

SAFLII Note: Certain personal/private details of parties or witnesses have been redacted from this document in compliance with the law and [SAFLII Policy](#)



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

CASE NO: 13493/2018

DELETE WHICHEVER IS NOT APPLICABLE

- (1) REPORTABLE: **NO**
- (2) OF INTEREST TO OTHER JUDGES: **NO**
- (3) REVISED: **YES**

26/01/2026

DATE

SIGNATURE

In the matter between:

RSL obo TM

Plaintiff

and

**THE MEMBER OF THE EXECUTIVE COMMITTEE
FOR HEALTH, GAUTENG PROVINCE**

Defendant

JUDGMENT

SKIBI AJ

The matter was heard in open court and the judgment was prepared and authored by the judge whose name is reflected herein and handed down electronically by circulation to the parties' legal representatives by email and uploading it to the electronic file of this matter on Caselines. The date of handing down is deemed to be 26 January 2026

[1] This is a quantification of the delictual claim for the plaintiff, RSL, in her capacity as a mother and natural guardian of TM, a 14-year-old male who was born on 28 June 2011 at Chris Hani Baragwanath Hospital (CHBH). TM, is a cerebral palsied brain damaged child. The Plaintiff's delictual claim is based on the argument that the cause of TM's cerebral palsy was due to the negligence of the medical staff employed at CHBH at the time of his birth.

[2] The issue of liability was resolved 100% in favour of the plaintiff on 3 April 2023.

[3] In the plaintiff's amended particulars of claim¹ the plaintiff, in her representative capacity, alleges that as a result of the defendant's unlawful breach of the legal duty of care, as well as *sequalae* thereof, she suffered damages in the amount of R 31 205 285.00 (*Thirty-One Million, Two Hundred and Five Thousand, Two Hundred and Eighty-Five Rand*)².

[4] The defendant in its amended plea raised a public healthcare defence. The defendant seeks the court to develop common law public healthcare defence, in that instead of the plaintiff being awarded monetary compensation this court should make an order directing the defendant to provide future medical treatment at its public health

¹ The amendment was granted.

² Caselines A118 to A-121.

facility i.e. Chris Hani Baragwanath Hospital (CHBH), in the event such services are not available grant an order directing the defendant to procure same from the public healthcare facilities. The defendant in its defences is also asking the court as an alternative to consider other ways including an order to order payment of damages in instalments rather than lump sum due to impact it is likely to have at its resources in providing healthcare services in fulfilling its constitutional obligations in terms of section 27 of the Constitution of the Republic of South Africa, 1996.

[5] In this judgment I propose to deal with the defences raised by the defendant in its amended plea followed by the quantum.

[6] The defendant when it raised public healthcare defence in its amended plea notes the following:³

“10.3 The Defendant pleads that, any duty of care resting on the hospital personnel and other medical staff, as claimed by the Plaintiff, was circumscribed by and subject to the reasonable financial, human and other resources available to the Defendant and the relevant Department of Health to equip staff and maintain the facilities available to members of the public and the aforesaid medical nursing staff at the hospital.

11. The employment of suitably qualified and experienced personnel is a function of resources.

11.1 Even if the court were to find that there was a failure to employ suitable qualified medical practitioners (which is denied) such would not constitute negligence.⁴

12. Section 27 of the Constitution provides that access to health services is

³ Caselines Section A53 to A57.

⁴ Caselines A55.

dependent on availability of resources.

12.1 To succeed on this the Plaintiff will have to prove that:

12.1.1 There are enough doctors in the country and the Defendant failed to employ them.

12.1.2. The province has enough resources to employ doctors and specialists as contended by the Plaintiff.

12.1.3 The province has sufficient resources to establish theatres and employ staff available on demand at every specific moment.⁵

13. Failure to employ nurses whether on a temporary or permanent capacity is a function of resources.

13.1 Before the court can make such a finding of failure to employ, the Plaintiff will have to prove that there are enough “suitably qualified and experienced nursing staff” in the country⁶.

...

15. Section 27 of the Constitution qualifies the access to health services. The obligation of the state is subject to availability of resources.

15.1 It follows that if the state does not have sufficient resources to ensure sufficient beds at all times, sufficient CTG at all times, sufficient Operation Theatres (O/T) at all times, that does not constitute negligence under the Constitution;

15.2 It does not constitute negligence in common law.

15.3 Equipment for performance of operations and theatres rooms are built with money.

15.4 If the state does not have money to build or expand hospitals that could not and

⁵ Caselines A55 para 10.3 to 12.1.3.

⁶ Caselines A55 to A56 para 13.1 to 13.2.

*does not constitute negligence.*⁷”

[7] Prior to the common law development of the public healthcare defence the Department of Health settled negligent medical claims in monetary compensation. These claims sometimes ran into millions per case which meant that with each claim honoured, the South African citizens and or residents in South Africa who could not afford private healthcare and rely on public sector healthcare were left with fewer resources in the health care system. To resolve this challenge the state has been pleading ‘public healthcare defence’ in most of its medical negligence claim dispute cases⁸.

The legal principles post DZ⁹ Constitutional Court judgment

[8] The public healthcare defence was first raised at the apex court in *MEC for Health and Social Development, Gauteng v DZ (obo) WZ (DZ)*¹⁰, where the department was found liable for R23 272 303 of which R19 970 631 was in respect of future medical expenses. The MEC for Health raised this defence to pay directly for every medical expense each time payment was required instead of making monetary compensation. The court found this defence to be contrary to the ‘once and for all’ rule and therefore rejected it. The latter refusal was appealed to the Constitutional Court (CC) where it was unsuccessful. The Constitutional Court however, left the door for development of this defence in cases where it is properly pleaded and evidence led in court.¹¹

⁷ Caselines A56 para 15.1 to 15.3.

⁸ Muano Mudzanani “The common law ‘public healthcare defence’ remains a viable defence despite the SCA ruling in Mashinini” *De Rebus* (July 2023) 5-6. See *MEC for Health and Social Development* 2018 (1) SA 335 (CC), *Mashinini v Member of the Executive Council for Health and Social Development, Gauteng Provincial Government* 2023 (5) SA 137 (SCA), *Gauteng v DZ (DZ)*; *MSM obo KBM v Member of the Executive Council for Health, Gauteng Provincial Government* [2020] 2 All SA 177 (GJ).

⁹ *MEC for Health and Social Development, Gauteng v DZ (obo) WZ*

¹⁰ *Gauteng v DZ* Id.

¹¹ Ibid ft 8

[9] This defence was further raised in several cases.¹² These cases will be highlighted in the following paragraphs.

[10] The genesis for the current existing public health care defence is further articulated in the judgment of *MSM obo KBM v Member of the Executive Council for Health, Gauteng Provincial Government* (MSM).¹³ In this case the court relying on the law as set out by the Constitutional Court in *DZ* case observed as follows:¹⁴

21. “The Constitutional Court considered the implications for the existing law of delict of all of these defences. The judgment of the Court is comprehensive and I do not intend summarising it in full. Instead, I will attempt an analysis that addresses the issues that arise for determination in the case before me.

22. As a starting point, it is important to note that in its analysis of the common law of delict as it exists currently the Court reached two conclusions:

22.1 First, there is little reason to doubt the continued existence of the rule that insofar as the Aquilian action is concerned, damages are to be awarded in money “because money is the measure of all things.”

22.2 Second, the ‘once and for all’ rule still forms part of our law of delict. This means that a plaintiff must claim, in one action, all past and prospective damages arising from one cause of action. This means, too, that courts are obliged to award these damages in one lump sum. This is to prevent the repetition of lawsuits, the harassment of a defendant by a multiplicity of actions, and the possibility of conflicting decisions. The Court consequently rejected the

¹² *MEC for Health and Social Development, Gauteng v DZ (obo) WZ* 2018 (1) SA 355 (CC); *MSM obo KBM v Member of the Executive for Health* 2020 (2) SA 567 (GJ), *Gauteng Provincial Government* [2020] 2 All SA 177 (GJ); *TN obo BN v NEC for Health, Eastern Cape* 2023 (3) SA 270 (SCB; *Mashinini v Member of the Executive Council for Health and Social Development Gauteng Provincial Government* 2023 (5) SA 137 (SCA).

¹³ [2020] 2 All SA 177 (GJ).

¹⁴ Id at para 21 - 22.2.

Gauteng MEC's foundational proposition in DZ, which was that in terms of our existing common law compensation need not sound in money."

[11] The *MSM* quoting the important finding by the CC in DZ the court noted as follows:¹⁵

35 "Ultimately, in *DZ* the Court found that:

'... any development of the common law requires factual material upon which the assessment whether to develop the common law must be made. Here that factual material is absent. The only possible factual foundation for an argument that the common law must be developed is the mere fact that WZ was born in a public healthcare institution and that is where the medical negligence occurred. This is woefully inadequate to ground development of the common law in the manner sought by the Gauteng MEC. The appeal must fail, for that reason.'

36. Consequently, although the court considered the issue of whether the development of the common law was necessitated, either on the grounds of s39(2) or s173, it made no finding in this regard. Despite this, there are, in my view, two important aspects of the Court's decision that bear emphasis for present purposes:

36.1 First, the Court expressly left the door open to the future development of the common law in cases like the one before me. It held in this regard that:

'But the failure of the appeal does not mean that the door to further development of the common law is shut. We have seen that possibilities for further development are arguable. Factual evidence to substantiate a carefully pleaded argument for the development of the common law must be properly adduced for assessment. If it is sufficiently cogent, it might well carry the day.'

¹⁵ *MSM* at para 35 – 36.2.

36.2 Second, although obiter, the Court discussed in some detail the ambit of the arguments that could be made to support the development of the common law. It did this in respect of both the public healthcare defence, and the development of the ‘once and for all rule’ to permit payments by instalments. In so doing, the Court lays down important guidelines for courts to follow when assessing whether a case has been made out for the development of the common law in cases involving claims for future medical expenses occasioned by the negligence of public healthcare officials in cerebral palsy cases.”

[12] The significance of the passage quoted above in *MSM* (as quoted from the *DZ* case) is a requirement that factual evidence must be led to substantiate what has been pleaded in the plea. The defendant in its argument highlighted that *DZ* dealt with damages claim for compensation for a cerebral palsy child that occurred at the public hospital due to the negligence of hospital staff similar to this case. The CC held that the fact that WZ was born in a public healthcare institution was described as “woefully inadequate to ground development of common law in the manner sought by the Gauteng MEC.”

[12.1] In so far as payment of compensation in instalments are concerned, the majority of the CC in the *DZ* case observed as follows:¹⁶

“As far as the payment of damages for future medical expenses by way of periodic payments is concerned, the majority judgment in DZ adopted what it called a cautious approach. It found that it had not yet been definitively decided at common law that it was permissible for a court to order the payment of an assessed delictual loss in instalments, rather than in one lump sum. On this basis, an order of this nature would also require a development of the common law.”

[13] After the Constitution Court judgment in *DZ*, the common law public health care defence was successfully¹⁷ raised in *MSM obo KBM v MEC for Health Gauteng Provincial Government*¹⁸

¹⁶ *MSM obo KBM v Member of the Executive for Health* 2020 (2) SA 567 (GJ) at para 31.

where the court had an opportunity to write a judgment to develop the common law public healthcare defence based on factual evidence presented in that particular case. The significance of this judgment is that the Department of Health, instead of making payment for delictual damages to the plaintiff, may request the court to develop the common law public healthcare defence, to direct that the department provide hospital or medical treatment of similar to those provided at private healthcare sector to the injured person instead of payment of lump sum for damages, or request an order that directs the department to make such payment in instalment, or request an order that direct the department to procure medical services or treatment from the private healthcare sector if it does not have such services or treatment.

[14] In *Mashinini v Member of Executive Council for Health and Social Development*¹⁹ the Supreme Court of Appeal (SCA) overturned the High Court judgment, which had earlier directed the MEC to provide medical services rather than awarding monetary compensation for a delictual damages claim. In this case the High Court granted an order that the defendant provides medical services similar to the services provided at private healthcare sector or services which are reasonably accepted. However, the SCA overturned the order and judgment on appeal finding that no factual evidence was adduced for the court to make such an order. The SCA held that the MEC's 'public healthcare defence' should accordingly have been dismissed by the high court since there was no evidence before it that medical services of the same, or an acceptably high standard would be available at no cost or for less than that claimed by the appellant. In fact, the only evidence before it, unchallenged by the MEC, was to the contrary." The SCA set aside the high court order and granted a monetary judgment for future surgical and medical expenses.²⁰

[15] After the *Mashinini Judgement* deliberations emerged and concerns were raised by some stating that the SCA in *Mashinini*, had extinguished the common law public healthcare defence. However, even after *Mashinini judgment* the public healthcare

¹⁷ Although the SCA in *Mashinini* says "Keightley J erred in holding that she was developing the common law. The SCA held that the order she granted was one based on delictual principles" See para 25 of *Mashinini*.

¹⁸ See n. 20.

¹⁹ 2023 (5) SA 137 (SCA).

²⁰ *Mashinini* at para 27.

defence do exist can be pleaded in these types of cases. It serves as a legal guide indicating when the public healthcare defence will fail. Each case is decided on its own merits. The Constitutional Court in *DZ* opened the door for this defence to be raised where factual evidence is led in a pleaded argument. The public healthcare defence is yet to be successfully raised since it was the case in *MSM*.

[16] The public healthcare defence did find its way in this particular matter in the defendant's amended plea and the plaintiff filed a replication to such.

[17] After the damages action was instituted by the plaintiff in this matter the defendant raised several defences, *inter alia*, an order seeking development of the common law (public healthcare defence).

[18] At the commencement of the trial it was indicated that the defendant bears the onus of proving that:

- (i) the common law ought to be developed, and
- (ii) that rather than providing TM with payment of his damages, the defendant should be entitled to provide TM with the medical and related services at its medical facilities. However, the defendant chose not to lead evidence on the defences it raised on its amended plead but argument were presented by the parties.

Submissions by the defendant's legal team.

[19] In advancing the argument the defendant contended that it did not have to lead evidence, it had planned to call witnesses from CHBH due to concession made by counsel for plaintiff that CHBH is able to provide the following services:

- [19.1] Neurodevelopment therapy;
- [19.2] Occupational therapy;
- [19.3] Speech therapy, and
- [19.4] Orthotist.

[20] The defendant submitted further that in light of the admission by the plaintiff calling witnesses to give evidence on non-disputed issue is time wasting hence it decided not to call those witnesses.

[21] The defendant's argument can be summarised as follows:

[21.1] In many other respects, however, this case is on all fours with the *DZ* matter. The relevance of the similarities is as follows: In *DZ*, after examining the relevant law, the CC noted that on account of the obligation that s 27(2) of the Constitution placed on public healthcare authorities and institutions, it is arguable that the applicable common law rules, which had been developed in the pre-constitutional era, may need to be developed in order that those obligations may be fulfilled.²¹ Further that in the course of reaching that conclusion, the Constitutional Court specifically dealt with the following matters: the approach to be adopted when a party asks that the common law be developed; why it is arguable that the common law rules relating to medical negligence claims against public healthcare authorities ought to be developed; and what such a defendant would require to establish in order for his or her plea to succeed.

[21.2] The defendant deals with the claim and the basis for the claim which is stated in the background above. The defendant further discusses the current legal position as outlined by the CC in the case of *DZ* and why the common law should be developed. The following key points raised by the defendant in his argument, as to why the common law should be developed, needs emphasis:

[21.2.1] First, before the CC's judgement in *DZ*, insofar as compensating claimants in actions for medical negligence were concerned, the only "defence"

²¹ *DZ* at para 45.

available to a defendant was the “mitigation of damages” defence. In terms of that defence, a defendant is entitled to lead evidence that the amount claimed by the plaintiff was unreasonable, either because such damages had not been suffered or because the amount claimed was excessive. However, once it was determined that the services were reasonably required and what the reasonable costs of such services were, two common law rules failed to be applied, the compensation that was ordered had to be in the form of monetary award; and that amount had to be paid in lump sum.

[21.2.2] Second, in DZ, among the issues that the CC was requested to consider is the negative impact that damages award in medical negligence claims against public health authorities has on their healthcare budgets and the adverse effect they have on the provision of access to public healthcare for everyone.²²

[21.2.3] Third, the CC was asked to consider three alternative mechanisms by which public healthcare authorities may order compensation in respect of persons who were negligently injured at their institutions, namely (1) claims for future medical expenses could be satisfied by an undertaking to pay service providers. (2), compensation need not necessarily sound in money, but may also be paid in kind, or claims for future medical loss may sometimes best be satisfied by the provision of actual medical services, rather than the payment of money.²³ (3), they ought to be permitted to pay for future medical expenses in instalments or periodically rather than being ordered to pay the assessed amount in a lump sum.

[21.2.4] Fourth, the similarities between the current matter and DZ are as follows: Both matters concern a claim based on the medical negligence of a state

²² DZ at para 13.

²³ The CC referred to this as the “public healthcare defence” paras 6 and 13.

health institution during the period when a mother was giving birth, causing the child concerned to be afflicted with cerebral palsy. In both these matters relief sought on behalf of the injured minor is concerned; the plaintiff prays for the following orders: the compensation be in the form of a monetary award; and that the full amount be paid in a lump sum. In both matters opposing the grant of such relief, the defendant asked that instead of being ordered to make monetary payment to the plaintiff, alternatives to be considered. In DZ, among the alternatives that the CC was requested to consider or did consider were the following: the provision of medical services in the public health sector, rather than the payment of money;²⁴ and an undertaking to pay for medical services or supplies that cannot be provided in the public healthcare sector.²⁵ And, similar to the position in DZ, the defendant requests this Court to consider the impact of ordering a large monetary payment on its department's ability to comply with its obligation under S 27(2) of the Constitution.

[21.2.5] Fifth, in the course of considering whether the two common law rules applicable to compensating injured persons could be developed, so as to allow for compensation by means other than monetary payment and payment other than by way of a lump sum, the CC undertook a comprehensive examination of the rules and suggested how they may be developed, if a proper case of such development were made. The defendant in the instant case therefore submits in this case, the plaintiff has made that admission and the Court does not have to go that far.

[21.2.6] The defendant further argues that what emerges from the DZ's judgment is this: It is now in principle open to a state defendant to ask that those two rules of common law be developed. However, in order to succeed in

²⁴ DZ at paras 6 and 12.

²⁵ DZ at paras 2 and 6.

securing an order that the common law be developed, evidence would have to be led on the 10th day of trial, showing that the Hospital can provide those services, justifying the development of the applicable rules of the common law.

[22] The defendant further submitted that the determination of that issue requires a proper consideration of the CC's judgement in *DZ* and in particular the approach that must be followed when a request is made to develop the common law.

[23] The defendant argued in terms of section 39(2) and section 173 of the Constitution that the High Court, Supreme Court of Appeal and Constitutional Court have the power to develop the common law. The defendant further contended that section 39(2) of the Constitution, requires Court to promote the spirit, purport and objects of the Bill of Rights. In terms of section 173 of the Constitution, the High Court, SCA and CC have the inherent power to develop the common law, taking into account the interests of justice.²⁶ The court may develop the common law in terms of either of the provisions mentioned in the interest of justice.

[24] The defendant discusses no less than fourteen points on these issues of which I have considered same. Of importance is the reasons why common law public healthcare defence should be developed. The following is the essence of the defendant's points of contention:

[24.1] It is submitted that the CC's decision in the *DZ* matter has far-reaching implications in respect of compensating a plaintiff by way of a payment of money, in the first instance, and if it is found that this is the way the plaintiff in question ought to be compensated, whether such payment must be made by way of lump sum payment, or whether the defendant in question may be permitted to make payment periodically or by instalments.

²⁶ *DZ* at para 32.

[24.2] As is clear from the defendant's plea, as amended, the amendments raise some of the 'special defences' that the CC has said, may be available to a Health MEC where a person suffers injury as a result of the negligent conduct of staff members of a state health institution that is complying with its obligation to make access to health care services available to everyone, as in the current case of TM. Those special defences involve a different approach to compensating the injured person: in order for the defence to succeed, the common law would have to be developed.

[25] The plaintiff also filed an amended replication in response to the defendant's amended plea,²⁷ where the plaintiff responded on the issues raised in the defendant's amended plea.

[26] The current common law is clearly articulated in the *DZ*, *Ngubane*²⁸, and *Mashinini* judgments and for brevity I propose to refer to a few extracts:

[26.1] The proper analysis by the majority judgment of DZ provide a distinction on the two important concepts, namely reasonable measure of damages (i.e. reasonableness and quantification of damages) as well as on the question as to whether payment must be made in accordance with 'once and for all' rule or payment in kind (i.e. rendering of medical services by the defendant's state facilities). The majority judgment penned by Justice Fronemann discusses this and sets out three scenarios²⁹:

- (i) Firstly, that the measure of damages is that of reasonableness and that in our law private medical care is regarded as the reasonable measure – with the rider that it is open to a defendant to prove (as a measure of mitigation) *that provincial care is just as good (or at*

²⁷ Caselines A81- A96.

²⁸ *Ngubane v South African Transport Services* 1991 (1) SA 756 (A); [1991] 4 All SA 22 (A).

²⁹ *DZ* para 12.

least good enough) so that it would in the circumstances be a reasonable measure of damages.

- (ii) Secondly, that our common law does not allow for periodic payments and requires once-off payment; and
- (iii) Thirdly, that our common law can be developed so as to allow for periodic payments if that appears to be just in all the circumstances..

[26.2] The SCA in *Mashinini* noted the following:³⁰

[13] “The Constitutional Court in *MEC for Health v DZ* endorsed the approach that was adopted by this Court in *Ngubane* when faced with the ‘public healthcare defence’. It expressed the view that *Ngubane* was authority for allowing a defendant to produce evidence that medical services of the same or higher standard, at no or lesser cost than private medical care, will be available to a plaintiff in future. It stated:

‘If that evidence is of a sufficiently cogent nature to disturb the presumption that private future healthcare is reasonable, the plaintiff will not succeed in the claim for the higher future medical expenses’.³¹”

[26.3] In the case of *Mhlatshana v Member of Executive Council for Health Eastern Cape Province*³² the court held the following:

“Having pleaded the public healthcare defence, it was incumbent upon the defendant, who bore an evidentiary burden, to rebut the *prima facie* case established by the plaintiff. *Mashinini* is authority for holding that absent the presentation of any evidence of the cost of the provision of caregiver services in the public sector, the public healthcare defence stands to be dismissed. As in that matter, there is simply no evidence that the same, or an acceptably high, standard would be available through

³⁰ *Mashinini* at para 13.

³¹ *DZ* para 21.

