

REPUBLIC OF SOUTH AFRICA



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

Case Number: 16264/2022

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

DATE

SIGNATURE

In the matter between:

ADV K MASHABA obo

NKOSANA MOTLHALE

Plaintiff

and

ROAD ACCIDENT FUND

Defendant

***Delivered:** This judgment was prepared and authored by the Judge whose name is reflected and is handed down electronically by circulation to the parties/their legal representatives by e-mail and by uploading it to the electronic file of this matter on Caselines. The date and for hand-down is deemed to be 3 September 2026.*

Summary: A claim for loss of earning capacity. Injuries not serious enough to affect the earning capacity of the injured. Claim for loss of earning capacity not sustainable. The evidence of the experts is unreliable and is based on unreliable evidence. The claim for loss of earning capacity and income falls to be dismissed.

JUDGMENT

MOSHOANA, J

Introduction

[1] This is an action instituted by a *curator-ad-litem* on behalf of the injured Mr Nkosana Motlhale (Mr Motlhale). Upon being instituted, this action was defended by the defendant, the Road Accident Fund (RAF). As it has become customary on the appointed trial date, the RAF failed to appear. As such, this action proceeded in terms of rule 39(1) of the Uniform Rules of the High Court. Evidence was admitted in terms of rule 38(2) of the Uniform Rules following the granting of an application for such an admission.

Background facts and evidence

[2] On 08 October 2018, a 19-year-old, Mr Motlhale, was a passenger in a motor vehicle bearing registration letters and numbers X[...] 5[...] G[...] when the motor vehicle lost control and overturned at N12, a kilometre away from Soweto/Lenasia off-ramp.

[3] Consequently, Mr Motlhale was injured and admitted at Chris Hani Baragwanath Academic Hospital (CHBAH) at around 16:08pm. For the purpose of this judgment, on admission, Mr Motlhale presented with bruised right side of the head. He did not present with any headaches or loss of consciousness. His GCS was 15/15. The bruise over the right temporal forehead was 7 x 5cm. On 15 October 2018 a non-contrast CT Brain scan findings revealed that there was undisplaced linear squamous right temporal bone. No acute intra-cranial injury was revealed. I interpose to mention that the fracture involved herein is a thin hairline crack in the flat, upper-outer portion of the right side of the skull where the bone pieces have not

moved out of alignment. Generally, undisplaced skull fractures often heal on their own over time as the bone knits back together.

[4] On 08 October 2018, Mr Motlhale was discharged. It is apparent from the clinical records that he was seen again on 09 and 15 October 2019. On those days the clinical records revealed that the abrasion on the head was healing well and that there was no intracranial pathology noted. Panado and Tramal tablets were prescribed to be taken over a period of two weeks. On 14 May 2019, Mr Motlhale was admitted at Leratong Hospital. He was discharged on 18 June 2019. The clinical records of Leratong Hospital are very difficult to decipher and only contain discharge summary. According to Leratong Hospital, the final diagnosis as of 18 June 2019 was recorded as "*Psychosis to head injury comorbid cannabis abuse*". Atypical antipsychotic medication of Risperdal 3mg was prescribed for Mr Motlhale.

[5] Relevant to the suggested head injury, on 14 December 2021, Mr Motlhale consulted with Dr Du Plessis, a qualified Neurosurgeon. Dr Du Plessis interviewed Mr Motlhale and his mother. In his examination, he noted faint scars of abrasions in the right temporal area. On the day, he referred Mr Motlhale for Magnetic Resonance Imaging (MRI) scan. The results were that no macroscopically visible post-traumatic intracranial abnormalities were shown. This simply meant that there were no structural brain changes resulting from the head trauma. Dr Du Plessis then formed the following opinion:

"Based on the history provided by the claimant and his mother, the clinical records and the impression gained on examination, he sustained mild concussion in the accident."

