical therapy. It is also necessary to consider the totality of the interventions he will be receiving. Even if additional physiotherapy might in the abstract yield some additional benefits he may simply not have time for it. ITT cannot be expected to live a life of constant medical intervention...*"

[184] I agree with the defendant that Somaroo was a poor witness and did not provide an objective opinion and left little doubt as to whose side she was on.

She placed extensive reliance on literature to support her recommendations. She was evasive and defensive under cross examination and I am of the view that she failed in her responsibilities to the court as an expert witness in this matter and I therefore cannot rely on her evidence.

[185] Narain on the other hand impressed me as witness and her conservative approach was justified based on A[...]'s presentation and the available facts. She was willing to compromise and make necessary concessions and a careful reading of her evidence reveals the logic on which she relies. What impressed me about her evidence was that in making her recommendations for physiotherapy, she adopted a holistic view taking into consideration the other therapies that would be provided to A[...], the duties of her caregivers and the possible benefit of the various interventions.

[186] In my view, the defendant's expert Narain's recommendations in respect of physiotherapy expenses ought to be accepted. In addition, given the variants in the respective rates used by Somaroo and Narain, they have agreed that an average rate be applied to the calculations and an agreed tariff is set out in table 1 of the joint minute and should be used by the actuary in determining the calculations.

[187] In reaching these conclusions, I am mindful of the concession made by Somaroo that A[...] is unlikely to acquire new skill following the intensive neuro-rehabilitative therapy. I also agree with Narain's assessment that A[...] given the interventions and medications it is unlikely that she will suffer a chest infection and a 50% contingency ought to apply.

Speech Therapy

[188] Rochelle Thanjan (Thanjan) a Speech Therapist employed by the plaintiff consulted with A[...] and her mother to prepare a report. She noted from her evaluation of A[...] that she has limitations in swallowing, feeding and communication. The oral peripheral examination revealed that A[...] presented

with moderate dysarthria, a motor speech disorder which results from impaired movement of the muscles used for speech production including her lips, tongue, vocal cords and diaphragm.

[189] A[...] presents with reduced strength, speed and coordination oral musculature including the cheeks, lips, tongue and jaw. She also presents with premature fatty pads with right sided prominence, compromised lip seal, absent tongue lateralisation and elevation, premature mild suckling, absent rotational and lateral jaw movements as well as absent jaw protruding during drinking.

[190] A[...] has a V-shaped palette and anterior diastema. A[...] presents with premature reflexes including premature suckling and oral sensory integration compromises. Such oral, sensory, structural limitations and abnormal or premature reflexes adversely affect her swallowing skills and speech production by affecting her ability to sustain movements necessary for feeding and speaking. The motor speech skills assessment conducted by Thanjan revealed compromises in the areas of respiration, articulation, phonation, voicing and fluency namely mouth reading, compromised length of exhalation, compromised head support for speech, compromised graded coordination of vocal intensity, compromised with the range of pitch variations and significantly compromised articulation.

[191] The swallowing assessment of A[...] revealed that she presents with moderate oro-pharyngeal dysphagia, moderate drooling which may reduce with drooling management program implemented by a speech therapist. However, Thanjan submitted this is not always effective and must be monitored to review her progress. If poor or no progress is noted, then saliva reducing medication can be implemented alternatively botox injections to the saliva glands performed by an Ear, Nose & Throat Specialist. During feeding A[...] is able to maintain an upright position, and a chair-seated position is recommended over floor seating.

[192] With regard to communication there is a mild compromise as A[...] is not orientated to time to eat and drink but communication cues are used by her

feeder. When the spoon is directed to her mouth she voluntarily opens her mouth but is unable to fully close it. A[...] is unable to request the next spoonful to sip so pacing is dependent on the feeder's judgement and is inconsistently too fast. Incorrect feeding techniques were evident and as a consequence she recommends that A[...]'s feeders would benefit from ongoing intensive training.

[193] In relation to feeding, A[...] presented with partial mouth closure during feeding, anterior spillage with thick purées, moderate to severe anterior spillage with thin purée consistency, severe anterior spillage within liquid consistency, poor bolus manipulation, compensatory effortful swallows for airway protection and tongue and pharynx weakness, compromised oral sensory skills characterised by reduced awareness of smaller portions and the delay in triggering the pharyngeal swallow, mildly prolonged oral transit with thin purées, weak jaw stability with cup drinking, premature sipping method, weak, purposeful bite reflex, absent midline transfer with solids and impaired chewing skills.

[194] A[...] also presented with choking and aspiration disc with all solid foods. She recommended that the swallowing and feeding skills indicated symptoms of GORD, being a gastro-oesophageal reflux disorder and further radiological investigation was recommended to assess the cause and effects of GORD. Because A[...] was resistant to feeding and swallowing techniques she would have to be weaned to changes in her eating skills.

[195] The language assessment revealed a significant delay in communication skills. In relation to receptive language, A[...] was able to understand some words, phrases and sentences. She was also able to follow some one-party instructions and benefits from repetitions and breaking down of instructions. She presents with object identification of common objects and is able to understand the self-made gestures used by her mother.

[196] Although A[...] can understand some commands and gestural cues, she however displayed significantly delayed receptive language skills as she is unable to understand a variety of words, phrases and sentences and thus is unable to

engage at a conversational level. She observed a significant delay in receptive language with the receptive language falling in the 9th to 15th month range, which is approximately a seven year delay.

[197] With regard to expressive language, A[...] communicates using head nodding, intentional eye gazes, vocalisations, tapping, waving, self-made symbols, two real words and facial expressions. Most of A[...]'s communication methods are non-verbal, like for example tapping her mother for attention. In order to call her mother she uses “AH” instead of “MA”. When asked to say “Funa” by the therapist, she was able to produce the words with consonant omissions U and A. She also uses “AH” for clarification, to request repetition when her mother gives her command. She has developed the use of the following symbols or objects to communicate her needs. She uses a cup to communicate thirst as an example.

[198] She has developed compensatory methods of communication but her communication skills remain significantly compromised and has contributed by the motor speech disorder dysarthria. As a consequence, A[...] is unable to communicate in a diversity of words, phrases and sentences, and at conversational level. Consequently, a significant delay in expressive language is observed and her expressive language falls within the 9 to 15 month range, which was an approximately seven year delay.