³² (1433/2015) [2024] ZAECHHC 19 (18 March 2024 at para 28.

public provision at no cost or for less than that claimed by the plaintiff.” (own emphasis)

[27] As to whether the common law in terms of section 39(2) read with section 173 of the Constitution as it is argued in this case, should be developed from the current existing one, Keightley J in *MSM held the following*³³:

34. “The DZ judgment includes an extensive discussion of the proper approach to the development of the common law. I highlight what I consider to be the most important aspects for purposes of the case before me:

34.1 To begin with, the Court stressed that the development of the common law does not necessarily entail the changing of a common law rule altogether, or the introduction of a new rule. It may also occur in the situation where a court must determine whether a new set of facts falls within or beyond the scope of an existing rule. What is important is that common law development cannot take place in a factual vacuum.

34.2 There are two potential legal bases for the courts’ development of the common law: s39(2) of the Constitution, or s173 of the Constitution. In terms of the former, the court must, among other things, enquire whether the existing common law rule offends s39(2). In other words, is it at odds with the normative framework of the Constitution and the Bill of Rights? In terms of s173, the enquiry is wider. The question there is whether, even if the common law is constitutionally compliant, there are wider interests of justice that necessitate its development.

34.3 In both instances, the court must also: (1) determine what the existing common law position is; (2) consider its underlying rationale; (3) if it offends s39(2), or if the wider interests of justice necessitate development, the court must consider

³³ Case No: 4314/15 at para 34 to 35.

how the development ought to take place; and (4) consider the wider consequences of the proposed change on the relevant area of law.

34.4 The Court cautioned courts to be mindful that, in accordance with the principle of the separation of powers, the major engine for law reform should be the legislature. However, courts should take into account factors such as whether the common law rule is a judge-made rule; the extent of the development required; and the legislature's ability to amend or abolish the law.

34.5 In determining whether a common law rule offends s39(2) or whether the wider interests of justice necessitate development, the context of the inquiry is important. In particular, in the case of DZ (as in the case before me), the court is dealing with a child suffering cerebral palsy occasioned by the medical negligence in a public healthcare institution:

'It is within that context that it is argued that the law should allow either an order to ensure the actual rendering of the necessary medical care or periodic payments of the assessed loss'".

Submissions on behalf of the plaintiff

[28] It was contended that there are many authorities dealing with the defence as highlighted above. A public healthcare defence is quite onerous in that the defendant does not just need to allege but is required to provide cogent evidence to succeed. This argument is developed in the paragraphs below.

[29] The defendant in its plea is that – it has constrained by its budget, in that if it does not have the requisite staff, theaters, services etc it is not negligent, but it is due to budgetary constraints. The plaintiff's legal team argued that no evidence whatsoever was adduced to demonstrate the existence of such nor at the liability hearing about those alleged budgetary constraints when it comes to providing medical care. It is further contended that in that type of situation if TM would be subjected to such, it would be a travesty of justice.

[30] With regard to the public healthcare defence, the defendant pleads that:³⁴

“The State provides outpatient and in-patient management of neonate, infant and child health, in accordance with the Integrate Management of Childhood Illnesses Guidelines and the National Standard Treatment Guidelines for Primary and Hospital Levels.

- (a) The plaintiff submitted that if one looks at the age of TM 14 years, and this makes provision for alleged healthcare services for children. So, it would only be applicable until he reaches majority.
- (b) Secondly, the plaintiff contended that the defendant never made discovery of the said guidelines and plaintiff’s suggestion is that it is safe to conclude that they do not exist. If they do exist nothing could have stopped the defendant to discover same.
- (c) The plaintiff further submitted that the defendant has failed to produce even a single document to this court in support of the public healthcare defence.”

[31] If one accepts the contention by the defendant on the issue of limited resources at least it should produce some evidence on the issue of (i) having budgetary constraints and/ or (ii) one would expect the defendant to produce documents to substantiate these allegations, either some financial statements or at the very least their contracts with employees within the various departments and their level of experience. Instead, the defendant comes to court empty handed with the attitude that their purported defence is simply for the asking. This argument that the defendant came to court empty handed may not be accurate where the plaintiff admitted that some medical services are available at the defendant healthcare facilities. However, the defendant has not adduced evidence that the available services are similar to the one provided at private healthcare facilities.

[32] In comparison to the *DZ matter* no evidence was led by the state regarding the

³⁴ Caselines A-30-A33.

services provided by the State hence the court decided not to develop the common law. The argument by the defendant in this particular case, that had it not been by concession of the plaintiff that the treatment/ therapy service/s is available to CHBH it would have called witnesses. There is nothing which stopped the defendant from doing so, as it was made aware of this just before it closed its case.

[33] The defendant in its plea at paragraphs 20.1 to 20.7 it is not substantiated by evidence before this court, in that no evidence was led by the defendant as stated in its plea that the standard of care in their public healthcare facilities is equal/similar to that of private or is even of a reasonable standard.

[34] It is trite that the 'once and for all rule' is the current legal position. It is so that the Constitutional Court in *DZ*³⁵ left the door open for the common law to be extended by way of cogent evidence. It was argued on behalf of the plaintiff that there is no evidence whatsoever, which was led by the defendant to suggest that the common law should be extended. There was no evidence proffered during the trial to suggest that the defendant cannot afford to pay for the damages being claimed. It was further submitted that the defendant discovered no documents (at all) relevant to either its budget, financial constraints or procurement.

[35] I was referred to the similar case where a concession was made by the plaintiff regarding the availability of healthcare services at the state facility in the case of *SMM (obo LPM) v MEC for Health, Gauteng (GJ)*; ³⁶ a cerebral palsy claim). The defendant raised the public healthcare defence but then led no evidence in support of the defence, but (similarly to the instant case) obtained the concession from the plaintiff that Chris Hani Baragwanath Hospital could provide some of the services and equipment which the plaintiff claimed (although the standard attached to those services was not admitted, as in here). In *SMM* case, Grant AJ dismissed the defence, and observed as follows at

³⁵ See above n 12.

³⁶ 25519/2016 (11 August 2020).

paragraphs 13 to 17 of his judgment:

“The proposition that a court may order that a particular public institution must provide specified services and equipment or devices to a plaintiff has been recognised as a question to be determined in each case by the facts: see *Ngubane v South African Transport Services*³⁷; *MEC, Health and Social Development, Gauteng v DZ*³⁸; *MSM (obo KBM) v MEC for Health, Gauteng*³⁹. The position is that there is a natural presumption that a plaintiff is only able to secure reasonable medical services and equipment from the private sector – but that this presumption may be disturbed by evidence from the defendant. The recent case of *MSM* appears distinguishable on the basis of the evidence for the MEC presented in that case – whereas no such evidence was presented in this case. In the case before me it is significant that the defendant led no evidence

The plaintiff admitted that CHBH is able to provide certain limited services and equipment required by the plaintiff. However, the plaintiff denied that CHBH could provide the services to the full nature and extent required and, critically, did not admit that the services and equipment would be of an equivalent or better standard than would be sourced from the private sector.

Thus, the defendant presented no evidence as required by the judgements of *Ngubane*, *DZ* and *MSM* ... counsel for the defendant rightly conceded that no evidence was presented on the basis of which it could argue that the presumption in favour of private healthcare should be disturbed.”

[36] When the defendant’s witnesses testified about the life of TM, they also canvassed the issue of public health care defence. The plaintiff’s legal team cross-examined these witnesses on the following aspects:

[36.1] Ms Radzuma testified that TM was and continued to receive therapy at a local government hospital (CHBH) where he will continue to receive

³⁷ 1991 (1) SA 756 (A).

³⁸ [2017] ZACC 37 (CC).

³⁹ 2020 (2) SA 567 (GJ).

multidisciplinary intervention from therapy, speech therapist and other relevant health professionals. The plaintiff has argued that this witness tailored her evidence and should not be accepted.

[36.2] Ms Mokgata made admission that when she compiles her medico-legal reports, it is only in birth injury stipulated the prospect of utilising state healthcare facilities even though she only specialises in birth injury cases.

[36.3] In the recommendations made by Dr Mteshana in her admitted report, she confirms the availability of neurological services at CHBH. Although Dr Mteshana, is the Head of Neurologist at CHBH she does not provide her expert report confirming that healthcare services provided at CHBH are on the same level as private care nor is it of a reasonable standard.

[36.4] The plaintiff further argued that another example demonstrates that, if the public healthcare defence were upheld, the therapy services TM would be restricted to would place him in serious danger, effectively becoming a death trap, similar as what occurred in the matter of *Bell v MEC for Gauteng*⁴⁰. In the latter case the MEC was taken to Court for contempt of court when it failed to comply with the order granted on 3 October 2023. The court ordered the rendering of services and provision of goods to a minor child, Mahlatsi but on 18 March 2024 such services had not been rendered. In this case, Twala J rebuked the MEC as it found that the MEC was culpable or grossly negligent in not complying with the court order. The defendant raised a counter argument that in *Bell's* case, it was an application for contempt of court order not dealing with the issue of a public healthcare defence.

⁴⁰ 2024 JDR 1429 (GJ).

[37] The defendant has filed a number of underlying reports in its case, one being the therapist services availability at CHBH which has been mentioned. The plaintiff also admitted or confirmed that some therapy services are available at CHBH. What is not clear is whether those services are at a reasonably acceptable level, similar or better than those provided at private healthcare facilities. The plaintiff 's legal team argued they are not. The reports of Dr Mteshana, Ms Radzuma and Ms Mokgata but no detail s given on the quality or standard of medical care that is available. It is thus unclear if the medical care that is being rendered is of a reasonable standard and / or similar to the healthcare services provided at private healthcare facilities.

[38] In the defendant's expert's reports not a single expert discusses the level of healthcare at the defendant's health facilities. The defendant filed a number of expert reports in terms of Rule 36(9)(b) who could have taken that golden opportunity to opine on the standard of care in public healthcare and whether the standard was comparable to private care, or even of a reasonable standard. Not even one attested to that fact, in some instances they made the statement that services were available at CHBH but none whatsoever, opined as to the standard of those available services.

[39] Dr Mteshana (the Defendant's paediatric neurologist) is the Head of Neurology at CHBH, in her Rule 36(9)(b) summary, even she does not offer an opinion on the standard of healthcare provided at CHBH being similar to private, or even reasonable, one would expect that the Head of a Department would be best placed to do so, yet she does not. I must point out that on the Third (Quantum) Pre-Trial⁴¹ held on 4 September 2025 the defendant was asked to provide a list of witnesses it intended to lead in this public healthcare defence. The defendant stated that it intends calling representatives/ Heads of Departments HoD in regard to various services provided at CHBH. The context of the concession was clarified by the plaintiff and the proceedings were halted to provide defendant's counsel the opportunity to listen to the recording so as to inform her on what was conceded the previous Friday when the matter resumed on the

⁴¹ Caselines Section A-109 para 3.1.3.

following Monday, when the defendant had to call officials from CHBH. When the matter resumed, the defendant chose to close its case without leading evidence to discharge the evidential burden of public healthcare defence. It is important to note that during the pre-trial conference referred above the parties discussed and agreed that at the commencement of the trial the plaintiff will have a duty to begin calling witnesses in quantification and reasonableness of TM's damages claim and then the defendant would adduce evidence on the public healthcare defence and the plaintiff would reserve the right to call rebuttal witnesses⁴². Since the defendant decided not to adduce evidence the plaintiff didn't see any need to call witnesses as there was nothing to rebut.

[39.1] The defendant's legal team chose not to lead evidence to the effect that treatment, equipment and services that TM will require will be available at CHBH, either at the same, similar or comparable standard rendered by private medical healthcare facilities and that the treatment rendered at CHBH would be free from administrative and bureaucratic uncertainty and delay. One of the allegations in the plaintiff's amended replication is that most of the treatment, equipment and services that the TM as a disabled child and individual may require is not available at the defendant's facilities, alternatively, where it is available, it is not sufficiently and readily available⁴³. There would be no fairness to subject or compel TM to make use of equipment and services available at the defendant's facilities which would subject him to long delays and limitations which will compromise his health. On the face of the said allegations the defendant chose not to adduce evidence to allay fears that TM would be provided substandard medical treatment.

[39.2] The defendant also pleaded that it tenders a certificate which the plaintiff will be entitled to produce at any state institution for each of the claims⁴⁴. This may be

⁴² Caselines para 3.1.5 page A-109 to A-110

⁴³ Caselines A-93 to A-94

⁴⁴ Paragraph 11.16 defendant's amended plea

referred to as a “certificate defence”. In addition to the fact that no stipulation as to what medical services and/or supplies TM would be entitled to and on what basis will it be determined whether the services or suppliers are available in the public sector and the procedure TM and/or the plaintiff would be required to follow in order to access such services. The defendant elected not to lead evidence on this.

[40] The plaintiff led the evidence of Ms L[...], in respect of which certain material aspects were not disputed, namely the following:

[40.1] TM received therapeutic intervention at CHBH on a monthly basis with a team of therapists (speech, occupational and physiotherapist) that lasted approximately 20 to 30 minutes. This continued until he was approximately 6 years old, whereafter he was transferred and informed that he was to receive his therapy at Lenasia Clinic. His therapy at Lenasia Clinic appeared to have been marginally better, with the monthly sessions lasting an average of an hour.

[40.2] At 7 years old, therapy services were stopped.

[40.3] TM continued to present annually at CHBH to date. TM's mother confirmed that TM missed his appointment with the neurology department during 2025, due to unavailability of funds. The plaintiff testified that during his annual consultation with the neurology department in 2024, she was advised that TM required Botox.

[40.4] During cross-examination of the plaintiff, these facts were not disputed. One would expect that, if the defendant's care was better than that, they would have the documentation to show that it was indeed the case, or it would at the very least have been put to the plaintiff to confirm or deny.

[41] The plaintiff in its replication dealt comprehensively with the issues raised in the defendant's plea. It was incumbent upon the defendant to lead evidence to enable the court to determine whether common law public healthcare defence should be developed or that the defendant cannot afford to pay the damages claimed by the plaintiff.

[42] TM has been utilising the services of CHBH, the state health facility. However, the plaintiff argued that as TM is a SA citizen it is absurd to suggest that he should utilise the services of a single healthcare facility. Ms Radzuma testified that it is unlikely that TM will ever leave the roof of his parents and have his own place. He is confined to singular healthcare facilities throughout the country. By implication he is confined only to living near CHBH hospital, which is within a 30 km radius. Ironically, there is judgment that the hospital recommended rendering therapy services for life is one which was found medically negligent for his brain damage. When TM's mother was testifying she said that "*she hates that hospital*". Although under cross examination she confirmed that she gave birth to TM's younger siblings at CHBH. It cannot be suggested that she likes the said facility

[43] TM is 14 years old and no one knows what the future holds for him in 5 or 10 years when he becomes more mature. To confine TM to one public healthcare facility with a history of a court matter (the *Bell* case) where the MEC was dragged to court for contempt of court for failure to render services as ordered. If this defence were to succeed, and later the defendant renegades on its commitment, TM would have to bring an application to court to compel compliance with the court order.

[44] There is no evidence led as to how the treatment would be implemented. The defendant initially planned to lead evidence on this by calling the case manager, but it later decided not to. No evidence was led as to what would happen to TM if one neurologist recommends using botox and later that recommendation is overturned by another medical practitioner.

[45] The defendant's public healthcare is purported to be free of charge or at a

substantially lesser cost depending on a means test. Counsel for the plaintiff did canvass this issue of free healthcare by asking the witnesses, Ms Radzuma and Ms Mokgata. They were unable to dispute that the services would not be free to those who do not qualify in terms of the means test as regulated by the defendant. Ms Radzuma and Miss Mokgata were also questioned with regards to the terms of the qualifying criteria, since TM would not be, in law, entitled to free healthcare at the state facilities nor would not be free at the defendant's healthcare facility. This was not disputed by the said witnesses.

[46] Section 39(2) of the Constitution, provides that when interpreting any legislation, and when developing the common law or customary law, every court, tribunal or forum must promote the spirit, purport and objects of the Bill of Rights. The defendant places reliance on the provision of this section and section 173 of the Constitution. In the *DZ* judgment the Constitutional Court considered the issue of whether the development of the common law was necessitated, either on the grounds of s39(2) or s173, the court made no finding in this regard. In the instant case, no factual evidence to the pleaded argument by the defendant to develop common law in terms of either Section 39(2) or 173 of the Constitution.

[47] The following comments are important to address in the conclusion, having regard to the authorities referred to above:

The defendant argued that since the plaintiff has accepted that CHBH is able to deliver the following services (i.e. Neurodevelopment therapy; Occupational therapy; Speech therapy; and Orthotist), the defendant did not have to call witnesses.

Final analysis and conclusion on the public healthcare defence

[48] In this particular case my considered view is that the defendant's request for an order directing the defendant to provide the said medical services cannot be sustained. I am guided by the SCA judgment of *Mashinini*, and the CC Judgment of *DZ*. In *Mashinini*, the SCA held that the high court should have dismissed the MEC's public

healthcare defence since there was no evidence before it that the medical services of the same, or an acceptably high, standard would be available at no cost or for less than that claimed by the appellant. In the current case, I am faced with a similar situation. The defendant has neither produced nor led evidence to the effect that the services available at CHBH are of similar or an acceptably high standard as provided in private healthcare facilities.

[48.1] The defendant has correctly argued that the provisions of section 173 of the Constitution enjoins the powers to the High Court, SCA and CC to develop common law. In the instant case there is no constitutional challenge of the legislation, but the development of the common law public healthcare defence is sought. In this case the court faces the difficulty of considering the development of the common law and ordering the payment in instalments or periodical payments instead of making an order for a lump sum for damages claim, in the absence of any evidence.

[48.2] The defendant's argument that the current case and DZ are in all fours is an incorrect assertion. It may be so that certain similarities exist, for example both the current and the DZ cases revolved around children born with cerebral palsy caused by the negligence of hospital staff at a public hospital; and in both cases a claim for medical expenses in lump sum, is made. This argument, similarly, was presented at the Constitutional Court in the *DZ matter*, but the court concluded that the fact the child was injured at public hospital is insufficient, to borrow the language used by the court this is "*woefully inadequate*".

[48.3] The defendant's reliance on the fact that the plaintiff has conceded that some therapy services are available at CHBH, without tendering any evidence, does not assist the defendant in its pleaded argument.

How can the court develop common law and direct the defendant to pay compensation for damages claim in instalments or direct to make periodical

payments when there is no factual evidence from the defendant about budgetary constraints or without evidence of financial statements that the defendant is unable to pay lump sums for these damages claim? The passage quoted above⁴⁵ amongst other things notes that common law cannot be developed in a factual vacuum. The CC in *DZ* cautioned about this, in that it may cause the multiplicity of claims and may cause conflicting judgments being delivered. Despite the fact that the CC has left the door open for development of the common law for this to happen the defendant chose not to call a single witness or discover financial statements which indicate / show budgetary constraints.

[48.4] *DZ* is a progressive judgment in terms of which it opened the door for development of the common law for payment to be made in kind or compensation be paid in instalments, in cases where an argument is pleaded and factual evidence led. However, in the instant case the defendant decided not call witnesses to give factual evidence to support its pleaded case on staggered approach for payment of TM's future medical healthcare expenses.

[48.5] Due to lack of cogent evidence from the defendant the court is unable to grant an order to develop common law by directing the defendant to procure medical services for TM instead of awarding damages in a lump sum. This court is also unable to grant an order directing the defendant to make payment in instalments without factual evidence that the defendant has no financial resources to make payment for compensation in lump sum. Furthermore, the court in the matter of *DZ* confirmed that the lump sum payment is still part of our law in Aquilian action. The court also does not have evidence before it that states that the medical services of the

⁴⁵ This is referred in paragraph 27 of this judgment by a Judge in MSM from *DZ* judgment para 34.1

same, or an acceptably high standard would be available at no cost or for less than what is claimed by the plaintiff.

[48.6] The argument by the defendant that, merely because of the concession by the plaintiff, it did not have to go far to call further witnesses, has no merit.⁴⁶ The SCA in *Mashinini* clearly confirms the law as it was held in the matter of *Ngubane*, and the *DZ* case adopted the same legal principles. Unfortunately, the abovementioned case law is clear in that development of common law cannot be done in a vacuum.

[48.7] I do not have evidence supporting defendant's pleaded case regarding other alternatives other than monetary compensation proven by the plaintiff in respect of all the medical services and devices claimed by the plaintiff'. All the listed similar features in the argument by defendant which are said to be in fours in this case and the *DZ* case, are of no assistance to the defendant's pleaded case. In *DZ*, the court gave guidelines for future cases where public healthcare defence is raised like in the current case. In actual fact the CC dismissed the argument due to absence of cogent evidence/factual evidence. The SCA in *Mashinini* cemented/confirmed this position.

[49] Consequently, having heard evidence, oral arguments and after considering the comprehensive heads of argument by both parties on the public healthcare defence I am not persuaded that the defendant has adduced evidential burden for the development of the public healthcare defence. As a result of the failure of the defendant to adduce evidence on the public healthcare defence I am unable to make an order directing the defendant to provide future medical healthcare services to TM or where it does not have those services direct it to procure same. I am unable to make

⁴⁶ See also the case of *SMM (obo LPM) v MEC for Health, Gauteng (GJ)*.

an order for payment TM's future medical expenses in instalment rather than in lump sum as stated above no evidence led by the defendant about budgetary constraints etc. In my view the issue of alternative ways of payment either in kind or in instalments, these are the issues which could have been resolved in a mediation and an agreement be reached and either party could approach the court and request such agreement be made an order of court so that if there is no compliant the aggrieved party could approach the court for contempt. However, I respect the choice of litigants as to which witness to call or a choice of not to call a witness.

[50] Having considered and decided on the defendant's plea I now proceed to consider the damages claim sought by the plaintiff.

[51] In the next topic of future medical and related expenditure the court did not have the benefit of having comprehensive heads of argument from the defendant as opposed to the previous topic i.e. public healthcare defence, submissions on future loss of earnings as well as general damages claim. It is understandable that the defendant's main defence was on the alternatives than on monetary awards. The defendant was requested to file supplementary heads of argument if they so wish but the request was not acceded to. It was already stated in their written submissions that oral submissions on other topics will be addressed in court. I do not have an issue at all with that. I am grateful to the oral submissions made by counsel for both parties.

[52] As a background of TM's conditions several underlying expert reports describe this 14 year old intelligent teenager who, had it not been for this incident, was going to study and complete his grade 12 , complete tertiary qualification, enter the job market earn a living, start his family, have children and retire at the age of 65 years. However, due to the injury he suffered at the hands of the defendant, allegedly, the experts who assessed him opined amongst other things that due to his brain damage he will never be independent, will more often require constant supervision, will never be gainfully employed, will never be able to effectively communicate with others, he will not be able

to socialize with his peers and his life expectancy is significantly reduced. He is more likely to live without a wife and children, and as he grows his life will deteriorate.