[6] Dr Du Plessis could not find focal brain injury nor any possibility of secondary brain damage. This meant that there was no delayed damage that occurs weeks after the initial head trauma, nor any damage of the specific or localised area of the brain. Dr Du Plessis also opined that Mr Motlhale had not suffered any neurological deficit as a result of the accident. He opined that Mr Motlhale had developed schizophrenia. Schizophrenia is caused by a mix of genes, chemical imbalances and structural differences. According to Dr Du Plessis, the accident did not cause a loss or impairment of normal brain. Regarding loss of earning capacity, Dr Du Plessis

specifically directed that to psychiatric conditions as opposed to neurological deficiencies.

[7] On 10 June 2025, Dr Du Plessis again consulted with Mr Motlhale and his mother. At that stage, he was favoured with reports from Dr Mazabow, Dr Naidoo and Ms Greef. This time around Dr Du Plessis opined as follows:

“Based on the neurosurgical criteria that are normally used to quantify the severity of a brain injury, he sustained a mild concussive brain injury in the accident. He did not sustain a focal brain injury or a secondary brain injury in the accident.”

[8] On 3 November 2025, this Court, after considering the injuries sustained by Mr Motlhale, expressed dissatisfaction on the question whether Mr Motlhale suffered head injuries that are serious enough to impact on his earning capacity. This Court directed that Dr Du Plessis must appear before it in order to clarify the extent of the head injuries. Indeed, on 26 August 2026, the Court heard evidence from Dr Du Plessis. Briefly, his evidence was that he still maintains that Mr Motlhale sustained mild concussive brain injury. The collateral information and the literature he consulted did not sway him otherwise. He accepted that generally, mild concussive brain injury does not have long term neurological cognitive defect effects. However, his views changed after considering the Article by Dr Daryl Fujii and Mr Iqbal Ahmed.¹ He testified that psychosis may be caused by various factors including abuse of cannabis. Taking into account the criteria used to grade the severity of the brain injury, he testified that Mr Motlhale almost did not make it to mild concussive brain injury.

[9] Regarding the sequelae, he suggested two possibilities for the onset of psychosis. Firstly, mild concussive brain injury and secondly, the stresses of the accident itself. Relying on the article of Dr Fujii and Mr Ahmed, he discovered, after many years of practice, that a mild concussive brain injury can cause permanent psychosis. He accepted that there are conflicting views in the literature. He further testified that from the clinical records only, it is difficult to grade the severity of the head injury. There was no evidence of loss of consciousness, but because Mr

¹ Fujii and Ahmed “Characteristics of Psychotic Disorder Due to Traumatic Brain Injury: An Analysis of Case Studies in the Literature” (2002) *Journal of Neuropsychiatric and Clinical Neurosciences* 130.

Motlhale did not remember certain portions of the events, he opined that he may have lost consciousness. This was based on the say-so of the collateral witnesses being Mr Motlhale and his mother. He could not have regard to ambulance records, particularly on the state of consciousness of Mr Motlhale before reaching the Hospital. Those records were not made available to him. He agreed that those records would have been of some significance.

Analysis

[10] In this judgment, the Court shall only pay specific attention to the loss of earning capacity claim, given the injuries revealed in the clinical records. This Court takes a view that since Mr Motlhale only suffered abrasion and bruises, the head injury is not as severe as to render Mr Motlhale to lose his earning capacity.

[11] In *Michael and Another v Linksfeld Park Clinic and Another*,² the Court expressed that an expert opinion carries weight only to the extent it is grounded in facts that are common cause, established by evidence, or capable of being proven. The opinion by Dr Du Plessis that Mr Motlhale suffered mild concussive head injury is not grounded on any established evidence. In the first report, he based that opinion on the history provided by the mother and Mr Motlhale, the clinical records and his impressions. Clearly, the evidence of the mother and Mr Motlhale cannot be objective and it is prone to exaggerations. On his own version, it is difficult to grade severity on the basis of the clinical records alone.

[12] In his second report, he based the same opinion on neurosurgical criteria that is normally used to quantify severity. In the Article of Dr Fujii and Dr Ahmed, on which Dr Du Plessis placed heavy reliance, the following was recorded:

“Severity of TBI was based on criteria set by the Mild Traumatic Injury Committee of the Head Injury Interdisciplinary Special Interest Group of the American Congress of Rehabilitation Medicine (ACRM).³ According to their criteria, a head injury is considered mild if the duration of loss of consciousness (LOC) is 30 minutes or less and moderate to severe if LOC is longer than 30 minutes.”

