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

CASE NUMBER: 23172/18

DATE: 15 August 2025

(1) REPORTABLE: YES/NO

(2) OF INTEREST TO THE JUDGES: YES/NO

(3) REVISED.

DATE: 2025.08.15

SIGNATURE:

ADV. NTOKOZO MJIYAKO obo T[...] S[...]

Plaintiff

V

THE ROAD ACCIDENT FUND

Defendant

JUDGMENT

MABUSE J

[1] On 22 August 2024, the above matter came before court for general damages and loss of earnings. The issue about loss of earnings was stood down, at the instance of the Defendant, to 25 October 2024. The court proceeded to hear

argument only in respect of the amount of general damages to be awarded. The court was informed by Ms Nelufule, the Defendant's attorney, that the Defendant had tabled an offer to the Plaintiff's legal team with regards to the Patient's claim for general damages and that the said offer was not acceptable. The court was informed further by Advocate Ras SC, counsel for the Plaintiff, that the offer made by the Defendant was not acceptable because it would be shot by R3 million.

[2] Having listened to the submissions by Advocate Ras SC, and Ms Nelufule, the court, without much ado, granted an order as set out in the draft order mark "PPP" without giving any reasons. Now the Defendant has requested the court to furnish reasons for its order. These are therefore the reasons for the said order.

[3] Before delving into the reasons for the said order, it is of paramount importance to point out that the issue relating to loss of income was resolved on 25 October 2024 when the court granted an order marked "XPS" in favour of the Patient. Still the court furnished no reasons for such an order, which prompted the Defendant to request the court to furnish reasons for such an order. Written reasons were furnished on 20 May 2025. Accordingly, these written reasons should be regarded as part of the written reasons handed down on 20 May 2025. This part of the judgment deals only with reasons for the general damages while the judgment of 20 May 2025 dealt strictly with the reasons for the order of loss of earnings. Therefore, this judgement must be read in conjunction with the judgment or reasons, if you choose to call them, of 20 May 2025.

[4] As a starting point, the Defendant conceded that the injuries sustained by the patient were serious. The Defendant accepted liability on the merit to pay 109% of the proven general damages. The patient in this matter is a boy, T[...] S[...], represented in this matter by Advocate Ntokozo Mjiako, the curator ad litem, and who at the time of the accident in question was only five years old. For purposes of convenience, I will refer to T[...] S[...] in this matter as the Patient

[5] The amount of general damages awarded to the Patient in this matter was determined based on the nature of the injuries sustained by the patient in the accident and the consequences of such injuries.

[6] On 11 January 2016, the Patient, who was a pedestrian, was involved in a motor-vehicle accident. As a consequence of the said motor-vehicle accident, the Patient sustained certain serious body injury. As indicated somewhere supra, the Defendant has conceded that it is liable to pay the Patient 100% of the proven or agreed damages arising from the collision.

[7] After the collision, the Patient was conveyed to Red Cross War Memorial Children's Hospital, Paediatric Intensive Care Unit. The provisional diagnosis of the Patient was traumatic brain injury. According to the clinical records of the Hospital, the Patient was diagnosed with:

[7.1] bilateral frontal contusion.

[7.2] left cerebral contusion.

[7.3] diffuse shearing.

[7.4] severe closed head trauma with Glasgow, scale of 40/50 (M3evt).

[7.5] intra ventricular haemorrhage.

[7.6] bilateral base of skull fracture involving left mastoid and sphenoid wing on the right period.

[7.7] secondary hydrocephalus and meningitis.

[7.8] blunt abdominal trauma with grade 11 liver laceration.

[7.9] pelvic fracture of the right diastases of the right sacroiliac joint and fracture of the right inferior public ramus.

[8] According to hospital records of government Hospital, the patient sustained the following injuries:

[8.1] very severe head injuries.

[8.2] loss of consciousness but not seizures.

[8.3] his GCS was 4T/15.

[8.4] his pupils were fixed and dilated.

[8.5] he had bilateral CSF otorrhea;(otorrhea, sometimes known as ear drainage, is the abnormal discharge of fluid from the ear. This condition can

be caused by various factors, including ear infections, perforated eardrums or even trauma).

[8.6] a CT scan done on 12/1/2016 showed bifrontal contusions, left cerebellar contusions, small subarachnoid haemorrhage and inter-ventricular haemorrhage.

[8.7] he had bilateral base of scalp fractures involving left mastoid and right sphenoid wing.

[8.8] CT abdomen showed grade 2 liver laceration.

[8.9] pelvic fracture (diastatic right sacroiliac joint and fracture of right inferior pubic ramus);

[8.10] TREATMENT

[8.10.1] the pelvic fracture was managed conservatively.

[8.10.2] ICP monitor inserted. It was ventilated in ICU.

[8.10.3] he had a failed extubation on 19.1.2016 due to vocal cords palsy. He was ultimately re-intubated.

[8.10.4] he had a tracheostomy done on 20/1/2016.