[199] Her assessment of A[...] revealed that she was a candidate for AAC as A[...] has the ability to use unaided communication in sign language or Makaton as well as aided communication being a picture communication device. As regards aided communication, A[...] is resistant to change and must begin at a symbolic level and gradually develop to a picture, low-tech level and eventually to a high-tech communication system. A[...] has the ability to use AAC to augment her communication skills so as to expand her knowledge and give her more control of her environment. As a consequence of her compromised language skills being falling within the 9 to 15 month range she was of the opinion that A[...] should receive a basic symbolic communication system and gradually move on to

a more advanced communication device as she communicates as well as sign language Makaton.

[200] In the result Thanjan recommends the following both physiotherapy to manage her fine motor difficulties and occupational therapy to manage functional skills. A referral to an ENT to investigate and manage suspected GORD. Radiological investigations to ascertain the exact nature of dysphagia, speech therapy techniques targeted at reducing A[...]'s drooling and investigation of saliva reducing medication or Botox injections. Placement within a special school and a case manager as well as the protection of her funds.

[201] Despite the lack of early intervention and the fact that A[...] is much older, Thanjan is of the view that she has potential to improve her ability to communicate as well as her feeding and swallowing skills. If individual direct speech therapy is provided at a school the therapy frequency can be subtracted from therapy that she is recommending. She recommends the following speech therapy. Up until age nine, 60 minutes three times a week, which will be focused on swallowing therapy, communication therapy, including AAC training and caregiver training.

[202] Speech therapy reassessments for two hours annually, multidisciplinary team meetings with professionals involved with A[...]'s treatment to discuss progress and holistic therapies. The rates will differ given the dependent on the other therapists involved in the meeting. A one hour meeting for speech therapy consultations, she estimated at the rate of R750 and multidisciplinary team meetings, she estimated 4 per annum.

[203] Thanjan completed a joint minute with Ms Sishi (Sishi) the defendant's expert who is a qualified speech therapist. Both the areas of agreement and disagreement are reflected in the joint minutes which they completed and signed. She confirmed that there are no prescribed tariffs for speech and language therapists, or audiologists and hourly tariffs of speech and language therapists and audiologists vary according to the therapist's level of expertise and the

location of the practice.

[204] She also indicated that another reason for the difference is that Sishi recommends rates based on the current tariffs as listed by Healthman, which is an agency which provides estimates of what different medical aids cover for speech therapy services. Private practitioners often charge over and above medical aid rates given the years of experience and the area of practice. What is also evident from the documentation provided and the estimates of the hourly rates is that the medical aid rates are usually lower than the private practice rates.

[205] Essentially, this a variable difference in the rates that they suggest and having regard to the joint minutes they both agree on the following, namely that:

(a) with regard to the speech, language and communication profile, A[...] presented significant impairments in the area of speech production, receptive and expressive language skills, oral-motor integrity and general communication skills;

(b) with regard to A[...]'s feeding and swallowing profile she presents with compromised oral and sensory-motor impairments that affect both her speech abilities as well as swallowing/feeding functions;

(c) with regard to alternative and augmentative communication, A[...] is a candidate for AAC devices.

[206] They disagree though on what devices she requires.

[207] They agree on the following AAC devices for A[...] namely the 3D communication symbol board, the super talker progressive communicator. The difference is that Thanjan recommends this once off for year 2 to year 3, Sishi recommends this every 4 to 6 years. Thanjan also recommends batteries for the super talker progressive communicator at R300 per annum.

[208] They cannot agree on the following high-tech AAC equipment recommended by Thanjan, namely:

(a) the iPad Pro-12 9 inch 64GB commencing from year 4 being replaced every five years;

(b) the iPad protective cover and adapter also commencing at year 4 and being replaced every five years;

(c) the Go-Talk Now commencing at year 4 and been replaced every five years;

(d) a battery device adapter for year 1 to year 3;

(e) toys that can be connected to the super talker progressive communicator via the battery device adapter from year 1 to year 3;

(f) a Makaton material once off.

[209] Thanjan has recommended these AAC devices based on A[...]'s diagnosis of motor speech impairment which prevents her from expressing her language potential. Because A[...] understands and uses gestures and head nods to communicate using these AAC devices Thanjan opines that she can use these compensatory methods to communicate. As A[...] uses objects to communicate her needs like taking a bowl to her mother or grandmother when she is hungry, her use of objects for communication paired with self-made gestures, in Thanjan's view indicate good potential for Makaton which is a sign language program as well as use of devices for communication.

[210] As A[...]'s proficiency improves additional devices are recommended so her language level can grow hence, she has advocated for additional devices to the super talker progressive communicator. The reason for this is because the super talker progressive communicator is limiting as it only allows up to 8 options.

So as an initial device it is recommended but as she progresses one would not want to limit her communicative potential and therefore other additional devices are recommended.

[211] With regard to speech therapy to address her feeding and swallowing impairment, AAC and language development they have not reached agreement with regard to the frequency and duration of speech therapy. Thanjan recommends from age 10 to 12 biweekly sessions of 60 minutes, from age 13 to 18 one weekly session of 60 minutes and from age 19 to life expectancy 60 minutes twice a month. The reason for this based on her profile is because the human brain is not fully mature until 20 years after birth.

[212] As a consequence, she advocates for more frequent rehabilitative therapies for 20 years to utilise the critical period of development. She has also relied on research to support this as well as the need for speech therapy until life expectancy. Having regard to papers she indicates that long-term study shows that individuals using AAC change in their pattern of communication over time.

[213] In addition, they have not reached agreement in relation to the necessity of A[...] attending group speech therapy. The basis for Thanjan's recommendation of group therapy is because speech therapists are trained to target pragmatic or social skills in a structured environment more specifically than in the school environment. A[...] on examination presents with compromised pragmatic skills as well as an inability to engage in incidental learning. As A[...]'s expressive language is limited because of the motor speech disorder, she has not had opportunities to exercise social language. Sishi conceded that whilst A[...] was in a school setting, she would benefit from group therapy at the rate of one per month as recommended by Thanjan and upon leaving school would benefit from one group therapy session every three months as recommended by Thanjan.

