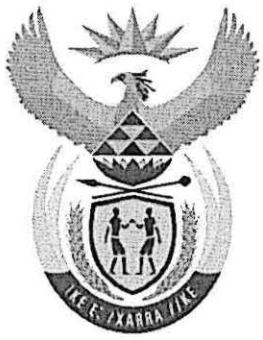

IN THE HIGH COURT OF SOUTH AFRICA
FREE STATE DIVISION, BLOEMFONTEIN

Not reportable
Case no: A209/2024

In the matter between:

MEMBER OF THE EXECUTIVE COUNCIL:	**APPELLANT**
DEPARTMENT OF HEALTH, FREE STATE PROVINCE	
and	
JANINE RONELDA HARRIS	**FIRST RESPONDENT**
GIRSHEN MARC ARTHUR HARRIS	**SECOND RESPONDENT**

Neutral citation: *Member of the Executive Council: Department of Health, Free State Province v Harris and Another* (A209/2024) [2026] ZAFSHC 250 (17 April 2026)

Coram: OPPERMAN, DANISO *et* VAN RHYN JJ
Heard: 30 January 2026
Delivered: 17 April 2026

Summary: Appeal medical negligence claims against MEC of Health – merits conceded in favour of the respondents. Damages – quantification – awards made by court a quo in respect of claims relating to loss of earnings, future medical expenses and general damages. Appeal lies against contingencies applied to first respondent's loss of income as calculated by appellant's actuaries, both respondents – future medical expenses as well as general damages. Principles restated.

ORDER

1 The appeal in respect of the respondents' future medical expenses is upheld.

2 The order of the court a quo is set aside and substituted with the following:

'2.1 Paragraph 30.1.3 of the trial court's order is amended by substituting the amount of R690 170, in respect of future medical expenses, with R663 150.

2.2 Paragraph 30.2.2 of the trial court's order is amended by substituting the amount of R90 870, in respect of future medical expenses, with R86 620.'

3 Save as aforesaid, the appeal is dismissed.

4 Each party shall pay their own costs including those costs incurred in respect of the application for leave to appeal.

JUDGMENT

Van Rhyn J (Opperman *et* Daniso JJ concurring)

[1] This appeal by the Member of the Executive Council for the Department of Health, the appellant, comes about as a result of a medical negligence claim instituted by the first and second respondents, Mrs and Mr Harris against the appellant for damages arising out of the alleged negligence of the medical staff in her employment. The appeal lies against the court a quo's award, delivered on 19 December 2023, in respect of general damages, loss of income and future medical expenses arising from the death of the respondents' first-born son, a mere two days after his birth. The appeal is to the full bench of this Division with the leave of Chesiwe J against those portions of the judgement and order of Gusha AJ as set out in the notice of appeal.

[2] The respondents instituted action for damages on 14 July 2016 as a result of the negligence of the appellant's employees at the Pelonomi Hospital in Bloemfontein subsequent to the hospitalisation of the first respondent on the 2nd of August 2013 and the birth of their son, Aristo, on 4 August 2013. Their son was born with a diagnosis of asphyxia neonatorum and hypoxic-ischemic encephalopathy and died on 6 August 2013. The appellant conceded liability for payment of 100% of the respondents' proven and/or agreed upon damages on 23 April 2019. With the merits conceded the trial commenced on 11 October 2023 in respect of the quantum of damages. The respondents filed medico-legal reports compiled by Dr D A Shevel, a Psychiatrist (Dr Shevel), Dr Kobus Truter, a Clinical Psychologist (Dr Truter), Dr Marc Peverett, an Industrial Psychologist (Dr Peverett) and Munro Forensic Actuaries. The appellant filed medico-legal reports by Dr R T H Lekalakala, a Psychiatrist (Dr Lekalakala), Dr Mariske Pienaar, a Clinical Psychologist (Dr Pienaar), Hardus van Pletzen, an Industrial Psychologist (Mr Van Pletzen) and actuarial reports compiled by Edge Actuarial.

[3] The first respondent claimed damages in the aggregate sum of R9 607 700 under the following headings:

(a) Future medical expenses R663 150.
(b) Past loss of income R1 707 385.
(c) Future loss of income R6 587 165.
(d) General Damages R650 000.

[4] The court a quo awarded damages in the total amount of R5 118 532.90 which is made up as follows:

(a) Future medical expenses R690 170.
(b) Loss of income R3 878 392.90.
(c) General Damages R550 000.

[5] The second respondent claimed damages in the aggregate sum of R751 620. under the following headings:

(a) Future medical expenses R86 620.
(b) Funeral expenses R15 000.
(c) General Damages R650 000.

[6] The court a quo awarded damages in the total amount of R390 870.which is made up as follows:

(a) Future medical expenses R90 870.

(b) General Damages R300 000.

[7] The appellant lodged an application for condonation and leave to appeal against the awards made by the court a quo. On 1 August 2024, Chesiwe J granted condonation for the late filing of the application for leave to appeal. The appellant was granted leave to appeal to the Full Court of this Division with the costs to be costs in the appeal. On the 20th of February 2025, the appellant's failure to deliver her notice of appeal within 20 days after the date upon which leave to appeal was granted was condoned and the appellant's appeal, which had lapsed, was reinstated. The appeal is directed at the amounts awarded by the court a quo on the grounds that the respondents have been overcompensated. The appeal is opposed by the first and second respondents. At the commencement of the hearing of the appeal, Ms Williams SC, counsel for the appellants, contended that the parties are in agreement that a court of appeal has limited power to interfere with the exercise of a lower court's discretion, such as in the matter at hand, where the court a quo exercised a discretion in the true (strict) sense.

[8] However, the parties disagree in respect of the contention on behalf of the appellant that the court a quo failed to have appraised and assessed the evidence adduced during the trial. This failure by the trial court resulted in the acceptance of outdated assessments, which pre-date the assessment done by Dr Lekalakala, resulting in the rejection of the opinion of Dr Lekalakala and the acceptance of the opinion of Dr Shevel. It is contended that the court a quo failed to address, in the judgment, the reasons why the opinion of Dr Shevel was preferred in respect of the diagnosis of the first respondent. The consequences in rejecting the evidence presented by Dr Lekalakala for the appellant, not only impacts upon the amount awarded for loss of income, but also the amounts awarded for future medical costs and general damages. Ms Williams SC contended that on the evidence adduced no case was made out for future medical treatment for the first respondent in the amount awarded by the court a quo.