² *Michael and Another v Linksfeld Park Clinic and Another* 2001 (3) SA 1188 (SCA) para 34-36.

³ *J Head Trauma Rehabil* (1993) 86.

[13] Dr Du Plessis did not obtain any evidence of LOC at the scene of the accident. The mother was not at the scene she only arrived at the Hospital after the accident. There were no ambulance records. The Hospital records do not bear him out in that regard. There was no LOC recorded in the clinical records. It is thus difficult for this Court to accept his opinion that because Mr Motlhale was unable to account for certain portions of the events, he must have lost consciousness. This is nothing but conjecture. Of critical importance, his opinion is contradicted by Dr Mazabow, a Neuropsychologist. Dr Mazabow examined Mr Motlhale on 7 July 2022. At the time of the examination, like Dr Du Plessis, he was furnished with the Hospital records and consulted with both the patient and the mother. In his report, in seeking to contradict the findings of Dr Du Plessis, Dr Mazabow stated the following:

“2.2.7. Dr du Plessis graded a mild concussion. An MRI brain scan is said to have been normal, with no indication of a focal brain injury. However, Dr du Plessis was not given the **information that Mr Motlhale was confused and disorientated and gave incorrect biographical data to the nursing staff** (as well as incorrect details of the accident) which would indicate that his mental status was in fact altered at the time.

2.2.8 It appears that Dr du Plessis also did not have sight of the CT scan report, which states that a **skull fracture was sustained** (involving the right temporal bone).

[14] Clearly, this information of confusion and disorientation emanated from the patient’s mother. As to why the mother could give conflicting account, it is unclear to this Court. According to Dr Du Plessis, the mother told him this:

“His mother says that she saw him later that afternoon. He was **asleep initially. He was not confused when she woke him up...**”

[15] From the first report of Dr Du Plessis, there are indications that he had sight of the CT scan. He commented that the radiological report showed no intracranial pathology. All the above notwithstanding, Dr Mazabow commented as follows:

“2.3.1 The above information is of significance blow to his head, giving rise to a right temporal bone fracture (according to the radiological report); **a period of dense/total post traumatic amnesia of 3 to 4 hours, followed by discontinuous memory (the duration of which is not possible to determine); disorientation evident to the**

mother at the time of her arrival several hours after the accident; initial confusion evidenced in his having reportedly given the incorrect information to the hospital staff (including biographical details, such as his name and address, and having incorrectly described the accident as a pedestrian vehicle accident); an initial Glasgow Coma Scale score of 15/15 (**which is incorrect in light of the above information**); alteration in his mental status reported by the mother over several days following the accident; and no focal brain injury evident on the initial CT brain scan or on the later MRI brain scan.

2.3.2 This information, taken as a whole, indicates that the head injury sustained was at least mild- to –moderate and more **likely moderate.**”

[16] It is very surprising to note that Dr Mazabow comments that the GCS is incorrect. What then was the correct GCS, he does not suggest at all. Given the contrast of collateral information from the same source, it also follows that the grading by Dr Mazabow is unreliable.

[17] An interesting opinion, again based on the narration by Mr Motlhale’s mother in an inconsistent manner, by Dr Naidoo the Psychiatrist was that Mr Motlhale sustained at the very least mild complicated traumatic brain injury. Contrary to Dr Du Plessis and Dr Mazabow, Dr Naidoo opined that clinically, Mr Motlhale presented with mild neurocognitive disorder due to traumatic brain injury. Neurocognitive disorder is caused by, amongst others acquired brain damage, structural changes or cellular degeneration that affect thinking, memory, and mental function. It must be accepted that cannabis abuse does cause damage to the brain function which leads to lasting problems with memory, attention and thinking. At Leratong hospital in 2019, almost a year after the accident it was recorded that psychosis was comorbid cannabis abuse. Medically, comorbidity is the simultaneous presence of two or more distinct medical or psychological conditions in a single person.

