

Editorial note: Certain information has been redacted from this judgment in compliance with the law.



**IN THE HIGH COURT OF SOUTH AFRICA
EASTERN CAPE DIVISION : BHISHO**

Reportable

Case No:

36/2017

In the matter between:

TN obo BN

Plaintiff

and

THE MEMBER OF THE EXECUTIVE

COUNCIL FOR HEALTH, EASTERN CAPE

Defendant

JUDGMENT

GRIFFITHS J:

[1] According to the Code of Hammurabi¹ a physician who in Babylonian times operated on a man with a severe injury and caused his death, had his fingers cut off.² Our modern law is, fortunately, less severe on physicians as it requires reparation in the form of lump-sum monetary compensation which is assessed on a once and for all basis. The defendant in this matter alleges that this common law principle has the result that this claim, together with many others similar to it, costs the provincial government an arm and a leg.

[2] The plaintiff, acting in her representative capacity as mother of the minor child BN, has sued the defendant for damages arising from the negligent conduct of medical staff in a public hospital falling under the aegis of the defendant. She alleged that BN suffered severe injuries during his birth as a result of negligence on the part of the defendant's servants. This much has been conceded by the defendant and this court is called upon to determine an appropriate remedy. In the normal course, based on the common law as it presently stands, such remedy would subsist in the payment of a lump sum duly assessed in accordance with the common law rules relating to the various claimed heads of damage.

[3] The defendant has however pleaded a novel combination of remedies not falling within the common law rules, which require an assessment of such damages in monetary terms on a once and for all basis. These remedies are what has come to be known as the "public healthcare remedy" and the "undertaking

¹ A Babylonian legal text composed c. 1755–1750 BC (Wikipedia).

² Section 218: "If a physician operate on a man for a severe wound with a bronze lancet and cause the man's death; or open an abscess (in the eye) of a man with a bronze lancet and destroy the man's eye, they shall cut off his fingers."

to pay remedy” and are often referred to as “the DZ defences”. In advancing various arguments in support thereof, the defendant has contended that instead of draining the public healthcare system of a massive lump-sum award for potential future medical care that BN may or may not ultimately use, the defendant wishes to provide such care to him as and when he needs it, if not by the department directly, then paid for in the private sector as the need therefor arises.

[4] BN is 11 years of age, and his life expectancy is 22.8 years. When these proceedings were instituted, he and the plaintiff lived in Mdantsane Township, which is close to Cecilia Makiwane Hospital (“CMH”) where he was born. His birth followed a period of prolonged labour and he suffered a brain injury. He has spastic quadriplegic cerebral palsy (“CP”), microcephaly, intellectual impairment and epilepsy. He is hearing and visually impaired and has a percutaneous endoscopic gastrostomy (“PEG”) tube for feeding. He is incontinent and will remain so for life. Consequently, he has poor head control, is unable to sit, roll, crawl, stand, walk, or speak. He is furthermore dependent on mobility transfers and positioning. He is also dependent regarding the general activities of daily living such as bathing, dressing, general hygiene, eating and drinking.

[5] He is classified at level five on the Gross Motor Function Classification System and level five on the Manual Ability Classification System. These are both at the most disabled end of the spectrum. He has an extremely low cognitive function and is not expected to improve. Furthermore, he is unemployable in the open labour market and thus has suffered a total loss of

earning capacity. Despite all this, he remains a child that deserves to play and learn.

[6] The plaintiff has claimed an amount of R 35,489,921.00 on behalf of BN comprising:

6.1 R30,523,518.00 in future medical care, medical and related expenses;

6.2 R386,087.00 in future loss of earnings, alternatively earning capacity;

6.3 R1,800,00 0.00 in general damages;

6.4 R2,780,316.00 representing 8.5% of the total award to protect and administer the award.

Settled Issues

[7] General damages have been settled in the sum of R 1,800,000.00.³ Loss of earning capacity has likewise been settled in an amount of R386,146.00. It has further been agreed that an amount of R650,000.00 is to be paid for an adapted motor vehicle on the basis that the plaintiff will be responsible for ensuring BN's attendance at various consultations and for other medical or surgical requirements.

³ This amount has already been paid.

[8] In relation to the claim for future medical expenses and supplies the defendant has pleaded the public healthcare and undertaking to pay remedies as were recognized in an obiter dictum by the Constitutional Court in *DZ*.⁴ Regarding the claim for protection and administration of the award, the defendant has contended that, should the DZ defences be upheld, the limited amounts payable as lump sums after the application of such remedies will not justify this.

[9] In the event of this court rejecting the DZ defences, the parties have reached agreement on most of the medical services and supplies that are required by BN, and the amount payable in respect of each such service or supply. These matters have come to be settled over time and are reflected in a document referred to as annexure “A” to the pre-trial conference minute.⁵ It is not necessary to repeat the details thereof in this judgment. Also, in this event, issues relating to the protection of the lump sum award in the form of a trust will have to be further addressed.

Disputed issues

[10] The following matters remain in dispute relating to their nature, frequency, duration, quantity, cost etc. irrespective of whether the DZ defences are upheld:

10.1 BN’s caregiving requirements;

⁴ *Member of the Executive Counsel for Health and Social Development, Gauteng v DZ obo WZ* 2018 (1) SA 335 (CC).

⁵ Annexure "A" also reflects the interest payable on the agreed amounts from the date of agreement of each item in terms of the relevant provision of the Prescribed Rate of Interest Act (No 55 of 1975).

10.2 Occupational Therapy;

10.3 Physiotherapy;

10.4 Home alteration costs to accommodate his disability;

10.5 Whether he requires a transporter buggy in addition to a wheelchair⁶;

10.6 Case management.

[11] As indicated earlier, the claim for cost of protection and administration of the award likewise remains in dispute.

[12] It will have become apparent from the foregoing that the question of the DZ defences forms a central issue in this case. In this regard it is necessary to consider whether the common law should be developed to accommodate such remedies, it being common cause that without such development they cannot be sustained. Should it be concluded that the common law ought to be so developed, there is also an issue as to the appropriate standard at which the hospitals (in this case CMH and Frere Hospitals (“Frere”)) should be able to provide such services in order to determine whether the public healthcare

⁶ Defendant's counsel indicated that he had no instructions to concede this but would not advance any argument against the provision hereof.

remedy can be sustained: a reasonable standard, an acceptably high standard, or a standard equivalent to that in the private healthcare sector.

[13] Should these questions be determined in favour of the defendant, it is then further necessary to establish which of the disputed services and supplies the plaintiff has established as being necessary and the type, amounts and frequencies thereof. Finally, it will be necessary to determine whether the required medical services and supplies should be provided in terms of the public healthcare remedy to the extent that the defendant has proved that she is able to do so according to the determined standard (or a lesser range of services and supplies) or in terms of the undertaking to pay remedy.

[14] Before I consider these questions, it is necessary to deal with certain preliminary skirmishes relating to the evidence led, the determination of which will affect my approach to the core issues. A dispute has arisen as to the burden of proof regarding the DZ defences. Disputes have also arisen regarding the admissibility of certain evidence.

The burden of proof

[15] There is consensus that, absent the plea relating to the DZ defences, the plaintiff bears the onus of proving BN's quantum of damages. The problem arises regarding whether the plaintiff or the defendant bears the overall onus regarding the DZ defences. In this regard, the plaintiff has argued that where the defendant seeks the development of the common law, it bears the onus of proving that such development promotes the spirit, purport and object of the Bill of Rights in terms of section 39(2) of the Constitution, or is in the interests

of justice in terms of section 173 of the Constitution. The defendant, on the other hand, contends that she bears an evidentiary burden to rebut any *prima facie* case made out by the plaintiff.

[16] In developing the argument, plaintiff's counsel pointed to the fact that the Constitutional Court in the *DZ* judgment did not, in the ultimate analysis, extend the common law. It did not do so because it concluded that, whilst it accepted that the common law could be so developed, there was insufficient evidence before the court to make that determination. This, so it was submitted, points to the fact that the Constitutional Court, albeit *obiter*, was of the view by necessary implication that the party pleading for an extension of the common law bore an overall onus to prove the necessity therefor on a balance of probability.

[17] In my view, this was not the only necessary implication. *DZ* can equally be read to have implied that in an instance where a plaintiff has provided sufficient evidence to establish a *prima facie* case regarding the damages claimed, an evidential onus is cast on the defendant claiming an extension of the common law to rebut it. As I read *DZ*, there is no suggestion that this resulted in a shifting of the overall burden of proof from the plaintiff to the defendant. Stated another way, whichever form of onus the Constitutional Court may have had in mind in concluding that there was insufficient evidence, it would have come to the same conclusion i.e. that there was insufficient evidence before it to make a determination with regard to an extension of the common law.

[18] The plaintiff has further argued that the judgment in *Pillay v Krishna & Another*⁷ is determinative of this issue. Davis AJA stated in that case that where

⁷ 1946 AD 946.

a person against whom a claim is made is not simply content to deny it but sets up a special defence, “then he is regarded quoad that defence, as being the claimant; for his defence to be upheld he must satisfy the court that he is entitled to succeed on it.”

[19] The defendant has argued that the use of an onus in the context of adjudicating a development of the common law is not appropriate. The Constitutional Court has never imposed such an onus and it is ultimately a question of law and not of fact as to whether the common law should be developed. Furthermore, the Constitutional Court has said that it has the power to develop the common-law *mero motu* after raising it with the parties and hearing argument on it.⁸ In this regard, the Constitutional Court has also found that whilst it may be preferable that the development of the common-law sought should be pleaded, the failure to do so does not preclude a litigant from raising it in the Constitutional Court⁹ and that indeed section 39(2) imposes a duty on the courts in this regard, not a discretion.