[9] The appellant furthermore contends that the court a quo failed to have regard to the pleadings in that the award made by the court a quo in respect of future medical

treatment for the first respondent in the amount of R690 170 exceeds the amount claimed under this heading of damages. The amount claimed is R27 020 less than the amount awarded for future medical treatment for the first respondent. It is argued by the appellant that when Dr Lekalakala assessed the first respondent, there was a marked improvement in her condition which is evident from the contents of his report and his testing. The correct approach would have been for the court a quo to award the items which were common cause between the experts and where they differed, the items should either have been disallowed in their entirety or allowed but with appropriate contingencies applied.

[10] As regards the first respondent's claim for loss of income and the award made by the court a quo in the amount of R3 878 362.90 it is argued that this came about principally as a result of the fact that the contingency deduction applied to the uninjured income are too low and those applied to the injured income are too high. Ms Williams SC argued that the injured income is so minimal and has already been attained before the first respondent underwent the recommended medical treatment. Therefore, no contingency adjustment should be made in the circumstances. The award made in respect of general damages is out of kilter with the awards made in comparable cases and is therefore not fair to either the first respondent, or the appellant.

[11] In respect of the second respondent the court a quo erred in awarding future medical expenses in the amount of R90 870 in that the judgment does not address the reason for such an award which is not supported by the facts of the matter. The amount awarded under this heading is also R4 250 more than the amount claimed. The court a quo erred in awarding general damages in the amount of R300 000 to the second respondent in that the award is out of kilter with awards made in comparable cases and is also not fair to both parties.

[12] In an appeal a party's dissatisfaction with the judgment of a court a quo may arise either because that party is discontented with a finding of fact made by the court, for example the party is of the view that the court incorrectly accepted or rejected the testimony of a witness whose evidence was material to the case or because the party is dissatisfied with a ruling of law made by the court (e.g., the party is of the view that the court misunderstood the law on a certain point). It may also turn out that a party feels that the court erred both in respect of the law and the facts and an appeal will then be lodged

on both grounds. It is trite that an appeal court is reluctant to disturb findings of credibility and fact by a trial judge who has the advantage, which the court of appeal cannot have, of seeing and hearing the witnesses and of being steeped in the atmosphere of the trial. Such findings are only overturned if there is a clear misdirection of the trial court's findings and clearly erroneous.[1]

[13] In addition to appeals against the decision of a court a quo on the facts or the law, a party may be faced with a situation where he or she wishes to appeal against the exercise of a discretion by the court. A discretionary matter may require the court to exercise a discretion in a wide or a narrow sense (a 'true' sense or a 'loose' sense), and the difference between these types of discretion may impact on the court of appeal's consideration of the issues on appeal. The nature of the two kinds of discretions has been decisively established as follows:

'[85] A discretion in the true sense is found where the lower court has a wide range of equally permissible options available to it. This type of discretion has been found by this court in many instances, including matters of costs, damages and in the award of a remedy in terms of s 35 of the Restitution of Land Rights Act. It is "true" in that the lower court has an election of which option it will apply and any option can never be said to be wrong as each is entirely permissible.

[86] In contrast, where a court has a discretion in the loose sense, it does not necessarily have a choice between equally permissible options. Instead, as described in *Knox,* a discretion in the loose sense – "mean[s] no more than that the court is entitled to have regard to a number of disparate and incommensurable features in coming to a decision".'[2] (Footnote omitted.)

[14] There are different tests for interference by a court of appeal, depending on the nature of the discretion exercised by a lower court. In the instance of a discretion in the loose sense, '. . . an appellate court is equally capable of determining the matter in the same manner as the court of first instance and can therefore substitute its own exercise of the discretion without first having to find that the court of first instance did not act judicially.'[3] In *Oakdene Square Properties (Pty) Ltd and Others v Farm Bothasfontein (Kyalami) (Pty) Ltd and Others*[4] Brand JA emphasised the principle that a court of appeal

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[1] *ST v CT* [2018] ZASCA 73; 2018 (5) SA 479 (SCA) para 26.
[2] *Trencon Construction (Pty) Ltd v Industrial Development Corporation of South Africa Ltd and Another* [2015] ZACC 22; 2015 (5) SA 245 (CC) paras 85 and 86.
[3] Ibid para 87
[4] *Oakdene Square Properties (Pty) Ltd and Others v Farm Bothasfontein (Kyalami) (Pty) Ltd and Others* [2013] ZASCA 68; 2013 (4) SA 539 (SCA).

may only interfere with the exercise of a lower court's discretion if it was influenced by wrong principles of law, or a misdirection of fact, or if it had failed to exercise a discretion at all. This limitation only applies to a discretion in the strict sense as articulated by Brand JA:

'The contention has its roots in the well-established principle that a court of appeal is not allowed to interfere with the exercise of a discretion merely because it would have come to a different conclusion. It may interfere only if the lower court had been influenced by wrong principles of law, or a misdirection of fact, or if it had failed to exercise a discretion at all. The reason for the limitation, it is said, is because, in an appeal against the exercise of a discretion, the question is not whether the lower court had arrived at the right conclusion, but whether it had exercise its discretion in a proper manner (see Mabaso v Law Society, Northern Province, and Another 2005 (2) SA 117 (CC) (2005 (2) BCLR 129) para 20). Equally well settled, however, is the principle that this limitation on interference only applies to the exercise of a discretion in the strict sense.'[5]

[15] In adjudicating the appeal the following facts are to be taken into consideration: At the commencement of the trial joint minutes prepared by the appellant's and the respondents' psychiatrists, the clinical psychologists and the industrial psychologists, setting out the issues in dispute and those on which the various experts agree, were prepared and handed up by agreement between the parties. In an endeavour to curtail the trial, the parties reached various agreements which Mr Zietsman SC, who appeared for the respondents (and during the trial on behalf of the plaintiffs) encapsulated in a 'further' rule 37 minute (the Further Rule 37 Minute). However, apart from revealing what was agreed in respect of the calculation of the first respondent's loss of income by an actuary, the Further Rule 37 Minute was not initially presented to the court a quo due to the fact that counsel who appeared on behalf of the appellant during the trial, Ms Nhlapo-Merabe, placed on record that instructions had been received that the defendant (appellant) intends to repudiate from the joint minutes compiled by the Clinical Psychologists (Dr Pienaar and Dr Truter) in so far as the Clinical Psychologists' joint minute are not in consonance with the report by Dr Lekalakala (the appellant's psychiatrist). This aspect stood down until the following day and upon reconsideration the appellant abdicated its intention to repudiate the said agreement. As a result, and by agreement between the parties, the Further Rule 37 Minute was handed to the trial judge. The Further Rule 37 Minute provided as follows:

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[5] Ibid para 18.