[18] According to Dr Fujii and Dr Ahmed, diagnostic difficulties hinge on two aspects. Firstly, establishing that psychosis is a direct physiological consequence of traumatic brain injury (TBI). Secondly, determining that the psychosis is not due to

another mental disorder. Several studies suggest that individuals who develop a psychosis after TBI had generally sustained moderate to severe head injuries.⁴

[19] Dr Du Plessis has opined that Mr Motlhale is schizophrenic. According to Dr Fujii and Dr Ahmed's article, in people with schizophrenia it is often difficult to determine if a psychotic condition is a direct physiological consequence of TBI or even if TBI contributes to or exacerbates the psychotic process. Dr Fujii and Dr Ahmed also opine that there may be multiple factors contributing to psychotic symptoms for example a genetic risk, substance abuse, or other neurological problems.

[20] That said, this Court must remark that the opinion of Dr Fujii and Dr Ahmed's article bears no evidentiary value to this Court. The Supreme Court of Yukon in *Wright v Yukon (Director of Public Safety and Investigations)*,⁵ Chief Justice Duncan placed reliance on *Sordi v Sordi*,⁶ where the Court stated:

"[141] ... Candidly. I have always been troubled by the idea that the court should just accept, at face value, the contents of academic articles submitted during argument, or found by the court on its own. Unlike any person offered as an expert witness during a trial, there is no opportunity to determine the degree of expertise [if any] of the author of the article, or to test the validity of the study, as it relates to the issues at hand. In this post. The inquiry into Paediatric Pathology in Ontario world, it is my view that trial judges should be very careful about incorporating social science articles into judgments, unless they have been produced in an acceptable fashion during the trial..."⁷

[21] The fact that Dr Du Plessis placed reliance on the Article of Dr Fujii, to support his testimony that he has since learned, after many years of practice as a Neurosurgeon, that mild trauma may lead to permanent psychosis, remains unconvincing to this Court. It remains untestable given its source. For an expert testimony to be acceptable to a court, the testimony must be (a) relevant; (b) necessary; (c) must involve special expertise; (d) reliable; and (e) admissible. To the

⁴ Fujii and Ahmed "Psychosis secondary to traumatic brain injury" (1996) *Neuropsychiatry Neuropsychology Behave Neurological* 133.

⁵ *Wright v Yukon (Director of Public Safety and Investigations)* 2023 YKSC 77.

⁶ *Sordi v Sordi* 2010 ONSC 2344.

⁷ Para 141 of *Yukon* judgment

extent that Dr Du Plessis places evidentiary value on the Article, such constitutes inadmissible hearsay evidence and remains unreliable. The same applies with regard to the other Article that Dr Du Plessis placed reliance to bolster his testimony i.e. *“The American Congress of Rehabilitation Medicine Diagnostic Criteria for Mild Traumatic Brain Injury”*.⁸

[22] The Article by Dr Fujii and Dr Ahmed was concluded in the following manner:

“Our study is exploratory and descriptive, and thus **the findings should be viewed as preliminary**. Its major limitations is the use of archival data that are subject to **biases in data collection**. For an example, there should have been a selection bias for more early-onset PDTBI cases because it would be easier to justify the relationship between TBI and the onset of psychosis.

[23] Accordingly, there is no reliable and convincing evidence before this Court that there is relationship between psychosis and mild concussive brain injury.

[24] That said, I now turn my attention to the report by the Educational Psychologist Ms E Prinsloo. This Court finds it difficult to accept her postulations. As a departure point, she has not provided any academic reports from grades 1 to 11 of Mr Motlhale. That being so, an opinion that he was a low-average-to below average performer is based on conjecture and only on grade 12 results. In 2017, Mr Motlhale completed grade 12. At the time when he met the accident, he was not at any institution of learning. As to why he was not at any institution of learning, such was not investigated by Ms Prinsloo. There was speculative statement by Mr Prinsloo that in 2017, 2018 and 2019, he could not have obtained a NAFSAS bursary. This is a baseless speculation. Such information of not being in an institution of learning, in the opinion of this Court, was a valuable information in order to make an informed postulation. On the available evidence, he had entered the job market working for his father for no pay. Ms Prinsloo in her report advanced an opinion she is not qualified to advance that Mr Motlhale continued to recuperate at home.