[20] The defendant has also contended that *DZ*, which is the judicial *fons et origo* of the defences pleaded in this case, indicated that in the context of this particular development it is for the defendant to adduce factual evidence to substantiate a carefully pleaded argument.¹⁰ As against the background of the earlier cases dealing with this aspect, this invocation appears to require the provision of a factual matrix to enable the court to evaluate the matter properly without being saddled with the question of an onus.

⁸ *Carmichele v Minister of Safety and Security and Another* 2001 (4) SA 938 (CC) at para 39.

⁹ *Phumelela Gaming and Leisure Limited v Grundlingh and Others* 2007 (6) SA 350 (CC) at paras 25-26.

¹⁰ *DZ* (note 4 above) at paras 57-8.

[21] In my view the submissions of the defendant in this regard must carry the day. Whilst the argument that these defences amount to special defences in the sense referred to in *Pillay* appears at first blush to have some merit, such special defences as referred to therein generally involve a form of confession and avoidance whether by way of a cession, a contractual provision to exclude liability or the like. The DZ defences do not fall within this category. It is implicit in these defences that the defendant not only admits liability in full but is also intent upon ensuring that reparation for the negligent conduct is made. She however contends that such reparation should be made in a more equitable fashion given the full factual matrix involved. In a sense, and as against the background facts placed before the court, the court in extending the common law in this regard is stating, or interpreting, the law as it is in accordance with the Constitution and its inherent norms and values. This does not seem to fall within the category of a special defence in the sense referred to in *Pillay*.

[22] Furthermore, it seems to me that *MSM*¹¹, a case where Keightley J found on the facts of that case that the common law ought to be extended regarding the public healthcare defence, is authority for this view. In that case Keightley J said that where the MEC provides sufficient cogent evidence to establish that the identified services will be available in the future at the hospital concerned at the same or higher level and at no, or less, cost to her than those available in the private sector, this will establish “an evidentiary basis upon which to consider whether this is an appropriate case in which to develop the common-law insofar as the MEC’s public healthcare defence is concerned.”

¹¹ *MSM obo KBM v MEC for Health, Gauteng* 2020 (2) SA 567 (GJ) at para 42.1.

[23] Although *Ngubane*¹² did not deal with the constitutional defences presently under consideration in this case, it dealt with what has been referred to as the “mitigation of damages defence” which, in and of itself, amounted to an incremental development of the common law by the then Appellate Division. It was made clear in that case that the burden of proof did not shift to the defendant but that the defendant is required to adduce evidence in support of its contention – an evidentiary onus.¹³

[24] I accordingly conclude in this regard that once a *prima facie* case has been established by the plaintiff apropos her claim for damages, and where the defendant pleads an extension of the common law as in the present matter, the defendant bears an evidentiary onus to rebut the *prima facie* case put up by the plaintiff.

Hearsay evidence

[25] The defendant has filed an application to admit the relevant medical records in terms of section 3(1)(c) of the Law of Evidence Amendment Act.¹⁴ I do not understand the plaintiff to have pursued any opposition to this. The application ultimately was persisted in only in so far as particular parts of the medical records were referred to in evidence or in addressing the court during the trial.

[26] In *AZ*¹⁵, Stretch J was faced with a similar application, albeit at the stage of determining liability and not damages. She dealt fully with the requirements

¹² *Ngubane v South African Transport Services* 1991 (1) SA 756 (A).

¹³ *Ibid* at 784C-E & 785C-D.

¹⁴ No 45 of 1988

¹⁵ *AZ v MEC for Health, Eastern Cape* (ECB) unreported judgment case no 140/2016 of 14 August 2018 at paras 137-142.

of the Act in this regard which in no small measure are applicable to this matter. I agree with the sentiments expressed there, and based thereon am satisfied that a proper case has been made out for the admission of the relevant documents.

Objections to opinion/expert evidence

[27] There are certain other preliminary issues relating to the evidence which the parties agreed would be argued at the end of the trial. These are:

27.1 Whether Dr Wagner, the head of the defendant department, and other witnesses in the employ of the department have impermissibly given opinion evidence that ought not to be admitted.

27.2 Whether certain articles and portions of a supplementary report delivered by the plaintiff's expert economist, Prof. Van den Heever, (and his corresponding testimony on these aspects) ought not to be admitted.

27.3 Whether the evidence of Ms Caga in support of the plaintiff's rebuttal case is inadmissible on the basis that it was not preceded by an expert summary and amounts to hearsay.

[28] Before dealing with these issues, it may be convenient at this stage, so as to understand the scheme, scope and extent of the evidence led in the trial, to briefly and chronologically set out the evidence which was led before me. It is

important to note that the parties agreed (without any concession as to the onus of proof) that the plaintiff would commence leading her evidence relating to the common-law claim issues which remain in contention. Thereafter, the defendant would lead evidence in rebuttal of the plaintiff's claim, together with evidence in support of the constitutional defences. Finally, it was further agreed that the plaintiff would be entitled to lead evidence in rebuttal of the constitutional defences. On this basis, the plaintiff commenced by leading the evidence of three expert witnesses:

28.1 Ms Heather Grace Hughes, the defendant's expert physiotherapist, testified with reference to her medico-legal report, dated 27 October 2018, and the joint minute between her and the defendant's expert.

28.2 Ms Thabisa Caga, the defendant's expert occupational therapist, testified with reference to her medico-legal report dated 24 August 2018, her addendum report dated 15 June 2020 and the joint minute filed by her and the defendant's expert.

28.3 Mr Bulelani Joel Ketsikile, the plaintiff's expert architect, testified as to his report entitled "N[...] Assessment Report", a final version thereof and the joint minute filed by Mr Ketsikile and the defendant's architect.

[29] The defendant thereafter led the evidence of the following witnesses:

29.1 Doctor Rolene Margarett Wagner, the Head of Department of the defendant department, testified with reference to her factual witness statement.

29.2 Doctor Gillian Margaret Saloojee, the defendant's CP expert and expert physiotherapist, testified with reference to her medico-legal report in respect of BN dated 5 August 2019, together with a supplementary report dated 3 April 2020. She further testified with reference to her report on "Rehabilitation Services for Children with CP: CMH and Frere Hospitals", dated 20 January 2020.

29.3 Mr Godfrey Lawson Howes, a deputy director at the Forensic Audit Unit of the Eastern Cape Provincial Treasury likewise testified pursuant to his factual witness statement.

29.4 Professor Milind Chitnis, the HOD of the Paediatric Surgery Unit at Frere Hospital and CMH, testified with reference to a summary of clinical records dated 3 November 2021 and an addendum thereto.

29.5 Doctor Isabel Michaelis, a paediatrician with specialization in neurodevelopmental and neuropaediatrics at CMH and Frere hospitals, testified with regard to her witness statement.

29.6 Mr. Andrew Robert Donaldson, the defendant's expert economist, testified regarding his expert report entitled "Public finance considerations relating to the method of settlement of damages claims against the state based on medical negligence" dated 17 December 2019, his supplementary report dated 19 June 2020 and his updated data relating to those reports.

29.7 Mr Sean Bernard Frchet, the Chief Director, Integrated Budget Planning of the defendant department, testified regarding his factual witness statement.

29.8 Professor Cooper did not testify because, apart from certain aspects thereof which had been objected to, his report was eventually admitted. The court heard argument regarding the objection and admitted the whole report, subject to the plaintiff's right to seek an adjournment to lead evidence in rebuttal.

29.9 Ms Kabi Krige, the defendant's expert occupational therapist, testified regarding her medico-legal report dated 24 June 2019 and a report dated 29 October 2021 which she prepared in response to an addendum produced by Mrs Caga.

29.10 Ms Shaida Bobat, the defendant's expert industrial psychologist, testified virtually regarding her supplementary

report on Ms N[...]’s prospects of employment, dated 18 March 2020.

29.11 Mr Siyabulela Jack, the defendant’s architect, testified regarding his “Condition Based and Structural Assessment Report” dated 22 May 2020 together with his revised report dated 22 October 2021.

[30] After the defendant had closed her case, the plaintiff called the following witnesses in rebuttal of the defendant’s constitutional defences:

30.1 Professor Alexander Marius Van den Heever, the plaintiff’s expert economist, testified with regard to his report (Version: March 2020), supplementary report (Version: March 2022) and annexures thereto.

30.2 Ms Busisiwe Moni-Tsawu, a physiotherapist formerly employed by the defendant department, testified regarding her experience at Frere Hospital.

30.3 The plaintiff, Ms N[...], testified.

30.4 Ms Caga was finally recalled to the stand to testify in rebuttal of the evidence of Doctor Saloojee pertaining to the constitutional defences.

[31] Prior to, and during the evidence of Doctor Wagner, counsel for the plaintiff raised certain objections to her evidence as being opinion evidence without her having been qualified as an expert. Similar objections were raised regarding other departmental witnesses. Whilst it was conceded by the plaintiff that Doctor Wagner herself was not a layperson, it was argued that she had not been qualified as an expert and, in many respects, voiced opinions which intruded into what was termed “expert territory”. It was however agreed that all this evidence would be provisionally admitted and argument in this regard would be presented at the end of the trial.

[32] It should be noted that the evidence of these witnesses was preceded by factual statements which, although elaborated upon in evidence, set out a full description of the evidence that they would present at the trial and that, when they did indeed testify, they gave their evidence in chief along the lines and in accordance with these statements. The plaintiff submitted that, despite this, certain aspects of the evidence led by these witnesses amounted to opinion evidence some of which was of an expert nature, and because they had not been qualified beforehand pursuant to the provisions of the rules of court, especially by way of the provision of expert summaries, such opinion evidence was not admissible and the court should not have regard thereto.