[214] When she is provided with an AAC device her expressive language opportunities will increase which will in turn create more opportunities for pragmatic / social skills and therefore therapy for these skills is imperative in a

group setting. She recommends it from age 10 to 12 two sessions a month, from age 13 to 18 a session once a month and from 18 years until life expectancy a session once per quarter. She also recommends annual reassessment to assess and document her progress and to form a baseline for therapy procedures to be performed in the following year because therapy procedures will change as A[...] develops through therapy. Ongoing therapy sessions will also focus on treatment and reassessment is recommended to ascertain whether she is reaching her potential with the current treatment plan or whether the treatment plan has to be reviewed. She recommends speech therapy reassessments of two hours annually.

[215] In addition to the annual speech therapy assessments she also recommends radiological investigations like the barium swallow test and fibre-optic and endoscopic evaluations of swallowing and recommends three. She has also catered for multidisciplinary meetings from age 10 to 12 four per annum, from age 12 to 18 two per annum, from age 19 until life expectancy once per annum. She recommends these quarterly meetings from age 10 to 12 as A[...] will be receiving frequent speech therapy and changes are anticipated in light of the frequency. This needs to be communicated to other team members and school staff so that a holistic approach can be adopted.

[216] Sishi on the other hand, recommends speech and language therapy, 45 minute sessions twice a week for 24 months, thereafter once a week for 24 months, thereafter once a month 20 sessions of 60 minutes each, a once off feeding assessment and annual meetings to determine the duration of speech therapy and therapeutic intervention.

[217] The basis for Sishi's recommendations is because A[...] presents with significant challenges with regard to all areas of communication. In her opinion, A[...] has passed the age of maximum benefit through early intervention being six years. The current models of early intervention recommend intensive intervention for the first six years of life.

[218] Because A[...] surpassed the age of maximal benefit from intensive intervention any and all therapy will be focused on functional skills and improvements in all areas targeted is likely to be slow. All improvements in her view are likely to only be qualitative rather than quantitative and it would be difficult to measure via standardised or traditional speech and language tests and batteries. Therefore, in her view, her recommended therapy sessions are sufficient.

[219] She also expresses the view that the recommendation of a daily stimulation centre would provide ample opportunity for A[...] to be exposed to social interaction. A typical daily programme in a stimulation centre for learners includes me-time and schedule playtime which offers opportunities for structured and unstructured social interaction for A[...]. Additional speech and language therapy is unlikely to result in further improved social skills for A[...] given her significant language deficits.

[220] As regards the purchase of feeding equipment, although they agree that A[...] requires specialised feeding therapy material, Sishi has catered for a once off cost of R10 000.00 whereas Thanjan has recommended various items as reflected in her report. Thanjan recommends specific oral equipment and feeding material tailored to A[...]'s compromises in oral and feeding skills. The recommendations for these devices include replacement frequency as well as duration of use.

[221] They also agree that she requires intervention from other professionals canvassed in their joint minute and that she requires assessment from an ENT to investigate and manage suspected GORD (gastro-oesophageal reflux disorder). They agree that speech therapy techniques targeted at reducing drooling is not always effective and saliva reducing medication is suggested. Should that fail then Botox injections into the saliva glands must be considered, performed by an ENT. They agree that A[...] should also be placed in a stimulation centre/school for learners with complex disabilities. In addition, they agree on the employment of a caregiver and defer to an occupational therapist relating to the number of

working hours etcetera and agree that the employment of a caregiver for the rest of her life will assist given her profound communication and feeding problems and because the burden of care is significant professional care giving is a necessity. They also agree that a case manager ought to be appointed for the rest of A[...]'s life to manage the arrangements that need to be made in relation to therapies and funds once same has been allocated.

[222] She testified in relation to the difference in approach between herself and Sishi. She indicated that she was thorough when she conducted her examination as she is a sensory oral and sequential trained feeding therapist in KwaZulu-Natal and is therefore upscaled in a number of approaches that look deeper in terms of the structure and function of oral structures pertaining to feeding. Such training looks at five different areas of feeding not limited to just the mouth like nutrition, medical influences, psychological influences and sensory. When she conducted her assessment it was based on a thorough feeding examination as well as an examination of A[...]'s oral structures and communication.

[223] In determining what recommendations to accept, I have tried to find a balance between the recommendations of Sishi and Thanjan. The focus in my view, ought to be improving her eating and swallowing skills and to improve her communication skills. As there is already an overlap with Casey's recommendations, I do not believe that all Thanjan's recommended therapies are necessary.

Pillay

[224] Dr Thasarathan Pillay (Das) a specialist paediatrician whose expertise was accepted confirmed that he has been in private practice for an excess of 28 years and he mainly sees patients with neuro-developmental and cerebral palsy. He confirms that he prepared a report in respect of A[...]. Cerebral palsy in children are where they are born with a deprivation of oxygen and blood that goes through the vein which causes insults that lead both to motor, emotional and mental problems.

[225] Primarily, most experts focus on motor problems where one has weaknesses in the upper and lower limbs of varying degrees ranging from where patients walk with an unsteady gait right down to the other end of the spectrum where they are unable to utilize both their upper and lower limbs and are bedridden. On an emotional side cerebral palsy patients have anxiety, depression, frustration, aggression and screaming attacks.

[226] In respective of their neurological aspects as a consequence of the deprivation of oxygen to the brain certain areas in the brain are damaged which leads to inappropriate stimuli that causes convulsions. Convulsions form a large part of the treatment of a cerebral palsy patient as if one does not control the convulsions patients either choke, aspirate, and die as a result thereof or fall as a consequence of experiencing convulsions and then suffer head injuries. A large part of treating cerebral palsy patients focuses on controlling the prevention of fitting and the complications relating thereto. He confirmed that the words convulsions and seizures and fitting are used synonymously.

[227] His report, which is dated 6 September 2019 emanated as a consequence of an interview with A[...] and her mother, based on a clinical examination. He was asked to prepare a report dealing with the various medical costs he foresees A[...] would require in the future. He indicated that he would recommend the following be catered for in relation to A[...]'s future medical treatment.

[228] The first being regular neurodevelopment paediatric consultations and he recommended three consultations a year from age 12 to age 17. The purpose of these consultations is to monitor any improvement for A[...] and to make sure that whatever other therapy she is receiving like for example, physiotherapy, occupational therapy and speech therapy the improvement thereof is monitored. Most of the time as well children in A[...]'s position are on anti-convulsion medication which results in weight gain. They use epilim to treat convulsions in patients such as A[...] and the dosage is quantified and computed according to her weight.