[8.10.5] two weeks after admission he was hypertensive and bradychardic;

[8.10.6] CT scan showed grossly dilated ventricles. As a result, an EVD was placed on 25.1. 2016.

[8.11] a VP shunt was placed on 26.1.2016.

[8.12] the trachi was removed on 3.2.2016. He developed an occipital pressure sore in ICU, which healed completely.

[8.13] his GCS remained at 8/15.

[8.14] on 15.12.2016 he was transferred to GSH for rehabilitation. While at GSH, he received occupational therapy, speech and physiotherapy.

[8.15] further observations of the Patient while he remained at the GSH.

[8.15.1] his lower limbs remained flaccid with no voluntary movement for a long time.

[8.15.2] MRI scan done on 18.3.2016 showed extensive brain injury, persistent hydrocephalus, and partially visualised left sinus.

[8.15.3] as he regained more active movement, his movements were very unco-ordinated and chorea-like. He was started on

Haloperidol, but it did not improve the chorea, and he developed severe dystonia. The Haloperidol was accordingly stopped.

[8.15.4] he had bilateral ptosis and bilateral cranial nerve iii palsy.

He was transferred back to St. Joseph Home for further in-patient rehabilitation.

[9] THE OBSERVATIONS BY CHRISTINE du TOIT, THE CHIEF OCCUPATIONAL THERAPIST AT GSH DONE ON 18 APRIL 2016:

[9.1] She reported that at her occupational therapist assessment on 18 April 2016, the Patient had an NG tube in situ. His eyes remained closed. He did not respond to stimuli. He also did not vocalise any sound. His lower limbs were flaccid, with no voluntary movement.

[9.2] he had full passive ROM (range of motion) of lower limbs. His upper limbs had increased flexor-tone, but full passive ROM. He had involuntary jerky movements of both upper limbs.

[9.3] he had no head or trunk control and was fully dependent for all ADL's (activities of daily living);

[9.4] THE TREATMENT:

[9.4.1] some intervention measures were taken to assist the Patient with some of his problems. Initially physical intervention included mobilisation of all four limbs and positioning to prevent contractures. Facilitation of transitional movements of the patient was done. Positioning in ward loan buggy was done for short periods during the day for feeds. She also worked on the head and trunk control and weight bearing upper and lower limbs in fully supported positions.

[9.4.2] as the Patient regained voluntary movement, she worked on active movement, reach, grasp and release. Cognitive intervention included orientation to the person, place and time. As this level of consciousness improved, the Patient started to engage more. Ms du Toit then worked on attention and the Patient's ability to follow commands.

[9.4.3] On 6.4.2016, a Buggy-to-Go was issued to the Patient. To provide neck to provide neck stability when sitting on the buggy, she used a neck pillow.

[10] According to Ms du Toit, despite all the interventions as set out above, the Patient's progress towards recovery has been too slow, even though he has shown some improvement and ability to engage in therapy. All these prove the severity of the injury sustained by the Patient because of the motor collision in question. The severity of these injuries is further shown by the Patient's inability to make considerable progress towards recovery.

[11] From Ms du Toit's diagnosis, it is crystal clear that some of his injuries are incurable and are of a permanent nature.

[12] THE OUTCOME OF ALL THE INTERVENTIONS:

[12.1] According to Ms du Toit, at the time of his discharge, the Patient had, following the interventions to help him to recover, made the following progress:

[12.1.1] he had full active ROM of both Arms with the power of 3/5. In supine position he can bring his hands to midline, and when he is holding an object, he can bring it to his mouth.

[12.1.2] He has voluntary movement of both his lower limbs, with power of 3.5. His left lower limb moves faster on command than the right. He does not have full active ROM of his lower limbs, but has passive ROM.

[12.1.3] he could grasp and release when commanded to do so. This means that he understood the instructions given to him because he did what was required of him.

[12.1.4] but still he was unable to manipulate objects in his hands. Still, this shows that he was unable, on his own, to figure out how to use an object in his possession. This was a demonstration of the extent to which the accident had affected his thinking abilities.

[12.1.5] the Patient's progress has been slow. But he has shown improvement and ability to engage in therapy. At the time of his discharge, his functioning was as follows:

Senior Motor: He has full active ROM of both upper limbs, with the power of 3/5. He can grasp objects with a gross grasp and release on command. He is unable to manipulate objects in his hands. His right upper limb is more functional in terms of grasp and speed of movement. In supine he can bring his hands to midline and when holding an object, he can bring it to his mouth. He has voluntary movement of both his lower limbs, with the power of 3-/5. His left lower limb moves faster on command than the right. He does not have full active ROM of his lower limbs, but he has full passive ROM. Due to the chorea, his lower limbs tend to move into adduction and internal rotation. His upper limbs movements are very jerky and in-coordinated. The Patient needs facilitation to roll supine to both sides and into prone. When positioned in the puppy he can maintain the position for a few seconds. In prone he can lift his head and push up on extended arms briefly. His head control has improved, although he still needs head support in sit. He still needs full trunk support sit. He needs supervision when sitting in the buggy, as he sometimes manages to get his head out of the head support and then he gets stuck.