[33] In response to the plaintiff’s challenge to this evidence, the defendant submitted that there are at least three reasons as to why such evidence ought to be accepted. Firstly, such evidence is indeed factual evidence as these witnesses are public servants who, if the constitutional defences are upheld, will be responsible for ensuring that the order sought by the defendant is complied

with. Their evidence was therefore indispensable in demonstrating to the court that senior staff existed within the department who had the competence, capacity, qualifications, experience and responsibility for ensuring the proper care of BN. This evidence could not have been replaced by evidence from outside experts. Such evidence was thus necessary to explain what had to be done to ensure compliance with the proposed order.

[34] These witnesses likewise were obliged to testify regarding the factually important standard required relating to the delivery of certain medical services and supplies as required by the proposed order.

[35] Secondly, even if the court were to consider that the factual witnesses' evidence was partially opinion evidence, it was submitted that such should nonetheless be admitted. As stated by Schwikkard and van der Merwe¹⁶:

“If the issue [at trial] is of such a nature that the witness is in a better position than the court to form an opinion, the opinion will be admissible on the basis of its relevance. Such an opinion has probative force... because it can assist the court in determining the issue. This explains why the opinions of laypersons and experts are at times received.”

[36] In this regard the court was referred to the Appellate Division case of *R v Vilbro & Another*¹⁷ and the English case of *Multiplex*.¹⁸ In *Vilbro*, the appeal court in essence found that where a witness is in a better position than the court to form an opinion, such opinion will be admissible based on its relevance as stated above. In *Multiplex*, a matter similar to the present in that there had not

¹⁶ P. J. Schwikkard, S. E. Van der Merwe *Principles of Evidence* 4 ed (2016) at p 93.

¹⁷ [1957] 3 All SA 200 (A) at 228-9.

¹⁸ *Multiplex Constructions (UK) Ltd v Cleveland Bridge UK Ltd and Another* [2008] EWHC 2220 (TCC).

been compliance with the relevant rule pertaining to expert evidence but a factual statement had previously been delivered, the English High Court held that in construction litigation an engineer who gives factual evidence may also tender statements of opinion which are reasonably related to the facts within his knowledge and relevant comments, based upon his own experience¹⁹.

[37] Counsel for the defendant submitted that by virtue of the issues raised by the public healthcare defence, the evidence of such factual witnesses from the department was both relevant to the issues and necessary for the court to decide the issues in dispute. Their positions, qualifications and experience including, in the case of Professor Chitnis and Doctor Michaelis, their having treated BN themselves, placed them in an extraordinary position to be able to provide valuable evidence after applying their minds to the questions at hand.

[38] Thirdly, it was submitted by the defence that the plaintiff was, in any event, given full warning in relation to this evidence. In this regard, the court was referred to correspondence dated 11 October 2021, well before the commencement of the trial, in which the defendant's attorneys drew the plaintiff's attention to the evidence of certain factual witnesses which she intended to call, including Doctor Wagner, Mr Frachet, Doctor Michaelis and Mr Howes. This letter proceeded as follows:

“Because the factual witnesses hold professional qualifications, because some of the factual evidence will be of a financial or technical nature, and further as a matter of caution to provide for the eventuality that the court might deem any component of their evidence in the nature of opinion evidence, we intend to provide you and the court with written summaries of the evidence before trial.”

¹⁹ Ibid at para 672.

[39] Indeed, such summaries were, well in advance of trial, supplied by the defendant to the plaintiff as foreshadowed in this correspondence. No objection was raised by the plaintiff nor was there any response to this letter. The factual statements referred to were detailed to the extent that they provided the plaintiff with far better advance notice of the evidence that was to be given than is required by rule 36(9)(b).

[40] In my view, the defendant's submissions must hold sway. Given the nature of the constitutional defences to which they testified, which shall be elaborated on more fully later, it was the defendant's obligation to place before the court as much evidence as possible relating thereto. By its very nature, this evidence in many respects not only relates to the past performance of the medical staff at the two hospitals concerned, but also to future conduct, particularly regarding BN's treatment by the staff in these hospitals in the event that such defences are upheld. Such future conduct required these witnesses, and in particular Doctor Wagner, to testify as to the expected future performance of the hospitals and their staff which by its very nature involves a degree of inference from facts which are entrenched and well known by Doctor Wagner by virtue of her position and experience. Because of her special and unique position in the department, and her experience, she is in a far better position than the court to interpret these known facts and to make inferences therefrom which may amount to opinion evidence.

[41] Additionally, the main purpose of Rule 36(9) is to give the other party sufficient information about the expert evidence so as to remove the element of surprise. However, it does make inroads into the fundamental right of a party to call a witness and requires such party to disclose the nature of the evidence in

advance. It has accordingly been held that the provisions of the rule should be interpreted restrictively.²⁰ I am of the view that the plaintiff had ample opportunity to absorb and digest all the information provided and that any element of surprise was removed. In so far as Doctor Wagner and the other witnesses may have strayed to a minor extent into the terrain of experts (given that she and they do have specialized knowledge), this was practically unavoidable in the circumstances and a necessity. In any event, the plaintiff had ample opportunity to consider all this evidence and to tailor the evidence available to her where necessary and/or to, wherever possible, obtain evidence in rebuttal.

[42] Plaintiff's counsel argued that despite all this, the failure to comply with the rules of court in this regard allowed the plaintiff to take the stance that she could simply disregard this evidence as a matter of strategy. I disagree. Given all that I have said, particularly the nature of the defences and all that foreshadowed this testimony, such an approach was, to my mind, incautious.

[43] I will accordingly have regard to all the evidence of these witnesses. I will also take heed of the fact that, to the extent that their objectivity may be affected by them being employed within the department, this is to a degree counterbalanced by their professional status and in the case of the medical professionals, their being bound by the Hippocratic Oath and their willingness to subject themselves to cross examination.

Defendant's objections to the supplementary report of Professor Van den Heever, certain newspaper articles and the evidence of Ms Caga in rebuttal.

²⁰ *Boland Construction Co (Pty) Ltd v Lewin* 1977 (2) SA 506 (C) at 508H; *Doyle v Sentrahoer (Co-operative) Ltd* 1993 (3) SA 176 (SE) at 180G–J.

[44] Shortly before the resumption of trial after an adjournment, the plaintiff filed a 79-page supplementary report prepared by Professor Van den Heever together with two newspaper articles. These were objected to in writing by the defendant because there was no prior warning that they were to be filed and the defendant was given a short time to prepare. As regards the newspaper articles, they were also objected to on the basis that they amounted to inadmissible hearsay evidence and were not reliable on their own to prove the point intended without independent evidence to support them.²¹

[45] As regards the evidence of Ms Caga, it was objected to as it was not preceded by an expert summary and the evidence was not put to the defendant's witnesses. It also, to some extent, involved hearsay evidence and strayed beyond her areas of expertise as an occupational therapist and case manager.

[46] I have considered the submissions in this regard and concluded that, largely because of the various reasons I have set out above relating to the constitutional defences, I will allow all this evidence subject to the qualification that I will consider the weight to be attached to it wherever necessary. It seems to me that this is the fairest and most reasonable way of dealing therewith.

Should the common law be developed?

[47] In this part of the judgment, I intend to deal with the evidence led relating to the development of the common law, and thereafter to deal with the question

²¹ *SAMWU & Another v The Nelson Mandela Metropolitan Municipality & Others* [2007] JOL 20536 (LC) at para 21.

as to whether it ought to be developed, and whether this is supported by the evidence. I shall also deal with the disputed issue as to the standard at which the departmental services should be measured.

Evidence led for and against the development of the common-law.

[48] In this regard the defendant led the evidence of Mr Donaldson, Mr Frchet, Mr Howes and to a lesser extent the evidence of Doctor Wagner. In rebuttal, the plaintiff led the evidence of Professor Van den Heever.

Mr. Donaldson

[49] Mr. Donaldson holds an M.Phil Economics degree from Cambridge University amongst various other qualifications. He has had extensive academic experience and is presently a Senior Research Associate at the University of Cape Town's Economics Department. He has held senior positions in the National Treasury and the former Department of Finance over a period of some 23 years. He has worked extensively in the fields of public finance, expenditure planning and budget coordination. He has also researched and published widely in the fields of social services, health and education.

[50] He testified that state resources are unavoidably constrained when one considers the range and diversity of possible purposes or uses to which they may, or ought, to be put. Society has a range of needs which require to be prioritized and if it is to meet its needs and to advance the social and economic well-being of its people, the state must use the resources at its disposal both efficiently and effectively. Professor Van den Heever largely accepted these

propositions adding that the public health system would never not be “resource constrained”.

[51] Mr Donaldson further made the point that the state resources are, whilst substantial, held in stewardship on behalf of the wider community. He said that it is not the state that ultimately suffers loss if unreasonable, excessive or unnecessary payments are made for particular purposes, it is the state’s capacity to meet its obligations that is diminished, including its constitutional obligations.

[52] He stated further that in determining whether the common law regulating payment of delictual damages should be developed, the capacity of the state to meet its manifold other obligations is a relevant consideration. Compensation which is paid in any particular instance is a charge of equivalent value against the state’s capacity to meet other social, economic or developmental obligations – as is implicit in the economic concept of “opportunity cost”. He explained that opportunity cost refers to “the things that might otherwise be done if spending was not allocated to any particular purpose”. It is relevant to these court proceedings in that by making an award “there is a sense in which the court takes on that responsibility that otherwise would be exercised by a treasury”.

[53] He explained that the cost of claims against an organ of state are expected to be made from within the available baseline of expenditure allocations to that organ of state. In exceptional circumstances however, taking into account the impact of such claims on service delivery, a provincial treasury or expenditure planning committee might recommend an addition to baseline for the purposes of meeting or partially meeting compensation claims.