[229] He indicated that the dosages between 20 to 30 mg per kilogram per day in two divided dosages. Between the ages of 12 to 18 there is a lot of growth as children go through puberty and they have their final growth stage. As a consequence, weight increases exponentially during that period. So the purposes of having monitoring three times a year would be to monitor the weight, the anti-convulsant therapy to make sure that the child is on the appropriate dosage to prevent convulsions and lastly, to see that the adjunctive medical therapists are doing what they are supposed to be doing in relation to emotional, mental, physical health and speech. So from the ages of 12 to 17 he costs it at R7500 per annum. From the ages of 18 and above he advocates two consultations per year with a neurologist physician.

[230] Pillay testified that paediatricians in South Africa only see children up until the age of 18 and they thereafter follow-up with an adult physician. By such age the child is fully grown, the weight fairly static and less frequently needed visits. Therefore, from the age of 18 he advocates two consultations a year to life expectancy.

[231] He testified that in relation to the treatment of epilepsy the most commonly used medication by paediatricians, paediatric neurologists or paediatric neurodevelopment specialists is Epilim hence why he advocates Epilim CR. Epilim is a broad-spectrum anti-epileptic medication which controls seizures and because one has various different types of seizures some anti-epileptic drugs treat specific seizures whereas Epilim is a very safe drug. It is widely used and administered as it is relatively safe. It is also easily administered as one can administer it in the morning and the evening. He further confirmed that in the last 28 years of private practice the primary anti-epileptic drug used was Epilim. He would start with Epilim to control the child's weight and if one does not control it with Epilim then he would add on a second anti-epileptic medication and sometimes a third if necessary.

[232] The next medical treatment that he advocated was that of serum drug level

testing four times a year in the first year and thereafter twice a year for life expectancy. Because anti-epileptics have a narrow therapeutic toxic ratio and you achieve quality optimum anti-epileptic cover to prevent convulsions, if you administer too little one experiences breakthrough convulsions. If you provide too much of a dosage or too high of a dosage you get the toxic side-effects of the anti-epileptic. So, the narrow therapeutic toxic ratio has to be monitored initially so that one obtains the right range and right dose of the drug, which is why in the first year one performs the serum drug level testing four times a year and thereafter once one achieves the optimum dosage twice a year to monitor it. Pillay cautioned that with anti-epileptic medication, inasmuch as it is used to control convulsions if one gives too high of a dosage it causes convulsions. Hence the reason why one needs to get the dosage absolutely correct.

[233] A further reason why one administers the drug serum level testing is that in some patients some have a high metabolic rate, which metabolises the drug quickly, but in others who are slow to metabolise it takes a long time to metabolise the medication and as a consequence, the blood levels rise higher than they should. Although the weight of the child is a guideline other factors also considered like for example whether the child has a slow or fast metaboliser and by doing the blood tests one gets the most accurate indication from the blood levels. In addition, one performs two blood levels at every visit being a peak and a trough. The peak is performed two hours after administering the medication which is the highest level that it can reach in the blood and thereafter the trough is just before one administers the medication.

[234] The next test that Pillay advocates for is the EEG (electroencephalogram). Just as one has the ECG in the heart which monitors your electrical waves in the heart to ensure that the heart is beating effectively the EEG does something similar in the brain to make sure that the brain is not inappropriately firing. In the first year he advocates two and thereafter once every three years to life expectancy.

[235] The last set of medication he advocates relates to the treatment of

behavioural disorders among cerebral palsy children. Such children suffer from severe emotional difficulties in the sense that when they are amongst other children they observe what other children do, and realise their limitations. They suffer from anxiety because if they have unsteady gaits they fall easily and also get depressed. In the treatment of cerebral palsy children, one also looks at the emotion wellbeing and provide medication to prevent frustration and anxiety.

[236] To assist with the control of the behavioural issues Risperdal is recommended. It is the most commonly used drug to control behaviour, irritability and also in instances where cerebral palsy children become aggressive and self-mutilate. He recommends a minuscule dose of 0.25 mg as he indicated that one obtains a good clinical response in controlling the irritability.

[237] He further testified that puberty is a fragile time for cerebral palsy children as they have an increase in hormones, specifically that of oestrogen in girls. This leads to severe anxiety and depression as they become aware of the opposite sex and have peers who are doing things around them which they cannot do. Often, one needs to increase not only anti-epileptic medication but also prescribe medication for the emotional and behavioural aspects and for mood stabilisation.

[238] For this he recommends Lamictin and it is one of the newer anti-epileptic medications. It works synergistically with Epilim as a consequence of which one prescribes less Epilim. The advantage of using Lamictin is that it has a secondary effect being that of a mood stabiliser as it inhibits the neuro transmitters which cause depression. One uses it in conjunction with Epilim for two reasons, firstly as one is as able to use less Epilim and one has the added benefit of having a mood elevator to treat depression in children with cerebral palsy. He advocates a cost of R2520 per annum for Lamictin.

[239] The next item he prescribes is that of an analgesia and suggests Panado or Myprodol. Children with cerebral palsy that have global development delay crave analgesia. Because the motor systemic brain is affected cerebral palsy children have an increased time so their upper and lower limbs have a tendency

to go into spasm and they cannot easily extend these limbs. Where there is no muscle spasm especially around the neck and postural areas they are susceptible to tension headaches which is why one provides Panado or Myprodol.

[240] It varies from child to child hence the two different medications he prescribes to treat the time defect in cerebral palsy. In A[...] he indicated that she has an ataxic gait and does not walk confidently like a normal child, almost like what he described as a stiff-legged type walk which would result in tension and aches and pain. Hence the need for analgesia per annum.

[241] The last item that Pillay spoke to was treatment for possible chest infections. He indicated that depending on the degree of cerebral palsy and the degree of muscle tone deficit, cerebral palsy children who are severely affected do not move effectively and as a consequence they suffer from hydrostatic bronchopneumonia due to their inactivity and lack of movement. They are more prone to postural type of secretions accumulating in the lungs.

[242] In a normal child because such a child is more mobile this occurs less frequently but because A[...] is ataxic she can aspirate. A further complication with A[...] is she drools a lot and has some swallowing difficulties. If she swallows food then she will suffer from aspiration bronchopneumonia as opposed to hydrostatic bronchopneumonia which one gets from stasis of fluids.