Vision: The Patient is unable to open his eyes fully. He can open them very slightly and only briefly. However, when his eyes are opened positively, he can imitate facial expressions and hand gestures.

Self-care: The Patient is fully dependent for all his self-care tasks.

Communication: The Patient is unable to speak. He tries to make sounds to attract attention. He smiles and laughs when he is happy and cries when he is upset.

Cognition: The Patient can identify a few body parts on himself by pointing. He can follow simple motor commands.

[13] On July 2024, the patient was sent to Dr Zayne Domingo Inc, the neurosurgeon, for assessment. At this assessment, Dr Domingo was armed with certain documents, namely, the road accident 141, the medical records and medical legal reports. He was given copies of the following medical legal reports:

[13.1] Dr JS Sangor, orthopaedic surgeon, dated 12 October 2017.

[13.2] Michelle Nester, occupational therapist's report dated 2 November 2017.

[13.3] Renee Dewitt, clinical psychologist dated 10 November 2017.

[13.4] Dr Dale Ogilvy, speech language pathologist dated 15 December 2017.

[13.5] Yolande Bakker, educational psychologist, dated 5 December 2017.

[13.6] Yolande Becker psychologist dated 31 May 2024.

[13.7] Dr T Sutherland, psychiatrist dated 21 June 2024.

[14] Present Conditions:

Before the assessment Dr Domingo was informed that the Patient's present conditions/problems were as follows:

[14.1] he was unable to walk and was wheelchair-bound.

[14.2] he was unable to stand unassisted due to poor leg coordination and weakness.

[14.3] poor coordination in both arms and hands.

[14.4] poor memory and concentration.

[14.5] he was cognitively slow.

[14.6] he laughs inappropriately.

[14.7] poor speech with dysphasia (impairment of the power to speak or to understand speech, as a result of brain injury, or stroke or disease) and dysarthria (difficulty in speaking because the muscles used for speech are weak).

[14.8] he had difficulty in communicating and expressing himself.

[14.9] had a squint on the right eye.

[14.10] he was unable to open the left eye.

[14.11] on specific questioning, it was reported that he had not had any seizures.

[15] In order to prove the consequences of the injuries on the Patient, one merely has to look at his condition prior to the accident. It is reported that at the time of the motor accident, the patient was about to start grade 1 (one). Prior to this, he had attended a Creche where he was reported to have been doing well. Due to the

accident, the patient was unable to return to the mainstream education as a result of his significant physical and cognitive problems. The Patient remained with the significant cognitive and communicative difficulties and is illiterate. He is unable to participate in any sport or leisure activities. He interacts poorly with his peers. He requires supervision and assistance with all his activities of daily living.

[16] HIS DISCOVERIES ON PHYSICAL EXAMINATION OF THE PATIENT:

On physical examination of the patient, Dr Domingo made the following discoveries on the central nervous system of the Patient:

[16.1] the patient was disorientated.

[16.2] he was cognitively slow and had difficulty understanding instructions.

[16.3] his behaviour was tight like with inappropriate laughter.

[16.4] he had poor speech with this dysarthria and dysphasia

[16.5] he had bilateral third nerve palsies with a divergent squint on the right.

[16.6] bracket he was unable to open the left eyelid (complete ptosis- the drooping of the upper eyelid, and person usually presents with the complaint of the defect in vision or cosmesis);

[16.7] he had poor upper limb coordination with past pointing and intention tremor.

[16.8] he had poor leg coordination.

[17] There was no evidence by Dr Domingo that the Patient was born with any of deficiencies mentioned in paragraph 16 above. There is no evidence that these deficiencies were caused by anything than the motor accident in question. Information from the mother has not hinted on the Patient being born with the above deficiencies or suffering from them at any stage after his birth.

[18] HIS ASSESSMENT:

Dr Domingo made the following assessment of the Patient:

[18.1] There was a significant blow to the head as evidenced by the extensive skull base fractures.

[18.2] based on his initial level of consciousness and prolonged period of post-traumatic amnesia he has sustained a severe traumatic brain injury.

[18.3] CT scan confirmed the presence of structural brain injury with multiple contusions in addition to cerebral swelling.

[18.4] the documented Hypo attention hypoxia and raised intracranial pressure would have resulted in additional secondary brain injury period.

[18.5] require intubation ventilation and prolonged rehabilitation.

[18.6] the patient has been left with significant physical disabilities. He has poor hand coordination and is wheelchair-bound.

[18.7] he has significant cognitive, cognitive communicative and behaviour deficits in keeping with the nature of the brain injury sustained.

[18.8] the extent and severity of the reported deficits have been confirmed on formal neuro psychological and speech and language assessment.

[18.9] result of his cognitive and communicative deficits, he has been unable to attend mainstream schooling and has been placed in the school for learners with special education needs. He remains illiterate.