[54] Regarding the constitutional defences as pleaded, his view was that in circumstances where there exist material uncertainties about future costs and requirements, such defences are consistent with the requirements of economy, efficiency and effectiveness to which the state is obliged to adhere. They are also consistent with the constitutional and statutory obligations pertaining to the management of public finance. Under cross examination he emphasized that in his view this position remained extant irrespective as to whether a particular department was facing elevated financial challenges such as the defendant department, as compared with other provinces that did not face quite such high or extensive claims. In essence, these defences would bring the court system into sync with the way the budgetary and appropriation of funds systems operate in terms of the Constitution, through the national and provincial treasuries.

[55] He said that an advantage of a commitment to meeting service needs as they arise is that one can reduce the uncertainty involved in courts having to estimate and predict future needs when awarding upfront payments. Resulting from this, is a cost-effectiveness argument in favour of an approach that focuses on meeting needs as they arise.

[56] Mr Donaldson agreed that there were instances where it would be sensible to settle certain aspects of damages claims upfront, such as general damages. However, an undertaking to provide services or to pay when the expenses arise would enable the department to better match its actual expenditure to needs and to adapt those commitments over time if needed. He

also stressed that in his view an added benefit of moving to a pay-as-you-go basis, is that the parties are likely to settle claims sooner.

[57] Mr Donaldson further described the restrictive budgetary forecast which is faced by the department in that in the present fiscal consolidation phase the country is experiencing limited budgetary increases both in the national and provincial departments. In the foreseeable future, government departments face considerable resource limitations even in nominal numbers which do not take inflation into account. Indeed, he said that the department is already “in a state of considerable financial stress” which in turn leads to stresses within the facilities such as congestion, excess demands, busy hospitals and challenges maintaining assets, amongst others.

[58] He also pointed to the fact that medical negligence claims against the state are rising even though there have been improvements in services. In this context, he described how the public healthcare service provides primary, secondary and tertiary services, largely without charge, to over 80% of South Africa’s population. As at 2018, this represented approximately 48 million adults and children and involved approximately 120 million primary health care visits per annum over 32 million hospital patient days.

[59] Because approximately 92% to 93% of the population in the Eastern Cape is uninsured, approximately 6,726,000 people are therefore reliant on the health department which is considerably higher than Gauteng and the Western Cape. However, over the long term there has been improvement in health service delivery with reference to improvements in the under-five mortality rate, infant mortality, early neonatal deaths and the proportion of births which occur

in health facilities. Despite improvements in healthcare services over time, several provinces have experienced rapid increases in medical negligence claims, particularly the Eastern Cape.

[60] The contingent liability in respect of medico-legal claims lodged increased in the Eastern Cape from about R3.5 billion in 2013/2014 to R16.7 billion in 2016/2017 and up to R38.8 billion as 31 March 2020. He added that the proportion of claims in the Eastern Cape is considerably higher than in most other provinces. In the most recent financial year in which financial statements had been finalized, almost R1 billion had been spent by the department in actual pay-outs.

[61] According to Mr Donaldson, the accumulated contingent liability in respect of medical negligence claims against health departments countrywide amounted to over 40% of the 2018/2019 public health spending nationally. The increasing claims against provincial health departments between 2018 and 2019 was 24%, whereas the resources available to provincial health departments are increasing between 7% and 8% per year, or 2% to 3% per annum in real terms. He added that, whilst there existed some uncertainty in this regard and that not all lodged claims would indeed materialize, it was clear that the claims are increasing considerably faster than available resources.

[62] He also stressed the point that claims are increasing more than the budget increase. In this regard, he said in his report that “Although not all claims result in awards against the State, it is readily apparent that the rise in medical negligence claims against the State represents a threat to the capacity of the State to provide and improve health service delivery. On present trends, the

annual increase in claims against State health departments already exceeds the real (after inflation) increase in resources available for health service delivery, and will soon exceed even the nominal annual increase in resources.” There is thus a cost or a self-defeating feature of payment of these claims upfront that undermines the capacity of the state to improve health service delivery over time. He also gave examples of this opportunity cost to public health in South Africa.

[63] He further stated that even considering actual payments made in respect of court cases in contradistinction to the question of contingent liabilities, these currently amounted to 3% to 4% of the health budget of the department and the difference would mean that the department would have no effective or real increase in its annual budget, or may have a real decrease. The actual expenditure remains a substantial drain on resources which could be used for other purposes. In his view, therefore “for the State rationally to provide the most cost-effective way possible for these costs, there is a case to be made for meeting them as costs arise rather than upfront.”

Mr. Frchet

[64] Mr. Frchet is the Chief Director, Integrated Budget Planning in the Eastern Cape Department of Health. He has held this position since June 2008 and is responsible to the Chief Directorate: Integrated Budget Planning. He testified that the Chief Directorate is responsible for the department’s efficient and effective financial budget planning, monitoring and evaluation of the implementation of the budget, management of budget reviews and expenditure

trend analysis, as well as management, planning, monitoring and evaluation of revenue activities.

[65] He testified that the department has been spending an increasing portion of its annual budget on the settlement of medico-legal claims. At present, these are upfront settlements, but they are incurred at the cost to the department of resources which would otherwise be available for health services for the uninsured population. Claims totalling R3.462 billion have been settled within the period 1 April 2014 to 31 March 2021. Whilst they are obviously uninsured, they are also not budgeted for, and unfunded.

[66] Because of the situation, and particularly because such pay-outs are unbudgeted, he explained how these extensive payments in each financial year require the department to utilize funds which were budgeted for expenditure under its various programmes in order to comply with its responsibility in meeting court orders and/or settlements. Consequently, funds which were allocated to the department by treasury for the purposes of funding programmes such as emergency medical services, support services, facilities management and hospital services are taken out of those programmes to meet these claims. This results in such payments being categorized as “unauthorized expenditure”.

[67] In practical terms, this affects the delivery of healthcare services as diminished funds are available for expenditure on their intended public healthcare purposes. Additionally, because such expenses cannot be budgeted, the department often experiences cash flow challenges resulting in supplies not being paid within the required 30 days. Those payments must then, in many instances, be deferred so that they may be paid out of the budget for the ensuing financial year. In turn, this results in the department commencing the financial

year with insufficient cash to achieve the full healthcare provision required. This obviously has a detrimental effect on the ability of the department to deliver healthcare to the public and to effect improvements to its services. It also reduces the ability of the respective programmes to reach their planned targets.

[68] He further testified that the department has seen rapid increases in medical negligence claims over the past years. The contingent liability of claims as at 31 March 2021 amounted to approximately R38,842,976,000 in comparison with R35,425,811,000 as at 31 March 2020. This amount was in excess of the current (as at the time he testified) annual appropriation to the department.

[69] Of great concern, Mr Frachet testified that the department anticipates that based on the then current trends in its contingent liabilities, settlements against the department are likely to increase rapidly and at a faster rate than the annual increase in its budgeted resources. If the department is required to proceed on its present course in paying out such claims based on upfront payments, this will in time overwhelm its capacity to meet its health service delivery obligations. In his view, therefore, it has become a necessity that consideration be given to alternative avenues for meeting medico-legal claims against the department.

Dr Wagner

[70] Dr Wagner is the head of the Eastern Cape Department of Health and has held this position since 1 August 2021. She obtained an MBChB (UCT) in 1996 and read for the M Phil in Public Health and Masters in Public Health degrees

through the universities of the Western Cape and Fort Hare during 2003 and 2018. She has held several senior and executive management positions predominantly in the public healthcare sector, and in the private healthcare sector. Approximately five years of these has been at an executive level in both the public and private sectors.

[71] As regards her experience, it would be helpful to repeat her own words in her witness statement as confirmed in her testimony, as follows:

“3 My career path since completing my internship at Groote Schuur Hospital in 1996, commenced with a grounding for six years as a Medical Officer in community health centres (CHC) in Mitchell’s Plain, Western Cape, and in Gompo, in the ECDoH. I was appointed Coordinator of the rationalisation of the East London Hospital Complex and later of all complexes and regional hospital services in the ECDoH; was Project Manager of the Vitamin A supplementation programme; promoted to Director of Complexes and Regional Hospitals in September of 2002; in 2005 became Chief Director Human Resource Development for the Province, and in May 2009 was appointed acting Chief Operations Officer (Deputy Director-General: Corporate Services) for the Department of Health in this Province in an acting capacity until I resigned in February 2011 to run a GP practice in association with colleagues at the Medicross in Berea.

4 I returned to the public sector in December 2012 as the CEO of the 900-bed Frere Tertiary Hospital where I spearheaded a turnaround in patient outcomes and experience of care, with the Frere team. The improvement in quality of care was recognised when Frere Hospital received the prestigious Dr Kwang Tae Kim Merit Award in 2018 from the International Hospital Federation - the only African finalist amongst 27 finalists in the four categories from over 180 public and private sector entries world-wide.

5 After serving as the Deputy Director-General: Hospitals and Clinical Support Management Services of the ECDoH, I returned to the private healthcare sector. I was appointed as an executive in Netcare, as the Medical Director of Netcare’s Primary Care Division on 1 August 2019. The main focus of my position was to promote the consistent provision of quality primary care services by implementing programmes that pursue the quadruple aim of quality healthcare (i.e. enhancing patient experience, improving population health, reducing costs, and improving the working life of healthcare workers). During this tenure, I developed a strategic framework that aligned the Division’s activities with this quadruple aim; and embarked on a road show to 61 Medicross practices across the country with colleagues, to engage doctors and secure their buy-in for the proposed activities. The proposed projects were aimed at transforming current practice, in anticipation

of major health sector reform, to meet the needs of our citizens, whilst ensuring a viable business model.