[243] He testified that an average child gets 3 to 4 upper respiratory and lower respiratory tract infections which is normally treated as an outpatient. However, with cerebral palsy children if they aspirate, they need intravenous antibiotics especially if they are unable to take oral medication at home. He advocates R1500 per annum in respect of antibiotics for chest infections. Dr Pillay also testified that on average a cerebral palsy child requires hospital administration at least once a year usually a 48 to 72 hour admission for intravenous antibiotics and thereafter one discharges with oral antibiotics. He has testified that he did not provide for hospital admission for A[...] as he does in most other cases where

children are either wheelchair bound or bedridden. The reason for this is although A[...] is ataxic, she is relatively more mobile than other cerebral palsy patients he has seen, which is why he provided for outpatient treatment.

[244] During cross-examination Pillay was questioned concerning the need for A[...] to remain on Epilim for the treatment of her seizures. The undisputed evidence was that A[...] had a series of seizures when she was a young child possibly 4 and she remained stable until April 2021 when she had a seizure. She was therefore diagnosed and was prescribed Epilim. In response, Pillay indicated that the answer to that was two-fold. Firstly in a normal child who has a convulsion and was treated for two years until they are fit free or convulsion free. After two years one does an EEG and stops the medication as when one does an MRI scan of the brain it is normal so one can stop the medication.

[245] However, in a cerebral palsy child, you are dealing with a child that has suffered a major brain insult at birth. So throughout that child's life she or he has scar tissue in the brain at different levels which at any stage can precipitate inappropriate electrical activity which then results in a convulsion. Because of this rather than take the risk of A[...] aspirating after a convulsion or falling and suffering a head injury or making her pre-existing conditions worse, he would prescribe Epilim for the remainder of her life.

[246] In response to questions from the court he confirmed that he worked closely with Dr Campbell on a number of occasions and their views were very similar in this regard. He indicated that A[...] would remain on Epilim for the remainder of her life expectancy and the only change would be an adjustment to the dosage.

Ebrahim

[247] Ashraf Ebrahim (Ebrahim), a specialist obstetrician and gynaecologist, confirmed that he prepared a medico-legal report in respect of A[...] in this matter. He testified regarding the main gynaecological problems that arise in relation to

girls who suffer from cerebral palsy. He confirmed that in puberty, one is concerned with the management of the menses and if there is sexual contact there is a risk of pregnancy.

[248] There are also social-psychological adjustments. It is unclear to what extent this affects the psyche of children with limited intellectual ability is. Depending on the severity of the cerebral palsy, the main issue relates to the physical changes being the development of the menses and the potential to become pregnant.

[249] He consulted with A[...] and her mother when she was 11. He indicated that initially menstruation in A[...] could be prevented with the insertion of a Mirena every five years. The Mirena is a plastic device which has a hormone which is a synthetic analogue of a naturally occurring hormone being progesterone. The Mirena device delivers a small amount of the reservoir of the hormone on a daily basis for its lifespan, which is about five years. It measures about 3 ½ to 4cm in length and 3cm in width and it is inserted into the cavity of the uterus. The hormone in this device causes thinning of the lining around the wall so that the uterus is unaffected and the lining becomes very thin to the extent that at the time when the menses is supposed to occur there is nothing to be shed and nothing which resembles a period is expelled. This continues without interruption for a period of five years. The device would have to be replaced every five years for it to be effective until menopause occurs naturally, which is usually in the early 50s. In a cerebral palsy child, the insertion of the device can be done in the doctor's rooms or in theatre. Once it is inserted there are strings attached to the device, which are trimmed very short to ensure that the child does not feel anything. Unfortunately, the Mirena is not infallible and one of the main side effects is bleeding.

[250] The second option advocated for A[...] is a hysterectomy either an abdominal one alternatively, a laparoscopic one. The operation involves removing the uterus which will stop the menstruation completely. In addition, the ovaries remain as they serve functions which are of importance to the health of the

individual over and above the menstrual function. The abdominal hysterectomy can be done through incisions carried out in the abdomen or vaginally. Both are done under anaesthetic. Given the advancement in instrumentation a hysterectomy can also be done laparoscopically, which involves passing the telescope into the abdomen through an incision, approximately a centimetre in size and one observes the inside of the pelvis without cutting open the abdomen.

[251] Other instruments of a similar size are placed into the abdomen through other incisions and the surgeon operates from the outside and is able to manipulate the instruments to carry out the incisions that are necessary to remove the uterus. In a minor child, given the size of the vagina, one is unable to take out the uterus through the vagina but instruments are used to reduce the size of the uterus to take it out less invasively.

[252] The laparoscopic hysterectomy is head and shoulders above conventional open surgery as it has fewer complications, less blood loss, a decreased risk of infection, less pain and a shorter hospital stay and a faster recovery period. The incisions for laparoscopic history hysterectomy are also small. Given the three options, Ebrahim was of the view that the best procedure for A[...] taking into account her condition and deficits would be a laparoscopic hysterectomy. Although it costs more than an abdominal hysterectomy given the diminished risk of infection and the reduced recovery time it also has resulted in minimal interference with the abdominal organs and minimal risk of infection.

[253] I agree that given A[...]'s condition, the laparoscopic hysterectomy is the most appropriate intervention as opposed to the abdominal hysterectomy.

Casey

[254] Maureen Anne Casey (Casey) an educator with specialization in teaching children with cerebral palsy and who have difficulty with communicating orally and who has extensive experience in augmentative and alternative communication (AAC) (whose expertise was not challenged) confirmed she prepared a

medicolegal report in late November 2018. Her evidence was proffered to augment that of the speech and language therapist Thanjan. She confirmed that cerebral palsy children have difficulty communicating via spoken language. Such children have complex communication needs with little or no functional speech where they have less than 15 intelligible words.

[255] A[...] is considered to be a child with complex communication needs as she did not have any intelligible words in her vocabulary when she interviewed her in 2018 but had communication function. A[...] had developed her own communication mechanisms to communicate without using words. Augmentative and alternative communication is multi-modal where communication is achieved through different modalities. Apart from oral communication one uses facial expression, gestures and body language.

[256] In a child with cerebral palsy who is unable to communicate via spoken language one wants to develop their skills so that children have better communication and people can understand them better. A[...] is unable to speak in full sentences at all. A[...] is able to match for colour and find primary colours when asked to do so. She did not know three basic shapes, but she was able to classify according to size. She was unable to count and even with the assessor counting out loud she could not move beads to demonstrate one-on-one correspondence. However, A[...] loved to be engaged and interacted with the person conducting the assessment.