[18.10] it is now more than eight years since the accident took place, and his physical and cognitive deficiencies are permanent. This means that his physical and cognitive deficiencies will never be cured.

[18.11] the Patient remained at the risk of developing late post-traumatic seizures. Provision will need to be made for the investigation and life-long treatment of seizures.

[18.12] for purposes of RAF Form for key classified injuries he pointed out that the patient's injury was serious. He went further and reported that the patient sustained a severe traumatic brain injury with associated intracranial haemorrhage that has resulted in significant residual physical, cognitive, communicative and behavioural problems. As a result of these deficits, the Patient was unable to attend mainstream schooling and would remain illiterate. His injury can be severe. He will continue to suffer a permanent and serious long-term impairment in respect of his work and personal life.

[18.13] the Patient is disfigured by his disabilities and dependence on a wheelchair.

[19] REPORT BY DR JS SAGOR. THE ORTHOPEDIC SURGEON:

[19.1] on 28 September 2017 comma the patient was sent to Dr J Sago, the orthopaedic session, for assessment. For the purposes of this assessment, Dr Sago had the following documents:

[19.1.1] RAF 1 Form.

[19.1.2] copies of the hospital's clinical records.

[19.1.3] a copy of the medical legal report by Dr J Reid dated 23.02.2017.

[19.2] he made the following clinical observations during his clinical examination of the Patient on 28.9.2017.

[19.2.1] the Patient, who had been accompanied by his mother to assessment, was wheelchair-bound.

[19.2.2] he had a bilateral, 1.5 tracheostomy. Yet no proper responses to questions. I must accept that this observation should be made by a neurosurgeon and not an orthopaedic surgeon. An orthopaedic surgeon is a medical profession who specialises in diagnosing, treating and preventing diseases and injuries of the musculoskeletal system which, includes bones, joints, ligaments, tendons, muscles and nerves. Accordingly, during clinical examination of the Patient he found no fractures of the face and skull and hence no report about it;

[19.2.3] according to Dr Sager, the Patient's pelvis was stable. Both hip joints have equal movement.

[19.2.4] the Patient's lower limbs are flaccid (soft and handy loosely, simply especially so as to look or feel unpleasant). He had absent reflexes. There were no spasms. There was no spasm in his hip's joints knee or feet (spasms as sudden involuntary muscular contraction or convulsive movement). The Patient was unable to stand or walk, one should add unassisted. This will be a permanent and incurable feature of the patient, all induced by motor accident in which he was involved.

The motor accident has imposed on the Patient deficits he was not born with.

[19.3] he remarked as follows on the patient's disabilities:

[19.3.1] the patient suffered from poly trauma (polytrauma and multiple trauma are medical terms describing the condition of a person who has been subjected to multiple traumatic injuries such as serious head injury).

[19.3.2] the Patient has permanently lost most amenities of life and is disabled and functionally impaired as a result of the head injury suffered.

[20] Michelle BESTER is an occupational therapist who practises out of Wellington. On 13 November 2017 the Patient was sent to her for assessment. There is clearly a misunderstanding here. As we all know, an occupational therapist is healthcare practitioner who helps you to improve your ability to perform daily tasks like dressing up or using a computer:

[20.1] an occupational therapist helps people to take part in the activities they need and want to do often following injury, illness, or disability. They assess a person's abilities and environment; they develop and implement treatment plans to improve functions and independence in daily living tasks. This can involve teaching new skills, changing tasks or environments, and recommending assistive devices.

[20.2] an occupational therapist assesses a person's physical, cognitive, and emotional abilities as well as their environment to find challenges and strengths.

[20.3] the purpose of referring the patient to Mr Bester was to enable her to assess the nature and extent of the Patient's injuries and the effect thereof on his ability, in future, to participate in overall activities including, personal maintenance, leisure, recreation and schooling, discuss the Patient's future treatment, assistive devices, adaptations and/or assistance in the costs thereof;

[20.4] at the material time of the assessment, the complaints about the Patient were that:

[20.4.1] the Patient was unable to stand and walk. The muscles of his core and lower limbs were very weak.

[20.4.2] when he walks supported, his gait is very ataxic (ataxic is a term for a group of disorders that affect coordination, balance, and speech. Any part of the body can be affected but people with ataxia often have difficulties with balance and walking, speaking, tasks that require a high degree of control, such as writing or eating, vision.

[20.4.3] his left side is much weaker and more affected than his right side.

[20.4.4] his hips tend to be more adduction (a movement away from the midline, adduction may occur when a joint moves apart from the body towards the mental midline, in other words, one place).

[20.4.5] his eyelids tend to the droop and are at times completely closed. His left eye is worse than right eye.

[20.4.6] his speech is slow and a bit slurred.

[20.4.7] he is incontinent.

[20.4.8] he displayed many behavioural changes. He tends to become aggressive at times.

[21] ASSESSMENT:

[21.1] the Patient sometimes offers that he suffered from headaches, and he will then hold his head and cry or just lie down.