6 I also headed the team reviewing the Primary Care Division's Quality Management System; and, in collaboration with the key stakeholders, developed a concept document that looked at not only simplifying and integrating the various quality assurance measures (such as Ideal Clinic, Netcare and British Standards Institute's standards) but also explored ways of positioning quality at the centre of the Division's business and promoting the continuous improvement and maintenance of world class healthcare standards. We developed a quality assessment tool that integrated the Ideal Clinic, British Standards Institute ISO 2009:2015 and Netcare critical service standards into a single tool for the Medicross facilities.

7 I have a specific interest and passion for developing clinical performance management systems. I coordinated the primary Care Division's response to the SARS-COVID19 pandemic, providing clinical leadership to the doctors, nurses, dentists and staff during both first and second resurgences and ensuring vaccination of the Division's healthcare workers."

[72] She confirmed the evidence of Mr Frachet as, as accounting officer, she is responsible *inter alia* for ensuring that there are adequate systems in place to prevent, monitor and address financial misconduct when it occurs. She is also responsible for budgeting for provision of necessary healthcare services. She confirmed that lump sum payments have impacted negatively on the department's operating budget. The outflow of funds from the department for such claims has increased exponentially year by year. She affirmed that each such payment comes with an opportunity cost to the department and results in money being taken away from other services. In her words, she said it is "a never-ending downward tightening, ever tightening spiral if we continue to pay in this mechanism." In her view, the department's liquidity problems threaten the liquidity of the rest of the provincial government.

[73] She also testified that such lump-sum payments similarly impacted the private healthcare sector. Responding to a question from the court, she testified that after the Road Accident Fund Amendment Act (19 of 2005) which came into

effect during 2008, there followed a notable increase in both the volume of medico-legal claims and their quantum in the private and public sector. This has resulted in the cost of professional insurance for obstetricians escalating at an alarming rate. Indeed, many such obstetricians have indicated that they do not see themselves continuing in practice in five years' time as a consequence. This, she said, in turn will become the public sector's problem if people with medical insurance can no longer access private obstetric care. At present there are up to 125,000 births annually in the private sector. This would increasingly become an additional burden upon the public healthcare system. She added that neurosurgery in the private sector is similarly affected. All this, in turn, threatens the public's constitutional right to health care.

Mr Howes

[74] Mr Howes is a forensic accountant with a BCom (Accounting) degree from the University of Cape Town, employed as a Deputy Director: Forensic Audit in the Eastern Cape Provincial Treasury. He has been involved in investigations into allegations of misconduct by individuals and/or their attorneys regarding medical negligence litigation and its proceeds.

[75] He testified that his investigations have revealed evidence indicating a high prevalence of abuse of the system governing medico-legal claims against the department, and in particular relating to claims for children with cerebral palsy. He also anticipated that his investigations would continue to uncover further abuse. He highlighted that such abuse not only impacts on the department, but results in reduced, and in some instances no benefit from the claim ultimately being enjoyed by the intended beneficiaries.

[76] In all the cases which he has investigated in the Eastern Cape, the courts had ordered that a trust be established to administer the damages awards. In accordance with the court orders, the trusts are to be created by the plaintiff's attorneys and the full award is required to be paid into the trusts after a deduction of attorney and own client legal fees. These trusts are typically to be established within three to six months of the date of the court order. Invariably in such matters, the plaintiff's attorney is engaged on a contingency fee agreement basis. In accordance therewith, there is a cap on such fees that the lawyers may claim at 25% of the sum awarded, excluding disbursements. Any legal costs recovered from the department, together with the remaining damages award, are to be paid by the plaintiff's attorney into a bank account established by the relevant trust which is overseen by a bona fide trustee, or trustees, duly appointed by the Master. Accordingly, these court ordered trusts are intended as a vehicle to protect the beneficiaries' interests. He made the point that most of these beneficiaries are minors who are severely disabled and lack the requisite capacity to manage their own affairs.

[77] He further said that the department is normally not privy to the establishment of these trusts and so would not ordinarily know how such damages awards are ultimately managed, whether or when the trust is established or how much of such damages are paid into the trust, if any.

[78] He testified that the investigations have uncovered conduct involving the following:

78.1 Court ordered trusts for the management of the damages awards are often set up well past the timelines mandated in the court orders, and in some instances have not been set up at all.

78.2 Payments of the awards from the attorneys' trust accounts into the trusts are often made late, in significantly reduced amounts, and in some instances, not at all.

78.3 The management of the trusts in instances where they have indeed been created, are fraught with irregularities including in the appointment of the trustees themselves, irregular and excessive draws being made in respect of trust administration costs, overreaching on legal fee claims from the award, and other accounting irregularities.

78.4 The plaintiff's attorneys in some cases recover excessive legal costs and fees from the final award even when cases are settled early, without proceeding to trial. Invariably 25% or more of the award goes to the attorneys, regardless that the primary cap is double the normal fee. A matter that settles early, even with the double or "success fee", should not come close to the secondary cap of 25% of the legal fees in cases involving a substantial quantum.

[79] He further testified particularly relating to an attorney who has since been charged criminally, that the experience with this attorney's firm is exemplified

in his investigations relating to various other firms. In the case of this attorney, of 30 trusts which were court ordered to be set up for the benefit of children represented by the plaintiffs in medico-legal claims against the department, the following has emerged:

79.1 In 16 out of these 30 cases, no trusts have yet been established, despite the deadline for the creation of the trusts having passed, in some cases, over 33 months ago.

79.2 Of the remaining 14 cases where trusts have been set up, 12 of these trusts were set up after the court ordered deadline for the establishment of the trust had passed, in some cases with up to 24 months passing before the trusts were set up.

79.3 Because no trusts have been established in 16 cases, the attorney's firm has not made any payments into those trusts at all despite the fact that the department has paid the damages award as per the court orders into the attorney's trust account.

79.4 In 13 of the 14 cases where the relevant trusts have been set up, even belatedly, significant delays were recorded between the creation of the trusts and the first payments by the attorneys into the trust, some with a delay of up to 12 months.

79.5 In 28 of the 30 cases, either no monies had been paid to the trusts by the attorneys, or the amounts paid were significantly less than what ought to be due to the beneficiary, even after deduction of legal costs. Where the figures for legal costs are available from these trusts to which payments have been made, it appears that between 31% and 33.9% of the award is ultimately claimed by the attorneys in legal fees, excluding disbursements. If disbursements are added, it takes the total amount deducted from the award in respect of fees and disbursements up to 41%. Although certain monies recovered upon taxation are theoretically payable to the client (less a fee charged for taxation) these are typically relatively small and are invariably not paid to the client.

[80] Mr Howes further testified that in respect of the 30 cases the department had made payments in the total amount of approximately R480 million to this firm of attorneys between 2015 and 2021. His investigation into these cases demonstrated that these funds are to a significant extent not applied to the benefit of the injured parties:

80.1 Only 24% of this amount has been made available to the beneficiaries' trusts. An amount of only R115 million was paid to these trusts. This leaves a difference of about R365 million between what was awarded by the court and paid by the department, and what has been paid by the attorney's firm into the beneficiaries' trusts. Whilst some of these funds may have lawfully been consumed in legal fees and/or may still be paid

into the trusts, some 76% of the awards has not been applied for the benefit of the intended beneficiaries.

80.2 Approximately R221 million or 46% of the awards that the department has paid to this firm are in respect of beneficiary trusts that do not presently exist because the attorneys have failed to comply with their obligation to establish and register such trusts with the Master.

80.3 Approximately R163 million or 74% of the R221 million which ought to be available for payment to the unformed trusts in the future is unaccounted for. In this regard, as at 30 July 2021 the firm's trust account held R101 million. Of this, R43 million was for trusts that had been formed but had not been paid, leaving about R58 million available for distribution to the yet to be established trusts. This leaves R163 million (approximately 74%) of monies paid by the department being unaccounted for in respect of these yet to be established trusts. He further testified that an examination of the ledgers of the firm's trust account demonstrates that there are hopelessly insufficient funds held in trust to distribute to these yet to be established trusts. Even if one takes into account approximately 40% of the R221 million being allocated (to a degree in contravention of the Contingency Fees Act No 66 of 1997) to legal fees and disbursements, the firm remains at least R74, 6 million short in its trust account for distribution to these yet to be established beneficiary trusts.

[81] He testified that there are further payments to this firm which have been identified and which are yet to be investigated. Taking these together with the R480 million referred to earlier, the total payments made by the department between April 2014 and March 2021 to this firm by way of damages awards amounts to the sum of R612.6 million.

[82] His investigation also showed that the delay in registering these trusts cannot be attributed to the Master's Office.

Professor Van den Heever

[83] Prof. Van den Heever testified on behalf of the plaintiff in rebuttal of the defendant's evidence relating to the constitutional defences. He holds a BA (Hons) and an MA (Economics), from the University of Cape Town. His master's thesis focused on the evaluation of health resource allocation requirements in Southern Africa. He has sat on numerous advisory committees, boards and commissions in relation to national health, finance and economics. He has also been involved with a strategic management team to support the establishment of the Gauteng Department of Health and a functional task team which established the Medium Term Expenditure Framework for South Africa. He has had extensive experience in economic advisory positions, particularly relating to government and in the area of health. Apart from his involvement with the Council for Medical Schemes, he has consulted with several major clients including the National Treasury, The National Department of Health and the Development Bank of South Africa.

[84] His expertise lies in the areas of health economics and financing; public finance, with a specific emphasis on health policy matters; strategic government policy, relating primarily to health and social security; and policy and planning modelling. He has also conducted extensive research and published widely. Indeed, from his CV it appears that he has been responsible for more than 80 publications, many of which involve healthcare and social security. Likewise, what he terms “key projects” in which he has been involved relating similarly to health, finance and related matters is impressive, and extensive.