[53] In this judgment regard will be given to the *viva voce* evidence of various witnesses led by both parties, experts underlying reports, joint minutes and actuaries.

[54] At the commencement⁴⁷ of this trial, I was asked to make several rulings after the hearing address by counsel of the parties. I characterise the said ruling as preliminary issues.

[55] This matter could have been resolved expeditiously without having to spend a lot of court time, but it ran just over 10 court days. However, there were some differences in the experts' underlying reports as well as on the joint minutes. On the last pre-trial conference (third pre-trial conference of Quantum) the defendant repudiated some of the expert's recommendations as recorded in the joint minutes. In some of the joint minutes the differences or disagreements are not significant. I will first deal briefly with the rulings I was asked to make on the first day of trial.

Preliminary issues

[56] At the commencement of the trial the court was requested to make a ruling on various issues, namely:

[56.1] The first ruling sought by plaintiff was the admissibility of the non-contested expert joint minute. In trials, any party who is aware of the potential introduction of hearsay evidence may invoke a limited sanction under the provisions of section 3 of the Law of Evidence Amendment Act⁴⁸. When the scope of the evidence is restricted and its admissibility maybe disputed, it may be suitable to admit it provisionally to allow the trial to proceed. The party requesting the admissibility of hearsay evidence must then request leave from

⁴⁷ Caselines A-118 to A-122.

⁴⁸ 45 of 1988.

the court to have the evidence deemed admissible. After hearing arguments by counsel, I ruled that the said joint minutes are admitted into evidence. The main reason being that had such evidence been admitted it would mean that the plaintiff would have to call over five hundred witnesses, something which was going to consume a considerable amount of court time on reports which are not disputed by the defendant.

[57] As a result of my ruling on this aspect Exhibit A to N were admitted. These Exhibits are underlying expert reports, experts' joint minutes and addendums. Those Exhibits will be referred to when dealing with the recommendations in their areas of specialisation/expertise. Due to long list of these Exhibits, I deem it unnecessary to list them here but will refer to same from time to time in this judgment.

[58] The next point the court was requested to make a ruling on was the issue of the defendant's repudiated clauses and/or unspecified clauses on the experts' joint minute, some of the expert reports included the following:

[58.1] Architect;

[58.2] Dentist reasons being that conclusions were based on incorrect facts therefore it is not binding on the defendant;

[58.3] Physiotherapist, on the basis that recommendations or opinions were on incorrect facts-i.e. life expectancy when the expert was not a life expectant expert;

[58.4] Orthotics, the basis for repudiation was that a conclusion was made on incorrect facts.

[59] During the address the plaintiff relied on the case of *Amelia van der Merwe NO obo MH and Member of Executive Council for Social Development, Gauteng Provincial Government*⁴⁹ where it was held that good cause for repudiation should be shown to exist. In this case it was contended that no cause was shown to exist. The defendant, relying on the same judgment, contended that the main principle is that a prior warning must be given to the plaintiff and same was given as far back as 12 September 2025 but the plaintiff did nothing.

[60] Reliance was placed on the judgment of *Thomas v BD Sarens (Pty) Ltd*,⁵⁰ penned by Sutherland J where he succinctly sets out the legal position regarding the effect of such agreements between experts in the following terms: “Where the experts called by opposing litigants meet and reach agreements about facts or about opinions, those agreements bind both litigants to the extent of such agreements. No litigant may repudiate an agreement to which its expert is a party, unless it does so clearly and, at the very latest, at the outset of the trial. In the absence of a timeous repudiation, the facts agreed by experts enjoy the same status as facts which are common cause on the pleadings or facts agreed in a pre-trial conference.”

[61] During the argument the plaintiff ultimately made a concession that the plaintiff will call an Architect, Mr Brummer and the defendant may call its own expert on the field.

[62] Having heard the parties on the repudiated joint minute and having considered the case law on the issue, I made a ruling that the defendant’s repudiated joint minutes⁵¹

⁴⁹ Case No 17553/2017 (judgment dated 04 April 2024) Horn AJ.

⁵⁰ (2007/6636) [2012 ZAGP JHB 161 (12 September 2012) at para 1 & 12.

⁵¹ The SCA judgment dealing with this issue, *NSS (obo AS) v MEC for Health, Eastern Cape* 2023 (6) SA 40 (SCA), the court is not bound by agreements between experts or parties’ agreements to be bound by joint minutes or reports and may test these opinions if deemed necessary. The court held at paragraph [24] of *NSS* that “... a party cannot bind the court to the opinion of her opponent’s expert witness by merely conceding that the opinion is correct. Put simply the decision on the opinion is for the court, not for the witness.” However, it is worth noting that Kriegler J’s apt description of the position in *S v M* 1991 SACR 91 (T) was quoted in the same paragraph as follows: “A court’s approach to expert evidence has been dealt with on many occasions. The court is not bound by expert evidence. It is the presiding officer’s function ultimately to make up his own mind. He has to evaluate the expertise of the witness. He has to weigh the cogency of the witness’s [sic] evidence in the contextual matrix of

are admitted and indicated that where the experts differ evidence may be led. I hastened to mention that in arriving at such a decision, there is a plethora of decided cases which underscore the advantages of parties admitting experts report and joint minutes in the interest of case management.

[62.1] In *Thomas v BD Sarens Pty (Ltd)*⁵² the court held the following:

“Where experts ... supply facts, either from their own investigations, or from their own research, and an agreement is reached with the other parties’ experts about such facts, such an agreement enjoys the same status as facts that are expressly common cause on the pleadings or in an exchange of admissions”.

[62.2] In *Bee v Road Accident Fund*⁵³ Rogers AJA (as he then was) also highlighted the importance of parties being bound by agreements contained in joint minutes as amongst issues is to limit issues to be tried: “...A fundamental feature of case management, here and abroad, is that litigants are required to reach agreement on as many matters as possible so as to limit the issues to be tried. Where the matters in question fall within the realm of experts it is entirely appropriate to insist that experts in like disciplines meet and sign joint minutes. Effective case management would be undermined if there was unconstrained liberty”⁵⁴

[62.3] The Judge President⁵⁵ of the Gauteng Division issued a Directive on 22 April 2025 (*‘Directive Introducing Mandatory Mediation in the Gauteng Division’*) which makes the valid point in paragraph 5 that what serves before a Judge prior to a decision “genuinely deserve the attention of a Judge”. This simply means that if parties (legal teams) can sensibly resolve

the case with which he is seized. He has to gauge the quality of the expert qua witness. However, the wise judicial officer does not lightly reject expert evidence on matters falling within the purview of the expert witnesses filed.

⁵² [2012] ZAGP JHB 161(GJ) at para 9.

⁵³ 2018 (4) SA 366 (SCA) at para 65 to 73.

⁵⁴ See also the case of *Denby v Ekurhuleni Metropolitan Municipality*⁵⁴; *JV v Road Accident Fund* [2019] ZAFSHC 42 (FS).

⁵⁵ As he then was, now Deputy Chief Justice of the Republic of South Africa.

matters, they would do so rather than leaving it up to a Judge to unnecessarily do so.

[63] In this particular case, there were various joint minutes where recommendations were made on the issue of quantum, it was incumbent on the legal team to debate and discuss in order to determine where necessary issues can be limited. However, at the last pre-trial conference some joint minutes were repudiated by the defendant. However, during the trial, engagements between the parties continued and the plaintiff's legal team was more willing to such an extent that some concessions resulted in the defendant taking a decision not to call some witnesses it initially intended to call. There is context to what was conceded as it will transpire when dealing with the aspect of the development of the common law public healthcare defence.

[64] The joint minutes, the reports and the experts' underlying reports were marked as Exhibits A to N which form part of the record. Furthermore, during the trial and the leading of various expert witnesses, a number of additional Exhibits were handed in and marked as Exhibits: "O" to "T". The said Exhibit names are listed in paragraph 57 above.

The Witnesses

[65] The plaintiff called 7 witnesses, Ms A Greeff, occupational therapist, Ms I Hattingh, a speech & audiologist expert, Ms R Mouers, the plaintiff, Mr J. Brummer, Architect, Dr VM Close, orthotist, Dr M Close, a psychiatrist and Mr K. Pretorius, actuary. On the other hand, the defendant led the evidence of Ms P. Radzuma (occupational therapist,); Ms MH Mokgata (speech therapist); Dr S. Ramokgopa (orthopaedic surgeon) and Mr N. Mavimbela, an actuary who compiled a report for the defendant. For the sake of brevity of this judgment on factual evidence I do not intend to summaries all the evidence led as the underlying reports and joint minutes were handed up.

Plaintiff witnesses

[66] The plaintiff, Ms RS L[...], in her representative capacity of the minor child TM, testified about the difficulties she experienced after giving birth to TM. She was employed a few months and had to quit her job to look after TM. She says TM is the first born of 5 children and her husband, who is the biological father of TM. TM has been attending therapy at CHBH as he was born with cerebral palsy. He has been assessed by various experts in different areas of expertise. She described the following:

[66.1] TM as intelligent child. She still feels bad about what happened to TM at birth it should not have happened. She was emotional at times during the course of her testimony. She describes TM has a child that does not move normal. His hands cannot function properly. He struggles to lift his arms. His legs are not normal, his left leg turns more into the inside. He falls when he rides bicycle. He runs on his toes. At 14 years he struggles and requires assistance. When he is eating, he messes himself. He struggles to speak. He has fewer companions only those who grew up with him. Sometimes he does not want to leave the house. When he meets new friends, they do not understand why he does not look like them.

[66.2] With regard to his schooling and therapy, Ms L[...] testified that although he passed all the grades, , his teachers say he is a slow learner. He passed all grades without repeating. He did not go to high school after passing grade 7. She says at Hope School, they did not admit him due to his condition. However, under cross examination it transpired he was admitted. In 2024 she was told by a doctor at CHBH that he will need Botox but later told her that he does not need Botox. She was told TM needs therapy in different specialists in order to sustain his life. She uses public transport to get to CHBH for therapy.

[67] Ms A. Greeff an occupational therapist by profession testified. She placed her qualifications on record. She obtained a Bachelor of Occupational Therapy at the

University of Pretoria in 1994. She has a master's degree in early childhood development from the University of Pretoria in 2019. She has various certificates from tertiary institutions abroad, United State of America in 1995. From 2025 to 2029 she enrolled for Spec Studies in Health Sc (PhD Pre) with the University of Stellenbosch. She is an active Case Manager. She makes concerted efforts to assist patients, including children with cerebral palsy. She conducted an assessment of TM on 14 August 2019 and compiled a report with her recommendations.

[67.1] She says TM was diagnosed with Hypoxic Ischemic Encephalopathy (HIE). She also did a school visit on 14 August 2018. She was referred to various paragraphs in her report regarding her recommendations for therapy of TM. She was also referred to the joint minute she signed with her counterpart, Ms P Radzuma. She explained her recommendations for therapy of TM and why she made a recommendation for more hours of therapy as a Case Manager. She also testified about the point of agreement and disagreement in their joint minute.

[67.2] Ms Greeff made analogy about the stages of the child, like a house, where a foundation, building, walls and roof. At the age of 14 a child should have developed, have skills to understand what he sees but TM struggles to fasten shoelaces, his teacher described him as slow, he becomes upset. She says TM requires therapy to sustain his life and has made various recommendations for the provision of therapy. She made various recommendations and confirmed that the recommendations for therapy of TM are fair and reasonable.

[68] Ms I. Hattingh is a speech-Language -Audiologist by qualification. Her qualifications were placed on record. She is qualified in her work and she works with children with cerebral palsy. Her work involves all aspects of communication. In her field she works with dentists. In her testimony she was referred to her underlying report where she made recommendations. She was also referred to the joint minute she

signed with her counterpart Ms M. Mokgata. She pointed out the agreements and disagreements. She testified that TM speaks one to three words, one cannot understand what he says. You can only understand or know in context, for example, when he uses gestures like pointing to something he wants. Ms Hattingh made recommendations in her underlying report and joint minute she signed with Ms Mokgata. She confirmed her recommendations for provisions of therapy are reasonable.

[69] Mr James Brummer, and architect by profession. He qualified as an Architect in 1986. He compiled an architect report for both the State and law firms. He compiled reports of about 90 for both law firms and the State since he started his practice. He compiled his report with the recommendation for the house of TM. He says his recommendations for provision of the house for TM are reasonable. His report forms part of the record. He signed the joint minute with the defendant's expert. There are points of agreements and disagreements. He was cross-examined by the defendant amongst others on the fact that he is not a qualified surveyor and does not have expertise to provide pricing of items of the house. Although he conceded not qualified as a qualified surveyor he noted that he is able to project costing in small projects.

[70] Dr M. V Close was also called by the plaintiff. She is an Orthopaedic surgeon, qualified in 1996. Her expertise and qualification are not in dispute. She also studied life expectancy from literature. She compiled an assessment. She referred TM to a Radiologist for x-rays and the result was that TM will require therapy on his spine as she discovered that the spine was not straight and has what she called scoliosis. She described scoliosis as a twist on the spine. She testified as to what the future holds for TM. TM's muscle imbalances may worsen as time goes on and he grows older. She said the muscle imbalances at TM's foot can be attended through the intervention of the physiotherapist. Dr Close recommended that TM will need medication on a monthly basis including *Stratter*; 46 sessions consultations, *Zoloft* and *Cymbalta* medication to sustain his life.

[71] Dr Mariam Close, a qualified psychiatrist, qualified at Wits university in 2008. She works as consultant at the hospital. She has a private practice for the past 15 years. She also obtained a LL.B. degree from Unisa. She compiled an assessment report and joint minute she signed with Dr LM Matjila. Her recommendations are not challenged. Dr Close and Dr Matjila agree that TM does not present overt mood, anxiety or psychological disorder at the moment. In the future he is at risk of developing same based on cerebral palsy. Both agree there is a cognitive compromise present with global developmental delay and intellectual disability. Both agree that a *Curator ad litem* be appointed. Both agree that TM will need psychotropic medication and consultations would be required. This medication for TM's lifelong management would be required. Dr Matjila agreed with everything except the cost. He said these services are available at CHBH.

[72] Mr Kobus Pretorius, is an actuary expert from Prima Actuaries. He prepared a report with calculations. He signed joint minute with his counterpart for the defendant, Mr N. Mavimbela. He explained the difference of his assumptions and that of Mr Mavimbela. His report and the joint minute were handed in as an Exhibit.

Defendant witnesses

[73] The defendant called witnesses in the counter part as those of the plaintiff, Ms P. Radzuma, occupational therapist, Ms M Mokgata, Dr Ramokgopa and Mr N. Mavimbela. The underlying reports and joint minutes of these witnesses were considered on the contingencies where there are differences in the recommendations.

[73.1] Ms Radzuma is a qualified occupational therapist. She obtained her bachelor's degree in 2006 at Medunsa and in 2014 she also obtained a diploma. She has been in practice for the past 17 years. She compiles assessment reports for law firms or the State, but mostly for the State. She assessed TM on instruction of the defendant. She confirmed signatures in her underlying report. She confirmed her conclusions and recommendations in her report. She was also referred to the joint minute she signed with her counterpart Ms

Greeff. She testified about recommendations where she agreed and points of disagreement with Ms Greeff.

[73.2] Ms Malusi Mokgata, is a Speech therapist & Audiologist who assisted the defendant in assessment of TM. She obtained her degree in 2000 for speech therapy at Wits University. She has about 25 years' experience in her profession. In her work she assesses children with cerebral palsy. She has been compiling medico-legal reports since 2010. She compiles for both the State and law firms. She confirmed her signature in the joint minute. She first saw TM, on 1 September 2023. He was 12 years old when she had a consultation with TM. He had functional difficulties. TM's parents gave information about TM. He has lot of friends. He plays soccer. He attended mainstream schools. He was at grade 6 at the time. He understands most of the things. His parents were concerned he is unable to fasten buttons. He had a level of independence. He attended therapy for 3 months and thereafter was transferred to attend therapy at the local clinic until he was 6 years old. Ms Mokgata explained the summary of her findings and recommendations.

[73.3] Dr S. Ramokgopa. He is a qualified Orthopaedic Surgeon, qualified in 2000. He confirmed he assessed TM in September 2023. He caused x-ray tests to be done. He never diagnosed anything on the spine. No sign of scoliosis was detected by Dr Ramokgopa. He testified no need to make provision for scoliosis for TM in the near future. He confirmed signing joint minute with Dr Close. He confirmed the points of disagreements in the joint minute.

[73.4] Mr N. Mavimbela is an actuary who was instructed by the defendant on costs assumptions for medical and related expenditure on medical items for provision of TM. He explained his assumptions and the difference of his projections than that of his counterparts, Mr Pretorius.

[73.5] Before I continue to briefly deal with the legal principles applicable to general damages, including the provisions required for TM as supported by the evidence led and the expert reports referred to, I wish to note the following.

The legal principles in damages claim

[74] Before dealing with the future medical and related expenses it is important to highlight the general legal principles in general damages claim. It is trite law that the plaintiff bears the onus of proving the damages claim as the merits have already been decided. The approach which has been followed by the courts has been a causal link between a particular damage whereby proof is on a balance of probabilities and once has been proven at 100% or merit conceded, quantum is proven on basis of their percentage probability or possibility.⁵⁶

[75] In this case there are medico-legal reports by experts in different fields, *viva-voce* evidence including the evidence of actuaries led by the respective parties. An expert witness gives his/her opinion on the field of his/her expertise. In some expert reports, when making their own assessments, regarding the needs (both immediate and TM's future) or opinion, they deferred their responses in matters falling outside their own area of expertise.

[76] In determining the damages claim for the plaintiff in this case, evidence of actuary plays a critical role. Two essential actuarial issues for consideration in TM's life expectancy mainly to ascertain what provision to be made for reduction in life expectancy⁵⁷ and the appropriate capitalization rates:

⁵⁶ *De Klerk v ABSA Bank Limited and Others* 2003 (4) SA 315 (SCA).

⁵⁷ In South African law, where (as here) life expectancy is reduced by the injuries in question, future loss (of income; medical expenditure) is determined on the basis of the *reduced* life expectancy. See *Lockhat's Estate v North British & Mercantile Insurance Company Limited* 1959 (3) SA 295 (A) 305-306 and *Singh v Ebrahim* [2010] ZASCA 145 (SCA) paras [143] and further. This is not the approach followed

[76.1] The first one is what provision to make for reduction of life expectancy is concerned both actuaries agreed that as far as the question of Life Table to use as a starting point is concerned both used *Koch's* Life Table 2 as a basis⁵⁸ on which reduction as a result of the injury is superimposed.

[76.2] The second one is the reduction of TM's life expectancy to total survival expected of about 55 years, due to unfortunate brain damage.

[77] The two actuaries did their calculations; the reduction of life expectancy of TM has been applied in their respective reports.

[78] The two actuaries prepared their joint minute⁵⁹ but were unable to reach an agreement on the following:

[78.1] The net discount rate on medical items⁶⁰

[78.2] Which items constitute medical items⁶¹ and

[78.3] Updating of recommendations in joint minutes and underlying reports to current (2025) figures.⁶²

[79] The law is clear that the court is not tied by the actuarial evidence at the end but it has a discretion. However, such a discretion must be exercised Judiciously.

in many comparable jurisdictions, but for the present can be accepted as being the approach in South Africa, the SCA having confirmed this in *Singh*.

⁵⁸ Life Table 2 is in effect the 1984/1986 Life Tables for white persons. According to *The Quantum Yearbook* "[t]he underlying mortality rates for all ages [of Life Table 2] are 100% of those of the SALT 84-86 (white) table".

⁵⁹ Exhibit P Caselines Q95-102

⁶⁰ Mr Mavimbela explained, courts have found that capitalisation rates can range from negative rates to 2,5% (the lower the rate, the higher the ultimate figure). Both actuaries utilised positive rates (i.e. a more conservative approach).

⁶¹ Mr Mavimbela suggested that there were very few medical items per se.

⁶² Both actuaries testified that they had both, in instances where clarity was not provided for in the joint minutes, made assumptions as to what year the recommended costing was based.

[80] The plaintiff has made a proposal to resolve the differences of which was accepted by defendant's actuary expert, Mr Mavimbela. The plaintiff suggested that both Mr Pretorius and Mr Mavimbela testify on these unresolved issues between them would not make a significant difference in terms of their respective calculations. Neither actuary was prepared to suggest that their counterpart's assumptions were incorrect and both testified that when it comes to the disputed aspects contained in the joint minute these are subjective assumptions and opinions, neither of their respective opinions could be faulted.

[81] In my view the plaintiff's proposal is well founded as it is supported in some decided cases⁶³.

[82] In essence the plaintiff put a practical approach with calculations⁶⁴ during cross-examination to Mr Mavimbela (defendant actuary) and Mr Mavimbela agreed that it would resolve the actuarial differences and produce a mean between their opinions:

[82.1] That, the plaintiff utilises Mr Pretorius' Schedule of Medical Expenses⁶⁵ that was provided to court and the legal teams as an A3 document during plaintiff's argument on future medical and related items.⁶⁶ This A3 document has been used throughout the trial.

[82.2] That, when it comes to the issue of future loss of earnings, that the parties

⁶³ Courts have found that capitalisation rates can range from negative rates to 2,5% (the lower the rate, the higher the ultimate figure). Both actuaries utilised positive rates (i.e. a more conservative approach). Positive rates can be considered conservative in light of *Khumalo v Minister of Law and Order 1998 (4) QOD A3-131 (W) A3-166 (negative 4.2%)*, *Fortuin v The Minister of Safety and Security 2007 (5) QOD A3-13 (C) A3-16* (the parties agreed on a positive 1%), *Van Zijl v Hoogenho (CPD) Case No: 9253/99, 25 May 2006*; Griesel J allowed a positive 1%), *Gwambe and Gwambe v Premier of the North West Province* (unreported North West High Court, Case No: 43/2007, 5 October 2010; Gura J allowed a negative 1.5%. See pp39- 42 of the judgment), *Singh and Singh v Ebrahim* [2010] ZASCA 145 (SCA) (26 November 2010, in which the majority agreed on pp29-30 that either no or a slightly negative net capitalisation rate should have been applied in respect of future medical items, whereas the minority spoke on pp81-83 of a negative rate of 3.5%).

⁶⁴ Exhibit "R".

⁶⁵ Exhibit Q.

⁶⁶ This was put into evidence during the Plaintiff's actuary's evidence to be a true reflection of his report (Exhibit "P2").

utilise the underlying pre-morbid figures contained in (a) the calculation of Mr Pretorius⁶⁷ in the amount of R4 828 086.00⁶⁸ and (b) the calculation of Mr Mavimbela⁶⁹ in the amount of R4 355 466.00⁷⁰ in order to account for the difference of the retirement ages (i.e. 63.75 years) and the differences in the underlying assumptions.