[21.2] her assessment was that the Patient's physical and neuro-cognitive limitations are of a permanent nature. The patient will be in the dependent position and unemployable for the rest of his life. This is the most important observation made by the occupational therapist. The Patient will never be employed.

[22] SELF CARE:

[22.1] the Patient needs help and aid with all his personal maintenance tasks.

[22.2] he is completely unable to help his mother in any part of these

activities. Thus, he needs to be dressed and undressed. His parents or caregivers struggle with dressing and undressing of his affected left side. He is unable to handle any mechanism such as zips or buttons. He gets intention tremors in his right hand and therefore it is difficult for him to manage fine motor activities with his right hand as well, although this is his least affected side.

[22.3] the Patient is unable to eat completely independently. Sometimes he tries to eat by himself with a spoon. Then he would spill a lot. According to his mother, his hands start to shake when he drinks from a cup. To avoid him spilling, he is made to drink from a squeeze bottle.

[22.4] the Patient needs to wear nappies on a constant basis because he has no control over these functions.

[22.5] the Patient started attending school at St. Joseph's RC Primary School, which is a school for children with special needs. The Patient is still in need of continuous support and help with most tasks.

[22.6] because of this accident, the Patient experiences daily severe physical as well as psychological limitations. His life and the lives of his family have been much compromised. The emotional impact of this accident on the patient father and his family is enormous. His limited physical abilities and therefore also his daily struggle to take part successfully in everyday life places a further emotional and financial burden on this family.

[22.7] according to Ms Bester, the Patient will be incontinent for the rest of his life.

[22.8] he needs a wheelchair that is bespoke.

[23] ASSESSMENT BY DR SUTHERLAND:

[23.1] The Patient was further sent to Dr Sutherland on 20 June 2024 for psychiatrist assessment. The purpose of this assessment was to determine if the Patient suffered from any brain injuries or medical disorder secondary to a pedestrian vehicle accident which occurred on 11 January 2016, and was if so, the nature or extent of the severity thereof, as well as to determine the treatment that could be applied to any injuries found;

[23.2] in his possession at the material time of the assessment, Dr Sutherland had in this possession all the material documents provided to him by the Plaintiff's attorneys. Some of these documents set out the personal history and social circumstances of the Patient. Among these documents were the clinical records from both the Red Cross and Groote Schuur hospitals, which records set out the injuries and interventions documented extensively.

[23.3] in his assessment report, Dr Sutherland noted the current symptoms that the Patient had. He also consulted with the Patient's mother who filled him up on the Patient's problems. These symptoms were well noted in some of the reports he had in his possession.

[23.4] his diagnosis of the Patient was as follows:

[23.4.1] polytrauma with shock.

[23.4.2] liver lacerations.

[23.4.3] pelvic fractures.

[23.4.4] traumatic brain injury. Extensive base of skull fractures. Diffuse axonal injury (axonal refers to anything related to or characteristic of an axon, which is the long, slender projection of a nerve cell (neuron) that conducts electrical impulses away from the cell body to other neurons, muscles, or glands. It is the part of the nerve cell that transmits signals. Extensive intracranial injuries including contusions and infarctions (obstruction of the blood supply to an organ or region of tissues, typically by a thrombus or embolus, causing local death of the tissue). Complicated by meningitis and acute hydrocephalus (hydrocephalus is the build-up of fluid in cavities called ventricles deep within the brain. The excess fluid increases the size of the ventricles which leads to the increase in the skull), with ventriculoperitoneal shunt (a shunt is a passage that is made to allow blood or fluid to move from one part of the body to another). Neurocognitive disorder secondary to a traumatic brain injury.

[24] OPINION:

[24.1] in his opinion, the Patient had sustained a severe traumatic brain injury at the tender age of five years old. All previously attained development skills

were lost and following the accident, he could not walk, speak, or eat independently. He was incontinent. He was 14 years at the time of the assessment. He stayed severely physically and cognitively disabled and dependent on full-time care and supervision. According to Dr Sutherland, the patient will never live or function independently; is permanently unemployable and extremely vulnerable to exploitation and abuse.

[24.2] it is quite clear that the motor accident has changed the Patient's life massively. He will never recover from the injury he sustained during the accident in question. He will therefore never live a normal life. He has lost all the life amenities. He will never be able to walk or talk or eat independently or to play with other children. The motor accident ruined all his future. He certainly must be compensated accordingly. No amount of money will assuage any desire he had to live a normal life.

[24.3] RECOMMENDATIONS:

[24.3.1] he recommends psychiatry assessment and treatment for emotional regulation and behavioural difficulties if needed in future.

[24.3.2] the patient should be checked by a neurologist for late onset of post traumatic seizures and treatment of same should they occur.

[24.3.3] an appointment of the curator bonis should be considered.

[24.3.4] provision live-in home-based care or replacement in a residential care facility as home and family circumstances dictate.

[24.3.5] individual psychotherapy for his parents and siblings and family therapy is advised.