'1.1 The first plaintiff's loss of income is to be calculated by an actuary on the basis as postulated in the joint minute of the Industrial Psychologists – Mr Marc Peverett and Mr Hardus van Pletzen – filed of record, provided that the contingencies to be applied will be the prerogative of the court.

1.2 The joint minute of the Psychiatrists – Dr Shevel and Dr Lekalakala – in respect of both the first and second plaintiff, filed of record, shall serve as evidence before court.

1.3 The joint minute of the Clinical Psychologists – Dr Truter and Dr Pienaar – in respect of both the first and second plaintiff, filed of record, shall serve as evidence before court.

1.4 The expert reports of Dr Truter and Dr Pienaar, filed of record, shall serve as evidence before court.'

[16] To curtail the issue of the first respondent's loss of income claim, the parties agreed that her loss of income be calculated by an actuary on the basis as postulated in the joint minute of the industrial psychologists. It was furthermore agreed that the appellant would instruct Edge Actuarial to calculate her loss of income, bar the contingencies to be applied, which calculation was accepted by the first respondent. This aspect therefore became settled save for the contingencies to be applied. The calculation by Edge Actuarial was as follows:

	Past Income	Future Income	Total Income
Income if incident did not occur	R717 586	R4 020 524	R4 738 110
Income given incident did occur	R56 947	R228 846	R285 793
Difference	R660 639	R3 791 678	R4 452 317

Therefore, the only issues for determination by the court a quo were the respondents' claims for general damages, the future medical expenses and the contingencies to be applied to the first respondent's loss of income as calculated by the appellant's actuaries, Edge Actuarial.

[17] During the trial the testimonies of the first respondent and second respondent were

presented. The respondents furthermore presented the testimony of Dr Shevel and Ms Valentine of Munro Actuaries. Thereafter the respondents closed their case. The appellant presented the testimony of Dr Lekalakala who examined both the first and second respondents and it was contended by Ms Nhlapo-Merabe that, from the joint minutes by Dr Lekalakala and Dr Shevel, '. . . the only aspects that are in dispute are the severity of the illnesses and the treatment . . .' thereof as suggested by the two psychiatrists.

[18] In the joint minutes of the psychiatrist meeting held on the 6th of October 2023 the following was, *inter alia* recorded:

'3. It was agreed that Mrs Harris had not had any psychiatric treatment or had experienced any psychological problems prior to the event.

4. It was agreed that Mrs Harris is currently suffering from a Major Depressive Disorder. Dr Lekalakala considers her chronic depression to be of a mild to moderate degree, whereas Dr Shevel considers her chronic depression to fall into the moderate to severe category.

5. Furthermore, Dr Shevel, from the history obtained, notes the presence of Chronic Generalized Anxiety with superimposed Panic Attacks and Agoraphobia.

6. Dr Shevel notes that she is now largely confined to her home environment.

7. Both Dr Shevel and Dr Lekalakala agrees that Mrs Harris requires psychiatric/psychological treatment.

8. The extent of the psychological/psychiatric treatment differs in that Dr Lekalakala believes that psychotherapy is necessary.

9. Dr Shevel's view is that long-term treatment, including the use of psychiatric medication and psychotherapy will be required.

10. With regard to her pre-August 2013 occupational functioning and the current situation, deference is given to the Industrial Psychologists.'

[19] Dr Shevel assessed the first respondent on the 10th of March 2020, and his report is dated the 16th of March 2020. It is noted that the life-threatening ordeal occurred close to five and a half years previously and the first respondent has ongoing symptoms of post-traumatic stress disorder (PTSD) and that she must be considered to be suffering from a chronic form of this condition. PTSD is a condition that has a high incidence of co-morbid major depression. According to Dr Shevel the first respondent has a significant depressive illness with a history of repeated overdose attempts. She has features of a panic disorder with associated agoraphobia. Agoraphobia can have a slowly increasing

negative impact on her quality of life in that she may become increasingly confined to her home due to her fear (phobia) of going out. Dr Shevel opined that the first respondent's psychiatric condition is moderate to severe and many of her symptoms are entrenched and will be difficult to treat successfully. It is noted that she requires psychiatric treatment but is not keen to take medication. She requires psycho-education in terms of taking psychotropic medication.

[20] It is stated that the first respondent will require long term, probably lifelong, psychiatric treatment which will consist of the use of psychotropic medication, follow up psychiatric consultations and psychotherapy. Even with an optimal response to psychiatric treatment and psychotherapy, the first respondent is likely to remain with residual symptoms of chronic PTSD, depression and panic attacks. Psychiatric treatment and psychotherapy should improve her quality of life and help deal with crisis situations that are very likely to occur from time to time. It is furthermore noted that there has almost certainly been a loss of occupational potential and that the result of the trauma (emotional and physical) has cost the first respondent to miss out on the window of opportunity to further her studies.

[21] In the medico-legal report compiled by Dr Lekalakala, it is noted that the first respondent was assessed on 24 April 2023, in order to establish the nature and extent of any psychological trauma which may have resulted from the incident and to establish whether there were any attendant psychiatric or psychological *sequelae* and their impact on the first respondent's psychological functioning. Lastly, it also determined and assessed whether any psychiatric intervention may be required as a result of the incident.

[22] The following current complaints are recorded by Dr Lekalakala:

'She currently continued to feel low and has lost trust in the public health care system. She reported having recurrent nightmares related to the incident, she had intrusive and distressing memories of the encounter. No avoidance symptoms were established during the interview and her memory of the events that occurred on the day were intact. She has been able to have positive emotions of happiness and love and was able to engage in social activities.'

Dr Lekalakala noted that the first respondent displayed a depressed mood, lack of interest in pleasurable activities and expressed feelings of worthlessness. She cited being suicidal post-incident, struggled with her sleep and had poor concentration as well as low energy

levels. She did not have any manic symptoms. Dr Lekalakala opined that the first respondent's psychiatric diagnosis did not result in any impairment that would hinder employment. A psychiatric diagnosis of 'major depressive disorder-severe without psychotic features' is recorded. A recommendation is made that the first respondent would benefit from at least 30 sessions of cognitive behavioural therapy.