[83] The defendant was opposed to this proposal by the plaintiff when parties were presenting oral arguments. Counsel for the defendant referred the court to the case of *NLM v Minister of Health, KZN*.⁷¹ I read this judgment and the cases referred therein. The *NLM* case deals with the contingency in generally in future and medical related expenses. In my view the practical approach suggested by the plaintiff is fair and reasonable. The defendant's expert's Mr Mavimbela conceded under cross examination.

Future medical and related expenditure- case law contingency deductions

[84] The parties referred the court to various decided cases on contingency deductions (or additions) in relation to future hospital, medical and related expenditure. Some courts apply 50% deduction, some 10% and others differentiate. In *AD and IB v MEC for Social Development, Western Cape*⁷² judgment in the Western Cape, 0% deduction was applied.

[85] The plaintiff averred that the South African courts followed different approaches when dealing with contingency deductions in relation to future hospital, medical and related expenditure and categorised them as follows:

⁶⁷ Caselines O-677 to O-686.

⁶⁸ Caselines O-679.

⁶⁹ Caselines P-475 to P-480.

⁷⁰ Caselines P-479.

⁷¹ Case No: 3079/2015 para [45 to [60 in particular para [59].

⁷² Case No: 9257/2017.

[85.1] individualised ranging from zero depending on whatever degree of uncertainty to be accounted,

[85.2] Cases in which no contingency deduction has been applied, because of the lack of uncertainty (or the fact that the odds on the one side were equal to those on the other;

[85.3] Cases involving a 5% contingency deduction across the board;

[85.4] Cases involving a 10% contingency deduction across the board; and

[85.5] Cases involving contingency deductions across the board of higher than 10%.

[86] In the instant case a 5% contingency deduction has been proposed in each and every sub-head of damage relating to future medical and related items in Annexure A of Exhibit P2.

[87]. In line with the decided cases, for items where provision is required to be made immediately, no contingency. In items where provision will be required when TM is 19 years of age, thus, 5 years from now plaintiff's counsel proposes 5% contingency deduction and in items where provision is for 10 years and more the proposal is one of 10% contingency deduction and over and above that percentage deduction an additional 5% is deducted.

[88] The plaintiff's legal team referred to the case of *Van der Merwe v Premier of Mpumalanga*⁷³. where individualised contingency deductions were applied. This is a matter where a prematurely-born girl who was blinded retinopathy of prematurity as a result of negligence on the part of the hospital personnel. Claassen J declined (save in a few instances) the defendant's request to apply a contingency deduction to the

⁷³ 2005 (5) QOD 13-15 (T).

various items of future hospital, medical and related expenditure. In this case a 50% contingency deduction was applied on the basis that the claimant might well in any event have made use of these services. A similar approach was followed by this Court in *Lochner v MEC for Health and Social Development, Mpumalanga*⁷⁴

[89] The cases where no contingency deductions were applied include the matter of *Wessels v AA Onderlinge Assuransie Assosiasie Beperk*⁷⁵ where the court refused to make any deduction, on the basis firstly that the point had never been debated, and secondly that “billikheidsoorwegings” (or ‘fairness’) were against it. In *Van der Merwe & Lochner* case the court also made no contingency deduction where the relevant experts were in agreement on an expense, and where the odds, for example, of the item ultimately being more expensive than envisaged were equal to those of it being less expensive. The same view was followed in the matter of *Mohlaphuli NO v The South African National Road Agency Limited*⁷⁶.

[90] Based on the case law, the facts of this case as well as TM’s life expectancy as stated by Dr Botha (defendant’s life expectancy expert) , a life span deduction of young TM, is suggested as follows:

[90.1] Firstly, probabilities are applied (for example– if there is a 10% chance of occurrence, a proposal has been made to apply 10% probability – or a 90% contingency to that specific recommendation or item).

[90.2] Where a recommendation is required immediately, no contingency deduction is applied (this is for the obvious reason that the earlier the requirement, the less chance of there being an uncertainty as to the need and/or use thereof).

[90.3] Where a recommendation is not for the immediate term, but for a shorter term (for example up until age 18 or 21 years), a 5% contingency deduction was

⁷⁴ [2013] ZAPPHC 388 (27 November 2013 at paras 13 and 14.

⁷⁵ 1989 (4) QOD A3-19.

⁷⁶ 2013 (6A4 QOD 146 (WCC).

applied.

[90.4] Generally, where a recommendation is TM's entire life span, a 10% contingency deduction has been applied.

[100] The defendant had a different view on the abovementioned proposal from the plaintiff, in fact, the defendant is not in favour of the plaintiff's proposed approach. Reliance is placed on the case of *NLM* by KZN Division where other cases like *Singh & AD & Another v MEC for Health, Western Cape Provincial Government*.⁷⁷

[101] Having considered the different approaches in previously decided cases and submissions by the parties, I am of the view that the individualised approach is fair and reasonable. The suggested addition of 5% over and above the individualised items in Annexure A is more advantageous to the defendant.

[102] The fact that those different scenarios have been taken into consideration and the approach suggested is fair and reasonable under the circumstances. All considerations have been taken into account. If one looks at the projections of life span of a young man, TM who is 14 years, the additional 5% which has been applied to all the hospital, medical and related expenditure is fair and reasonable. Some items are due immediately and others will be due when he is 18/19 years of age and others when he is 35/36 years of age and the more he grows some ailments may develop. The proposed 15% is based on the deducted life span of TM with a further 5% where applicable. In *AD and IB v MEC for Health and Social Development, Western Cape*⁷⁸ where Rogers J (as he then was). The learned judge said the following (the case related to a 7 and half year old cerebral- palsied boy):

"...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

⁷⁷ 2016 (7A4 QOD 32 (WCC).

⁷⁸ Supra at page 601 and 603.

reasonable and, if so, its reasonable cost. In regard to time-based interventions, ... I have taken into account what can reasonably be accommodated.... 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....

...

Accordingly, I do not intend to make a general contingency deduction from medical expenses. This is by no means novel....”

The recommendations on each item and the applicable contingencies

The Architects

[103] The Architects, Mr Brummer for the plaintiff and Ms F. Zondi for the defendant, agree that TM needs a house with the specifications to cater for his conditions. This is needed with immediate effect. The property where TM lives is not cerebral palsy friendly. Although both Architects did not visit the house, they interviewed TM's parents. In their joint minute they agreed on the house and the cost of the same. Mr Brummer testified but Ms F. Zondi did not testify. The joint minute of Mr Brummer and Ms Zondi is repudiated by the defendant. The defendant challenged Mr Brummer's expertise in that he is not a quantity surveyor therefore he was not qualified to provide costing of the other items relating to the specificity of the house provision for TM. Mr Brummer's report is contained Exhibit O-545 to O-547.

[104] Although Mr Brummer conceded that he is not a quantity surveyor he possesses the ability and expertise in small projects and alterations. It must be stated from the evidence that Mr Brummer's years of experience dates back from 1986 when he established his own practice. He has been assisting many law firms, about 90, and at times he prepared architectural reports for State Attorney's office. He has vast experience. Although it was put to him that he used cut and paste from previous reports, he stood firm on his evidence that he is able to provide costing. It was contended that some other items were overstated or inflated. Mr Brummer's evidence was not contradicted as Ms Zondi was not called by the defendant. Although there

were some issues being questioned in Mr Brummer's expertise on costing, those were adequately dealt with.

[105] He was extensively cross-examined on the quotes in items at O-545 to O-547, more importantly, provision for TM's helper or domestic room (item on O-546) was for "finishes only" in the amount of R14 200.00.

[106] In items 2 and 3 Notional House additions and alterations for new purchase open land and standard house cost at R511 869.00 and R816 895.00 with 100% probability a zero contingency item 1 (alterations) was applied by the plaintiff's legal team which resulted in an amount of R1 537 649.00 and item 4 (professional architectural fees) is R141 386.00 totalling R1 679 035. Mr Brummer had difficulties in explaining the items like helper's room. On the main, it has been argued that it will not be in the interest of TM, a 14-year old with brain injury, to nullify his recommendations to which I am in agreement.

[107] In an attempt to reduce costs in items 1 and 4 as calculated by Pretorius in the joint minute, the plaintiff's legal team suggested 50% contingency reduction to avoid elongated debate resulting in reducing the figure to R839 517.00.

[108] The plaintiff legal representatives further reduced the said amount by 5% based on the differences between actuaries, Mr Pretorius and Mr Mavimbela, which reduced costs to R797 542. It was contended that this approach is reasonable under the circumstances. I fully agree with this approach. It must be stated that even in the joint minute when Mr Brummer was in discussion with Ms F Zondi, the defendant's expert, he lowered his provision amount for the house. In addressing whatever concerns the defendant has there is a further reduction of 50% with additional 5%. The argument that evidence of Mr Brummer must be disregarded has no merit. Both these experts agreed that there is need for a house for TM.

[109] It should be noted that Ms F. Zondi in her report recommended that TM should be provided a house through the state vehicle of providing houses to the citizens, the challenge with this is, he may be subjected to a long waiting period. The approach adopted by the defendant on this suggesting the provisions made by Mr Brummer should be rejected, if such argument is accepted, a brain damaged cerebral palsied child may end up staying at a sub-standard house where his life may end up being adversely impacted rather than being improved. If I reject Mr Brummer's suggested provision for housing of TM what alternative provision will there be for his shelter? Nothing. It will be irresponsible for this court as the upper guardian of all minor children to ignore the undisputed provision of this child on an issue both experts agreed upon in their joint minute although they disagreed on the modalities. One suggested the state provision of shelter and the other for a house but ultimately both agreed to a house.

[110] The cost for the property and its components which were reduced drastically from R1 689 440.00⁷⁹ to just under R800 000.00 which is not a price of a luxurious property in the city of Johannesburg. However, different views have been addressed by application of a median mean between the experts, where a 50% contingency has been applied catering for point of disagreement. A further 5% was applied, which brought the total costs on this to R797 542.00. My considered view is that it is fair and reasonable.

[111] Having considered both written and oral submissions and evidence presented before me, I am persuaded by the submissions made by the plaintiff on the cost of the Architects. The applied contingency reductions are fair and just. It must be remembered the cost provision by Architect is where the defendant repudiated but only Mr Brummer, the Architect for the plaintiff testified. Ms F. Zondi, Architect for the defendant was not called despite vigorous dispute in Mr Brummer's evidence in costing amongst others that his expertise had been questioned.

The Travel allowance

⁷⁹ Caselines O-545 to O-547.

[112] Concession has been made by the plaintiff that although travelling may be necessary for TM to collect medication and costs associated with that there may be a times when a single trip will be needed to receive both therapy and medication. Mr Pretorius, an actuary for plaintiff, testified that although allowances made by mobility experts relating to costs and maintenance of the vehicles recommended for TM,⁸⁰ those items did not reflect specified rates in accordance with the underlying reports and joint minutes. There was a projection of R150.00 per item. However, the plaintiff's legal team in the spirit of reasonableness decided to leave/omit this item. This is in the spirit of fair and reasonableness and cannot be faulted.

[113] I have inspected these items in Exhibit P2 O-723 and confirm that there is zero costing.

[114] There is 20% contingency deduction on travel to and from the therapists in accordance with Mr Pretorius's evidence, as based on recommendations by various experts' reports based on the fact that there may be a single trip to and from the therapist. In my view that is fair and reasonable.

The Dieticians

[115] The Dieticians, Ms Bruk⁸¹ and Ms Letsoalo,⁸² joint minute⁸³ of underlying reports reflect full agreement. The agreed recommendations contained in the agreed joint minute items 13,15,16,18 and 19 on the actuary's Exhibit Q.⁸⁴ The plaintiff, Ms Moures, testified about TM's eating habits as follows: when he is eating he cannot hold a spoon properly, he struggles to hold a knife when he cuts something and when he is eating he messes himself. As a result he is being assisted when eating.

[116] The plaintiff's legal representatives argued that TM's brain injury has caused

⁸⁰ Items 151,162,166 in O-723.

⁸¹ Exhibit G1 Caselines O—273.

⁸² Exhibit G2 Caselines O-283.

⁸³ Exhibit G.

⁸⁴ Caselines O-720.

difficulties with regards to eating, chewing and swallowing. In paragraph 3 on Q-57 the dieticians record TM's various difficulties and propose their agreed recommendations to manage these difficulties in paragraph 6 on Q-58 (costed in table form on Q-59).

[117] The agreed recommendations are follows:

[117.1] Item 13 (first consultation annually; R36 160.00), item 15 (until age 19; R7 481.00) and item 16 (from 19 years onwards for life; R28 678.00) all relate to dieticians' consultations from now and for TM for life. In this regard:

- (a) Although there is *agreement* between the dieticians as to the *need, the rate and the frequency*, the plaintiff suggested that agreement (and Dr Botha's having already accounted for TM's feeding difficulties by way of a 15% contingency), no contingency deductions ought to be applied to these agreed items.
- (b) The plaintiff's legal team proposed that in relation to line item 13 (annual first consultation), no contingency deduction ought to be applied but 5% be applied to line item 15 (sessions until age 19 years) and a 10% contingency applied to line item 16 (sessions from 19 years for life).
- (c) This results, as per Exhibit "Q", in a figure of R36 160.00 (item 13), R7 104.00 (item 15) and R25 811.00 (item 16), which after deduction of the relevant contingencies results in a figure of R69 078.00 for these items.

[117.2] Item 18 (nutritional supplement; R229 371.00) and 19 (multivitamin; R55 049.00) relating to the agreed provision for nutritional support. The same approach on individualised contingencies for lifelong provision. The plaintiff's legal team has applied a 10% contingency deduction resulting in a figure for nutritional support in the amount of R244 977.00.

[117.3] In respect of item 18, namely the travel allowance contained in Schedule “Q” the plaintiff’s legal team contended that it decided to omit / discard the travel allowance associated with the collection of the nutritional supplements (R41 812.00) out of account, and utilised only the costs of travel associated with consultations (item 13 – R3 719.00; item 15 – R1 986.00; and item 16 – R10 581.00). Once again, those items have already been reduced by 5% and a 10% contingency deduction applied to these consultations which results in a figure of R10 996.00.

[117.4] As reflected in Schedule Q (the medical and related expenses Schedule) the plaintiff’s legal team reduced the combined underlined figures above (in the amount of R336 051.00) by an additional 5% in order to account for these differences (i.e. application of the median between the actuaries), resulting in a figure of R319 248.00.

[117.5] All in all and with all the contingency reductions in different items from the dietician reports the plaintiff proposes the figure for TM’s nutritional needs caused by his brain damage amounts to R319 248.00. The plaintiff’s legal team contended that the figure is fair and reasonable.

[117.6] Counsel for the defendant argued for reduction of R10 996 although a concession was made that is a minimum reduction that will not make a difference

[118] After having considered evidence and arguments, the amount of TM’s nutritional needs after application of 5% contingency reduction is fair and reasonable. I am in agreement with the plaintiff’s legal team that the amount of R319 248.00 after contingency reduction is fair and reasonable to cater for TM’s nutritional needs.

The dentists

[119] There is no dispute when it comes to the dentistry costs. The figure relating to dentistry is calculated to the amount of R558,715.00. In addition to this, the plaintiff's legal representatives applied the 5% contingency reduction to the total of the underlined figures (558,715.00) which brings the total to R530,778.00. I agree that the figure is not fair and reasonable.

[119.1] The evidence relied upon, is dentist's joint minute Exhibit N⁸⁵ and underlying reports of Dr Ballyram⁸⁶ and Dr Makobe-Chiloane⁸⁷. The items relating to the recommendations contained in the dentists' joint minute and their underlying reports are line 26 to 32; 35 to 38, 41 to 52, 55 to 66 and 69 to 77 (Dr Ballyram) and line items 83 to 85, 87, 89 to 90, 92 to 94, 96, 98 to 101, 103, 105, 107 to 110, and 112 to 122 (Dr Makobe-Chiloane).⁸⁸ Although there are disagreements on the joint minute of dentist, the parties agreed to take the median of the dentists in the event of differences between their opinions. Therefore, none of the parties called a dentist, although the plaintiff states that they had reserved Dr Ballyram to testify.

[119.2] There is quite a number of items covered by the experts on this filed, spanning from line item 26 to 122 the figure in those items total the amount of R 538,937.00.

[119.3] The travel costs to and from various consultations of which there is a total of 6 items relating to travel, and all those allowances have been reduced as per contingencies. The plaintiff's legal team has omitted claims for travel as appears to line items 27 to 32 (preventative home hygiene) with a cost value of R17,521.00 which leave the remaining five items, travel allowance associated with consultations and/or dental procedures with a total amount of

⁸⁵ Caselines Q-24 to Q50.

⁸⁶ Caselines (O-189 to O-22) Exhibit N1.

⁸⁷ Caselines P-304 to P-339 Exhibit N2.

⁸⁸ Exhibit Q Caselines at O-721 to O-722.

R19,778.00. The said figures have been aligned with actuarial mean by applying 5% reduction to the total of the underlined figures above R558,715.00. With effect of contingency reductions results to the dentistry figure of R530 779.00.

[120] The defendant's legal team conceded that TM will require dental treatment which will come at a cost. However, it was argued on behalf of the defendant that a reduction of R19 778.00 from the total of R530 779.00 should be applied.

[121] Having considered the arguments by both parties and considered the evidence I am persuaded that the applied contingency reduction of 5% to the projected amount of R558 715.00 which resulted in the amount of R530 779.00 is fair and reasonable. The duplication of costs to and from collection of TM's medication has been eliminated. Various contingencies ranging from 0% to 20% depending on the item have been applied.

The educational psychologists

[122] On this item reliance is placed on the joint minute⁸⁹ of two experts, educational psychologists, Dr van der Ryst⁹⁰ and Dr Prag⁹¹. The two experts are in full agreement in their recommendations as contained in their joint minute items 130 - 132 and 142 on the Schedule for Future Medical Expenditure⁹². With regards to the recommendations of the two educational psychologists amongst the issues of contestation is one in relation to the recommendation, with TM's admission at Hope School.

⁸⁹ Exhibit K Caselines Q-73 to Q-77.

⁹⁰ Exhibit K1 Caselines O-45 to O-66.

⁹¹ Exhibit K2 Caselines P-39 to P-84.

⁹² Exhibit Q _O -722 and O-723.

[122.1] The plaintiff testified that herself and her husband are unemployed and cannot afford school fees at Hope School. TM has passed grade 7 at Steve Ramoba Primary School where he studied his early stages of his life. Hope School is a fee school where TM will have to complete his further education. She said she cannot afford school fees and the travel to school costs about R600.00. per month? In cross-examination it was put to her that she can utilise TM's social grant, and she responded that the social grant money is used for TM's food and other needs and cannot be utilised for travel. It was further put to her that Hope School provides bursaries to children and in fact a bursary application form was given to her, but she never returned same to school.

[122.2] The recommendations by the two educational psychologists for Hope School (also referred to as LSEN) are in item 130 (tuition fees) where the total amount is R152,764.00 and 131 (aftercare) R79 620.00 and item 132 (hostel) R159, 727. Items 142 relates to the equipment of educational psychologist's report for the application (R11 242.00).

[122.3] Since, TM's parents are unemployed, the plaintiff's legal team has suggested that since the process of the payment of the awards would take months before it is finalised and since TM's parents will continue to be unemployed TM will not be able to afford school fees at Hope School and is more likely to only commence school in 2027. It was further contended in those items highlighted above zero contingency deduction will apply with the understanding that Hope School has actually guaranteed a schooling position/placement at that school. Therefore, in items 130 to 132 a full amount allowance in the amount of R392 117,00 where item 142 is also added with an amount of R11 242.00.

[122.4] Attending Hope school TM will require money for traveling to school, he will be transported to Hope School on Monday morning and be picked up on Fridays as there is a possibility that he will stay at the boarding school if admitted at Hope School. As per the evidence of TM's mother where transport costs of

R600.00. Considering the two-way trips to school and back home on Fridays, Mr Pretorius, actuary for the plaintiff, has suggested an amount of about R1000.00 per two-way-trip to and from school. TM will be transported by a dedicated transport to school as per mobility experts. A suggestion in the amount of R389 525.00 was provided. In the amounts to cover costs of items 130, 131, 132 and 142 with a cumulative amount of R793 172.00 was reduced by 5% to align with the agreed actuarial mean which resulted in a figure of R753, 513.00.00. The plaintiff argues that the said amount of educational needs is fair and reasonable.

[122.5] The defendant argued that the school fees at Hope School as stated is far less than the amount suggested by the plaintiff's legal team. When the plaintiff was giving evidence, it was put to her that witnesses from Hope School, Miss Lindelwa Madonsela, School principal, will be called to testify as well as Ms Babalwa. The latter was to be called to testify on the issue of the bursary application form which was said to be given to the plaintiff, but she (the plaintiff) never returned the application. However, the said witnesses were not called but a document which shows TM's name on the school register was handed in as an Exhibit, but his absence is recorded on the attendance register at Hope School.⁹³ No evidence was presented to show how much less school fees are at Hope School. The issue of a sponsored entry in the form of a bursary for TM at Hope School will be for at least around 2027 and even then, costs of transport to and from school fee will not be covered by his disability grant. It is common knowledge that Hope School is not a free fee school. Therefore, the suggested costs for TM's educational needs are justified and both experts agree that there is a need for provision of same.

⁹³ Exhibit "S" This document is an application form which was signed by T's parent which she applied for space of T at Hope School. The attendant register is attached thereto where T's name appears albeit shows that he never attended school.

[123] Having heard evidence and the underlying reports of Dr Prag and Dr van der Ryst as well as their agreement in their joint minute, which is not disputed, I am of the considered view that the plaintiff's legal team proposed amount for TM's educational needs after considering the actuarial mean of 5% an amount of R753, 513.00 is fair and reasonable. TM's disability grant of R2 310.00 per month would be insufficient to cover TM's monthly travel to and from school (as per plaintiff evidence R600 per trip (R2,400.00). TM has to eat and be clothed, and all his other needs must also be taken care of.

The mobility experts

[124] The evidence on this aspect can be found at the joint-minute⁹⁴ of two experts, Mr Rich⁹⁵ and Ms Milne⁹⁶ and their underlying reports. There is full agreement in their joint minute. The agreed recommendations by both experts are contained in the Exhibit Schedule,⁹⁷ Exhibit Q at line items 150, to 152, 155 to 157, 161, 163, 166 to 167, 171 to 173 and 176 to 177. The plaintiff's legal team suggested a situation where TM would own a vehicle which will cater for his needs and what quality of expense would it be. The provision for this eventuality is catered for at items 171 to 173, a 30% of pre-morbid TM having owned a vehicle to which mobility experts agreed. The argument put which is valid is that at the age of 6 (pre-morbid) TM would not have owned a vehicle. As a result of this the plaintiff's legal representatives proposed a reduced figure of R190 049.00 for items 171 to 173 is suggested.