[25] Some of the treatment recommended in paragraph [24] above will be covered by a certificate issued in terms of the Road Accident Fund Act. There is no independent claim for caregiving services. But I was informed that such services will be provided for in the section 17 certificate. Quite clearly the Patient's disabilities have now placed certain limitations on his family members.

[26] ASSESSMENT OF THE PATIENT BY DR J REID (THE NEUROLOGIST):

[26.1] On 23 February 2017, the Patient was sent to Dr J Reid, a neurologist, for assessment. Having referred to the hospital records of both hospitals and

having considered the Patient's then current condition, he made his own diagnosis.

[26.2] HIS DIAGNOSIS:

His diagnosis of the Patient was as follows:

[26.2.1] very severe brain trauma; hydrocephalus; profound neurocognitive and neurological deficit.

[26.2.2] according to Dr Reid, neurological deficits are irreversible. No further intervention will make a material difference to the outcome.

[26.2.3] he is of increased risk for meningitis while shunt is in situ.

[26.2.4] the Patient cannot be educated. He will therefore remain illiterate for the rest of his life.

[26.2.5] he will arrive in adult life unemployable.

[26.2.6] he will need around the clock physical care from a responsible adult, for the rest of his days. The adult should be compensated for performing such duties and for the loss of his/independent income.

[26.2.7] life expectancy is limited to approximately 57 years.

[26.2.8] quantum should include proper compensation for pain and suffering and the mental anguish of severe brain trauma in a young boy.

[26.2.9] he will never enjoy the pleasures of schooling, sport, relationships, and independent career.

[26.2.10] injuries have been classified as profoundly serious.

[27] ASSESSMENT BY YOLANDE BEKKER, THE EDUCATIONAL PSYCHOLOGIST:

[27.1] The Patient was sent to Yolande Bekker, an educational psychologist, for assessment on 13 November 2019 and also for an update on 9 July 2024. The purposes of these assessments were to determine the impact of the accident on the Patient's educational potential.

[27.2] For the purposes of these assessments, Mrs Bekker had all the necessary documentation in her possession.

[27.3] Based on the medico-legal reports that she had perused, her opinion, briefly, was that the Patient would not be able to complete any form of schooling and would remain illiterate. According to her, the Patient was

severely disabled, cognitively as well as physically. He was unable to write, read or speak.

[27.4] pre-accident, Ms Bekker is of opinion that had accident not occurred, the Patient would have been able to complete his Grade 12 (NFQ level 4). He would have been able to apply for an NSFAS and continued to complete his NQF level 6 (diploma), if he applied himself.

[28] ASSESSMENT BY DR R DE WITT. A CLINICAL PSYCHOLOGIST:

[28.1] Renne de Witt, is a clinical and neuro psychologist. The Patient was sent to him for assessment on 9 November 2017, one year nine months after the accident had occurred and when the Patient was seven (7) years six (6) months old. In his possession, he had all the relevant documents, particularly the RAF Form 1, the clinical records from Red Cross Hospital, the medico-legal report, and RAF Form 4 by Dr Reid.

[27.2] For the purposes of compiling this report, he had an interview with the Patient's mother, Miss L[...] S[...], telephonic conversations with Mr Lucy Smith, the Patient's pre-accident teacher at Sunrise Education Centre and another one, with Miss Arendse, the Patient's pre-accident teacher at St. Joseph School. He also perused a written communication by Miss Arendse addressed to the Patient's mother which was copied from the Patient's homework book.

[27.3] In this expert report, he dealt with the Family and Personal History; Birth and Development Milestones; Schooling, Pre-and Post-accident, and the medical history of the family. The Patient's mother told Dr de Witt that the Patient was healthy prior to the accident. He had no health problems.

[27.4] He referred to the Patient's injury as set out in the Medico-legal report of Dr JW Van Der Spuy of the Red Cross Hospital of The Red Cross and to the clinical records of the Red Cross Hospital.

[27.5] HIS NEUROPSYCHOLOGICAL ASSESSMENT:

Dr De Witt made the following observations about the Patient during his psychological assessment.

NEUROPSYCHOLOGICAL ASSESSMENT:

[27.5.1] Severe neurological deficits are present, as set out in this report, and formal testing was not possible. He continues to present with gross and fine motor difficulties and is unable to walk and stand independently, as well as expressive and receptive language difficulties and is unable to communicate his needs and emotions effectively. He lacks in terms of basic, pre-school taught type of information. At the age of seven years and six months, he does not know his age, address or telephone number; he does not know the name of his school or teacher; he is unable to identify numbers and can only count to 10, he is unable to recite the days of the week and months of the year,; and he cannot write this name or draw a man or any other recognisable figure (mother said that he could write his name and surname prior with accident);

[27.5.2] the nearest psychological deficits present with a consistent with the nature and severity of the head injury suffered in the accident, his presentation in hospital and reputation post accident, and the persisting, severe difficulties reported by mother.

[27.5.3] at the time of this assessment, it was 2 years since the accident had occurred. Neurological deficits can be considered permanent. No improvement of functional value is expected.