[23] Certain parts of the record, more specifically the transcription of the testimony of Dr Shevel and that of Dr Lekalakala, are extremely unclear. It is attributed to the fact that these experts testified virtually. In an effort to rectify the problem, a further transcription was prepared and filed, referred to as the supplementary transcription of Dr Shevel's and Dr Lekalakala's testimonies. Dr Shevel's evidence in chief could however not be reconstructed.

[24] Dr Shevel testified that he considers the first respondent's chronic depression to fall into the moderate to severe category. He furthermore confirmed the diagnosis made as contained in the psychiatrists' Joint Minute. The diagnosis made by Dr Shevel, save for the severity of the PTSD, was not challenged during cross-examination.

[25] In the Joint Minutes of a meeting between Drs Truter and Pienaar (clinical psychologists) on 19 March 2022 regarding the first respondent the following points are, *inter alia,* recorded:

(a) The first respondent did not suffer from predating diagnosed psychopathology. She repeated Grade 11 and matriculated at Heatherdale High School. Before the incident she applied at the South African National Defence Force (SANDF) for a nursing position. She was reportedly successful in her application.

(b) During her period of recuperation, she still presented with medical complications and could not accept her appointment. She was then employed by Mr Price as a sales lady. She resigned after two months.

(c) The incident: when she was 38 weeks pregnant, she visited the Heidedal Clinic. She was transferred to Pelonomi Hospital and admitted on 3 August 2013 as a result of gestational hypertension and pre-eclampsia. Her baby was born on 4 August 2013 (a vaginal delivery) but died two days later on 6 August 2013 as a result of severe asphyxia.

(d) No disagreement of fact is noted. Under the heading 'Points of agreement of opinion' the Clinical Psychologists noted as follows:

'3.1 The situation surrounding the birth contributes to her ongoing Post-traumatic Stress Disorder (PTSD)- features.

3.2 The couple could not attend the funeral, which contributes to the persistent emotional distress. Mrs Harris suffers from a mood disorder of depression. She has already attempted suicide. Triggers for her low mood (and anxiety) are described in our respective reports.

3.3 We agree to the following grading: American Medical Association (AMA): Global Assessment of Functioning Scale (GAF) impairment score: 10%-12% (ten to twelve).

3.4 Medical complications: She complains about physical discomfort (in her kidneys), is diet-sensitive and at times develops problems with her urinary flow. She has to rely on medication. The opinion of a urologist is indicated. We agree that her psychological prognosis is inter-related to her medical status. A detailed proposal in this regard was presented in our respective reports. She remains vulnerable and relapses may occur from time to time.'

[26] Dr Pienaar interviewed and assessed the first respondent and the initial medico-legal report is dated 10 July 2017. On 22 February 2021, she interviewed and assessed the first respondent for a clinical and psychological re-assessment. The re-assessment report filed of record is dated 1 March 2021. In the re-assessment report, it is mentioned that the self-report questionnaire highlighted that first respondent was experiencing severe depressive symptoms the previous two weeks (Total Score = 40; 13 in 2017). It is noted that the first respondent's mood had deteriorated since 2017. Significant symptoms were loss of pleasure, guilt feelings, and loss of interest. Suicidal ideation was reported. Hypothalamic functions were disturbed (sleep, appetite, libido and energy). The Trauma Symptom Inventory (a test of posttraumatic stress) and other psychological sequelae of traumatic events supported the observed clinical picture with depressive symptoms above the T-score cut-off point of 65 for clinical significance.

[27] In Dr Pienaar's re-assessment report it is noted that the first respondent's anxiety symptoms worsened since 2017. Dr Pienaar reported that the incident in August 2013 was very traumatic and unexpected. The incident and unfortunate facts surrounding the trauma has set the stage for the development of chronic treatment-resistant mood disorders (depression, anxiety and PTSD). According to Dr Pienaar, the first respondent had in all probability reached Maximum Medical Improvement (MMI). It is recommended that the first respondent be ordered by the court, and also monitor, referrals to a clinical psychologist to assist her in dealing effectively with mood disorders and a psychiatrist to

treat the mood disorders pharmacologically due to the fact that the first respondent would probably not choose this route voluntarily. According to Dr Pienaar, the probability that the first respondent would opt for receiving intensive psychological and psychiatric assistance is low due to lack of emotional insight, unwillingness and avoidance behaviour which is part of PTSD.

[28] During his testimony in chief, Dr Lekalakala explained that as ten years had lapsed since the incident and many of the acute symptoms had largely resolved at the time of the assessment, he considered the symptoms to be mild to moderate. Regarding the difference of opinion between himself (Dr Lekalakala) and Dr Shevel's extent of treatment required revolves around his belief that psychotherapy is necessary whereas Dr Shevel believes that both the use of psychiatric medication as well as psychotherapy will be required. Dr Lekalakala once again replied that the severity of the symptoms was not as Dr Shevel had reported it and enough time had lapsed so that pharmacological intervention would not be necessary and psychotherapy would be the ideal mode of treatment.

[29] During cross-examination by Mr Zietsman SC, Dr Lekalakala explained that the diagnosis is that of major depressive disorder and not PTSD and the severity of the symptoms is not as indicated by Dr Shevel. When questioned on his finding that the first respondent's psychiatric diagnosis did not result in any impairment that would hinder employment, Dr Lekalakala explained that she is employable and she has not received any psychiatric care in any form. She only received one month of treatment after seeing a general practitioner post the incident. When asked whether it would mean that there is a good possibility that she will be treated both through medication as well as psychiatric sessions, Dr Lekalakala replied that psychiatric sessions, at the moment, would be the first line of treatment. The first respondent cannot be deemed to be unemployable if she has not gone through all, or at most electroconvulsive therapy and clinical intervention.

[30] Dr Lekalakala explained that there are treatment algorithms recognised by various institutions in mental health care and that he is not opposed to medication being administered, but psychotherapy is first-line treatment both in respect to the first as well as the second respondents and only if there is no response, then pharmacological treatment should be administered. It was put to Dr Lekalakala that his opinion that

pharmacological treatment should be administered first was not put to Dr Shevel during cross-examination with the result that Dr Shevel was not afforded the opportunity to respond to his contention in this regard. Furthermore, his opinion regarding the severity of the first respondent's major depressive disorder is not in line with the admitted opinion of Dr Pienaar (being the clinical psychologist employed by the appellant) who evaluated the first respondent during March 2021 and diagnosed severe depressive symptoms.