[85] The first point which the professor made both in his report and in his evidence was that to compensate victims of medical negligence other than through a lump sum pay-out would result in an unjustified transfer of risk, and would amount to a departure from the principle of social solidarity that underpins the public and private health systems. He said that any failure to incur the cost of implementing reasonable and rational measures to minimize the risk of medical negligence is not a saving and would represent a departure from social solidarity principles of any publicly provided health service, or a national health system. He further argued that not to cover the costs of a rightful claim for damages is equally a departure from the principle of social solidarity as it transfers an important risk back to the private individuals and families who are structurally in a more precarious position in terms of carrying such a risk.

[86] In his reports, and in his evidence, the professor dealt with and assessed the capability of the defendant to provide a standard of healthcare equivalent to that which pertains in the private sector, based on various proxy indicators. Having conducted extensive research in this regard and having provided two lengthy and detailed reports pertaining thereto, he expressed strong doubt that the

department indeed has the capacity to provide the healthcare which BN requires at a standard equivalent to that which pertains in the private sector.

[87] In this regard, he relied on three separate, and in his view important, proxy indicators. These are: health outcomes in the form of maternity mortality ratios (“MMR”); findings of the Office of Health Standards Compliance (“OHSC”); and numerous reports from the Auditor-General of South Africa (“AGSA”).

[88] In dealing with MMR, he testified that this index stood at 138 in 2015 which was more than double the ratio in various developing countries of equivalent economic status, including Argentina, Brazil, Colombia, El Salvador, Ecuador and others. In his experience and coupled with this, he said that South Africa has a poorly performing public health sector which cannot simply be explained away by stating that it is limited by the resources allocated to it. From his analysis, he concluded that there are many countries which have a much lower per capita GDP than South Africa, which perform far better with reference to MMR.

[89] He further contrasted the MMR of certain provinces in South Africa with what he termed the benchmark. From this, he said that the provincial comparison shows that the Western Cape outperforms the other provinces despite having similar socio-economic situations and challenges, such as HIV and AIDS and the recent pandemic, and despite the fact that it receives fiscal allocations consistent with all the other provinces. From this he said that the only reasonable conclusion which could be reached is that such services are managed more efficiently in the Western Cape than in the other provinces and that, of

importance, this suggests that the MMR reflects structural differences in managerial capabilities across the provinces.

[90] Prof. Van den Heever also relied on the OHSC audits in conjunction with the MMR. He said that the OHSC attempts to assess the quality assurance features which are in place within various health facilities. He noted that by considering both MMR and OHSC scores together, there was an indication of a high degree of consistency i.e. provinces scoring poorly on outcomes such as MMR also scored poorly on their quality assurance assessment. This, in his view, served to fortify his conclusions.

[91] Upon an analysis of the OHSC audits his reports reflect that the Eastern Cape health department has the second lowest weighted average score for public hospitals from the OHSC compliance scoring and, as indicated above, a relatively high MMR. He thus maintained in evidence that his conclusion based on the MMR itself as dealt with earlier, was fortified and underscored by the OHSC audits and that these combined appeared to be valid indicators of the lack of managerial capability within the Eastern Cape Health Department.

[92] The third proxy indicator which the professor considered to be of importance and of relevance to the managerial capability of the department was the findings of the AGSA. Once again he concluded, on an analysis of these findings, that they are, province by province, broadly consistent with both the MMR and OHC results. In evidence he explained that the findings of the AGSA illustrate glaring issues regarding the capability of the defendant to deliver on its various promises. Such findings demonstrate a deep-rooted problem within this province because they are, along with the OHSC findings, indicative of general

performance. In his reports, he gave extensive examples of such comments as made by the Auditor General in relation to various recent financial years.

[93] Regarding the proxy indicators, the professor concluded as follows:

“So that’s the kind of issues and I would say over a three-year period one’s getting a pattern where the performance information is repeatedly regarded as unreliable. There are repeated problems with financial management and there are repeated problems that deal with compliance with legislation. I think that all of these, again when looking at this information as a kind of proxy indicator, suggests that the department has trouble implementing systems. And without those systems it is very difficult for the department to address systemic issues that it has to face. And now I think that does have to be understood that provincial health departments are very complex departments dealing with very complex problems. And you can’t actually resolve them effectively without designing your system to be sufficiently agile to cope with complex problems. That means that you have got to build constantly your capability to deal with those things that you can predict, but you have got to have systems and services for which you have got a systemic response, the planned things, the TB’s, the HIV’s, your elective surgeries, all of those things can be subject to reasonable levels of planning. And then there are things that happen that you cannot predict and you must have a department that is sufficiently agile to be able to respond to those. My assessment is that the Eastern Cape, as with.....most of the other provinces, lacks the agility to respond to the complex problems and also to relatively simple problems, and that is certainly a concern. If we go to page 512 and table 6, this just provides a summary now as I have been doing all the way through, consistently using the Western Cape as a benchmark. And in comparing the Eastern Cape with the Western Cape in terms of irregular expenditure accruals and unauthorized expenditure and fruitless and wasteful expenditure, this just basically demonstrates the difference in the patterns.”

[94] The professor used these proxy indicators in comparison with other provinces to determine the department’s comparative performance. In this regard he found that the most apposite differential would be the Western Cape Department of Health for various reasons. He found that the Western Cape department is materially more capable than the Eastern Cape and that the performance weaknesses arising from the differences in capability are revealed through poor health outcomes and poor financial management. He also found that the Eastern Cape, in comparison with the Western Cape, lacks the systems in place to ensure continuous improvements in performance.

[95] Prof. Van den Heever devoted a fair portion of his evidence to describing how the department is the author of its own downfall and its arguments that the financial and other difficulties which it experiences, and which were described in the evidence of Dr Wagner and Mr Donaldson as being a consequence of the large CP claims and awards which have emerged over the past eight to ten years, are not correct. This outcome, he opined, was due in part to the poor management capability of the department as described above. However, a major contributing factor in his view was the way the department budgets, or does not budget, for these awards.

[96] As foreshadowed above in the summary of Mr Donaldson's evidence, the department, as with all of government, does not budget in advance for its contingent liability in respect of damages awards as will likely be made by the courts, or through agreements duly executed in settlement of these claims. This, according to the evidence of Mr. Donaldson, is in accordance with accounting convention which spans many years and, as a result, a Treasury instruction has been issued to all departments in the province not to budget for such claims.

[97] According to Prof. Van den Heever, this approach by the Provincial Treasury is incorrect, and indeed unlawful. He went further and alleged that compliance with Treasury's instruction not to budget for medical negligence claims amounts to financial misconduct and a wilful failure to "take effective and appropriate steps to prevent unauthorized irregular and fruitless and wasteful expenditure... resulting in criminal conduct."

[98] In my view, and because of reasons which I shall deal with later in this judgment, it is not necessary to spend time summarizing the extensive and various arguments advanced by these witnesses for and against the requirement to budget in advance for such claims.

The existing common law and the rationale for its development

[99] In claims for compensation which arise out of delict, the plaintiff must claim in a single action all damages already sustained, or expected to arise in the future, insofar as they are based on a single cause of action.²² This is the “once and for all” rule which has its foundations in English law²³ and has been adopted and applied in the South African courts. It comprises two components: firstly, that all damages, present and future, should be claimed in a single action and secondly, that such damages are claimed as a lump sum.²⁴

[100] Under the *Aquilian* action a defendant is obliged to make good the difference between the value of the plaintiff’s estate after the commission of the delict, and the value it would have had if the delict had not been committed²⁵. This must be done in money and not in kind.²⁶

²² Boberg, *The Law of Delict* at p746. See also *Custom Credit Corporation (Pty) Ltd v Shembe* 1972 (3) SA 462 (A) at 472: ‘The law requires a party with a single cause of action to claim in one and the same action whatever remedies the law accords upon such cause.’ See further *Signature Design Workshop CC v Eskom Pension and Provident Fund and Others* 2002 (2) SA 488 (C) at 498B-E; *Symington and Others v Pretoria-Oos Privaat Hospitaal Bedryfs (Pty) Ltd* [2005] 4 All SA 403 (SCA) at 412.

²³ *Cape Town Council v Jacobs* 1917 AD 615; *Coetzee v SAR & H* 1933 CPD 565 at 574. The rule was formulated in *Fitter v Veal* (1701) 12 Mod 542; 88 ER per Holt CJ. The case is also reported as *Fetter v Beale* (1701) 1 Salk11; ER. It concerned a plaintiff who sued successfully for damages for assault and battery, but later discovered that “a piece of his skull was come out” from the same incident. A second action claiming damages for the newly discovered harm to the plaintiff’s skull failed.

²⁴ *DZ* (note 4 above) at para 16.

²⁵ *Dippenaar v Shield Insurance Co Ltd* 1979 (2) SA 904 (A) at 917B and E.

²⁶ *DZ* (note 4 above) at para 14.

[101] In *Ngubane*²⁷, the Appellate Division was faced with the following argument in opposition to a claim for damages in respect of future medical expenses and adaptive aids:

“Once the possible alternative of State medical services is raised, counsel for the respondent submitted that

‘(t)here is no general authority that a plaintiff is entitled to be awarded the costs of a private clinic in preference to the costs of a public hospital’,

and that therefore

‘(w)hen the possibility that cheaper treatment is possible than that claimed by the plaintiff it becomes his duty in discharge of the general onus resting on him to deal with these possibilities. It is not for the defendant to quantify his damages for him.’”