[124.1] The Items 150 (dedicated vehicle at a cost of R194 141.00) 151 (annual running costs of R53 630.00); and item 152 trade-in (R74 079.00) are for a vehicle in the next 6 years then trade-in. In that scenario it has been suggested by the plaintiff's legal team that item 151 be reduced by 20% overlap with the travel allowance, which results in the amount of R42

⁹⁴ Exhibit B.

⁹⁵ Caselines Q-86 to Q-88, Exhibit B1.

⁹⁶ Caselines P-140 to P-218- Exhibit B2.

⁹⁷ Exhibit Q page 4 line 150 to 177.

904.00. Now because the cost items 150, 151 and 152 may overlap, such costs have been reduced further to R162 966.00. The amount of R162 966, is made up by adding R194, 141 (Item 150 (dedicated vehicle value) plus R53 630.00, (Item 151-annual running costs) less 20% it equates to R162 966.00. From the age of 14 year to 20 years, it is unlikely that TM would have been able to own a vehicle. However, when looking at around 22/23 years (pre-morbid) as per Industrial psychologists' postulations⁹⁸ TM would have been earning below minimum wage which means that it is unlikely that he will be able to afford a vehicle at that age. A 30% probability has been applied by plaintiff's legal team where a provision for pre-morbid vehicle is made. This means that before deduction of the pre-morbid vehicle allowances an amount of R162 966.00 was provided.

[124.2] In the next 12 to 13 years which is when TM is about 35/36 years old, the costs are contained at item 155 (dedicated vehicle – R296136.00); 156 (annual running costs- R59 795.00) and item 157 (trade-in costs at R81150.00. The plaintiff's legal team has reduced the trade in value at item 157 from some of the items 155 and 156 (less 20% deduction for the travel allowance which equates to the amount of R262 822.00.

[124.3] A scenario is also drawn where TM at pre-morbid plausibility for him having owned a vehicle, and costs associated with it. The industrial psychologists make a postulation that TM would have reached grade 12. In the joint minute of the industrial psychologists⁹⁹, at about 26/27 years of age TM will be at a salary level of A3-B1, lower quartile (R155, 519.00 per annum or R12,959.00 per month). At about 30.5 TM would have progressed to median Paterson B2/B3 (R303 947.00) per annum or R25 328.00 per month). At an estimated vehicle value of R200 000.00 excluding insurance,

⁹⁸ Caselines Q-91: Joint minute of Mr A Lamprecht and Dr LM Tabane.

⁹⁹ Caselines Q-92.

the estimated monthly instalments of about R3 500.00 to R5 000.00. It is argued, correctly so in my view, that it is unlikely that TM would have been able to afford such a reliable vehicle or a loan to purchase a vehicle for such an amount. At pre-morbid it is suggested that TM would be able to buy a vehicle at a third of the cost of this vehicle and plaintiff is proposing a 30% contingency deduction.

[124.4] When looking at TM at the age of 35/36 years onwards, mobility experts suggest two options: (i) same as above, if TM were to remain fully mobile as in line item 161 (dedicated vehicle- R273 435.00; 162 (annual running costs- R51 205.00 less 20% = R40 964.00 and item 163 (trade-in – R63 263.00 (total 251 136.00. Option (ii) his physical condition may deteriorate, and a wheelchair may be required, items 166 (dedicated vehicle R830 787.00, item 167 (annual running costs- R74 247.00; less 20% = R59 398.00; Item 168 (trade in- R295 000.00 and item 169, (adaptations for wheelchair - R328 841.00 total R923 996.00 which is calculated at O-723.00.

[124.5] Based on the above, and the uncertainty of TM's future life prospects, the plaintiff's legal team contends that his life will most likely deteriorate and his life expectancy has been reduced at about 25% from those of general population and as occupational therapist has projected that at about the age of 35/36, he will most probably need a wheelchair. With the probabilities even matched with the possibility for TM being mobile or immobile a median of option 1 and 2 has been suggested for utilisation. An application of 50% contingency deduction has been suggested by the plaintiff's legal team in items 161 to 163 (option 1) and items 166 to 169 (option 2) resulting in the median between the two options. A further contingency deduction of 10% has been suggested which resulted in a figure of R533 828.00.

[124.6] The plaintiff's legal representatives when dealing with TM pre-morbidly, noted correctly that TM would likely not have owned a vehicle at the age of 6 but say in the spirit of reasonableness a 30% deduction in item 171 to 173 which account for R190 049.00 deducted from the underlying figures which equals R769 567.00. This figure appears when one considers / focuses on Schedule Exhibit Q¹⁰⁰ at page 5. Items 176 and 177 which are alternative dedicated transport, have been left out of account.

[124.7] Furthermore, to cater for actuarial differences a 5% contingency deduction in the amount of R769 567.00 results in a figure of R731 089.00 is suggested to be a fair and reasonable figure for compensation for TM's mobility needs and is fully justified.

[125] The defendant when arguing on the mobility aspect contended that Mr Mavimbela, actuary for the defendant referenced to alternatives whereas plaintiff referred to probabilities where pre-morbid would have been earned. Furthermore, the defendant contended that from the joint minute there is an overlap and alternatives are proposed. The defendant suggested that an amount of R59 759.00 should be deducted from R731 089.00. It is not clear how the said figure(R59,759.00) has been calculated. I am not persuaded that it should be deducted in the absence of evidence to the contrary as proposed by the plaintiff's legal representatives.

[126] Having considered the arguments by counsel for both parties, and joint minute of mobility experts, and underlying reports as well as actuarial reports and their joint minute, I am persuaded that the figure of R731 089.00 is fair, just, not inflated and evidence based. As indicated both actuaries are experts and I have no reason to doubt or to prefer the evidence of one over the other. In cross examination by plaintiff's counsel Mr Mavimbela conceded that median way can be found by applying 5% contingency to address any difference in opinion of Mr Mavimbela and Mr Pretorius.

¹⁰⁰ Exhibit Q page 5 with the totals.

The overlapping has been addressed, items 176¹⁰¹ (alternative dedication of own transport until 18 years of age for allowance until 2029 - R122 025.00¹⁰²) and item 177¹⁰³ alternative to dedicated own transport, for life R261 993.00¹⁰⁴ have been left out of account to avoid any possible duplication. The postulations by the Industrial psychologists regarding the earning levels pre-morbid have been considered. It is important to note that the joint minute of these experts was not disputed.

The paediatric neurologists

[127] On this sub-head of damages, reliance is placed on the joint minute¹⁰⁵ of Dr A. Keshave¹⁰⁶ and Dr P.Z Mteshane¹⁰⁷ which were handed in as exhibits. Various recommendations are contained in the Schedule of Future medical expenses also known as Exhibit Q¹⁰⁸ at line items 184, 185, 187, 188, 189, 192 and 195 and same can be found at Exhibit Q at O-723 to O-724. The defendant wished to call Dr Mteshana, but she was not called when the plaintiff admitted recommendations in her report, i.e. in that where her (Dr Mteshana)'s recommendation/s in her report differ/s to the one of the plaintiff's neurologist, Dr Keshave, plaintiff's legal team admitted Dr Mteshana's report on its entirety.¹⁰⁹

[127.1] With regard to neurological consultations, the accepted provision as contained in item 185 made provision for an amount of R122 489.00 whereas Dr Keshave¹¹⁰ who provided an amount of R341 195.00, Dr Mteshana's provision¹¹¹ was accepted by the plaintiff's legal team. A 10% contingency

¹⁰¹ Exhibit Q at page 4.

¹⁰² Schedule of Future Medical and related expenditure- also referred to as Exhibit Q, page 4 lines 176.

¹⁰³ Exhibit Q, page 4.

¹⁰⁴ Schedule of Future medical expenditure also referred as Exhibit Q, page 4 item 177.

¹⁰⁵ Exhibit C, Caselines Q70-Q-72.

¹⁰⁶ Exhibit C1 O- 584 to O-594.

¹⁰⁷ Exhibit C2 Caselines P-95 to 104.

¹⁰⁸ Exhibit Q at page 5 lines 184 to 195 as well at O-723 to O-724.

¹⁰⁹ The plaintiff qualified this by stating that it was admitted that neurologist services is provided at Chris Hani Baragwanth Hospital.

¹¹⁰ Exhibit Q page 5 item 185.

¹¹¹ Exhibit Q line item 184, page 5.

deduction was applied since the provision is for lifelong resulting to an amount of R110 240.00.

[127.2] The recommendation relating to behavioural and sleeping disturbances are contained at item 187 to item 189¹¹². In the joint minute,¹¹³ both paediatric neurologists agree to TM's 30% of lifelong behavioural disorders such as self-injury and aggressiveness. As a result of that the plaintiff's legal representatives have made suggestions hereunder:

[127.2.1] Although TM is not currently suffering from sleep pattern impairments but same is projected in the near future, a 50% contingency reduction has been applied by the plaintiff's legal team to the recommended medication, namely Melatonin at item 187 with a cost of R301 856.00. Over and above that the plaintiff adds further 10% contingency deduction results to the amount of R135, 835.00.

[127.2.2] On the medication called *Risperdal* item 188 with an amount of 301, 856.00, the plaintiff's legal team has applied 30% probability where both paediatric neurologists agree on probability, 70% contingency deduction has been applied by the plaintiff and a further 10% contingency deduction resulted in an amount of R81, 501.00 for this item.

[127.2.3] On the items which relate to blood test and goes hand in hand with *Risperdal* (item 189 with a probability of 30% and a further 10% contingency deduction to the amount of R19,967.00 and a further reduced figure of R5,391.00.

¹¹² Exhibit Q page 5.

¹¹³ Caselines Q O-70.

[127.2.4] Both experts agreed about the need for oral baclofen (item 191 with a cost of R588,620.00 and Botox injection (item 192) costing R4, 658 915.00 for TM's spasticity and dystonia. Although the plaintiff's legal team was of the view that no contingency should be applied but anyway 10% contingency deduction was applied which resulted to a figure of R4,722,782.00.

[127.2.5] As for the recommendation contained in item 194 (MRI) an amount of R55,470.00 and (item 195) x-rays of the hips and spine with a cost of R79, 867.00. Both experts agreed on a need for this medication from age of 15 years. The plaintiff's legal team applied 5% contingency deduction resulting in a figure of R52,697.00. On this item the plaintiff's legal representatives decided not to allow it and there is nil.

[127.2.6] With regard to the travel allowance contained in Schedule Q also reflected at item O-723 and O-724 in items 185 (consultations, R4, 441,00.); 192 (Botox injection course; R29 820.00) and 194 (MRI) R274.00. The plaintiff's legal team argued that the contingency deduction to those items which have already been applied in the underlying items have already been applied by the actuary to travel related travel totalling an amount of R34 334.00.

[128] A 5% contingency deduction in respect of all the above in order to cater for the differences and actuarial mean has been allowed resulting in a figure of R5,142 980.00 which was reduced to R4, 885 831.00.

[129] The defendant argued that costs associated with sleeping disturbance and behavioural disorder amount to duplication of costs as this is covered in costs associated with psychiatrists' treatment. With regard to costs associated with Botox, the defendant's legal team argued that such service is available at CHBH. It was further argued in the alternative, that a 10% contingency deduction on Botox injection treatment

is very low and no indication whether the treatment is with immediate and a 20% contingency deduction was suggested by the defendant's legal team.

[130] I have considered the evidence presented and arguments regarding TM's paediatric neurology treatment. I raised my concern with counsel for the plaintiff on the costs associated with Botox which costs a lot, i.e. over 4 million rand is someone is looking at such a cost it will consume a lot from the fiscus to be spent on a single item, to service one individual. It was argued that based on the experts report this is an expensive therapy. I have fully considered the submission by defendant's counsel regarding the alternative of getting the Botox services at CHBH. However, the plaintiff has testified that she was referred to a doctor at CHBH where TM was going to receive Botox treatment but on arrival there, she was told she should return on another day. Upon her return she was turned away. Any possible duplication regarding travel to get treatment associated with neurology treatment has been taken into consideration.

The Orthotists

[131] This item is addressed by evidence of the underlying reports of the Orthotists, Mr Du Plooy¹¹⁴ and Mr Louw¹¹⁵ as well as their joint minute¹¹⁶ handed in as Exhibits. Both Mr Du Plooy and Mr Louw agreed in their recommendations as recorded in their joint minute dealing with items 203, 205, 206, 212, 126 and 217 reflected in the Schedule for medical expenses.¹¹⁷

[131.1] Item 203 deals with measuring, casting fitting and follow-up appointments. The plaintiff has suggested the cost of R545 605.00 for this item.

[131.2] Item 205 (Neuro Swing System Ankle Joint including AFO shoes) and item

¹¹⁴ Exhibit L1 Caselines O-223 to O-257.

¹¹⁵ Exhibit L2 Caselines P-272 to P-284.

¹¹⁶ Exhibit L Caselines Q-60 to Q64.

¹¹⁷ Exhibit Q page 5.

206 (seamless, ankle-free socks with moisture-wrecking). These items relate to TM's right foot inversion that requires urgent rectification. Item 203 costs R1 065 198.00 and item 205 costs R85 880.00. No contingency deduction is applicable on those two items as they are required immediately.

[131.3] Items 209 and 210 relate to the agreed recommendations for provision of custom foot orthotics. Item 209 relates to skeletal orthotic device with a cost of R27, 319.00 and item 210 also orthotic device to be started with after the age of 18 for life with a cost of R363, 879.00 on the latter amount is the total after 10% contingency deduction.

[131.4] Item 213 is an orthotic device called SPIO garments at a cost of R381 689.00. The experts say this SPIO garments will be beneficial and enhance postural control, balance and co-ordination. A 5% contingency deduction has been applied to the cost associated with this item resulting in a total of R362 604.00.

[131.5] Items 216 and 217 relate to wrist hand orthosis for both hands in order to reduce possibility of developing permanent flexion contractures¹¹⁸. The costs associated with the devices in item 216 is R12 729.00 whereas item 217 is said to be costing R47 137.00. Since the orthotic device on item 216 is applied until the age of 18 no contingency deduction has been applied whereas on item 217 a 10% contingency deduction has been applied due to the fact it is lifelong from the age of 18. This means item 216 costs R12 729.00 and item 217 after 10% contingency deduction gives a total of R42 424.00.

[131.6] Since Mr Pretorius (plaintiff's actuary expert) has made provisions for items 203, 206, 209 and 210 with regard to transport costs, the plaintiff contended

¹¹⁸ Caselines Q-63.

that the only travel costs relating to item 203 where transport costs should be provided. The amount associated with this is R58 904.00.

[131.7] In all costs associated with orthotics devices the plaintiff also applied 10% contingency deduction in an amount of R2 566,513.00 resulting to the reduced amount of R2 438 187.00.

[132] The defendant has argued that since it was conceded by the plaintiff that orthotics services are available at CHBH there is no need for provision of these services on the plaintiff's claim. This was an alternative argument in the event that I find that a case has been made on the defendant's public health care defence which was dealt with above. The defendant has argued that transport costs as suggested by the plaintiff, are incorrect.

[133] I have considered evidence presented from the underlying reports and joint minute by Mr Du Plooy and Mr Louw (orthotists) and the assumptions by actuary referred to on this item (Orthotic services). I am of the view that the costs for orthotist services required for TM is justified. The defendant's argument that these services are available CHBH and are accessible may be the case. However, it was incumbent upon the defendant to lead evidence that orthotist services provided at CHBH are of similar standard or better than those rendered at private health care facilities. The contingency deductions (on costs associated with orthotist services) where applicable, are fair and reasonable. The possibility of duplication of travel costs has been addressed, for only travel costs in item 203 is included. On other items listed above, which relate to orthotists treatment travel costs are excluded.

The orthopaedic surgeons

[134] The orthopaedic surgeons, who prepared assessment reports for TM testified in these proceedings. Neither party questioned the expertise of these orthopaedic surgeons. It is common cause that both these witnesses assessed TM at about three

months apart, Dr VW Close on 1 June 2023 and Dr Ramokgopa on 13 September 2023. I will deal with their evidence interchangeably. I am satisfied that both Dr VW Close (for the plaintiff) and Dr Ramokgopa (for the defendant) are qualified experts based on their qualifications and their respective experience which were placed on record. Both experts compiled assessment reports¹¹⁹ regarding TM's orthopaedic surgical needs both in the medium and long terms. The joint minute¹²⁰ signed by both Dr Close and Dr Ramokgopa was handed up as Exhibit S and the assessment report by Dr Close was marked Exhibit S1 and that of Dr Ramokgopa as Exhibit S2. The differences in their assessment will be highlighted below. A reference is also made to the "Schedule of Future Medical Expenses" documents named Exhibit Q pages 1 to 14 and its similar line items in actuary joint minutes Exhibit P2¹²¹ referred hereto.

[134.1] Dr Close's recommendations on TM's orthopaedic treatment and interventions are listed at items 226, 228, 231, 233, 235, 236 and 238. The costing of orthopaedic surgeon on items recommended by Dr VW Close can be found in O-724 to O-725. Her counterpart, Dr Ramokgopa, made no treatment recommendations for TM either presently or in the near future.

[134.2] Both these experts testified and were cross-examined and the differences in their reports were tested when they gave evidence. Although Dr Ramokgopa described gross motor functional classification system (GMFCS) of TM as at Level I whereas a number of other clinicians who assessed and/or examined TM described TM's GMFCS Level II, the plaintiff's legal team did not argue that the court should make a credibility finding against Dr Ramokgopa in respect of his experts testimony including Dr Ramokgopa.

[134.3] It was argued on behalf of the plaintiff that Dr Close thoroughly explained her recommendations as experienced cerebral palsy orthopaedic surgeon. I was

¹¹⁹ Dr CVW Close Caselines O-165 to O-186 and Dr Ramokgopa Caselines P-265 to P-271.

¹²⁰ Caselines Q-65 to Q-68.

¹²¹ Caselines O-705.

also further contended that Dr Ramokgopa made an incorrect diagnosis regarding the functioning of TM's lower and upper limbs and argued that his assessments as reflected in his report was non-specific. He (Dr Ramokgopa) conceded in cross-examination that, although he made no provision there may be areas he could have made provisions, probability vis-a-vis possibility. In an attempt to resolve this, the plaintiff's legal team argued that they would not argue that Dr Ramokgopa conclusions and recommendations were incorrect, but instead suggest taking the mean of all Dr Close's recommendations (percentage of occurrence) deducting 50% to align it with the median of her recommendations and Dr Ramokgopa's non recommendations. This is done for the sake of reasonableness, the plaintiff contended. The costs of orthopaedic expenses are dealt with below:

[134.3.1] Item 226 is surgical stabilization of scoliosis observed by Dr Close during her clinical examination of TM on 1 June 2023, which was confirmed by Dr Both (Dr Botha confirmed presence of mild scoliosis on TM), a life expectancy expert for the defendant. This has a cost of R329,325.00. Dr Ramokgopa who examined TM on 13 September 2023 did not diagnose scoliosis on TM. The plaintiff's legal team argued that there is credence to Dr VW Close's evidence. Based on the evidence which support Dr Close there is a 10 % probability of surgical procedure for stabilization of scoliosis, but despite that possibility it was suggested to half that to 5% chance and further apply 10% contingency deduction resulting at a total reduced by R14, 820.00

[134.3.2] Despite Dr Close recommending bilateral forefoot surgery (item 228) at a cost of R341,796.00 to be performed when TM is 15 years of age but Dr Ramokgopa testified, he (Dr Ramokgopa) did not see any concern relating to TM's toes. The plaintiff's legal representatives argued that they are prepared to take mean between these two experts and apply 50%

contingency and add 10% contingency deduction this reduced cost of the item 228 to R153,808.

[134.3.4] Dr Close testified that cerebral palsy children like TM may require surgery to be performed at 20 years of age. She recommended bilateral adductor tenotomy (item 230) to be performed on TM when he is at the age of 20. This has a cost of R208 172.00. Dr Ramokgopa only notes that he saw TM has some difficulties with hip flexion of which there will be no need for an operation. Due to the fact Dr Ramokgopa not having observed what Dr Close diagnosed there is 10% possibility, but the plaintiff's legal team will half it by 5% instead, which brings down the cost for item 230 to a total of R9, 368.00.

[134.3.4] Dr Close made a provision for a small chance of a bilateral adductor tenotomy when TM is at about 30 years of age. This is item 231 with a cost of R170, 057. With 2% probability this has been halved by 1% and apply 10% contingency deduction, reducing costs to R957.00.

[134.3.5] According to Dr Close, 10 % chance of tendo-achilles gastrocnemius lengthening (item 233) with a cost of R208,172.00. Dr Ramokgopa disagreed. Due to this disagreement the plaintiff's legal team proposed to reduce 10% to 5% (creating a median) and apply a 10% contingency deduction resulting in a reduced figure of R9, 368. 00.

[134.3.6] In item 235 and 236 Dr Close made recommendations for minor injuries and surgery in case TM falls and sustain an injury. Dr Ramokgopa made no such provision although under cross-examination conceded that TM was more prone to falling and sustaining injuries. Dr Ramokgopa in his assessment report recorded a fresh injury to TM due to falling and Dr Botha reduced TM life expectancy amongst other things for falling being an eventuality. Dr Ramokgopa even when pressed with questions as to

the slight possibility of TM falling, he maintained that falling would not happen and will not result in bone fracture. In fact, Dr Ramokgopa made no provision for TM injuring himself even when that age was postulated at 40 years. As a result of the two differences, which is 50% probability (i.e. median) of occurrence or not according to Dr Ramokgopa and 10% contingency deduction to these items resulting to totals of R10, 382.00 (item 235) and R192, 834.00 (item 236).

[134.3.7] Dr Close has given a globular amount for TM's lifelong management (item 238) with an amount of R807, 502.00. Dr Close in her evidence in chief stated that there were some overlaps in respect of therapies for TM, consultations and monitoring TM's scoliosis. Due to Dr Close concession of some overlaps, she proposes a 50% probability a 50% contingency deduction has been applied occasioned by Dr Ramokgopa's non recommendations, resulting to R201 876.00.

[134.3.8] The plaintiff's legal team argued further that when one looks at the travel allowances by Mr Pretorius, the significant contingencies as well as median and further contingency described above, and other various allowances all combined gives a total amount of R664.00.

[134.3.9] Furthermore, it was argued on behalf of the plaintiff that for the sake of aligning the actuarial calculations of Mr Pretorius with the mean between the actuarial differences they apply a 5% contingency deduction to the total of the underlying figures contained above (R594, 075.00 minus 5% contingency deduction of the said amount gives a total of R564,372.00.