[31] The first respondent testified that her first attempt to commit suicide was during November 2013. The second attempt was when her next born son was a year and six months old. On both occasions she used medication (pills). She had lost a tremendous amount of weight and had lost her appetite. She suffered from sleeplessness, had problems with her memory and she and the second respondent did not engage in sexual relations for a period of three years because she had suffered from constant bleeding (menstrual cycle) and physical problems (internal stitches and a balloon being inserted to support her womb). Mr Zietsman SC explained to the first respondent that her claim for loss of income has been, to a large extent, settled, resulting in his questions to her being curtailed. When questioned regarding her career ambitions, the first respondent replied that she aspired to become a nurse because many of her family member where nurses, including her mother and her uncle.

[32] During cross-examination, the first respondent explained that even though she had been advised that the situation will get better with the passing of time, it has not been her experience. She explained that she is still hurting. As to taking prescription medication and therapy to assist her psychological functioning, the first respondent explained that if medication and psychological intervention are prescribed and recommended, she is willing to accept such advice and will take the medication.

[33] The evidence tendered by the second respondent during the trial, which is relevant to the adjudication of the awards in respect of general damages to both respondents, can concisely be summarised as follows: He was summoned to Pelonomi Hospital at around 22h00 on the 3rd of August 2013 and found the first respondent on a stretcher in the passage. She repeatedly apologised and mentioned to him that their baby has brain damage. He pressed with his hands on the stretcher and felt that his hands were wet. When he lifted the sheets, he noticed that his wife was lying in a pool of blood.

He entered a room/ward, while pushing the first respondent on the stretcher, where he asked for help from the nursing staff. The nursing staff pushed back the stretcher whereafter an argument ensued between him and the nursing staff during which the nursing staff threatened to call the security personnel and police to remove him from the premises. A security guard arrived and grabbed him. Thereafter the second respondent collapsed. According to his testimony he suffered a stroke. He was unable to speak, to see what was happening and his face appeared skew. The police arrived and asked him and his parents, who were at the hospital with him, to leave. Subsequent to his mother and father intervening, he was allowed to remain at the hospital.

[34] After being left on the bloodied stretcher during the night until 13h00 the following day due to a lack of beds being available, the first respondent was only operated on at 15h00. The second respondent testified that he feared for his wife's life. The first respondent was taken to surgery to stop the bleeding. Thereafter she was transferred to the Universitas Hospital. Meanwhile, the second respondent was informed that the baby had suffered severe brain damage (80% brain damage) and that the baby would probably die. In the event of their baby surviving, his quality of life would be extremely poor. It was explained to him that the APGAR score was 3 and then went down to 2 as a result of the baby's head being crushed during the birth process. The first respondent was placed on dialysis with treatment every second day until the 14th of August 2013. The baby died on the 6th of August 2013, incidentally also the birthday of the first respondent.

[35] In the judgment of Gusha AJ it is stated that the facts giving rise to the litigation between the parties are largely uncontroverted. In para 8 of the judgment the following comment is made:

'I pause here to mention that, seeing and listening to the first plaintiff tender her evidence, was the most agonizing and difficult experience in my judicial life. So emotional was she that it was often difficult to hear or make sense of her evidence throughout the screams. To not be affected by that, one would have to be devoid of all human emotion. No human being should ever be subjected to the treatment that she was.'

In determining the award in respect of general damages the court a quo restated the general applicable legal principles and held as follows: 'Attempting to determine an adequate solatium for the plaintiffs' suffering is, of course a daunting task as no monetary compensation can ever make up for the loss of their child and the resultant mental

anguish they suffered.'

[36] Expert witnesses are in principle required to support their opinions with valid reasons. Much will depend on the nature of the issue and the presence or absence of an attack on the opinion of the expert.[6] It is settled law that the court is not bound by the view of an expert witness.[7] Of importance is that the facts on which the expert witness forms an opinion must be capable of being reconciled with all other evidence in the case. For an opinion to be underpinned by proper reasoning, it must be based on correct facts.[8] The expert must satisfy the court that, because of his special skill, training or experience, his views are acceptable.

[37] Dr Lekalakala ended his expert report with the following disclaimer:

'This report is based on the history supplied by the client/informant, medical records and reports of the client and an assessment of the client. I have the right to alter my opinions in the event of new information coming afore. This report is valid for a period of three years after the assessment, beyond that the client will have to be reassessed.'

The argument on behalf of the appellant is that Dr Lekalakala is the last expert to have assessed the first respondent prior to the trial which was heard during October 2023. The same argument applies to the second respondent. It is contended on behalf of the appellant that there has been a marked improvement in the condition of the first respondent when Dr Lekalakala assessed her during 2023. Ms Williams SC argued that the court a quo therefore should not have accepted the opinion of Dr Shevel because of the historic facts, as set out in the 2020 report by Dr Shevel, which had been surpassed by later events, and once the court of appeal accepts this argument raised by the appellant, it gives the court of appeal the right to intervene and to adjudicate upon the awards made in respect of the first respondent. Ms Willams SC contends that it is clear from the evidence and report by Dr Lekalakala that the first respondent 'got better' and had improved without any psychological or pharmacological intervention. It is argued by the appellant that this was clearly not taken into consideration by the trial court in assessing the evidence presented by Dr Shevel.

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[6] *S v Mthimkulu* 1975 (4) SA 759 (A).
[7] *Road Accident Appeal Tribunal v Gouws* [2017] ZASCA 188; 2018 (3) SA 413 (SCA) para 33.
[8] *Bee v Road Accident Fund* [2018] ZASCA 52; 2018 (4) SA 366 (SCA) para 23.

[38] Although the judgment of the trial court does not deal in detail with the evaluation of the evidence presented by Dr Shevel and Dr Lekalakala, the contention on behalf of the appellant is correct that the evidence of Dr Shevel was indeed accepted. In the joint minutes by the psychiatrists, it was agreed that the first respondent was currently suffering from a major depressive disorder. The only disagreement was regarding the severity of her chronic depression and on the extent of the treatment required. The evidence presented by Dr Lekalakala in chief was as follows:

'Adv Nhlapo-Merabe: And the extent of the treatment required differs in that you believe that psychotherapy is necessary, whereas Dr Shevel believes that the use of psychiatric medication and psychotherapy will be required. Can you please also relate to the court why you recommend only that mode of treatment?