[25] There is no tangible explanation offered as to why the whole of 2019, Mr Motlhale did not enter any institution of learning. As to why he only decided to enter

⁸ Silverberg *“The American Congress of Rehabilitation Medicine Diagnostic Criteria for Mild Traumatic Brain Injury”* 2023 *ACRM*.

the institution of learning in 2020, there is no explanation offered. For reasons that are not spelled out anywhere, in 2020, Mr Motlhale simply did not meet attendance and was absent from the exams. In 2021, he repeated N4 of his studies in Business Management. He passed all the four modules. As to why he managed to pass with the alleged psychosis conditions no explanation is discernible from the report of Ms Prinsloo. In 2022, he enrolled for N5 and decided to discontinue in the middle of the year. No academic records for the period he attended before discontinuing was made available.

[26] Mr Motlhale informed Ms Prinsloo that he discontinued because he struggled to cope with the content of the work and manage his elevated levels of anxiety. The statement that he was not coping with the work was made in hollow. It would have been reliable if it was backed with some academic record for that year he decided to discontinue. On the available evidence, he enrolled at the beginning of the year and midstride he discontinued. There must have been work done and assessed for that year to demonstrate that he was not coping particularly after having coped the previous year. In 2025 he instead entered the job market after having been inactive for 2023 and 2024. The last medical attention that Mr Motlhale received was in 2019 at Leratong Hospital. In 2025, he told Dr Du Plessis that he was not readmitted for psychotic symptoms. He had not started to smoke cannabis again. He informed Dr Du Plessis that he has not attempted to further his studies due to financial constraints. His only complaints then were headaches that occurs daily.

[27] In a follow-up with Dr Mazabow, in June 2025, there is an indication that he failed all N5 subjects. This contradicts the information given to Ms Prinsloo. As reported by Dr Mazabow, the bursary was withdrawn for 2022 because of his failure to complete the first semester of 2022. Contrary to what was told to Dr Du Plessis on 10 June 2025 that he sleeps better, on 11 June 2025, the very following day, Dr Mazabow was informed by the mother that N5 could not be completed because he was tired in the mornings and had sleeping disturbances. Dr Naidoo only consulted with him once in 2022 and there was no follow up.

[28] Turning back to Ms Prinsloo, she postulated that Mr Motlhale would have completed N4-N6 and achieve NQF5. This postulation is poorly reasoned particularly because she did not collate academic records from grade 1 to 11. The struggle to

cope with the content of the work is not supported by any academic record for that half year or semester. The alleged anxiety levels are not medically supported. An opinion that he will experience significant difficulties in pursuing any further studies is based on nothing but the conflicting reports by Dr Du Plessis, Dr Mazabow and Dr Naidoo. This Court has already pointed out difficulties with the opinions of the experts in the field of head injuries. The fact that Motlhale abused cannabis for an extended period of four years seem to be downplayed by all the experts. Leratong Hospital in 2019 mentioned cannabis abuse as comorbid for psychosis.

[29] There is no clear evidence that the alleged poor performance educationally is linked to the abrasion or bruises, or it is largely linked to the abuse of cannabis. Syllogism suggests that as Mr Motlhale passed N4 modules with the conditions present, had he not discontinued N5 studies for reasons better known to him he would have passed N5 and N6 and reached his postulated NQF5. No tests were presented to demonstrate that Mr Motlhale indeed stopped abusing cannabis in October 2018 after the accident. Why, in 2019, the following year after the accident, did Leratong Hospital comorbid psychosis with cannabis abuse if he had stopped in 2018. Accordingly, when regard is had to the less serious head injuries, as testified by Dr Du Plessis before seeking to rely on Dr Fujii and Dr Ahmed Article, mild concussion has no long-term neurological deficiency effects. The conclusions reached by Dr Mazabow that there was moderate trauma is unsupported.