[135] The defendant's legal team disagrees with the argument by counsel for the plaintiff. The defendant contended that the court should reject Dr Close's report and accept the report of Dr Ramokgopa. It was contended that Dr Close's recommendations on scoliosis, and issue of deformity is not supported since other

experts who assessed TM did not make diagnoses of scoliosis. The defendant argued that the court should accept Dr Ramokgopa's evidence.

[136] I have considered the evidence of the two experts; the underlying reports and their recommendations or lack thereof in their joint minute on this head of damages, the dispute on scoliosis diagnosis is not far-fetched. Dr Botha, life expectancy expert instructed by the defendant, is mentioning the existence of mild scoliosis in his report. There are several clinicians who mention the presence of scoliosis. I agree with the plaintiff's legal team that there is need for provision of scoliosis surgery for TM in the near future. The approach adopted by the plaintiff's legal representatives in applying median contingency deduction to cater for the dispute by Dr Ramokgopa is justified to cater for the differences in their diagnosis and recommendations.

[136.1] Dr Ramokgopa disputed Dr Close's evidence regarding the results of x-rays which were done three months apart in June and September 2023 respectively. However, under cross-examination Dr Ramokgopa conceded that he was not present in the room where TM's x-rays test was conducted and did not see the position of the patient (TM) when the x-ray test was conducted, therefore the possibility exist that when TM's x-rays test was done he (Dr Ramokgopa) was not in a position where he could be able to observe it. There is a possibility that scoliosis surgery by a Spinal Surgeon may be conducted on TM in the near future. The 10% probability of this happening divided by two as there were two diverse opinions of these two experts resulted to a 5% instead of 10% and further reduced by a 10% contingency deduction as this surgery is not going to be done immediately. The provision for this for such possible surgery was reduced from R329, 325 to a mere R14,820.00. This median in between Dr Ramokgopa and Dr Close on probability and a further 10% contingency deduction is fair and reasonable. This is based on evidence led.

[137] In essence I am of the considered view that the calculated figure of R 564 372.00 after deduction of 5% contingency for TM's paediatric surgery is fair, reasonable and not inflated and based on evidence. The argument that I must reject Dr Close's testimony has no merit. I am not prepared to accept recommendations of one expert and reject the recommendation of the other. The disagreements between these experts are catered for in the contingency applied on the provisions for TM's future orthopaedic surgical treatment.

The occupational therapists

[138] The occupational therapists, Ms Greeff, occupational therapist for the plaintiff and Ms Radzuma on instruction of the defendant testified. Both Ms Greeff¹²² and Ms Radzuma¹²³ assessed TM and compiled assessment reports with recommendations. They signed a joint minute which was also handed in as Exhibit¹²⁴. Ms Greeff and Ms Radzuma's qualifications as experts are not in dispute. Both experts placed their qualifications and expertise on record. I accept that both are qualified occupational therapists based on evidence placed on record regarding their educational qualifications, experience and expertise respectively. I will deal with their evidence interchangeably. The evidence of these witnesses is highly contested with regards to their recommendations to TM's occupational therapy needs. There are agreements and disagreements regarding their recommendations which will become clear in the paragraphs below. The plaintiff's legal team argued vigorously that Ms Radzuma's evidence should not be accepted, pointing to certain discrepancies and to put it more strongly, that she tailored her evidence to the defendant's legal team. I will deal with items of agreement followed by those items of disagreements and indicate which is reasonable and why.

¹²² Exhibit D1 -Caselines O-19 to O-44.

¹²³ Exhibit D2 Caselines P-239 to P-264.

¹²⁴ Exhibit D at Q-78 to Q-75.

[139] Before I deal with evidence of the two experts I need to comment as to what is expected on the evidence of an expert witness as it has been done in previous cases and as stated in legal literature:

[139.1] In *Rondel v Worsley*¹²⁵ Lord Morris of Borth-y-Gest described the court process as follows:

“It is desirable in the public interest that a case in court should be regarded by all concerned as being a solemn occasion when the utmost endeavour is being made to arrive once and for all at the truth and to achieve a fair and just result. The atmosphere must be created in which every person concerned is given full opportunity to play his part. See also Cresswell J at 81-82 of *National Justice Compania Naviera SA v Prudential Assurance Co. Limited “The Ikarian Reefer”*¹²⁶ Lloyd’s Rep 68 (Q):

1. Expert evidence presented to the court should be, seen to be, the independent product of the expert uninfluenced as to form or content by the exigencies of the litigation...
2. An expert witness should provide independent assistance to the court by way of objective unbiased opinion in relation to matters within in his expertise... 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....
4. An expert witness should make it clear when a particular question or issue falls outside his expertise...

¹²⁵ [1967] 3 All ER 993 (HL).

¹²⁶ [1993] 2 Lloyd’s Rep 68 (Q).

5. If, after exchange of reports, an expert witness changes his view on a material matter having read the other side's expert's report or for any other reason, such change of view should be communicated (through legal representatives) to the other side without delay and when appropriate to the court..." (own underlining)

See also *PriceWaterCoopers Inc. and Others v National Potato Co-Operative and Another*¹²⁷

[139.2] When dealing with admissibility of expert witness: Zeffertt and Paizes¹²⁸ states that:

"The opinion of expert witnesses is admissible whenever, by reason of their special knowledge and skill, they are better qualified to draw inferences than the judicial officer.

...

It is the function of the judge to decide whether the witness has sufficient qualifications to be able to give assistance. The court must be satisfied that the witness possesses sufficient skill, training or experience to assist it. His qualifications have to be measured against the evidence he has to give in order to determine whether they are sufficient to enable him ... to give relevant evidence."

[139.3] The key important points in the cases referred to above, an expert witness testimony should be objective and independent, uninfluenced and provided in an unbiased manner. Although I am persuaded by the plaintiff's argument that Ms Radzuma's inconsistency in her recommendations (vis-a-vis in the

¹²⁷ 9451/10120 [2015] ZASCA 2 (4 March 2015) at para 98 referring to Diemont JA in *Stock v Stock* 1981 (3) SA 1280 (A) at 1296 E-G where it was held '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 witness is of little value where he or she is partisan and consistently asserts the case of the party who calls him. I may add that when it comes to assessing the credibility of such witness, this Court can test his reasons and is accordingly to that extent in as good a position as the trial court was.'

¹²⁸ Zeffertt and Paizes *"The South African Law of Evidence"* 2nd edition (LexisNexis Durban 2009) at page 321 and 324.

joint minute) and reasoning behind her change thereof should be rejected, her recommendations lack consistency, no plausible explanation is given as to why there was a sudden change on TM's therapy provisions in terms of hours. Ms Radzuma postulations are for a short period whereas Ms Greeff is lifelong. Ms Radzuma reduces the caregiving duties to parents which is not supported by courts in previous court judgments. Her sudden change of recommendations during joint minute lack neutrality in her postulations.

[139.4] I cannot speculate that Ms Radzuma changed her recommendations based on the advice from the defendants' legal representatives. The defendant's legal team in this case subscribes to ethical professional conduct sanctioned by Legal Professional Council (LPC) in my view it is unlikely they can risk their profession, and Ms Radzuma subscribes to a professional body and is very unlikely she may compromise her profession.

In an Article authored by Justice Rogers, and published in the *Advocate April 2019 titled "Argument and Expert"*¹²⁹ at page 59 a reference is made to the Canadian case of *Moore v Gertuhun*¹³⁰ which discusses a mechanism as how to tackle such an exigency. The court of appeal in that case held that the objectivity of expert witness is fostered in various ways: (i) The ethical standard of the legal profession forbid counsel to engage in practice likely to interfere with the expert's independence and objectivity; (ii) The ethical standard of most professions place on them a duty to be independent and impartial when giving evidence. (iii) The adversarial process, particularly cross-examination, is an effective tool to deal with cases where there is apparent substance to the suggestion that counsel improperly influenced an expert. When Ms Radzuma was confronted during cross-examination, with this serious allegation of being influenced or advised by the defendant's legal

¹²⁹ *Advocate April 2019* pages 56 to 64 title "Argument and Opinion: Advocate and Expert".

¹³⁰ *Moore v Gertahun* 2015 ONCA 55 (ConLII)

team to change her recommendations in the joint minute, denied it.

[139.5] In the instant case I do not have evidence or facts to draw an inference that Ms Radzuma on advice of her legal team changed her initial recommendations and conclusions made in her underlying report when she engaged Ms Greeff during their discussions when drafting joint minute to suit a particular narrative, i.e the defendant's case. It is a fact that she changed her recommendations during the discussion when the joint minute was compiled which militates against acceptance of her recommendations. I cannot comment on the source of her change of her recommendations in the joint minute.

[140] The line items relating to the various recommendations contained in the occupational therapists' joint minute¹³¹ and their underlying reports are included in Exhibit "Q"¹³² running from line item 245 up to and including line item 319.

[140.1] Line item 263 and 264 in Exhibit "Q" relate to the agreed figures for case management (item 263 – 8 hours for initial set up; R9 535.00 and item 264 – crises management; R77 387.00). To the initial set up (item 263) the plaintiff's legal team suggested to apply no contingency deduction and that the full figure of R9 535.00 be allowed. To crisis management (item 264) a 5% contingency deduction was applied which reduces that total to R73 518.00.

[140.2] The next area of agreement between the occupational therapists is at paragraph (f) of their joint minute¹³³ and line items 277 up to and including 301 on Exhibit "Q". The agreed allowances for special and adapted

¹³¹ Caselines Q 65 to Q68.

¹³² Caselines O-725 to O726 and Schedule of future medical expenses document pages 6 to 8.

¹³³ Caselines Q-81 to Q82.

equipment for TM (as required now) are reflected in items 277 to 287. The plaintiff's legal team suggested that these items be allowed in full in the amount of R40 327.00 because they are required immediately and not in the distant future. As per experts' recommendations, these items are essential and required now.

[140.3] Further agreed on the provision for assistive devices listed in items 290 to 299 will be required by TM at the age of 25 years. The total amount for these items has been calculated at R32,513.00 with 10% contingency deduction due to the fact that they will only be required at the age of 25 years reducing the total to R29,262.00.

[140.4] Item 301 relates to special and adapted educational scholastic home use in the agreed provision amount of R10,220.00. To this item a 5% contingency deduction was applied resulting in a total of R9,710.00.

[140.5] The last agreed item is items number 303 (electric wheelchair) with a cost of R104 418.00; and item 304 (lightweight wheelchair costs R41,755.00. These items will be required when TM is at 35/36 years of age. Both experts agreed the importance of TM having these devices and Ms Radzuma confirmed the absence of other alternatives in that lightweight wheelchair as a backup to electric wheelchair. On the basis of the agreed requirement the plaintiff opted not to apply any contingency to these items which results to a total of R146,173.00

[141] The following are the items where there is no agreement in the joint minute of the occupational therapists. Comments will be made as these matters are being dealt with as the experts hold divergent views in their postulations

[141.1] The plaintiff's legal team takes an issue with the huge discrepancies between these experts which is not reflected in the recommendations in their

underlying reports. Ms Radzuma, in her report, recommended an hourly session per week (52 hours), two home programs and two home visits per annum coupled with an in-depth re-assessment to formulate the next phase of therapy every three years. Ms Greeff recommends 56 hours for the first two years of intervention including home and school visits. These recommendations look almost identical. A point is made that in interpretation of Ms Radzuma's re-assessment after three years suggests that those 56 hours per annum would be for the next three years not the next two years as per Ms Greeff's recommendation. In essence Ms Radzuma's recommendations contained in her report exceeds Ms Greeff's in the joint minute.

[141.2] In the joint minute¹³⁴ at paragraph (b) Ms Radzuma's opinion suggests a comprehensive assessment at CHBH of 4-5 hours and thereafter 1-hour sessions for the remainder of 3 year (as compared to her initial 52 hours of therapy to this now, 10 hours in the joint minute). When Ms Radzuma was asked about this change in her recommendations in the joint minute as compared to what she suggested in her report she noted that Ms Greeff advised her that TM received therapy until the age of 7 years and on that basis she determined that TM had received adequate therapy to date.

[141.3] The plaintiff's legal representatives argued that this sudden change in Ms Radzuma's opinion does not hold muster and does not make sense due to the fact that when she assessed TM in her underlying report, she found that he requires 56 hours per annum. It further contends that this sudden change in Ms Radzuma's opinion occurred as a result of being advised by the defendant's legal team as to the frequency of availability of therapy services at CHBH. This made her tailor her recommendation in the joint minute. When she was questioned on the sudden change of her recommendations in the

¹³⁴ Caselines Q-80.

joint minute as being biased towards the defendant, the denied it.

[141.4] The plaintiff's legal team submitted that taking into consideration that Ms Radzuma's initial recommendation in her underlying report mirrors the recommendations postulated by Ms Greeff's, the tailored recommendation of Ms Radzuma in the joint minute should be rejected.

[142] I have seriously considered this change of opinion by Ms Radzuma, I agree with the plaintiff this 180 degrees turnaround by Ms Radzuma is a cause for concern and in the absence of plausible explanation it is rejected. However, I do not have sufficient facts to suggest that she was influenced by the defendant's legal team. If one looks at the pre-amble of the joint minute, it precedes with an "Undertaking" that their recommendations are not influenced by external forces¹³⁵. Whether she followed that (undertaking) with her conscience as it is not a statement under oath, is unclear to this court. I find that there is merit in the argument that Ms Radzuma's change of opinion contained in the joint minute lack's objectivity in her postulation of TM's life in the long term. Her change of opinion from what she recommended in her individual assessment report and the opinion she gave in her recommendations in the joint minute militates against acceptance of her recommendations where there are disagreements. For those reasons I reject Ms Radzuma's postulations as they are riddled with inconsistencies. In fact, the number of hours she projected in her underlying report is more reasonable than what she postulated in the joint minute. I find that there is no evidence to support the argument that Ms Radzuma was influenced by her legal team to change her postulations on her recommendations in the joint minute with Ms Greeff.

[143] The plaintiff 's legal team argued further that Ms Radzuma's recommendations contained in items 256 and 261 in relation to occupational therapy be disallowed and

¹³⁵ Caselines Q78 para 2: "We declare that we are not influenced by any external sources by whatever means (telephonic, consultations, written instructions, comment to us approval of the joint minute) other than the relevant expert opinions provided to us, our assessment results, collateral information, and medical records in compiling joint minute. The joint minute presents our profession opinion with regard to TM's functioning and interventions to facilitate and enhance the highest possible level of function and independence."

instead, the recommendations of Ms Greeff at item 245, 246, 250 and 253 be allowed and apply no contingency deduction as such is required in the first 2 years. In item 245 and 246 a 5% contingency deduction has been applied until the end of his school (item 249 and 250). Item 253, with regards to occupational therapy for life, the plaintiff has applied 10% deduction resulting to a total cost of R208,580.00 for TM's occupational therapy. There is no reason not to accept Ms Greeff's postulations as they focus at TM's conditions in several years to come in the future whereas Ms Radzuma recommends occupation therapy for TM until the age of 21 years and after that for life with no specificity.

[144] The next point of disagreement between the occupational therapists relates to the provision for case management.

[144.1] Ms Greeff testified as having vast experience in dealing with children with cerebral palsy like TM in this case. In her analysis she described the significant role of a case manager describing it as an intermediary between the Trust and all other service providers such as architecture, therapists, care givers etc. In other words, whenever there is a need for assistive devices the case manager first has to confirm with the Trust, then gets quotations. The Trustees will consider the motivation, thereafter, release funds and then the assistive device would be purchased. Ms Greeff says the case manager will need time to facilitate TM's needs. The work Ms Greeff relates to are items 267 to 269¹³⁶ in Exhibit Q.¹³⁷

[144.2] On the other hand. Ms Radzuma¹³⁸ recommends that TM should get therapy at CHBH. She reduces her recommendations for case management on the basis that "he (TM) will require case management sessions if he attends therapy at a local government hospital because the health professional will all

¹³⁶ Caselines Q81 at paragraph D.

¹³⁷ Caselines O-725.

¹³⁸ Caselines Q-81 at paragraph E & O-725.

be available in one hospital and patients are given return dates for the hospital visits and those visits are coordinated between the occupational therapist, the speech therapy and physiotherapy.” The plaintiff’s legal team argued that this recommendation is a clear indication that Ms Radzuma has received instruction from the defendant’s legal team to attest that at CHBH occupational therapy is available. I disagree that she gets this from the defendant’s legal team. As far back as 9 January 2024, Ms Radzuma compiled her assessment report for assessment done on 12 September 2023, where she says TM may get therapy at a public facility and that government therapy sessions are free¹³⁹. The joint minute was signed on 10 April 2025 where she changed her recommendations.

[145] The plaintiff’s legal team further argued that Ms Radzuma’s recommendations in items 272 to 275 must be rejected and that of Ms Greeff at items 267 to 269 should be accepted in quantification of TM’s needs for case management, and no contingency deduction is suggested as the provision is for the first two years (items 267 and 268) whereas in item 269, the plaintiff applied 10% contingency deduction resulting in a figure in the amount of R570 274.00.

[146] The next point of disagreement is item 307, provision for a tandem Schwinn bicycle. This item costs R12 508.00. Although the plaintiff regards this dispute as necessary, the plaintiff’s legal team opted to forgo this item. Therefore, this is a nil allowance.

[147] Another item of dispute is caregiving, where Ms Greeff and Ms Radzuma have divergent recommendations.¹⁴⁰ It is common cause that TM will require supervision for the remainder of his life by way of a live-in companion/caregiver. Ms Greeff testified that TM would need constant motivation, someone to assist him in going to the shops,

¹³⁹ Caselines page P-260

¹⁴⁰ Caselines Q-83 para (j) and (k)

verbalizing his needs, someone to motivate him to get out of bed. Without this type of motivation provided by a caregiver, children end up in the streets and/or with substance abuse.

- [147.1] Ms Greeff recommends a caregiver provided by a caregiver agency who is trained with specific needs of a child like TM. Ms Greeff explained the reason why a caregiver should be provided through agency in that labour related issues like sick leave, labour disputes, difficulty with personalities disputes etc all those issues are best handled by the agency.
- [147.2] Ms Radzuma's recommendations for caregiving are in the amount of R7,000 to R7 500.00. It was argued by the plaintiff that Mr Pretorius (actuary) testified that this is essentially a minimum wage for someone who works 24/7 all year. The plaintiff's legal team contended that this approach to compare the caregiver with a domestic worker has been rejected by the courts.¹⁴¹ Ms Radzuma was asked in cross-examination as to what would happen if TM's caregiver wanted to go home over weekend, requires leave or was sick and she responded that TM's caregiving would fall to his parents. The plaintiff's legal representatives referred to the several cases which rejected the notion of parents being responsible for caregiving.¹⁴²
- [147.3] Ms Radzuma was asked if TM would at some stage move out from under the roof of his parents' home, she said no. The plaintiff's legal team questioned if the defendant has made so much an argument about TM's intelligence and argued that the notion that TM will stay under the roof of his parents for the remainder of his life does not make sense. Therefore, it was contended that Ms Radzuma must have been advised by defendants' legal team. Ms

¹⁴¹ Van der Merwe judgment and Lochner; Mtshali v MEC for Health KwaZulu Natal (Kzn Local Division Case 10460/15 (2 May 2023

¹⁴² See *Cunning v Harrison and Another* [1973] 3 All ER 463 (CA); *Bennie v Guardian National Insurance Company Ltd* (1989) 4 QOD A3-34; *General Accident Insurance Company Ltd v Uijl N.O* 1993 (4) SA 228 (A) at 236I-237B and *Van der Merwe v Premier of Mpumalanga* (2005) 5 QOD 13 -15 (T) at 13-42.

Radzuma, in re-examination, conceded that maybe a relief caregiver would be provided.

[147.4] It was argued further that Ms Radzuma's provision for caregiving contained in item 310 with the amount of R2, 168 790.00¹⁴³ ought to be rejected for the reasons set out above. The plaintiff's legal team argued that Ms Greeff's recommendations for caregiving expenses were fully justified in her evidence. The plaintiff's legal team allowed care provided in items 315 to 319, 5% Contingency deduction has been applied resulting in a total of R5 267 451.00. These are recorded in the *Schedule of Future Medical Expenditure, Annexure Q line item 315 to 319*. According to Mss Greeff when TM grows up the hours of care needed will increase. Ms Greeff postulation has an hourly rate of R28.79.

[148] With regards to the issue of travel costs for collection of special devices and adapted equipment as calculated by Mr Pretorius in Exhibit Q, those costs have been disallowed and only allowed travel costs associated with the occupational therapy requirements as indicated by Ms Greeff in her recommendations. The plaintiff's legal team contended that Mr Pretorius has already applied several contingency deductions to various items and calculated a total of R28 620.00.

[149] The defendant disagreed with the submissions made by the plaintiff on this in that there was no biasness in Ms Radzuma 's recommendation on caregiving provisions. It argued that there was no basis to reject Ms Radzuma's opinion, in that she testified she has been practicing for 17 years, her recommendations have been made based on her experience and expertise in her area of work.

[150] Having considered the submissions by the plaintiff and the defendant on the

¹⁴³ Caselines O-726.

caregiving expenses, I accept the recommendations made by Ms Greeff. Her recommendations on this aspect are well explained, and her postulations have been consistent in her report and during the joint minute discussions. More time is required for services of the case manager as he/she is an intermediary between the Trustees and service providers, and a lot of work needs to be done. She thoroughly explained why the caregiving services must be done through an agency. On the other hand, Ms Radzuma struggled to explain as to what happens if the caregiver is sick or on leave and suggested that the responsibility of a caregiver would fall on his parents. The court in the decided cases as referred to above do not support this notion of parents' taking responsibility of caregivers.¹⁴⁴ Even though Ms Radzuma has 17 years of experience in her area of expertise, qualifying her to give evidence as an expert her opinion was expressed without factual basis having been established by way of admissible evidence.

[151] Furthermore, Ms Radzuma could not explain why TM in his adult life would not come at a time when he decides to move out of his family house where a support for his condition will be most probably required. Ms Radzuma could not explain why she changed her recommendations on case management hours from 52 hours in her report to a mere 10 hours in the joint minute. Her explanation that, because TM had received therapy until the age of 7, is not plausible. This reason too is not recorded either in her assessment report or in her comment on the joint minute, although she had access to other underlying reports, if this would be her reason for this drastic change of opinion one would expect it to be recorded somewhere. The possibility of duplications on travel costs has been avoided. With those reasons Ms Greeff's proposed time and caregiving for TM is accepted.

[152] When it comes to the reduction of the total underlined figures (R6,383 448.00), 5% is deducted to account for the actuarial differences resulting in a total of R6,064

¹⁴⁴ See the cases of *Cunning v Harrison and Another* [1973] 3 All ER 463 (CA) and *Bennie v Guardian National Insurance Company Ltd* (1989) 4 QOD A3-34.