Dr Lekalakala: At the time of the assessment, the severity of the symptoms was not as Dr Shevel had reported it. And enough time had lapsed, so that pharma logical intervention would not be necessary. So psychotherapy, in order to assist her at the moment, would be an ideal mode of treatment.'

The explanation provided by Dr Lekalakala was that the assessment of the first respondent was conducted some ten years after the incident occurred and due to the lapse of time many of the acute symptoms which happened at the time had largely resolved at the time of the assessment. That was the reason why, at the time of the assessment, he considered the symptoms to be mild to moderate. However, he agreed with Dr Shevel that, at the time of the meeting between them for purposes of compiling the joint minutes, the first respondent was currently suffering from a Major Depressive Disorder. In this regard it is also important to note that Dr Lekalakala only assessed the first respondent (and also the second respondent) once.

[39] During cross-examination by Mr Zietsman SC, Dr Lekalakala explained that he, in terms of clinical findings, also found severe anxiety symptoms and that the anxiety symptoms had worsened as reported by Dr Pienaar. He agreed with the findings of Dr Pienaar, that the first respondent displayed significant symptoms where loss of pleasure, guilt feelings and loss of interest were recorded. Dr Pienaar also noted suicidal idealisation, similarly to what Dr Lekalakala found when he assessed the first respondent during 2023. Dr Lekalakala agreed with the finding made by Dr Pienaar that hypothalamic functions i.e. sleep, appetite, libido and energy, were disturbed. Dr Lekalakala however differed with the findings by Dr Pienaar that the first respondent showed clinical symptoms

of PTSD. When asked whether he had pointed the discrepancy regarding his findings in this regard to the appellant, he replied that he had not done so because he had received the other reports and are of the view that his findings would relate in particular to those of Dr Shevel rather than somebody of a different profession.

[40] In addition, Dr Lekalakala was confronted with the contents of the two industrial psychologists' reports and their joint minute (Mr Peverett for the first respondent and Mr van Pletzen for the appellant), who after having considered all the expert reports filed of record, arrived at the conclusion that in the context of what has transpired post-incident, the first respondent is deemed significantly compromised insofar as her employment is concerned. Dr Lekalakala responded that he disagrees with their findings and remains of the opinion that she is employable.

[41] The purpose of cross-examination is to elicit facts favourable to the cross-examiner's case and to challenge the truth or accuracy of the witness's version of the disputed facts.[9] A party has a duty to cross-examine on aspects which he disputes. A party's failure to cross-examine may, in appropriate cases, have evidential consequences in that an adverse inference may be drawn against him/her. A failure to cross-examine is generally considered to be an indication that the party, who had the opportunity to cross-examine, did not wish to dispute the version or aspects of the version of the particular witness who was, during the course of the trial, available for cross-examination.[10] Dr Shevel's diagnosis, save for the severity of the PTSD, was not challenged during cross-examination.

[42] The joint minute of the clinical psychologists disclose that they do not disagree on any significant aspects insofar as their expert opinions are concerned. Dr Truter found that the first respondent suffers from chronic low grade mood disorder of depression which is triggered by various factors. She also presents with an incomplete PTSD image secondary to her chronic low grade mood disorder of depression. According to Dr Truter the first respondent's depression is severe, she projected suicidal ideation and difficulty in adhering to life's demands and in adhering frustrations. Dr Truter, who evaluated the

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[9] *Carroll v Carroll* 1947 (4) SA 37 (D).
[10] *President of the Republic of South Africa and Others v South African Rugby Football Union and Others* 2000 (1) SA 1 (CC) para 61.

first respondent some six years after the incident, reported that the first respondent is not malingering. She is found to be apprehensive and harbours persistent negative expectations that harm may befall her family members. Her mental focusing ability has been negatively impacted. Her ongoing grief regarding her son's death is confirmed in the *Grief Scales*. Severe symptoms, related to panic disorder, were indicated on the Severity Measure for Panic Disorder – Adult and her PTSD was confirmed in the Posttraumatic Stress disorder Checklist.

[43] Having regard to the contents of the admitted report by Dr Pienaar, who recommended that a psychiatrist treat the first respondent's mood disorders pharmacologically, the admitted report of Dr Truter as well as the admitted reports of the two industrial psychologists, it is evident that the opinion of Dr Shevel, with regards to the severity of the first respondent's psychological condition and the treatment regime, is to be preferred. Dr Shevel's findings are in line with the admitted evidence of both Dr Truter and Dr Pienaar. Notwithstanding the fact that Dr Lekalakala was provided with the other experts' medico-legal reports, he, quite strangely, decided not to discuss the differences of opinion pertaining to the treatment of the first respondent and her employability with the appellant prior to him testifying in court. Apparently neither did counsel, who appeared during the trial, bother to discuss the apparent discrepancies with Dr Lekalakala in as afar his opinion differs from their other expert witnesses.

[44] The further dilemma which the appellant did not deal with during the trial, is the issue that the different opinion expressed by Dr Lekalakala was never put to Dr Shevel during his cross-examination. Having regard to the opinion of Dr Pienaar, that the first respondent's depressive mood disorder has deteriorated since 2017, the contents of the joint minutes of both the clinical psychologists and the industrial psychologists, submitted by agreement between the parties, the acceptance of the opinion of Dr Shevel by the court a quo then makes perfect sense.

[45] The contention on behalf of the appellant, which was also not addressed as a ground of appeal, that the assessment of the first respondent by Dr Shevel was actually outdated and that the court a quo relied upon historic facts by accepting Dr Shevel's opinion, was not part of the contentions on behalf of the appellant during the initial trial. On the contrary, the appellant agreed to the submission of the joint minutes by the experts

during the trial and was fully aware of the fact that the opinion of Dr Lekalakala regarding the degree of the first respondent's major depressive disorder and the proposed treatment was not in line with the opinion of Dr Pienaar, one of the appellant's expert witnesses and the contents of the joint minutes by Dr Pienaar and Dr Truter. This problem caused a delay in the initial trial, yet the appellant (defendant) decided to proceed with the trial notwithstanding the glaring discrepancy and contradiction. Raising a new argument or ground of appeal, that was not raised during the initial trial, is generally discouraged. The finding by Dr Pienaar that the first respondent had on all probability reached maximum medical improvement during 2021 already was not challenged in any way or addressed by the appellant during the initial trial.