[257] Casey testified that when cerebral palsy children like these have had no stimulation and no intervention, the kind of skills that you would expect of a typical child, they would not have had. It does not mean that because A[...] did not know it she is unable to learn it because from her assessment of her there are already skills that A[...] is demonstrating to say that she has developed learning. There are certain concepts she has not learnt but with intervention of a structured and repetitive nature A[...] would be able to learn.

[258] Casey testified that in her practice she has worked with children who have

less skills than what A[...] shows who have actually made significant progress. There is potential for further development when the child is supported.

[259] During the assessment although no words were heard A[...] understood the reciprocal nature of communication and understood turn taking. Although A[...] did not show good memory retention and could not make the sounds after a five minute break with therapy and follow-up at home she is expected to master them.

[260] She confirmed that A[...] was able to use the talking bricks to answer simple yes or no questions. The talking brick was a little square that has a round bottom on the top and different colours and it gives you eight seconds to pick up and record. It is a simple communication device. The pictures are at the bottom and when one presses the picture, it then speaks to describe the picture.

[261] A[...] is also able to do certain things by way of non-verbal means. There was also a mismatch between what she understood, receptive language and what she was able to communicate being expressive language and Casey is of the view that with intervention by a speech and language therapist appropriate strategies could be used by A[...]'s carers at home to enable her to become proficient in the use of AAC devices.

[262] In field of AAC there are three tiers of being able to express oneself. The first tier and the most sophisticated would be high-tech, that is anything that uses a computer chip. So, for example, it could be a computer, a tablet, an iPad or a dedicated device. Such device is specifically made for the group of people who have complex communication needs or little or no functional speech but with the iPad or a tablet, applications can be downloaded which will assist, like for example the talking bricks.

[263] The second tier are low-tech, which is paper-based or cardboard-based where one would make communication cards like flashcards with pictures on it and then one has cards using pictures and photographs with line drawings. The

second tier is that of medium tech, which are battery operated devices like talking bricks or the quick button items.

[264] The dedicated device which Casey spoke about for cerebral palsy children is exorbitantly expensive and commences at a cost of around R250 000.00. Such devices are used for children with cerebral palsy, autism, or children with Down Syndrome who cannot speak. She indicated that for A[...]'s purposes the gold standard would be the device which cost R250 000.00 but in A[...]'s case it is not necessary and the iPad would be sufficient.

[265] When doing the comparison of her items which she recommends and that produced by Thanjan she confirmed there was a lot of duplication. She indicated that the duplication arises from what the speech therapist wants and she would defer to her in respect of what she would require for A[...]'s therapy as a speech therapist. She indicated that AAC is multi-professional and could be used by an occupational therapist, a special needs educator or a physiotherapist and even an IT specialist. The carers appointed to assist A[...] would be trained to use the devices by the therapists.

[266] One of the reasons why she opined that AAC strategies would assist A[...] was because even though she had very little to no speech and vocabulary, A[...] showed great promise in that she developed her own vocabulary to communicate with others. In addition, although A[...] has limited concentration and tries to conform to requests, she is a non-verbal child, but is able to communicate and make her needs known. A[...] was interested in all the toys which she was shown and showed great pleasure and fear when playing with the dancing bunny.

[267] During the course of the consultation, A[...] was able to sit independently on the sofa and on the floor but became fatigued. She was cooperative and try to engage during the assessment. She was able to match for colour but was unable to find the primary colours when asked to do so. She was unable to identify the three basic shapes, unable to count and although was unable to engage with the beats to count, loved to be engaged and interacted with the assessor.

[268] A[...] was able to make use of an array of pre-verbal communication means. She would reach out and touch her mother or look at her to get her attention. She also gave the switch to the assessor so that the assessor could assist her in fixing it if the protective casing came loose. A[...] would lift up her hand to say stop and would use eye gaze and would point to an item if she wanted it and was unable to reach it or would touch or take it if it was within reach. She would shake or nod her head to indicate yes and no and would use proximity to an object to indicate a desire or dislike for it as well as facial expressions. At home she pointed to her bottom to indicate that she needed to use the toilet or to bring an item of desire to her. She would demonstrate her love for her mother or her granny by giving them hugs.

[269] She vocalised and nodded her head when asked if marshmallows were nice and she tried to imitate hand signals for more, help, nice and finished. She did not show good memory retention and could not make the signs after a five-minute break. However, with therapy and follow-up at home Casey was of the opinion A[...] will master them.

[270] As regard to communication functions, A[...] was able to via gesture greet and wave goodbye, request assistance, request action, deny or negate, direct actions of others and state possession. She was unable to via verbal or non-verbal means, describe or partly describe objects, request information and/or comment.

[271] In order to determine whether A[...] would benefit from AAC devices and be able to use them, she indicated that A[...] was able to extend her arms to move them towards and away from her body, she was able to clap her hands together and bounce a medium-sized ball. Although her right hand and arm were significantly less functional and less used than her left arm and hand, fluctuation in tone was not observed and she used her right hand for some stabilisation and to execute crude hand function.

[272] A[...] could use her left and for some activities but with reduced functionality and with significantly lesser degrees of proficiency than that of a typical peer. She was able to grasp and release using both hands with the left being more efficient. She could hold a large crayon in a closed web, had sufficient pressure and control to scribble although she was unable to copy horizontal or diagonal lines or shapes.

[273] A[...] was able to isolate her index fingers on her left hand for the purposes of pointing and for the purpose of activating the keys on the computer or cells on the iPad. She could use the cold fingers of her right-hand to activate the touchscreen of the iPad. Although A[...] was unable to press a small button like that on a cell phone as she was unable to see small icons, she could touch cells ranging from 6cm x 6cm to 2,4cm x 4 cm and 2½cm x 2½cm. Although the 2.5cm cells were more difficult she managed and accuracy was noted to increase with the introduction of a key guard. A[...] could hold a stylus and activate a small cell of 2cm x 2cm.

[274] A[...] was able to point to a specific icon and a communication device on both a high-tech and low-tech device and when the single button devices like talking brix and step-by-step were offered she was able to activate the message by lightly tapping the face. A[...] could lift and hold her arm over a touchscreen of communication device in order to press the screen and repeat the action.