[30] This Court must conclude that the injuries sustained at the accident are incapable of causing any conditions that would lead to permanent psychosis. On the contrary, there is scientific evidence that substance abuse has a relationship with psychosis. In any claim for loss of future earning capacity, two key questions arise; namely (1) has the plaintiff's earning capacity been impaired by his or her injuries; and if so, what compensation should be awarded for the resulting financial harm that will accrue over time.⁹ When Mr Motlhale saw Dr Du Plessis in 2025, his only complaints were headaches. In *Butler v Blaylock*,¹⁰ considering that complaints of pain cannot easily be disproved, the Court said:

⁹ *Dornan v Stephens* 2019 BCSC 701 at para 94.

¹⁰ *Butler v Blaylock* [1981] BCJ at para 18.

“I am not stating any new principle when I say that the court should be exceedingly careful when there is little or no objective evidence of continuing injury and when complaints of pain persist for long periods extending beyond the normal or usual recovery...”

[31] One of the considerations when dealing with loss of earning capacity is whether the plaintiff has been rendered less capable overall of earning income from all types of employment and that he or she is less marketable. There is evidence that Mr Motlhale gained employment in 2025 as a cleaner. He worked for two months. According to his mother, he stopped employment because he did not enjoy the work. Mr Motlhale informed Ms Prinsloo that he gained employment at a supermarket. He could not cope with the physical requirements and he was regularly absent. He subsequently left that employment.

[32] Mr Kobus Prinsloo, the Industrial Psychologist stated that as a post-morbid scenario, Mr Motlhale will be unemployable in the open labour market, inclusive of the informal sector, a self-employed trader, given his disorganised thinking and poor decision-making and impaired judgment. Although this is conveniently pinned to the abrasion and bruises, it is indeed so that cannabis abuse does affect thinking and impairs judgment. Owing to Mr Motlhale gaining employment with Panda Mart in Roodepoort, it is difficult to accept the opinion of Mr Prinsloo. Mr Motlhale left his position at Panda Mart before the end of his probationary period. This must be the employment he left because he could not cope with the physical requirements. According to Ms Phooko, Manager at Panda Mart, she could not have confirmed probation of Mr Motlhale because of the lack of consistency, commitment and ability to cope with job demands. This is consistent with what Mr Motlhale informed Ms Prinsloo. Nevertheless, Mr Motlhale could have exercised his labour rights against the views of Ms Phooko. Of significance, Mr Motlhale was employable contrary to the opinion of Mr Prinsloo.

[33] This Court is unable to disagree with the approach taken by the Northwest High Court division in the matter of *Phepheto v Road Accident Fund (Phepheto)*,¹¹ where the Court stated amongst others, the following:

“[42] The plaintiff’s GCS, as is evident from the hospital records, was slightly depressed for a period of 2 hours and 10 minutes after his admission at hospital. This could be attributable to a number of reasons including medication administered on scene. The plaintiff indicated to Bout that he can remember standing next to the road and from that time onward he can only remember from when the ambulance personnel were on the scene. The plaintiff reported to Smuts that he was unconscious after the accident and woke up the next day in the hospital...

[43] Having regard to the aforesaid I am not convinced that the plaintiff sustained a significant head injury or that reference to memory and concentration... will hinder his ability to work in a sedentary environment even on a very basic level as postulated by Doran...”

[34] Similar to the concerns raised in this judgment, the Court in *Phepheto* had the following to say:

“[29] The court notes that Smuts simply accepted the plaintiff’s reporting that he was unconscious and woke up the next day in hospital still confused, without verifying that this was in fact so, had Smuts done this he would have been alerted to the patient transfer form, which he had in his possession, and which indicated that the plaintiff had a GCS of 15/15, 2 hours 10 minutes after his admission to hospital and that he was alert and orientated.”

[35] In being critical to the approach of experts simply accepting the self-reporting of patients, the Court in *Phepheto* placed reliance on various judgments¹² which are also critical of the similar approach by experts. The injuries in *Phepheto* were recorded as being scalp abrasion. In *Phepheto* Dr Smuts the Neurologist, with such injuries after examining the plaintiff opined that the plaintiff sustained significant head injury and was left with a mild to moderate brain injury. That notwithstanding, the

¹¹ *Phepheto v Road Accident Fund* [2025] 1 All SA 458 (NWM).