[46] An appeal is a mechanism through which higher courts review decisions made by lower courts to ensure that the law has been correctly applied and that justice has been achieved in the original proceedings. It is not a forum for the introduction of facts, arguments or evidence that could have been presented during the initial hearing but were not. A party who takes a matter on appeal is bound by the record of the case in the court a quo and cannot raise a new point by relying on a circumstance which does not appear from, or which cannot be deduced from, the record. The role of the court of appeal is not to serve as a second trial or to allow parties to retry their case, nor to entertain argument that were not presented at the original hearing.[11] The entire trial was conducted without any issues being raised by the appellant that the expert report by Dr Shevel was outdated.

[47] In any event, the fact that the judgment of Gusha AJ does not deal in detail with the evaluation of the evidence of Dr Shevel and Dr Lekalakala is not a self-standing ground of appeal. An appeal is not aimed at the reasoning of the lower court but at the order of the trial court.[12]

[48] A further issue, pertaining to the calculation of the first respondent's loss of income, raised by Ms Williams SC is the argument that the first respondent had ' . . . not worked for years . . .' when she gave birth to their baby on 4 August 2013 and has ' . . . spent a vast period of her working life unemployed'. It is furthermore contended that a scenario

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[11] *Cooper and Others NNO v Syfrets Trust Ltd* ZASCA 40; 2001 (1) SA 122 (SCA) at para 21; *Road Accident Fund v Mothupi* [2000] ZASCA 27; 2000 (4) SA 38 (SCA).
[12] *Prinsloo NO and Others v Goldex 15 (Pty) Ltd and Another* [2012] ZASCA 28; 2014 (5) SA 297 (SCA) at [17].

had been agreed upon which has never actually been part of the first respondent's working history. The income agreed upon between the parties during the trial, has also never been earnings that the first respondent has earned in the past. The contention on behalf of the appellant is therefore that, although the first respondent was given the benefit of the doubt regarding her earnings, how a 15% contingency could have been applied remains inexplicable having regard to the facts of this matter and taking into consideration the first respondent's inconsistent working history and the fact that she had never worked in a permanent position prior to the incident.

[49] From the contents of the joint minutes by the industrial psychologists, it is evident that having regard to the contents of their respective reports and based on the available evidence, an agreement was reached on the probable earning scenario applicable to the first respondent. The expert for the appellant, Mr van Pletzen, noted that he is of the opinion that a higher contingency should be allowed for the fact that the first respondent had limited work experience prior to the incident and there is also a chance that she could have decided not to work, to dedicate the time to care of their children. The industrial psychologists agreed that, concerning the expert opinions available and in the context of what has transpired post-incident, the first respondent's pre-incident career and earnings projection is deemed significantly compromised. Taking into consideration her prevailing and entrenched psychiatric symptoms, it was agreed that he future earning capacity would probably be similar to what transpired post-incident.

[50] The first respondent was born on 6 August 1991, and the incident occurred from 4-6 August 2013 when she was 22 years old. She attended high school in Bloemfontein from 2005 to 2010. She repeated Grade 11. During 2010 she was employed as a casual worker for approximately four months at Ackerman's and from December 2011 to January 2012 she worked at Mr Price as a casual worker. She applied to join the SANDF, was accepted in February 2013, and passed the entrance exam during June 2013. Post-incident she was hospitalised from 4 August 2013 to 19 August 2013 and remained unemployed until 2017 whereafter she was self-employed and generated a limited income, selling home-made baked goods. Therefore, to a certain extent, the argument raised by the appellant that the first respondent presented an inconsistent working history pre-incident, is correct. The first respondent attended school until she was 19 years old whereafter she worked as a casual worker for brief period of time while she was

approximately 20 years old. She was only 22 years old at the time of the incident and was in the process of establishing a career when all her ambitions and plans for the future were tragically shattered by the conduct of the appellant's employees.

[51] During the proceedings in the court a quo, it was contended on behalf of the defendant (appellant) that a 50% contingency deduction should be applied to the first plaintiff's (respondent's) loss of income in the post-incident scenario. It was proposed that the total loss of income in the amount of R3 933 384.50 be awarded to the first respondent. Mr Zietsman SC argued that the amount proposed by the defendant (appellant) is actually R100 000 more than what the first plaintiff (first respondent) suggests and the amount suggested by the opposing party cannot be supported on the basis that the defendant applied a contingency deduction of 50% in the injured scenario, which according to Mr Zietsman SC would be too favourable for the first respondent.

[52] The determination of a suitable contingency deduction falls within the discretion of the trial court. Contingencies discount the vicissitudes of life, and it is a method used to arrive at fair and reasonable compensation. The question of contingencies was dealt with in *Southern Insurance Association Ltd v Bailey NO*:[13]

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

In *Dlamini v Road Accident Fund*[14] the court dealt with and applied some guidelines referred to by Koch in *The Quantum Year Book*:

'Normal contingencies" as deductions of 5% for past loss and 15% for future loss.

"Sliding scale": 1/2 % per year to retirement age, i.e. 25% for a child, 20% for a youth and 10% in the middle age and relies on Goodall v President Insurance 1978 (1) SA 389.

"Differential contingencies" are commonly applied, that is to say one percentage applied to earnings but for the accident, and a different percentage to earnings having regard to the accident.'

[53] The contingency deductions applied by the court a quo amounted to 15% in the

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[13] *Southern Insurance Association Ltd v Bailey NO* 1984 (1) SA 98 (A) at 113G and 116G-117D.

[14] *Dlamini v Road Accident Fund* (59188/13) [2015] ZAGPPHC 646 (3 September 2015) paras 30-31.

uninjured scenario and 35% in the injured scenario amounting to a 20% spread between the two scenarios. There is a plethora of case law dealing with a 15% deduction in cases of a young person who has entered the labour market or is about to enter the labour market.[15] Having regard to the relative young age of the first respondent, who was only 22 years old at the time of the incident, I agree with the contention on behalf of the first respondent that the contingency deduction of 35% in the prospective (future) income scenario having regard to the incident cannot be faulted.