276.00 for occupational therapy and related treatment. It was submitted that this figure is reasonable. The SCA in *NK v MEC for Health, Gauteng*¹⁴⁵ (NK) judgment notes that applying contingency deduction should not be done whimsically. In my view the 5% median applied is fair and reasonable and there would be no unfairness on its application as this was canvased when the evidence of actuary was led.

The psychiatrists

[153] In this provision, Dr M. Close, a psychiatrist instructed by the plaintiff, gave *viva voce* evidence during the trial, whereas the defendant did not call its psychiatrist, Dr KM Matjila. There is a joint minute of the psychiatrists which forms part of the evidence¹⁴⁶. The underlying reports¹⁴⁷ of Dr Close and Dr Matjila also form part of the evidence. The recommendations by these experts are contained in their underlying reports and reflected in Exhibit Q at line items 335 to 337, 340 to 341 and 343 to 344 (Dr Close) and items 346, 349 to 350; and 352 (Dr Matjila).

[154] Dr M. Close testified amongst other things about what she understands under the agreement contained in the joint minute concerning the recommendations for TM and also testified about the figures in the underlying report. Although it was put to Dr Close during her cross-examination that Dr Matjila would be called to testify, he was not called. The plaintiff argued that Dr M Close's appreciation of the recommendations should stand. A significant issue raised by the defendant was that there are overlaps on the costs for future medical expenses. However, Mr Pretorius made allowance for collection of the medication and for travel to and from consultations where there a 15% contingency deduction has been applied resulting to a travel cost allowance of R6 871.00.

[155] The total underlying figures calculated in this provision is a total of R687, 671.00 wherein a 5% contingency deduction was applied resulting to the figure of R653,288.00.

¹⁴⁵ 2018 (4) SA 454 (SCA).

¹⁴⁶ Exhibit H.

¹⁴⁷ Exhibit H1 Dr M Close report at O-411 to O-423 & Dr Matjila Exhibit H2 at P-123 to P-139.

[156] I agree with the plaintiff that this figure is fair and reasonable and fully justified by evidence. Dr M. Close's evidence was not challenged by evidence of another expert. The defendant's challenge of Dr Close's testimony is of no significance and there is no reason to reject her recommendations.

The physiotherapists

[157] On this sub-head of damages claim reliance is on the joint minute¹⁴⁸ of the physiotherapists, and the underlying reports of Ms C. Botes¹⁴⁹ and Ms S. Mkhansi¹⁵⁰ respectively. The recommendations agreed upon are contained in items 360 to 416 on the Schedule of Future Medical Expenditure Exhibit Q)¹⁵¹. The provisions for neurodevelopment therapy (items 360 to 373- different years of TM's life); annual intervention; treatment for pain (items 377 to 389) post-surgical intervention) chest treatment for secondary infection; post-fall and injury treatment and equipment braces).

[158] Ms Botes and Ms S Mkhansi are in full agreement as to TM's need for physiotherapy and these items are dealt with in brief below:

[158.1] The physiotherapy sessions for neurodevelopmental therapy of TM as of now and for the remainder of his life are listed in items 360 to 373. In item 360 (first year) therapy is needed immediately no contingency deduction has been applied at a cost of R392.00, item 361 therapy sessions during the first-year total costs R19 466.00 no contingency was applied resulting to a total figure of R19 858.00.

[158.2] The therapy recommendations from year 2 until 19 years of age for TM (items 364 and item 365 with 1 session per month cost of R42

¹⁴⁸ Exhibit M Caselines Q-1 to Q4.

¹⁴⁹ Exhibit M1 -Caselines O-391 to O-410.

¹⁵⁰ Exhibit M2- Caselines P-01-P38.

¹⁵¹ Caselines O-728 to)-729.

015.00 with 5% contingency deduction applied gives a total of R41 342.00.

[158.3] The recommendations for TM's physiotherapy starting from the age of 19 for the remainder of his life for 5 sessions per annum (item 368) totals R4 967.00; item 369, 5 sessions per annum until age of 35 totals R61 907.00; item 372 evaluation at age 35 at a total of R6 076.00 and item 373, a total of 12 sessions per annum for life at a total of R 180 640.00. On the last item there was a 10 % contingency deduction resulting in a figure of R228 230.00

[158.4] The next item is item 375, training of caregivers and new caregivers, (about 5 years) agreed between the physiotherapists a figure of R12 288.00 with no contingency deduction applied.

[158.5] The other agreed physiotherapy treatment for pain is recorded in items 380, 381 and 385 until the age of 18, no contingency applied resulting in a total of R24 744.00 for these items. The recommendations in items 388 and 389 are provided for the remainder of TM's life with a reduced cost of R76 023.00.

[158.6] Line items 392 and 393 agreed by physiotherapists for post- surgical intervention (item 392- evaluation R2 696.00, item 393- in-hospital and outpatient treatment (12 sessions); R52 235.00. Due to disagreement between Ms Botes and S. Mkhansi on this operation/surgical procedure the plaintiff's legal team decided to forgo item 392 and 393 in the amount of R54 926.00, consequently allow zero/nil.

[158.7] Items 398 and 399 with a total of R73 542.00 for post-intervention treatment, provision for intervention relating to falls and consequent injuries.

A 50% contingency deduction and a further 10% contingency have been applied resulting in a significantly low figure of R33 094.00.

[158.8] Items 402, 403, 406 and 407 relate to physiotherapy for chest treatments for secondary infection. Dr Botha (life expectancy expert) has made provision for hospitalization in the event TM contracts an intercurrent chest infection. Dr Botha provided for 10% probability annually, whereas the physiotherapists make provision for treatment every three years. A 50 % contingency deduction and an additional 10% have been applied resulting in a total of R54 670.00 for these items.

[158.9] Item 412 a provision for post-sprains and strains (8 sessions at R500 per session) assumed every 5 years. Due to its distinction that it is not an orthopaedic recommendation (surgical intervention) has been reduced by 10% contingency deduction resulting in total of R26 743.00 due to the fact that it is a lifelong recommendation.

[158.10] Item 416 is an agreed recommendation by physiotherapists for rehabilitation equipment, repairs and replacement, a 10 % contingency reduction has been applied resulting to a total of R3 876.00.

[158.11] With regard to Mr Pretorius's provision for travel, where contingency deduction has been applied in other items stated above, although cost relating to post-surgical treatment has been left out, the remaining items have been calculated resulting in a reduced figure of R58 650.00.

[158.12] The application of 5% contingency deduction to the cumulative figure of R606 518.00 to all TM's physiotherapy treatment items gives a total figure of R576 192.00.

[159] The costs associated with each item and different periods (from year one, year two etc. are fully set out in detail in the Exhibit Schedule for Future Medical Expenditure, Exhibit Q. The physiotherapists fully agree in their recommendations as to the needs of TM on an item-by-item basis. As a result, I agree that the provision and cost associated with each item which make a cumulative amount of R606 518.00 with 5% contingency deduction in order to make provision for differences in the actuarial joint minutes, reduces the said figures to R576 192.00. In my view this figure is fair and reasonable and it is evidence based.

The speech, language and audiologist therapists

[160] The plaintiff and the defendant led oral evidence of their speech, language and audiologist therapists. Ms I. Hattingh for the plaintiff and Ms M. Mokgata for the defendant gave evidence during the trial. These witnesses were taken through their signed joint minute¹⁵² which was handed up in court and was dealt with during the testimony of Ms Hatting and Ms Mokgata. The underlying reports¹⁵³ of these speech, language and audiologist therapists (experts) were also handed in and form part of the record. Their recommendations are contained in items 428 to 471 of the Schedule of Future Medical Expenditure marked Exhibit Q¹⁵⁴. Items 428 to 436 deal with dysarthria management; items 438 to 443 deal with oral hygiene; items 448 to 460 deal with feeding and items 462 to 517 deal with speech and language.

[161] Both speech, language and audiologist experts are indeed experts in their field, Ms Hattingh having been in practice for about 41 years and Ms Mokgata has 25 years' experience. Their qualifications were placed on record when their evidence was led. Both experts justified their recommendations made in in their respective reports. The differences were also explained. Neither was prepared to suggest that either of them is incorrect. Both relied on their experience in working with cerebral palsied children. To address the issue of divergent experts' recommendations, the plaintiff's legal

¹⁵² Exhibit E Caselines Q-05 to Q-20.

¹⁵³ Exhibit E1 (O-286 to O-359- Ms Hatting & Exhibit E2 Ms M Mokgata Caselines P-123 to P-139.

¹⁵⁴ Pages 11 to 12 (Exhibit Q and a mirror of these items in document at O-729 to O 732.

representatives has suggested to take the median between the two experts' recommendations. This approach is allowed and has been followed by our courts.¹⁵⁵

[162] Various recommendations and provisions where both experts agree and disagree are listed in the Schedule of Future Medical Expenditure marked Exhibit Q read with O-714 to O-717.

[163] Item 428 deals with dysarthria management. TM's difficulties with pronunciation and being heard and understood have been canvassed at a great length. Both experts are of the view that TM requires an initial assessment for dysarthria management in the amount of R5 483.00. No deduction was applied to this amount.

[164] In item 431 the experts disagree (first 18 months – intensive speech therapy; R211 120.00) and item 432 (thereafter follow-up therapy for life; R850 326.00) and Ms Mokgata's recommendations appearing in item 435 (65 hours for the first 52 weeks; R88 319.00) and item 436 (thereafter 24 hours as and when required for life; R38 380.00). In this scenario where the experts disagree with both having vast experience, i.e. Ms Hatting, 41 years and Ms Mokgata 25 years' experience, the mean between these two experts' recommendations has been utilized.

[165] A comparison Ms Hattingh's item 432 with Ms Mokgata's item 435 in respect of immediate therapy and the median mean adopted resulting in a figure of R149 720.00. The same approach has been followed in item 432 (Ms Hattingh's recommendations) and item 436 Ms Mokgata's mean has been applied resulting in a figure of R444 353.00 a further 10% contingency deduction has been applied resulting in a further deduction of R399 918.00.

[166] Item 440 to 443 contains Ms Hattingh's recommendations in respect of oral hygiene. Ms Mokgata defers these to the dentist. There is nil allowance on both items.

¹⁵⁵ See the case of *Zungu v MEC for Health & Social Development, Kwa-Zulu Natal* Case No 14079/2013 at para [7].

Items 445 and 446 where both experts agree about a need for video fluoroscopic swallow study, a cost of R14 709.00 has been suggested which is allowed in full. Item 448 to 460 both experts agreed on the recommendation for TM's feeding intervention. On these items where provision is needed immediately no contingency deduction is applied, where intervention is needed after five years a 5% contingency deduction has been applied and from ten years to lifelong intervention a 10% contingency decision has been applied which related to the figure of R231, 484.00.

[167] Items 466 to 470 deal with a language intervention. Ms Hattingh gave cogent evidence as to the difference between language intervention and dysarthria management and suggested both are required whereas Ms. Mokgata says in her view it has already been provided for, a 50% percentage contingency deduction has been applied to cater for that difference. A further 0 to 10% contingency deduction has been applied as per different periods, where a provision is for immediate, short term (5%) and for lifelong (10 %). This resulting in a reduced figure of R761 132.00.

[168] With regards to Items 476 and 477 both experts agree on classroom intervention (R53 192.00) and group therapy (37 634.00) which makes a total allowance of R90,826.00.

[169] The above items from 428 to 470, together with the figures in items 480 to 571 all relate to costs associated with speech, language and audiologist therapy for TM. This totals to an amount of R3 744 091.00 with a 5% (reduction?) for the alignment of the actuarial differences to the figures resulting in a total of R3 556 886.00.

[170] During the closing argument, the parties agreed on the issue of making provision for speech therapy intervention although at an initial stage during the testimony there seemed to be differences. The defendant submitted that even if the court is not in agreement with them on the public healthcare defence the cash intervention for TM is needed with immediate effect, although a lesser figure (R399 918) was suggested. This concession is well made and highly commendable as it shows the spirit of compassion

to TM's care. Had this concession been made earlier there is a likelihood that both these witnesses were not going to be called which was going to save courts time. I agree that the figure of R3 556 886.00 for TM's speech, language and audiology therapy is fair and reasonable. Based on the concession, in my view it is well made.

The urologists

[171] Both parties did not lead oral evidence on the provision of urologist therapy to TM. However, the underlying reports of urologist experts, Dr IJ van Heerden and Dr KK Ijane, form part of the record as well as joint minute signed by the urologist experts have been filed on record as Exhibit F¹⁵⁶, F1¹⁵⁷ and F2¹⁵⁸ respectively. The joint minute by the urologists reflects full agreement for provision of urology therapy to TM.

[172] The agreed recommendations made by the urologists can be found at line items 579, 580 and 582 Exhibit Q on O-732. In paragraph 3 of the joint minute, both urologists agree that TM presents with a neurogenic bladder¹⁵⁹ secondary to ischemic brain damage as a child to alleviate TM's symptoms. The urologist experts also agree on alternative medication options (items 579 and 580) on O-732 of Future Medical Expenditure Schedule Exhibit Q. Regarding the alternative an approach adopted was to take the mean (R160 047.00) added to which a 10% contingency deduction has been added resulting to an agreed figure of R144 042.00 for balder control.

[173] Items 582 to 584 relate to the agreement for visits to a urologist and the necessary ultrasounds and studies. On these items 10 % contingency deductions to each of the three items have been applied due to the pustulated for the long-term resulting in reducing the figure from R132 966 to R119 670.00. Travel costs for collection of medication has been disallowed, only costs relating to consultations with a total of R3 613.00 were allowed.

¹⁵⁶ Exhibit F -Joint minute Caselines Q-21 to Q-23.

¹⁵⁷ Exhibit F1 assessment report by Dr van Heerden Caselines O-581 to O-583.

¹⁵⁸ Exhibit F2 assessment report by Dr Ijane -Caselines P-85 to P-94.

¹⁵⁹ Neurogenic bladder symptoms include urinary incontinence (loss of bladder control) a sudden or frequent urge to urinate and difficulty starting or emptying the bladder.

[174] The total for the above figures R267 325.00 with a further 5 % contingency deduction to account for the actuarial differences, resulting in a figure of R253 960.00.

[175] With all the various provisions for future medical and related expenditure contained in the paragraphs above, the plaintiff's legal team has submitted that a fair and reasonable compensation for future medical and related expenditure is R22 125 163.00.¹⁶⁰ In my view the calculated amount for compensation of TM's future medical and related expenditure is fair, reasonable and not inflated. All the contingency deductions and any possible duplication have been eliminated. Where a provision is made for collection of medication and transport costs, a provision is made to avoid duplication of transport for collection of medication and or therapy as there may be a single trip for both collection of medication and attending therapy. In instances where the experts are in disagreement the contingency is split in two, for instance. if the contingency is 10% it is reduced to 5% etc to cater for disagreements in experts' opinions or recommendations.

[175.1] I applied my mind to all the costs associated with future medical and related expenses, the provisions, the contingency dedications), the figures are fair, reasonable and not inflated. They are supported by evidence. There is no evidence from the defendant to suggest that the proven quantum of damages is excessive or overstated save on Architect costing on some items were said to be excessive. In cases where there are disagreements the median mean in between is provided. The actuarial differences have also been addressed by application of median mean to resolve the points of differences. An exception is the preference of the recommendations made by Ms Greeff as opposed to those made by Ms Radzuma as above.

¹⁶⁰ The breakdown of this figure is also contained in the Schedule of Medical Expenditure Exhibit Q pages 1 to 14 total at page 14.

[175.2] This brings me to the summary of the award for TM's future medical and related expenses.

[176] The total award for TM's future hospital, medical and related expenditure is R22 125 163.00¹⁶¹.

1. The Architects	R797 542.00
2. The dietician	R319 248.00
3. The dentist	R530 779.00
4. The educational psychology	R753 513.00
5. The mobility	R731 089.00
6. The Orthotists	R2 438 187.00
7. The paediatric neurologists	R4 885 831.00
8. Orthopaedic surgeons	R564 372.00
9. The occupational therapists	R6 064 276.00
10. The psychiatrists	R653 288.00
11. The physiotherapists	R576 192.00
12. The speech, language & audiology therapists	R3 556 866.00

¹⁶¹ This breakdown calculation is also recorded in Caselines AA-176 to AA189 & Exhibit Q pages 1 to 14.

Future Loss of earnings and/or earning capacity

[177] The legal principle in respect of a claim for diminished earning capacity is trite. The plaintiff must be placed in the position TM would have been in had the injuries not occurred.¹⁶² In our law, the capacity to earn money is considered to be part of a person's estate, and the loss or impairment of that capacity constitutes a loss, if such loss diminishes the estate.¹⁶³ To succeed in the claim for loss or diminished earning capacity, the plaintiff has to establish on a balance of probabilities that, as a result of the incident, TM's earning capacity has been compromised, resulting in the diminishment of his estate.¹⁶⁴ The evidence to assist the court on this aspect can be found in the reports of educational psychologists, Dr van der Ryst¹⁶⁵ and Dr Prag¹⁶⁶ and their joint minute¹⁶⁷ as well as the reports of Industrial psychologists Mr A Lamprecht¹⁶⁸ and Dr LM Tabane¹⁶⁹ and their joint minute¹⁷⁰.

[178] The issue of life expectancy of TM in this case is crucial. A life expectancy report by Dr Botha, was not disputed by the plaintiff.

[179] The first question (pre-morbid educational and income scenario). The parties have submitted divergent views on the issue of loss of future earnings for TM.

[180] The evidence from educational psychologists and industrial psychologists in their

¹⁶² *Dippenaar v Shield Insurance CO Ltd* 1979 (2) SA 904 (A) at 917A-D.

¹⁶³ *Ibid.*

¹⁶⁴ *Rudman v Road Accident Fund* 2003 (2) SA 234 (SCA) para 11.

¹⁶⁵ Exhibit K1- Caselines O-45 to O-66.

¹⁶⁶ Exhibit K2 Caselines O-260 to O-390.

¹⁶⁷ Exhibit K – Caselines Q-73 to Q-77.

¹⁶⁸ Exhibit J1 Caselines O-1 to O18.

¹⁶⁹ Exhibit J3 Caselines P-219 to P-229.

¹⁷⁰ Exhibit J Caselines Q-91 to Q-94.

joint minute¹⁷¹ provides some factual basis on this sub-head of damages, where they agree as follows:

[180.1] *Educational psychologists*

***“We Agree:** if it is assumed that [T..] would have progressed in line with his family history and could have surpassed them, he would have passed Grade 12 (NQF4) in mainstream education, probably without exemption.*

***We agree:** considering the familial pattern in economical/financial background, he would have had the ability to enter into the open labour market and seek employment, and/or attend in-house training opportunities, while he would have had the ability to work himself up in the workplace. Depending on opportunity and the availability of funds, he could have completed certificate training courses to a NQF5 – level. His choices would have depended on the availability of funds, and opportunities.”*

[180.2] *Industrial psychologists*¹⁷²: contained in their addendum joint minute:

“Career development: taking the Educational Psychologist’s opinion into consideration and due to the claimant’s young age we agree that a general postulation of Mr Mouers pre-accident likely earnings should be used to postulate a likely pre-accident career progression (the following is suggested):

After completing his Grade 12 at age 18/19 years, he finds himself job hunting. He may be unemployed for approximately 36-48 months, although he might find short periods of temporary work not more than 1 month at a time in the informal market. He would then be earning in the region of the lower quartile of the semi-skilled worker.

*He then enters the labour market at the age 22/23 and might be employed in the **informal work sector** on an intermittent basis around 8-10 months per year on contract basis, for*

¹⁷¹ Q – 74 para 2.2 and 2.3.

¹⁷² Exhibit J Caselines Q-91 to Q92.

*approximately another 3-4 years. He would be earning around the median of the **semi-skilled** worker category of the informal worker sector.*

According to the Quantum Yearbook (2025), the suggested earning assumptions for a semi-skilled worker are R40 700 – R87 000 – R228 000 per annum. Normal annual increases could apply. The possibility exists that he could have progressed further in the informal sector and end up earning between the median and upper quartile of the semi-skilled worker assumption.

*He could have secured permanent employment in the **formal sector** at around the age of 26/27 and earn on par with the basic salaries of the Paterson levels. He advances to the Paterson Salary Level A3/B1, Lower Quartile (refer to remuneration information, Quantum Yearbook, 2025, Annexure A).*

Within 3 to 5 years, he advances to the median of the Paterson Salary Level B2/B3 and thereafter to the next Paterson Salary Level within 3 to 5 -year intervals. With a certificate he could have reached his career ceiling earnings on the Paterson B5/C2 median (Total Package) level between the ages of 45- 48 years.

*Retirement age: **AL** believes that he could have been able to work until the retirement age of 65 years. **LMT** opines that he could have expected a working lifespan on 40-45 years, with retirement at the age of 60 to 65 years.” (AL refers to Mr A Lamprecht and LMT refers to Dr Tabane).*

[181] Mr Pretorius (actuary expert for the plaintiff) calculated the agreed scenario contained in the industrial psychologists’ joint minute,¹⁷³ utilising retirement age of 65 (as per Mr Lamprecht’s postulation contained in the joint minutes). Mr Mavimbela (actuary expert for the defendant) calculated the agreed scenario contained in the industrial psychologists’ joint minute¹⁷⁴.

[182] From the evidence based on calculations of the actuaries, when the plaintiff was

¹⁷³ Caselines O-677 to O-687.

¹⁷⁴ Caselines P-475 to P-480.

cross-examining Mr Mavimbela, referred to a document with calculation projections in an attempt to find median mean in between the calculations of Mr Pretorius and Mr Mavimbela. When the plaintiff utilized Mr Pretorius's calculation 65 years retirement (gross pre-morbid figure of R4 828 086.00 (pre-morbid gross figure of R4 355 466.00 and taking the median of these calculations in that it would result in a corrected retirement age (the mean of 63.75 years and account for actuarial differences between the actuaries.

[183] Based on the above the plaintiff submitted that the gross income figure is thus R4 591 776.00. On the question of post morbid income, the industrial psychologists and educational psychologists agreed that TM has no post -morbid earning future.

[184] The next question is the issue of contingency to be applied. The case law and legal literature provide some guidance on this issue. The plaintiff referred the court to a number of cases dealing with this issue of contingency in the past and future loss of earnings. I will highlight the principles mentioned in a few: In the matter of *Southern Insurance Association v Bailey NO*¹⁷⁵ Nichola JA made the following remarks:

*"Where the method of actuarial calculation is adopted, it does not mean that the trial Judge is "tied down" by inexorable actuarial calculations. He has a large discretion to award what he considers right" (per Holmes JA in Legal Assurance Company Limited v Botes 1963 (1) SA 608 (A) at 614F). One of the elements in exercising that discretion is the making of a discount for "contingencies" or the "vicissitudes of life". These include such matters as the possibility that the Plaintiff may in the result have less than a "normal" expectation of life; and that he may experience periods of unemployment by reason of incapacity due to illness or accident, or to labour unrest or general economic conditions. The amount of any discount may vary, depending upon the circumstances of the case. See *Van der Plaats v South African Mutual Fire & General Insurance Company Limited* 1980 (3) SA 105 (A) at 114-5. The rate of the*

¹⁷⁵ 1984 (1) SA 98 (A) at page 116-117.

discount cannot of course be assessed on any logical basis: The assessment must be largely arbitrary and must depend upon the trial Judge's impression of the case."