[27.5.4] the mother reported that she showed normal daily development and did not present with any cognitive or behaviour difficulties pre-accident. He was clever and could write his name and surname. He was about to start grade 12 when it happened. His teacher in the year prior to accident 2015 reported that it was a normal little boy and he coped well with the pre-grade 12 academic curriculum and did not present with any behavioural deficits. Dr De Witt noted that the Patient's older brothers were progressing well at school according to the mother and they never failed. Based on the various opinion of the experts that there is no reason to believe that the Patient would have been able to pass grade 12 at school and if he had the opportunity some form of education.

[27.5.5] POST ACCIDENT:

He attended St. Joseph School since February/March 2017. His teacher, Ms Arendse, reported that he was restless, disruptive, unable to do work on his own, needed one-on-one help, was unable to write or draw, he was emotional outbursts and will scream or cry for no plain reason, and he showed little to no academic progress. Dr Dewitt was of opinion that the patient will never be able to progress at the mainstream school, and it is highly likely that he will acquire reading and write skills. The focus should be on basic skills training. The Patient will be unemployable in any role.

[27.5.6] The Patient will need full-time care and supervision for the rest of his life and provision should be made for this. Should relatives no longer be able to care for him, he will need to be institutionalised.

[27.5.7] His eyesight should be assessed by an ophthalmologist. He presents with episodes of sudden falling/dropping into the one side and unresponsiveness, suggestive of epileptic seizures. Allow neurologist to investigate.

[27.6] Dr de Witt assessed the Patient again on 25 July 2024, in other words, 14 years 2 months after the accident in question and when the Patient was 14 years 2 months old. This time he had additional medico-legal reports. His clinical and informal neuropsychological assessment was the same as the initial one.

[28] KOTZE BLAKES & ASSOCIATES

Kotze Blakes and Associates, the industrial psychologists, had an opportunity to assess the Patient on 12 March 2020. The purpose of the assessment was to determine the sequelae of the injuries sustained in the accident, the Patient's career prospects and the Patient's associated likely earnings in terms of the projected post-accident career.

[28.1] At the time of the assessment the Patient had the following challenges:

[28.1.1] he was wheelchair-bound.

[28.1.2] he had impaired vision and impaired balance.

[28.1.3] he was incontinent.

[28.1.4] cognitively, he had marked challenges in respect of: comprehending information.

speech production.

sustaining attention.

[28.1.5] he had the following psychological or emotional challenges:

Emotional liability.

AGGRESSIVENESS:

[28.2] They then dealt with all the future challenges the Patient would have as assessed by the various experts.

[28.3] according to them, the Patient will never be able to enter the labour market.

[28.4] FORMULATION OF FUTURE CAREER PROSPECTS:

The probable impact of the accident on the Patient's future career prospect and likely earnings is determined by first projecting probable future career prospects with associated earnings in terms of the projected pre-accident career, followed by a projection of probable future career prospects with associated earnings in terms of the projected post accident career.

[28.5] POST ACCIDENT FUTURE CAREER PROSPECTS:

They remarked that when evaluating the Patient's future post-accident career prospects, cognisance should be taken of his residual physical ability as well as cognitive, emotional, and psychological functioning, the unique circumstances of the individual, relevant medical experts' opinions and collateral information. In addition, cognisance must be taken of the social economic realities of South Africa.

[28.6] IMPACT ON FUTURE CAREER PROSPECTS:

[28.6.1] Based on the expert opinions of the other experts and on their own assessments, the Patient's future career prospects have been affected in the following manner:

[28.6.2] all the medical experts agree that the incident and sequelae have made the Patient unemployable in the open labour market in future.

[28.6.3] the Patient sustained a very severe brain trauma in the incident, which resulted in profound neurocognitive, neuropsychological,

cognitive-communicative and neuropsychological deficits making him 93% whole person impaired.

[28.6.4] as per the educational psychologist, pre-accident, the Patient would have been able to attend Grade 12 (NQF level 04) as well as a National Diploma) (NQF level 06). Post accident, that he would not be able to complete any schooling and would remain illiterate for the rest of his life.

[28.6.5] based on the opinion of the other experts with whom they agree, the Patient's occupational functioning and subsequent career prospects have been obliterated by the sequelae of the injuries sustained in accident.

[29] An amount of R4 million in respect of the general damages was awarded to the Patient on 22 August 2024. This court is now requested to give reasons for the said award. A claim for general damages is a claim for non-economic losses. These losses include pain, suffering and of equal importance, emotional distress resulting from the injuries sustained during an accident. When a court assesses general damages, it does so upon a consideration of several factors, e.g. the severity and nature of the injuries sustained by the claimant: the impact of such injuries on the claimant's quality of life and finally, the time it takes for the injuries to heal and comparable cases.

[30] A BREAKDOWN OF WHAT THE COURT CONSIDER IN THE AWARD OF GENERAL DAMAGES AS FOLLOWS:

[30.1] Physical Injuries:

These injuries include fractures, dislocations, spinal cord injuries, head trauma and other physical impairment.