[275] Casey confirmed that on an iPad, a speech application can have as many as 128 different cells if the screen is big. Because A[...] did not receive previous speech and language therapy or AAC as part of a trans-disciplinary team approach Casey was of the view that A[...] required the provision of a highly structured hierarchical individualisation development programme to be devised, implemented and closely monitored. She anticipated that with appropriate interventions and accommodations, A[...] will be capable to make progress, albeit limited with regard to development, perceptive and expressive skills, cognitive concepts and reciprocal communication.

[276] Because there was an overlap with Thanjan, she was of the view that on her list she would advocate for a full-colour communication card booklets, mats and flashcards. This would be supplied by an AAC therapist at a cost of R1500 and she would advocate this every year for five years and thereafter every two years for life. Casey's list of items were also listed in a schedule and to some extent overlapped with that of Thanjan. The reason why she would advocate for the communication boards was that they are laminated and say things like what "I want", "I feel", "sad" and this would enable A[...] initially to point to them and they would be developmental and one as she improves populated with more and more words. This would teach her vocabulary. She would have access to 400 words in the English language.

[277] During the course of cross-examination, Casey acknowledged that she was a special educator with advance qualifications in AAC. She acknowledged that 4 years had elapsed since she had seen A[...] in 2018 and A[...] suffers from moderate to severe cognitive impairment or the inability for logical and abstract thought, poor attention and concentration, and does not show good memory retention.

[278] She agreed that A[...]'s severe intellectual disability will result in slight improvements but that she was effectively untrainable. As a consequence, it was suggested to her that given her severe cognitive delay and intellectual impairment as well as poor concentration the devices she recommends A[...] would be unable to use. She disagreed and opined that A[...] would be able to utilise low-tech devices.

[279] In going through the devices recommended in the joint minutes of the speech therapists she acknowledged that certain of the devices were low-tech. The 3D communication symbol board was a low-tech device and a fairly basic device. The Super Talker Progressive Communicator is a high-tech device which has eight overlays, which one touches and a message to come out. It is a flat little block which one places an overlay on with the screen guard over and each cell would say something different. There would be a maximum of eight messages.

This device generates a sound. One can use it to learn colours or the therapist could record a question, for example, it would say “I would like the red crayon”. The trainer could be trained to utilise this.

[280] The super talker progressive communicator would provide basic communications for A[...] and the maximum number of messages would be 64 if she has the 8 grid. Because in 2018 A[...] was already showing more than eight communication functions she was of the view that she would benefit from this despite its classification as a “high tech device”. The Go Talk device only goes up to 32 words and the Super Talker to 8. Although the Go Talk goes to 32 it has five levels and it will give her access to more than the Super Talker, but both of them are very clunky.

[281] She was of the view that A[...] would be able to operate the Super Talker and the Go Talk. She also agreed with Thanjan that A[...] would benefit from the Makaton material as this is the unaided one which would be signing, gestures and facial expression. She was of the view that she would not recommend the Makaton as it has limitations as it is not the South African sign language, which is why she was of the view that the low-tech flashcards and booklets would be a better option.

[282] She testified that although A[...] had problems with fine motor function she would be able to operate the iPad Air as she will be able to use her fingers. Although she cannot draw, write or scribble she can hold a crayon and therefore with a stylus is able to access the iPad Air. The stylus is a pen or a pointer that works with touchscreen and she operates like a kid.

[283] Having regard to the evidence of Casey the reservations expressed by the defendant that A[...] will not be able to operate the iPad fall away. She testified that A[...] was able to operate the iPad more efficiently with her left hand and was able to isolate her index fingers on her hand for the purposes of pointing and activating the keys. She was also very accurate with the stylus. In addition, she confirmed that the quick talker was not an unnecessary duplication. I agree that

despite A[...]'s severe cognitive difficulties, the use of AAC equipment will expose A[...] to devices that would expand her vocabulary and restore some dignity to a severely impaired child. I am fortified in this view having regard to the evidence of Casey that she has the physical ability to use the iPad and should be given the opportunity to expand her communication skills.

Anderson

[284] Sue Anderson (Anderson) a qualified Nursing Sister who started Disabled People South Africa testified in relation to her medico-legal report which she prepared after the interview with A[...] and her mother on 1 November 2018. She confirmed the contents of her report and testified regarding the future medical costs she recommended for A[...]. She indicated that she recommended treatment for skin care and abrasions as well as simple fractures and lacerations. Her reason for doing so was as consequence of cerebral palsy children falling especially as they get older. The common fractures are wrist fractures and they are more prone to abrasions.

[285] As A[...] gets older she will become less stable. She also recommends a fold down shower seat as when she interviewed A[...] she was unstable and unable to stand in a shower. The fold down shower seat allows her to sit down and shower whilst someone is attending to her. Because she is unstable and especially when one is washing her hair, her eyes are closed and she is less stable. The fold down shower seat would need to be replaced every five years.

[286] The next item which Ms Anderson spoke about was that of incontinence. As the parties agreed on the number of nappies she did not testify on the number of nappies required. She also advocated the use of Vaseline and various other skin treatments in addition to routine skin care for A[...] as a cerebral palsy child. She advocates the use of Aqueous cream as well as tea tree oil which is often used to heal skin. It will keep A[...]'s skin supple and if there are tiny little abrasions the tea tree oil will heal these. The second cost she advocates for A[...] as she gets older for skin care treatment is that of a Zinc starch and boracic

powder. This prevents fungal infections which are very common in cerebral palsy children and cerebral palsy adults where they are wearing nappies. It is used in the folds of the skin to prevent fungal infections.

[287] During cross-examination of Ms Anderson the focus was on a number of factors. It was suggested to her that in light of the fact that A[...] had not fallen or suffered a fracture with injuries, her estimate in relation to catering for a fracture and everything therewith is over generous. She indicated that when she interviewed A[...]'s mum she confirmed that she had fallen but these were not serious falls which resulted in any fractures.

[288] It was suggested to her that another expert had suggested catering for four fractures in A[...]'s lifetime and she indicated that would be fair and was more than what she estimated in her report. She indicated that although she usually mixes the tea tree oil with Epimax if the child has dry skin or Aqueous cream if the child does not. She had no difficulty if the tea tree oil was mixed with whatever normal cream A[...] was using. She indicated that the tea tree oil was expensive as opposed to the Aqueous cream.

[289] When asked to comment on her recommendation that the night attendant be less qualified than the day attendant, she indicated that the night attendant is normally someone who is there to assist her when her sleep is disrupted and would be required to be less qualified than the day attendant. It would appear that the only issue which the defendant had with Ms Anderson's recommendation related to what creams she had recommended and what A[...] was already using.