[54] The courts have acknowledged that the assessment of quantum for general damages is fraught with difficulty, as few cases are similar.[16] Previous authorities relating to assessment of general damages serve as a useful guide to what other courts have considered to be appropriate, but have no higher value than that.[17] From the evidence, more particularly, the expert evidence by Dr Shevel, Dr Pienaar and Dr Truter, and as confirmed by the first and second respondents, it is clear that the respondents, but more so the first respondent, have suffered psychological, emotional and behavioural sequelae as a result of the traumatic events experienced at Pelonomi Hospital after the first respondent was admitted for the birth of their first born son. Gusha AJ, in the judgment, set out how the events impacted upon both the first and second respondents and their marital relationship. As a result of the incident the first respondent attempted to end her life on two occasions. The first respondent furthermore suffered physical injuries, further hospitalisation and years of further mental anguish and distress.

[55] Taking into consideration the case law relied upon by the respondents[18] as opposed to the case law relied upon by the appellant[19] it is evident that the cases referred to by the appellant do not include any matters where the claimant (the first respondent) had actually also suffered any physical injuries apart from the mental anguish, trauma and emotional shock subsequent to having been informed about the passing of a child.

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[15] *Zarrabi v the Road Accident Fund* 2006 (5) QOD B4-231 (T); *Wright v Road Accident Fund* 2011 (6A3) QOD 19 (ECP); *Radebe v Road Accident Fund* 2013 (6A4) QOD 220 (GNP).
[16] *Protea Assurance Co Ltd v Lamb* 1971 (1) SA 535H-536B.
[17] *AA Onderlinge Assuransie Assosiasie Bpk v Sodoms* 1980 (3) SA 134 (A) at 141G-H.
[18] *Komape & 3 Others v Minister of Basic Education & 3 Others* 2020 (8K3) QOD 1 (SCA); 2020 (2) SA 347 (SCA); *Siwayi v MEC of Health, Eastern Cape Province* 2018 (7K3) QOD 26 (ECG) (*Siwayi*); *Povey v Road Accident Fund* 2022 (8K2) QOD 1 (GNP).
[19] *Mbhele v MEC for Health for the Gauteng Province* (355/15) [2016] ZASCA 166 (18 November 2016) paras 13-18; *Siwayi* at K3-26.

[56] The principles applicable when a trial court adjudicates upon an award for General Damages is succinctly set out in *Road Accident Fund v Marunga*[20] by the Supreme Court of Appeal as follows:

'This Court has repeatedly stated that in cases in which the question of general damages comprising pain and suffering, disfigurement, permanent disability and loss of amenities of life arises a trial court in considering all the facts and circumstances of a case has a wide discretion to award what it considers to be fair and adequate compensation to the injured party.'[21]

I am of the view that the appellant has not demonstrated that the court a quo had exercised its discretion capriciously or on a wrong principle or has brought an unbiased judgment with regards to the awards in respect of General Damages to both the respondents.

[57] The final aspect relates to the issue regarding future medical costs where the court a quo awarded amounts to both the respondents in excess to what were claimed in the particulars of claim. The first respondent claimed future medical costs in the amount of R663 150 and an amount of R690 170 was awarded. The second respondent claimed damages in the amount of R86 620 under this heading and an amount of R90 870 was awarded by the court a quo. During argument, Mr Zietsman SC explained that these discrepancies, on probabilities, came about as a result of the fact that fresh quantifications were made during the trial and due to the interest component, the actuarial calculations eventually amounted to more than the amounts claimed by the respective respondents.

[58] Unfortunately, the respondents did not seek an amendment of the amounts claimed under the headings of future medical costs during the trial. Mr Zietsman SC argued that the increased amounts where canvassed during the trial and with reliance on *Marine & Trade Insurance Co Ltd v Van der Schyff*[22] contended that the claim amounts be 'enlarged' to include the amounts awarded by the court a quo. In the alternative, Mr Zietsman SC sought an amendment of the amounts claimed by the respondents in respect of their medical costs to include awards made by the court a quo.

[59] A plaintiff can increase his/her amount claimed in respect of future medical costs

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[20] *Road Accident Fund v Marunga* 2003 (5) SA 164 (SCA).
[21] Ibid para 23
[22] *Marine & Trade Insurance Co Ltd v Van der Schyff* 1972 (1) SA 26 at 44H-45.

above the amount initially specified in the particulars of claim provided that the correct procedural steps, as envisaged in rule 28 of the Uniform Rules of Court, has been complied with. A notice of intention to amend must be served and the opposing party who has ten days to object to the proposed amendment. The core test is whether the amendment causes injustice to the other party. I am of the view that the application to amend the claim amounts at appeal stage cannot be allowed and that the argument on behalf of the respondents that the quantification of the claims for medical costs was canvassed during the trial, does not assist the respondents where the specific amounts awarded by the trial court exceeds the amounts claimed in the particulars of claim. Therefore, the arguments on behalf of the appellant have merit and the awards under the heading of medical costs in respect of both respondents should be decreased accordingly.

[60] In all the circumstances I consider that the contingency deductions for loss of earnings in respect of the first respondent and the amounts awarded to both respondents in respect of general damages are fair and that the appeal in this regard ought to be dismissed with costs. However, the amounts awarded by the court a quo in respect of future medical expenses should be reduced and in this regard the appeal should be upheld.

[61] Generally, in appeal cases, the successful party is entitled to their costs. Since the appeal succeeds in part only, the costs of the appeal, including those incurred in respect of the application for leave to appeal shall be borne by each party.

[62] I thus make the following order:

1 The appeal in respect of the respondents' future medical expenses is upheld.

2 The order of the court a quo is set aside and substituted with the following:

'2.1 Paragraph 30.1.3 of the trial court's order is amended by substituting the amount of R690 170, in respect of future medical expenses, with R663 150.

2.2 Paragraph 30.2.2 of the trial court's order is amended by substituting the amount of R90 870, in respect of future medical expenses, with R86 620.'

3 Save as aforesaid, the appeal is dismissed.

4 Each party shall pay their own costs including those costs incurred in respect of the application for leave to appeal.

[redacted]

VAN RHYN J

I concur.

[redacted]

DANISO J

I concur.

[redacted]

OPPERMAN J

Appearances

On behalf of the Appellant:	R Williams SC The State Attorney BLOEMFONTEIN
On behalf of the Respondents:	J Zietsman SC On instruction of: Honey Attorneys BLOEMFONTEIN