[30.1.1] it will be recalled that according to the clinical records of Red Cross Children's Hospital, the Patient had sustained bilateral base of skull fracture involving left mastoid and sphenoid wing on the right. Furthermore, according to Dr Sangor, the Patient had a fracture of the pelvis involving the right inferior pubic ramus and right sacroiliac Joint. The Patient had lacerations of the liver.

[30.1.2] he was wheelchair bound. He was squint and incontinent. The Patient's limbs were flaccid. He had no reflexes. He was unable to stand or walk. He had suffered from polytrauma.

[30.1.3] if you have a fractured or broken bone, doubtlessly you would have suffered tremendous pain, apart from that such a person would have to endure months of suffering and inconvenience while the injuries are healing. In some instances, life in the current case, fractured or broken bones do not heal correctly, which means that the person who has suffered a broken bone or fracture might be left with some form of ongoing disability. In this case, because of the fracture the Patient has sustained, the Patient cannot walk or stand independently. Broken bones that do not fully heal or align correctly can result in ongoing residual pain or disabilities like the inability to walk or stand up independently.

[30.2] Psychological Injuries:

These injuries include, PTSD, depression, anxiety and other health issues. The patient has severe neuro-psychological and communicative deficits. He has significant physical neurological impairment.

[30.3] Loss of Amenities of Life:

There has been a loss of amenities of life lost by the Patient. He is incapable of independent living. He will not have the freedom of choice in many aspects of his life. He will not know what it is to fall in love, to play with friends or to take part in any form of sport. Or to watch sport with any understanding.

[30.4] The Impact of The Injuries on the quality of life.

Much has been said by the experts in this regard. It is correct that when it comes to the award of general damages, a court has a discretion, which discretion must be exercised judicially. These Court must also have regard to the comparable cases. But the court warned in **Protea Assurance Co. Ltd v Lamb 1971 1(1) SA 530 (A)** that:

"Comparable cases, when available, should rather be used to afford some guidance, in a general way, towards assisting the court in arriving at an award which is not as substantially out of general accord with previous awards in broadly similar cases, regarding being had to all the factors which are relevant in the assessment of general damages."

[32] I wish to point out, however that comparable cases merely serve as guidelines for, each matter must be judged on its own merits.

[33] Counsel for the Plaintiff referred the Court to the following judgments:

[33.1] **Bonesse v RAF 2014(7A3) QOD 1 (ECP)**: This was a matter which was heard by Pickering J, as he then was, on 20 February 2014. The Plaintiff was a young lady who had suffered Serious Physical Injuries, Disfigurement, Psychological Injuries and which injuries had an Impact on the Quality of the Plaintiff life. The Court awarded her general damages of R2,500,000.00. The current value of the said amount is R4,145,000.00. If that matter were heard in 2024, ten years after 2014, the court would have been entitled, based on the injuries sustained by the Patient, to award, R4,000,000.00 as it did.

[33.2] the second judgment is **Mertz v RAF 2023 (BA2) QOD 6 (GNP)**: This is a matter that was heard by the Full Court of this Division consisting of two senior Judges and an Acting Judge, namely Potteril J, Molopa J, and Bokako AJ. The matter was heard on 2 December 2022. The plaintiff in the matter was an adult woman who had been made a tetraplegic (tetraplegic is the term used to describe the inability to voluntarily move the upper and lower parts of the body), because of the serious injuries suffered in a motor-vehicle collision. In 2022, the Full Court awarded the plaintiff, for those injuries full described in the judgement, R3, 500, 000.00 whose current value is, according to Quantum of Damages, in 2024, R4, 288, 000.00. There are material similarities in the injuries suffered by the plaintiff in that case and the Patient in this case. These are the factors that this court must consider in figuring out the amount of general damages to be awarded to the Patient. So, in my view, the sum of R4,000, 000.00 awarded to the Patient on 22 August 2024 as compensation for general damages is not egregious.

[33.3] the third judgment, the Court was referred to was **Morake v RAF 2018 (7A2) QOD 9 (GNP)**: This matter was heard before Tlhapi J on 6 November 2017. To the Plaintiff who had been made a quadriplegic in a motor-vehicle accident (quadriplegic is a form of paralysis that affects both arms and legs, typically resulting from damage to the spinal cord in the cervical (neck) region),

the plaintiff was awarded R2.500, 000.00 in 2017. The current value of the said amount is R3 532, 000.00 as at 22 August 2024.

PM MABUSE
JUDGE OF THE HIGH COURT

Appearances:

Counsel for the Appellants: Adv. F Ras (SC)
Assisted by Adv. Anton Laubscher
Instructed by: Addendorff Attorneys Inc.
c/o Savage, Jooste & Adams Inc.

Attorney for the Defendant ; Ms L. Nelufule
Instructed by: The State Attorney

Date hearing and the Order: 22 August 2025
Date of the Reasons: 15 August 2025