[102] This argument was rejected by the appeal court which set out the legal position as follows:

“Though the *onus* of proving damages is correctly placed upon the plaintiff, this submission, which is really concerned with the duty to adduce evidence, is to my mind unsound. By making use of private medical services and hospital facilities, a plaintiff, who has suffered personal injuries, will in the normal course (as a result of enquiries and exercising a right of selection) receive skilled medical attention and, where the need arises, be admitted to a well-run and properly equipped hospital. To accord him such benefits, all would agree, is both reasonable and deserving. For this reason it is a legitimate - and as far as I am aware the customary - basis on which a claim for future medical expenses is determined. Such evidence will thus discharge the *onus* of proving the cost of such expenses unless, having regard to all the evidence, including that adduced in support of an alternative and cheaper source of medical services, it can be said that the plaintiff has failed to prove on a preponderance of probabilities that the medical services envisaged are reasonable and hence that the amounts claimed are not excessive.

This approach conforms, in my view, to the requirements of proof in any claim for delictual damages.”²⁸

[103] And later:

“Thus in the instant case the respondent was required to adduce evidence - a 'voldoende getuienisbasis' in the words of Jansen JA - in support of its contention, that is to say, that for the next 35 years, or for some shorter period, medical

²⁷ *Ngubane* (note 12 above).

²⁸ *Ibid* at 784C-E;

services of the same, or an acceptably high, standard will be available to the appellant at no cost or for less than that claimed by him.”²⁹

[104] The Constitutional Court in *DZ* expressed the view that *Ngubane* was authority for allowing the defendant to produce evidence that medical services of the same or higher standard at no, or lesser cost, than private medical care, will be available in the future to the plaintiff to defeat or reduce a claim for future medical services. In this regard it said:

“If that evidence is of a sufficiently cogent nature to disturb the presumption that private future healthcare is reasonable, the plaintiff will not succeed in the claim for the higher future medical expenses. This approach is in accordance with the general principles in relation to the proving of damages.”³⁰

[105] The Constitutional Court further said in this regard that:

“This approach does not offend the ‘once and for all’ rule. It is a ‘once and for all’ factual assessment on the evidence adduced that, although the claimant will need medical care in future, it has not been proved on a balance of probabilities that this entails a loss in the sense that the claimant’s patrimony after the delict is less than it would have been had the delict never occurred. It is not the mere injury and its future consequences that justify an award of damages, but the actual diminution in the claimant’s patrimony”.³¹

[106] The court referred to this as the “mitigation of damages defence”. The defendant in this matter argued that whilst it does not rely on this defence, it is important to recognize its existence and ambit because this demonstrates that the development of the common law sought by the defendant is incremental, and not radical. *Ngubane* itself represented an incremental development of the common law. The common law position before *Ngubane* was as stated in *Williams*³², that there is no authority for the proposition that “where a potential patient demands provision for future medical treatment he is entitled to be

²⁹ Ibid at 785C-D

³⁰ *DZ* (note 4 above) at paras 21-2.

³¹ Ibid at para 22.

³² *Williams v Oosthuizen* 1981 (4) SA 182 (C) at 184H-185D.

awarded the cost of a private clinic in preference to the cost of a public hospital”.³³

Authority for the development of the common law

[107] As foreshadowed earlier in this judgment, it is *DZ* which opened the door for the possible introduction of the constitutional defences pleaded in this case. The majority found, *obiter*, that the way was open for such defences but that it could not entertain them as the foundational evidence in support thereof had not been placed before it. It however explored the scope for the development of the common law in this regard.

[108] In doing so, the Court considered the origins of the once and for all rule and its corollary, that a court is obliged to award damages in a lump sum, and the delictual principle that damages sound in money.³⁴ It further found that the common law requirement, to the effect that damages should sound in money, is not beyond scrutiny and that to “require compensation in money as the ‘measure of all things’ therefore appears to be an evaluative normative choice.”³⁵ The Court also held that it was “arguable that the fundamental right of everyone to have access to healthcare services and the state’s obligation to realize this right by undertaking reasonable measures introduce factors for consideration that did not exist in the pre-constitutional era.”³⁶

[109] In dealing with the public healthcare defence, the Constitutional Court said:

³³ Ibid at 184H-185D. See also *Dyssel NO v Shield Insurance Co Ltd* 1982 (3) SA 1084 (C) at 1086H- 187A.

³⁴ *DZ* (note 4 above) at paras 41and 44.

³⁵ Ibid at para 45.

³⁶ Ibid at para 45.

“Future medical expenses are awarded in respect of medical services that the victim may need in the future, which would have been unnecessary had there been no delict. In principle the actual rendering of these services would fulfil the twofold purpose of redressing damage and compensating the victim...

In logic and principle compensation in a form other than money does not appear to be incompatible with the aim of making good 'the difference between the actual position that obtains as a result of the delict, and the hypothetical position that would have obtained had there been no delict.'” [Footnote omitted.]

[110] The Court further pointed out that the lump sum and once and for all rules are similarly not beyond scrutiny and added:

“As Nicholas JA pointed out in *Southern Insurance Association*, the enquiry into damages for future loss 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.'

Professor Fleming calls these shortcomings 'lamentable beyond imagination':

'It would be bad enough if the choice were between guessing either right *or* wrong: but our methods virtually assure that the choice *must* turn out wrong. For the accredited approach is to compromise, that is, neither to award the whole amount nor yet to refuse all, but instead to assess and *award the value of the chance*.'"³⁷

[111] In dealing with the undertaking to pay defence the Constitutional Court likewise indicated that there is room for development of the common law as follows:

“Although the 'once and for all' rule, with its bias towards individualism and the free market, cannot be said to be in conflict with our constitutional value system, it can also not be said that the periodic payment or rent system is out of sync with the high value the Constitution ascribes to socioeconomic rights. There is no obvious choice at this highest level of justification. What appears to be called for is an accommodation between the two. Is that possible?...

³⁷ *DZ*, paragraph 51

If the only choice open to us was at this level then it would probably be better to leave reform to the legislature. But this may not be so. Resolution of the dilemma may lie in leaving the choice at the level of each individual case, depending on which form of payment will best meet its particular circumstances...

We must remind ourselves again of the context in which the argument for development of the common law is made here. We are not called upon to decide the fate of the 'once and for all' rule in all personal injury cases arising from medical negligence. The most important future imponderable is the ultimate one: death. Periodic payments subject to a 'top-up/claw-back' will give less speculative expression to the general principle of compensation for loss. And the likelihood of a dependant's claim, which might present problems in other cases, is less, if not entirely absent, here". [Footnote omitted.]

[112] Having regard to the sentiments expressed by the majority of the Constitutional Court in dealing with the constitutional defences presently before me, I can only but conclude that these *dicta* amount to powerful and persuasive support from the apex court, albeit that they are *obiter*.

[113] As noted in the *DZ* judgment, other jurisdictions have departed from a strict presumption that delictual damages for medical negligence claims should necessarily sound in money or should be paid out in a lump sum.³⁸ The judgment concludes by noting that “[t]here is no obvious choice” between the once and for all rule and the alternative systems at the level of principle.³⁹

³⁸ *DZ* (note 4 above) at paras 47-8 —

English law: Jones, Dugdale and Simpson (eds) *Clerk and Lindsell on Torts* 21 ed (Sweet & Maxwell Ltd, London 2014) at paras 28-7 2 to 28-76. See further: See Lord Steyn in *Wells v Wells* [1998] 3 All ER 481(HL)at 502*e-h*.

Canadian Law: Provincial governments in Canada have put in place legislative frameworks regulating the periodic payment of damages in medical negligence matters [see, for example, the 1990 Ontario Courts of Justice Act (sections 2 and 116). Prior to this, the Supreme Court of Canada refused to exercise judicial powers to vary the once and for all rule [*Watkins v Olafson* [1989] 2 SCR 750 (SCC)].

³⁹ *Ibid* at para 54.

[114] An aspect which was of some concern to me during this trial was the question as to why it has been left to the courts to assist the government with a problem which could be solved by approaching the legislature. The Constitutional Court in *DZ* did not however regard this consideration as closing the door on the development of the common law in this regard, particularly if such development were not to involve the wholesale rejection of the common-law rules themselves as is sought by the defendant. As alluded to by Dr Wagner during her evidence, and referred to in *MSM*,⁴⁰ a draft bill has been presented before Parliament for the amendment the State Liability Act to permit both periodic payments and orders for the state to provide treatment to an injured party at a public health establishment. This was gazetted in May 2018. We are now entering 2023 and it has not yet made the statute books. To repeat the words of Keightley J in this regard “It is simply no answer to the defence raised by the MEC to say that he should wait until Parliament decides to adopt the amendment, if indeed this comes to pass.”⁴¹ She added that as these rules are judge made, it would be appropriate for the courts to develop them.⁴² Indeed, Dr Wagner testified that the problem was escalating in the interim. It is also well known that legislation of this nature which may impact upon the income of the legal profession is likely to face powerful opposition in the committee stages of the bill’s passage.

[115] It is also of some relevance to bear in mind that the common law rules were developed in the English courts, the origin of the once and for all rule having been traced back to *Fetter v Beale*,⁴³ a 1701 judgment. The rules were absorbed into the South African common law driven by contemporary policy

⁴⁰ *MSM* (note 11 above).

⁴¹ *Ibid* at paragraph 188.

⁴² See further: *Paulsen and Another v Slip Knot Investments 777 (Pty) Limited* 2015 (3) SA 479 (CC) paras 15-16.