[290] I am of the view that the recommendations of Ms Anderson be accepted as they were not seriously challenged and appear fair and reasonable in the circumstances.

Items agreed upon by the parties

Kerr

[291] At the commencement of the initial trial, the parties were not in agreement in relation to the cost of alterations to the home to cater for A[...]. To this end the architect Roger Kerr (Kerr) prepared a report in 2019 as to the probable costs to revamp the rural home in which A[...] and her mother stayed to accommodate her needs. Subsequently, a Trust was established and it purchased a home for the plaintiff and A[...] which was more suitable to A[...]'s needs in the suburb of Noordsig, Empangeni.

[292] As a consequence there was an amendment to the costs required for the alterations to their new home. Kerr revised his initial report on 11 August 2022, to make provision for the recommendations of Somaroo and Bainbridge as per their reports completed in 2021. Kerr prepared a further report and the estimated costs of the alterations to the home in the sum of R143 653.26.

[293] After the evidence of the occupational therapists and physiotherapist, one of the therapies advocated for A[...] to assist her was aqua therapy given that there was a pool at their home. As a consequence, Kerr was specifically requested to provide a supplementary report of costs related to the use of the pool and the maintenance thereof. He confirmed that the pool would require heating and ongoing maintenance. At the time of his inspection, the pool was full of untreated green water and appeared not to be in use. He indicated that there ought to be once off costs of a P-Shape grab rail, a heat pump and a heat blanket with allied costs relating to installation, electrical, piping and sundries. These costs were estimated at an amount of R36 500.00.

[294] In addition, there would be ongoing pool maintenance costs relating to monthly pool maintenance, annual heat pump servicing, heat blanket replacement, pool net replacement, filter sand replacement, filter pump motor servicing, pipe replacements and kreepy replacements as well as surface touch ups and fibre glass re-lining. These costs would be approximately R19 696.67 annually.

[295] I do not believe that the costs relating to the pool ought to be allowed given the various therapies that A[...] will be receiving. Should the plaintiff wish to follow the recommendation to provide her with aqua therapy as suggested, this should be an expense that should come from the monies already received.

Dieticians

[296] The parties have agreed on the costs and applied an appropriate contingency based on the joint minute of the experts of 9 June 2020.

Motor vehicle

[297] The costing and replacement of the vehicle as set out in the report of Rosslyn Rich dated 23 August 2022 has been accepted. Although this has been agreed the necessity for such a vehicle and from when it would be needed remained in dispute. The defendant submits that the given the award already made to A[...] the costs of a vehicle beyond age 22 must be a cost for A[...]'s personal expense financed out of her income.

[298] The plaintiff disagrees with this approach and submits that in the award made in respect of loss of earnings a contingency was applied to account for travelling expenses and the defendant's stance that A[...] would have had to purchase her own vehicle amounts to a double deduction.

[299] A[...] is a day scholar and travels to and from school in a school bus. Public transport is utilised which poses problems for A[...] and whomever is taking her anywhere. She cannot travel alone and I agree that she is a child who is vulnerable to falling especially on uneven terrain. Moreover, she will need to be transported to therapies which do not take place at school and a vehicle will be needed for such purpose. I am of the view that a vehicle is necessary for A[...]'s use specifically to transport her to and from therapies. This starter vehicle as indicated by Ms Rich can be allocated at age 18 at seven year intervals thereafter. The actuaries are also to add a 10% contingency deduction to this

expense.

Nappies

[300] The parties have agreed the cost and frequency of nappies for A[...] at 1 and a half per day to life expectancy as per Sue Anderson's report.

Dentistry

[301] This too has been agreed by the parties as per Dr Y Singh's report and the calculations can be done as per such report.

Past medical expenses

[302] The parties have agreed on this in the sum of R129 642.03 as per the schedule supplied by the Plaintiff.

Draft order

[303] The parties agree that once the actuary does the calculation from the directives, a draft order, hopefully by consent, can be presented to the court. Should there be an dispute regarding the actuarial calculations and/or the directives be unclear a further hearing will be necessary.

Costs

[304] As regards costs of the action, I am of the view that they should follow the result, such to include the costs incurred by the Plaintiff consequent upon the engagement of both senior and junior counsel. The scale of junior counsel on scale B and that for Senior Counsel on scale C applicable from the date of amendment of the Uniform Rule 67. The costs can be included in the draft order.

Directives

Therefore I make the following directives:

(a) the agreed costs are to be calculated in accordance with ‘A, A1 to A4’ hereto;

(b) the cost of the Obstetrician and Gynaecologist Dr A Ebrahim in accordance with ‘B’;

(c) the cost of the Nursing Sister Sue Anderson in accordance with ‘C’;

(d) the cost of the Specialist Paediatrician Dr Das Pillay in accordance with ‘D’;

(e) the cost of the occupational therapy, case management, crisis management and report writing and sourcing and interviewing of care givers in accordance with ‘E1 and E2’;

(f) the cost of the physiotherapy in accordance with ‘F’;

(g) the cost of the AAC in accordance with ‘G’;

(h) the cost of the speech therapy in accordance with ‘H1 & H2’;

(i) the cost of caregiving and the caregivers’ remuneration, in accordance with paragraph 180 of the judgment. In addition, provision must be made for training for the caregivers as suggested by Bainbridge.

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Henriques J

CASE INFORMATION

APPEARANCES

Counsel for the Plaintiff	:	K C McIntosh SC M A Oliff
Instructed by	:	Justice Reichlin Ramsamy Attorneys Inc Suite 3, 72 Richefond Circle, Umhlanga Ridge Tel: 031 305 3844 Email:mohamed@jrr.co.za
Counsel for the Defendant	:	G Van Niekerk SC M Moodley
Instructed by	:	The State Attorney 6th Floor, Metlife Building 391 Anton Lembede Street Durban Email: NtMajola@justice.gov.za / NPeete@justice.gov.za
Dates of Hearing	:	29, 30 & 31 August 2022; 01, 2, 05, 06, 07 & 09 September 2022; 13 & 27 October 2022; 8 June 2023 & 20 September 2024
Date of Judgment	:	09 May 2025

This judgment was handed down electronically by circulation to the parties' representatives by email, and released to SAFLII. The date and time for hand down is deemed to be 14h30 on 9 May 2024.