¹² *Twine and another v Naidoo and another* [2018] 1 All SA 297 (GJ); *Ntombela v Road Accident Fund* 2018 (4) SA 486 (GJ); and *Bee v Road Accident* 2018 (4) 366 (SCA).

Court in *Phepheto* rejected a conclusion that the plaintiff is unemployable post the accident.

[36] The Full Court of this Division in *Adv Yvette Isaacs obo Niyaaz Ebrahim v Road Accident Fund*,¹³ held that:

“[8] ... An expert is required to assist the court by laying out a factual basis for his/her conclusions explaining his/her reasoning to the court. A court is required to satisfy itself as to the expert's correct reasoning. An expert's opinion must be underpinned by proper reasoning in order for a court to assess the cogency thereof. Absent any reasoning the opinion becomes inadmissible.”

[37] This Court is not satisfied that the onset of psychosis has a relationship with the abrasion and bruises on the head. If anything, the psychosis has a direct relationship with cannabis abuse. As testified to, by Dr Du Plessis, mild concussion has no long-term neurological deficiency effects. His testimony in this regard is supported by a litany of medical literature.¹⁴ Consequently, this Court is not satisfied that the poor educational performance, albeit not clearly demonstrated by empirical evidence, has any relationship to the mild head injuries sustained by Mr Motlhale in the accident. There is no causal nexus established between the injuries sustained and failure to reach NQ5 as postulated. As indicated above, there is no proper explanation as to why Mr Motlhale passed all his modules in 2022, whilst being in the same condition, he failed the modules in 2021. If his condition was permanent, it defies syllogism for him to pass the following year, when according to the experts his condition was deteriorating over a period of time. There is no concrete evidence that the discontinuation in 2022 midstride has any relationship with the injuries he sustained in 2018. Sadly, Mr Motlhale was an abuser of cannabis as evidenced by the records of 2019 held by Leratong Hospital. Ruling out cannabis abuse and pinning his conditions of psychosis to the minor injuries on his head, which would have healed a long time ago, seem illogical and not persuasive.

[38] For all the above reasons, I am constrained to make the following order:

Order

¹³ *Adv Yvette Isaacs obo Niyaaz Ebrahim v Road Accident Fund* Case A140/2025.

¹⁴ Traumatic Brain Injury 2023 *Journal of Neurotrauma* Traumatic Brain Injury 13.

1. The Defendant shall pay 100% (one hundred percent) of Mr Motlhale's proven damages.
2. The application in terms of Rule 38(2) is granted with no order as to costs.
3. The claim for loss of earning capacity and future loss of income is dismissed.
4. The Defendant indemnifies Mr Motlhale against any supplier's claim.
5. The Defendant is ordered to, furnish Mr Motlhale with a statutory undertaking free from caveats and qualification, in terms of section 17 (4)(a) of the Road Accident Fund Act for 100% (one hundred percent) of the costs of the future accommodation of Mr Motlhale or supplying of goods to Mr Motlhale arising out of Mr Motlhale's injuries sustained in the motor vehicle collision which gave rise to the action, after such costs have been incurred and upon proof thereof.
6. The Defendant shall pay the plaintiff's taxed or agreed costs on a scale of party and party, such costs to include the costs of experts employed as per case lines, inclusive of reports, addendum reports, consultations and confirmatory affidavits. The costs of both the plaintiff's counsel, inclusive of preparation, appearance fees and heads of argument, and those of the *Curatrix ad litem* to be allowed at scale B.
7. This Court lacks jurisdiction to hear the determination of the issue of General Damages.

GN MOSHOANA
JUDGE OF THE HIGH COURT
GAUTENG DIVISION, PRETORIA

APPEARANCES:

For the Plaintiff:

Mr A Maluleka

Instructed by:

Savage Jooste & Adams Pretoria

For the Defendant:

No appearance

Date of the hearing:

03 November 2025 and 26 August 2026

Date of judgment:

03 September 2026