[185] The plaintiff's legal team has contended that with a general statement a contingency *deduction* is applied, and that the "normal" contingency deductions (i.e. the contingency deductions that the court will apply when all things are equal, with the underlying calculation being neither overly liberal or overly conservative) are 5% accrued and 15% prospective. A reference is made to the following authorities and literature:

[185.1] Robert Koch's Newsletter¹⁷⁶ says that he is often asked to apply "normal contingencies", that in theory there is no such thing, that what is appropriate depends on the circumstances and the period involved (he refers to "the widening funnel of doubt"), but he says that RAF claims handlers do have a predilection for deducting 5% for past loss and 15% for future loss, regardless of the realities. This formula is applied to both claims for loss of earnings and claims for loss of support. It seems fair to say that if there is such a thing as "normal contingencies" then it must be 5% for past loss and 15% for future loss.

[185.2] The plaintiff also referred to the judgment authored by Rabie J in the matter of *De Bruyn v Road Accident Fund*¹⁷⁷. In the case of a 37 year old electrician applied at J2-77 what he "*described as the usual 15% contingency...*".

[185.3] Further reference was made to the case of the plaintiff in *Wright v Road Accident Fund*¹⁷⁸ who was 21 years old when he was paralysed in a motor accident. He had left school prematurely in Grade 11 but would likely,

¹⁷⁶ Koch "The Quantum Yearbook" (June 2003) No.50 Robert Koch Newsletter at page 2.

¹⁷⁷ 2003 (5) QOD J2-69 (W).

¹⁷⁸ 2011 (6A3) QOD 19 (ECP).

Eksteen J found, in the absence of the collision, have returned to school to complete his Grade 12, and although he might have qualified as a millwright (an artisan who is qualified in two different trades), he would more likely simply have qualified as an artisan. His injuries had rendered him permanently unemployable.

Eksteen J decided (see para [51] of his judgment) on a pre-morbid contingency deduction of 15%. There was of course no post-morbid contingency deduction.

[185.4] I was also referred to the case of *Radebe v Road Accident Fund*¹⁷⁹ where Kubushi J made the following remark:

“Contingencies are normally calculated at 5% for past loss and 15% for future loss.”

Contingency in this case

[186] When making an order for future loss of earning/earning capacity, the court is expected to make use of contingency deductions to provide for any circumstances which may occur in future but cannot be predicted with precision.¹⁸⁰ The plaintiff’s legal representatives argued that I should follow those cases in this case apply contingency of 15%. They argued (plaintiff counsel) highlight TM is 14 years of age. The plaintiff contends that TM’s pre-morbid functioning is agreed, and they suggest a conservative. As per industrial psychologists and educational psychologists, a conservative pre-morbid postulation in respect of TM’s projected earnings. Initial periods of unemployment, working temporary/contract work over a number of years, progress slowly to formal work slow upward and hitting his career ceiling at approximately R40 000.00 per month at about 46.5 years in current earning terms.

¹⁷⁹ 2013 (6A4) QOD 220 (GNP) at para [17].

¹⁸⁰ *Sithole v Road Accident Fund* (35916/18) [2023] ZAGPPHC 355 (28 July 2023) para 30.

[187] The plaintiff's legal representatives argued that with Dr Botha, liberal approach to TM's life expectancy with a 25% deduction thereof suggests that in itself lends conservatism.

[188] Based on the above the plaintiff's legal team suggested a 15% contingency deduction to be applied to gross pre-morbid earnings, R4 591 776.00 which reduces the figure to a total of R3 903 010.00.

[189] On the other hand the defendant's legal representatives argued that in the absence of agreement between Industrial psychologists, in respect of the period of unemployment and the age of retirement suggested an amount of R4 400 641.00 the median of the two bases as is Mr Mavimbela less 20% contingency equals R3 520 512.00 is fair and reasonable for the loss of earnings.

[190] In determination of the amount for compensation of past and future loss of income, the SCA in the matter of *Road Accident Fund v Kerridge*¹⁸¹ confirmed that any claim for future loss of earning capacity/income requires a comparison of what the claimant would have earned had the accident not occurred, with what a claimant is likely to earn thereafter. In *Santam Versekeringsmaatskappy Bpk v Byleveldt*¹⁸² the Appellate Division (as it was) stated the following:

"Basically, it is true, the compensation our Courts award is also for impairment of the capacity to earn, but generally it is measured by reference to the loss of earnings. Where the injured party was in normal employment at the time he was injured and would have continued in it but for his incapacitation, such employment is ordinarily regarded as reflecting his earning capacity. His loss of earnings, actual or prospective, is, therefore, usually taken as the true measure of the impairment of his earning capacity."

¹⁸¹ [2018] ZASCA 151 at para 40.

¹⁸² 1973 (2) SA 146 (A).

[191] Having heard arguments by the parties and having considered the case law and evidence from the underlying reports of educational psychologists and industrial psychologists, actuaries and the life expectancy expert about TM's pre-morbid, I am of the view that 15% contingency is appropriate on the facts of this case. The proposal is supported by evidence. I agree that a compensation for TM's future loss of earnings is a total of R3 903 010.00 after 15% contingency deduction. This is fair and reasonable. The SCA in *NK* held that *the court* cannot simply take contingency agreed upon by parties. Something more substantive is required not only if a court departs from the normal range of between 15 and 20 percent but also simply to take the median of what the respective parties asked for.¹⁸³

[192] The SCA in *NK*¹⁸⁴ was against the method used by the court of first instance where the two different suggested percentages (20% and 50%) were combined and divided into two to get take the median the between two. I could not take both suggested approaches of the plaintiff and the defendant and divide the total into two. What the SCA says in *NK*¹⁸⁵ even if there is an agreement about the percentage of contingency deduction/median between the parties, a judge does not simply approve the agreed percentage. Be that as it may, in this case of TM there is no agreement between the parties which means I must take the approach which I believe is fair and reasonable. I have opted for the normal 15% which is applied in cases involving loss of earnings ¹⁸⁶. At the end the court exercises its discretion when considering contingencies to be applied. I believe the said percentage is one to be applied taking into the vicissitudes of life.

General damages

¹⁸³ NK para 16.

¹⁸⁴ See above n 192.

¹⁸⁵ See above n 192.

¹⁸⁶ See above n 221 Robert Kock Newsletter.

[193] The legal principles in determining the general damages claim are set out in the following cases:

- a. In *Sandler vs Wholesale Coal Suppliers Ltd*¹⁸⁷ Watermeyer JA remarked as follows:

“...it must be recognised that though the law attempts to repair the wrong done to a sufferer who has received personal injuries in an accident by compensating him in money, yet there are no scales by which pain and suffering can be measured, and there is no relationship between pain and money which makes it possible to express the one in terms of the other with any approach to certainty. The amount to be awarded as compensation can only be determined by the broadest general considerations and the figure arrived at must certainly be uncertain, depending upon the judge’s view of what is fair in all the circumstances of the case.”

- b. In *AD and IB v MEC for Health and Social Development, Western Cape Provincial Government*¹⁸⁸ the court noted that:

“Money cannot compensate IDT for everything he has lost. It does, however, have the power to enable those caring for him to try things which may alleviate his pain and suffering and to provide him with some pleasures in substitution for those which are now closed to him. These might include certain of the treatments which I have not felt able to allow as quantifiable future medical costs (eg NMES therapy, SPIO suits, psychotherapy and physiotherapy in excess of the allowances I have made, e-books and the like).”

[194] It is accepted as a norm that general damages claim for personal injuries are not meant to be a punitive measure or punish the defendant but to bring some form of

¹⁸⁷ 1941 Ad 194 at page 199.

¹⁸⁸ 2016 (7A4) QOD 32 WCC at para 618.

compensation to the plaintiff. The task of the court is to ensure that the award of damages is fair and reasonable.

[195] In this case TM, suffered various impairments: TM has been described as an intelligent child even though he has cerebral palsy. Although one may consider this favourable to him, he will look different to his peers for the rest of his life, he is unable to intelligibly hold a conversation with anyone. When looking at other able bodies that look different to him; he will see his family and his peers becoming productive members of society with jobs, families social circles etc and he will not have such for himself.

[196] The plaintiff referred to various underlying reports and joint minutes which attest to quite a number of difficulties TM has and is still likely to have for a number of years:

[196.1] *“We agree: Drooling and oral deficits that negatively impacted speech and feeding. Severe facial athetosis...severe dysarthria...with less than 20% intelligibility during normal communication”.*¹⁸⁹

[196.2] *“We agree: Poor saliva management and inadequate swallowing, limited to eating softer/mashed foods...food avoidance is evident. Significant difficulties managing a variety of food stuff. Using liquid to wash food down with. Multiple swallows required. Mess eating with additional time required.”*¹⁹⁰

[196.3] *“We agree:...[T...] is compromised in terms of social interaction and fulfilling his role in society. He will require long-term support and assistance.”*¹⁹¹

[196.4] *“We agree: Due to T...’s injuries and the subsequent cognitive, physical and communicative challenges he is living with, he will not be able to make any life decisions independently.”*¹⁹²

¹⁸⁹ Joint minute-speech therapists paragraph B 1: Q-01.

¹⁹⁰ Joint minute speech therapists- paragraph B.2 Q-05.

¹⁹¹ Joint minute speech therapists paragraph B.9 -Q-07.

[196.5] *“[T...] has a neurogenic bladder secondary to ischemic brain damage as a child.”*

[196.6] *[T...] has spastic diplegia with superimposed right hemiplegia.... He complains of pain in this lower limbs with prolonged walking ... He complains for pain in his spine and asymmetries can be seen linked to altered walking biometrics and poor postural adaptations.... He struggles to grip.... He cannot climb stairs.... He has poor balance”.*¹⁹³

[196.7] *“Although verbal communication will be encouraged and expanded as far as possible, [T...] is unlikely to ever become an effective verbal communicator using speech alone T.. will remain with social difficulties and will struggle to be accepted and function effectively in society. Many opportunities will remain closed to him. He will never be independent and will have to rely on others for assistance in all activities.”* (T is TM is the name of the minor child referred throughout this judgment)

[197] The occupational therapists agreed that when TM ages he will need a wheelchair when he is at approximately at the age of 36. He will live in reliance to a live-in carer. His life expectancy has been significantly reduced.

[198] I was referred to the following cases which specifically deals with cerebral palsy cases where damages were awarded.

¹⁹² Joint minute speech therapists' paragraph -paragraph D.3 in Q-09.

¹⁹³ Joint minute of physiotherapists paragraph 2 -Q-01.

- [198.1] *Sgatya v Road Accident Fund*¹⁹⁴ (R800,000.00 in 2001 but present equivalent R2 904 000.00.00 as per Koch's *The Quantum Yearbook*)¹⁹⁵ and
- [198.2] *Megalane NO v Road Accident Fund* (R1 000 000.00 in 2006 equivalent to R2 864 000.00 as per *The Quantum Yearbook*)¹⁹⁶.
- [198.3] Another reported judgment on general damages in cerebral palsy cases was Koen J's judgment of *Singh and Another v Ebrahim*¹⁹⁷ Establishing the exact facts of *Singh*, insofar as they relate to general damages, is difficult on the strength of the judgment, and to that end it is best to read it together with the unreported SCA appeal judgment, *Singh v Ebrahim*¹⁹⁸, even though the matter went on appeal on virtually everything save for general damages. Koen J awarded R1 200 000.00 on 20 March 2008. As per the index on p3 of *The Quantum Yearbook 2025*, the current equivalent thereof is R2 876 616.00.
- [198.4] *Mngomeni (obo Zangwe) v MEC for Health, Eastern Cape Province*¹⁹⁹ involved a cerebral-palsied boy who was 6 years old at the time of trial, and whose life expectancy was estimated at a further 30 years. He was severely mentally and physically retarded, with all of the symptoms associated with the condition. Brooks J awarded R2 000 000.00 on 20 June 2017. The present equivalent of that award is R2 947 000.00, according to *The Quantum Yearbook 2025*.²⁰⁰

¹⁹⁴ 2001 (5) QODA2-1 (E).

¹⁹⁵ Koch "The Quantum Yearbook" (2025) No.50 Robert Koch Newsletter at page 45.

¹⁹⁶ Id at page 22.

¹⁹⁷ [2010] 3 All SA 187 (D).

¹⁹⁸ [2010] ZASCA 145 (SCA) (26 November 2010).

¹⁹⁹ 2018 (8A4) QOD 94 (EC).

²⁰⁰ See above n 243 at page 65.

[198.5] *Mpobo (obo SP) v MEC for Health, Eastern Cape Province*²⁰¹ involved a cerebral-palsied boy who was 13 years old by the time of trial. He was incontinent, unable to stand without assistance and able only to roll or crawl and was severely affected speech. His cognitive functions were, however, at a higher level. His life expectancy does not appear from the judgement. Brooks J awarded R2 000 000.00 on 22 May 2018. The present equivalent of that award is R2 816 000.00 as per as per p65 of *The Quantum Yearbook 2025*.

[198.6] *Kriel NO (obo S) v MEC for Health, Gauteng*²⁰² related to a child classified as a GMFCS Level II (spastic quadriplegia, microcephaly, severe developmental delay, permanent intellectual impairment, not able to speak, and totally dependent on care), aged 8 ½ years at the time of trial. Life expectancy was predicted to be at the age of 52. Meyer J awarded general damages of R2 000 000.00 on 4 November 2020, the present equivalent of which is R2 619 000.00, as per *The Quantum Yearbook 2025*.²⁰³

[199] The defendant's legal team proposed general damages award for compensation of TM in the amount of R2,200.000.00 citing the following factors mitigating against awarding the highest compensation amount for TM general damages:

[199.1] TM has been attending mainstream school and had progressed quite well.

[199.2] He has friends that he plays with and has been able to play soccer and cricket.

[199.3] He is not wearing nappies.

[199.4] He is able to walk, run, and jump even though it is said that he falls.

²⁰¹ 2018 (8A4 QOD 87 (EC).

²⁰² 2021 (8A4) QOD 26 (GSJ).

²⁰³ See above n 243 at page 65.

[199.5] The educational psychologist noted, remarkable improvement compared to when he was assessed in 2019 versus 2023.

[200] During the oral arguments counsel for the defendant referred to the matter of *KTP obo OP v The Minister of Health & others*²⁰⁴. This judgment deals with several decided cases and different awards of damages awarded by various courts over several years.²⁰⁵

[201] The defendant's legal team correctly argued further that the court exercises a discretion in determining the quantum of damages claim. In *KTP* the court was dealing with a child with level 5 severe cerebral palsy, where an award for general damages compensation was set at R2 200,000.00. *The KTP* case was decided in 2024, which is the most recent case and the child was impacted by the most severe cerebral palsy.

[202] In the instant case this court is dealing with a child with level II cerebral palsy. Counsel for the defendant contends further that in the cases referred to in *KTP* case, the damages claims were awarded ranging from R1 800.00 to R2 200 000.00. Therefore, the defendant argued further that an award in the amount of R2,200,000.00 is fair and reasonable in the instant case.

[203] In assessing general damages, a broad discretion is exercised by a court, based on what it considers fair and adequate in the circumstances. The nature, severity of the injuries sustained and consequences thereof, be it pain and suffering, disfigurement or lack of amenities of life are all considered. Comparable cases are also used as a guide in determining an appropriate quantum of damages²⁰⁶.

[204] To bring it closer to home, counsel for the plaintiff referred me to cases dealing with cerebral palsy children where the degree of severity differs and the award for

²⁰⁴ Unreported judgment, Case No 109/2017 decided on 6 May 2024.

²⁰⁵ at paragraph 7 to paragraph 21.

²⁰⁶ *Protea Assurance Co Ltd v Lamb* 1971 (1) SA 530 (A) at 536A-B

damages is diverse, for example, in *CS (obo TGS) v MEC for Health, Gauteng*²⁰⁷, an 11-year old cerebral palsy child who could not walk or talk, was incontinent with severely reduced hearing and vision had a life expectancy of 19 years was awarded damages of R1 800.000.00 in the 2025 Quantum Yearbook that amount is R2 534 000.00. Again, the case of *AD and IB MEC for Health and Social Development, Western Cape*²⁰⁸ involved an 8-year old athetoid cerebral-palsy child who was still wearing nappies was awarded an amount of R2 792 000.00.

[205] Counsel for the defendant argued correctly that each case is decided on its own merits. Counsel for the plaintiff also argued that some of the award for damages claim in the case law relied upon by the defendant have been outdated by inflation as it is reflected in Quantum Yearbook 2025.

[206] It needs to be emphasised that in some cases referred to above cerebral palsy was severe, whereas in this case the experts say this is a level II cerebral palsy. This is a clear indication of the principle that each case is decided on its own merit, and that there is no one-size-fits-all approach. However, on the other hand, it is undisputed that TM's life has been adversely impacted. If he receives adequate therapy, he may live longer when such eventuality happens. If he is under compensated, he may struggle to survive.

[207] In consideration of all the facts of this case, evidence from the underlying experts' reports in particular extracts quoted above, as well as arguments by counsel of the respective parties, I have the difficult task of determining how much compensation to award to TM. The plaintiff's legal team has asked a question, how much one compensates TM for his spastic gait, his falling over without warning, his incoherent speech difficulties, his never fitting into the social world, his inability to be independent,

²⁰⁷ 2018 (8A4) QOD 104 (GNP).

²⁰⁸ 2016 (7A4) 32 (WCC).

other members of society will look at him as sub-human, when he sees himself looks different from others etc.

[207.1] The majority judgment of the SCA in the matter of *MEC for Health, Gauteng Provincial Government v AAS obo CMMC*²⁰⁹ draws a distinction between pain and suffering and loss of amenities of life. In that case the high court granted a globular figure for general damages claim in the amount of R2,200.000.00. The SCA remarked that although the pain and suffering are often forming part of general damages these are two distinct components. In this case the SCA warned against the disregard of the amount awarded for special damages component when the court is also tasked to determine the general damages component in the same action. In that case the plaintiff had already been awarded R13, 330 578.28 in addition it awarded the R2.200, 000.00. for the general damages component. The majority judgment of the SCA held that the high court erred and overturned the high court judgment and awarded no damages claim for the plaintiff/respondent. In that case the child was in an unconscious state which is not the case here.

[207.2] In the instant case, the plaintiff has already been awarded special damages claim i.e. TM's future medical and related expenses with an amount of R22, 125 163.00, the cost provisions for occupational therapist, speech and language therapy, and assistive devices, caregiver, physiotherapist, dental care, architect relating to adaptation paediatric surgeon etc. It will not be proper for me to ignore all of that when determining the quantum for TM's general damages.

[208] Having considered the comparable case law²¹⁰ referred to above, and after assessing all the above and having revisited the experts' reports filed by the parties, I am of the view that an amount of R2 600 000.00 would be a fair and reasonable award for TM's general damages.

²⁰⁹ 2025 (6) SA 152 (SCA) delivered 20 June 2024) at para 51 to 59.

²¹⁰ As stated by Watermeyer JA in *Sandler &* followed in *AD* case supra, no price tag can be attached to the adverse life to be lived by TM for the rest of his life.

[209] I now consider the issue of the protection of the award.

The costs for protection of the award

[210] It is common cause that from the underlying reports and the joint minutes²¹¹ in the matter that the award should be protected.²¹² During the closing arguments counsel for the defendant raised concerns with regard to the Trust Deed as to whether it complies with all the requirements in close reference to the case by the full bench of this division.²¹³ After having read the full bench judgment I am satisfied there is compliance although it could have been more appropriate to have a *curator ad litem* appointed. I was assured by lead counsel for the plaintiff who has silk status that this child's interests will be well protected.

[211] The parties in the pre-trial conference, Third (Quantum) Pre-trial Conference Minute, parties agreed on the creation of a trust and appointment of professional trustees.²¹⁴ See the matter of *In Re Protection of Certain Personal Injury Awards (Pretoria) Society of Advocates and Others, amici curiae*²¹⁵

[212] The parties also agreed on the calculation of the costs of protection of the award by way of the usual 7.5% add-on calculation.

[213] The protection award is thus calculated by simply adding-on 7.5% to the agreed/awarded figure.

[214] The calculated protected award is R2, 147 113.00.

²¹¹ Caselines A- 114.

²¹² Caselines Q-84 The occupational therapists & speech therapist at Q-09.

²¹³ *In Re Protection of Certain Personal Injury Awards (Pretoria) Society of Advocates and Others, amici curiae* 2022 (6) SA 446 (GP)

²¹⁴ See *In Re Protection of Certain Personal Injury Awards (Pretoria) Society of Advocates and Others, amici curiae* 2022 (6) SA 446 (GP).

²¹⁵ 2022 (6) SA 446 (GP) para [32] to [58], in particular para [58]

The Total Award

[215] I therefore find that the plaintiff, on a preponderance on probabilities, has proven the damages in the amount of R30 775 286.00 (Thirty Million Seven Hundred and Seventy-Five thousand Two Hundred and Eighty-Six rands) consisting of the following:

1.	Future hospital, medical and related expenditure	R22 125 163.00
2.	Future Loss of earnings and/or earning capacity	R3 903.010.00
3.	General damages in the amount of	R2 600 000.00
4.	Protection award	R2 147 113.00

Costs

[216] The plaintiff has succeeded, and this matter required the services for employment of two counsel due to its complexity. There is no reason to deviate from the normal rule that costs follow the result, but different scales will be applied with senior counsel at a higher scale. The judgment is awarded with costs for employment of two counsel on a scale B & C respectively.

Order

[217] Consequently, the following order is granted:

1. I make an order in terms of the draft marked "X", which incorporates a Deed of Trust marked "A".

N.L SKIBI

**ACTING JUDGE OF THE HIGH COURT
GAUTENG DIVISION, PRETORIA**

Appearances:

On behalf of the plaintiff:

Adv. S.J Myburgh S.C assisted by Adv. A.L Easte and
instructed by Werner Boshoff Incorporated

Email address: laura@wb-inc.co.za

Tell: 012 752 7702

On behalf of the defendant:

Adv. N. Makopo assisted by Adv. J. Daniels and
instructed by State Attorney

Email address: wmabaso@justice.gov.za

Tell: 011 330 7600

Date heard:

06/07/08/09/10/13/14/15/16/20/23 October 2025.

Date of Judgment:

26 January 2026