⁴³ *Fitter v Veal* (note 23 above) and *Fetter v Beale* (note 23 above).

concerns, and it may well be appropriate that they be revisited to accommodate the present-day situation.⁴⁴

[116] The principles set out in this regard in the *DZ* judgment have generally been well received by academic commentators⁴⁵, whilst also cautioning that the legislature should be the “engine of reform”.⁴⁶

[117] The importance of the *DZ* defences was affirmed by Madlanga J in the *PN* judgment in substantiating why the court should interpret an order separating liability and quantum to permit the MEC in that matter to lead evidence raising the *DZ* defences.⁴⁷

[118] The principles set out in the *DZ* judgment have found expression in several subsequent judgments from the high courts in Gauteng, KwaZulu-Natal and the Eastern Cape. In *MSM*⁴⁸ the Gauteng division considered a claim similar to the present. In that matter, the defendant raised the public healthcare defence and pleaded that any amount due by way of monetary damages should be paid by way of periodic payments, rather than a lump sum. The court considered both the existing common law and what a defendant would be required to establish for the development of the common law.⁴⁹ The defendant led the evidence of the CEO of the hospital that it intended should provide services in

⁴⁴ Van der Walt CFC *Die Sommeskadeleer en die ‘Once and for all’-Reël* (LLD thesis Unisa 1977) at pp308-314.

⁴⁵ P Pauw ‘Alternative Relief in Delictual Claims – A Step in the Right Direction’ (2018) 81.1 *TSAR* 176, 180; AB Wessels “The Expansion of the State’s Liability for Harm Arising from Medical Malpractice: Underlying Reasons, Deleterious Consequences and Potential Reform” (2019) 1 *TSAR*, 15.

⁴⁶ MX Shibe (2020). *A Feasibility Study of the Legislative Intervention to Reform the Medical Negligence Litigation and Damages in South Africa* [Unpublished masters’ dissertation] University of Pretoria,18.

⁴⁷ *Member of the Executive Council for Health, Gauteng Provincial Government v PN* 2021 (6) BCLR 58 (CC) at para 28.

⁴⁸ *MSM* (note 11 above).

⁴⁹ *Ibid* at paras 16-42.

kind, a senior manager in the provincial health department and the evidence of medical specialists who would primarily be responsible for the care of the child, in order to lay a basis for the ability of the state to care for the child.⁵⁰ On the basis of this evidence, it was concluded that sufficient evidence had been adduced by the defendant to establish that the state was indeed able to provide the services at a standard equivalent to, or better than, the standard prevailing in the private sector.

[119] In coming to this conclusion, the court considered various aspects including the following:

119.1 The socio-economic constitutional obligations of the state pursuant to the provisions of section 27(2) of the Constitution;⁵¹

119.2 The fact of the increasingly large damages awards against the state in similar cases and the resultant reduction in resources available to meet its constitutional obligation to progressively realize the right to healthcare services for the populace;⁵²

119.3 Should the reparation in kind make good the harm inflicted whilst at the same time guard against a reduction in the state's resources and capacity to meet its obligations in terms of section 27(2), this would amount to a compelling basis for the development of the common law;⁵³

⁵⁰ Ibid at paras 92-172.

⁵¹ Ibid at para 177.

⁵² Ibid at para 178.

⁵³ Ibid at para 179.

119.4 As emphasized in *DZ*, the development would be limited in ambit as it would be confined to the case of a child with CP injured at a public hospital and would not affect all medical negligence cases;

119.5 Based on the evidence led before the court, Keightley J further commented that there is a:

“double edged sword hanging over the state: while it faces expensive damages claims for cerebral palsy births, it remains constitutionally obliged to continue to render health services to everyone. Axiomatically, the more the state must pay out in monetary compensation, the less resources are available to it to comply with its constitutional obligation.”⁵⁴

119.6 On the strength of the evidence led before it, the court found that it was both necessary and in the wider interests of justice that the common law be developed to “make orders for compensation in kind as opposed to being restricted to making orders for monetary compensation for future medical expenses”.⁵⁵

[120] As I understand the *MSM* judgment, it provides compelling support for the development of both *DZ* remedies pleaded in this case. The *ratio decidendi* of that case was, furthermore, approved of and applied in the subsequent case of *Mashinini*.⁵⁶

⁵⁴ Ibid at para 186.

⁵⁵ Ibid at para 194.

⁵⁶ *Mashinini v Member of the Executive Council for Health, Gauteng Province* (GJ) unreported judgment case 1352/2017 of 25 January 2021.

[121] It should be mentioned that *PH obo SH*⁵⁷ would appear to be authority against the development of the common law. However, I must respectfully differ with the findings made by that court in this regard. In the main, the court found that:

“It appears to me, with respect, that the Court in *DZ* did not sufficiently consider the impact of the fundamental aspects of the so-called public healthcare defence on the provisions of the Constitution.”⁵⁸

[122] In an interlocutory judgment delivered by Zilwa J in this case,⁵⁹ it was found that this matter is distinguishable from *PH* as a matter of interpretation of the antecedent court orders in each matter in terms of which the defendants were found to be liable on the merits. Despite what was said in *PH*, Zilwa J’s judgment is generally supportive of the development of the common law as contended for by the defendant and it considered the plea in this matter to be one that complied with the requirement of “a carefully pleaded argument” as laid down in *DZ*.⁶⁰

[123] As against this background, the defendant has contended that the development of the common law is justified in terms of sections 39(2), 173 and 172(1)(b) of the Constitution based on the evidence led by her. On the other hand, the plaintiff, pursuant to what was said in *PH* relating to the alleged failure of the Constitutional Court to sufficiently consider the impact of the *DZ* defences on the provisions of the Constitution, has contended that various rights of the plaintiff (and her child) and of other similarly placed individuals, would

⁵⁷ *PH obo SH v MEC for Health, KwaZulu-Natal* 2021 (1) SA 530 (KZN).

⁵⁸ *Ibid* at para 28.

⁵⁹ *TN obo BN v MEC for Health, Eastern Cape* [2020] JOL 48994 (ECB).

⁶⁰ *Ibid* at para41.

be infringed should the common law be so developed. The plaintiff has also contended that the defendant has not established, for the purposes of section 39(2), that the existing common law is contrary to a specific constitutional right or, more broadly, the spirit, purport and object of the Bill of Rights.

[124] Before dealing with these arguments, it will be necessary to consider the evidence led by both the defendant and the plaintiff and as to whether, on a conspectus of all the evidence, it is sufficiently cogent in the defendant's favour to "carry the day".⁶¹ Before doing so however there is one further aspect which requires determination as it is intertwined with the various matters I must consider before reaching this conclusion. That is the question of the standard against which the defendant's services should be measured.

What is the standard required by the law against which the defendant's services should be measured?

[125] Should the court conclude that the common law ought to be developed to include the public healthcare remedy, it is necessary to determine the standard which it should set for the defendant to establish that it can provide the required future medical services. In this regard, the defendant has pleaded the required standard as being a reasonable standard, alternatively an acceptably high standard, alternatively a standard "at least equivalent to that provided in the private health sector".

[126] In *MSM* it was concluded that, pursuant to *Ngubane*, the required standard ought to be the equivalent of that existing in the private healthcare

⁶¹ *DZ* (note 4 above) at para 58.

sector, or an acceptably high standard.⁶² In this regard, the defendant has a submitted that this court ought to depart from the approach in *MSM* for the following reasons:

126.1 There is no scientific or empirical basis for the assumption that the private sector is automatically the provider of a suitable standard of care. Dr Saloojee and Dr Wagner testified to the flaws in that assumption. Prof. Van den Heever also referred to certain problems in the private healthcare sector, albeit different ones to those in the public sector. No real evidence has been led in this case to establish that the standard in the private sector is indeed superior.

126.2 The standard of private healthcare is not universal. It may be that the standard is low in a particular area where a plaintiff might find him or herself. In the circumstances, holding the defendant to the standard in private healthcare for purposes of applying the public healthcare defence may operate to the plaintiff's prejudice. The adoption of a "reasonable standard" is thus more capable of objective application which is consistently beneficial to the injured party.

126.3 The *Ngubane* judgment, upon which the aforementioned conclusion in *MSM* was based, predates the Constitution. Section 27(2) thereof as read with the jurisprudence on socio-economic rights, has adopted the reasonableness

⁶² *MSM* (note 11 above) at paras 92-172; *Ngubane* (note 12 above) 783F-785D.

standard as the one which guides the level at which state policy and practice should deliver on socio-economic rights. This would operate to prevent inconsistent treatment as between CP children with, and those without, the benefit of medical negligence claims.

126.4 The testimony of Dr Wagner, Prof. Chitnis and Dr Michaelis highlight why this assumption should not prevail. They demonstrated in the witness box that they are highly qualified, skilled and award-winning professionals who possess a sincere concern for their patients and a commitment to public service. Ms Moni-Tsawu, who was called by the plaintiff and criticized the capacity of Frere hospital, also accepted that the healthcare workers at that hospital are efficient, hard-working, compassionate, very skilled, competent and dedicated.

126.5 To require a standard of service that is relative only to the private sector, does not take into account the uncontested evidence that the public and private sectors each have their strengths and limitations. It would be better for the plaintiff to have the best of the strengths of both sectors which a “reasonable standard” would allow. This would also be consistent with section 28(2) of the Constitution which requires the court to consider the best interests of the child.

126.6 There was also evidence to the effect of “overservicing” in the private healthcare sector, and it would be wasteful to hold the defendant to a standard which to some extent is based on overservicing.

[127] It was the plaintiff’s argument in this regard that the standard set by *DZ* was indeed that it is necessary to establish that the public healthcare services are the equivalent of, or a higher standard than, that existing in the private healthcare sector. It was submitted that this was indeed the standard accepted in *MSM*.

[128] It is of importance to note three things about the dictum relied on by the plaintiff in *DZ* in this regard. Firstly, in dealing with the required standard, Froneman J was dealing with the mitigation of damages defence, a defence which the defendant has purposefully jettisoned and not relied upon in this case. Secondly, whilst it is correct that Froneman J said *Ngubane* is authority for allowing a defendant to produce evidence of medical services of the same or a higher standard, in doing so he was effectively summarizing the dictum in *Ngubane*.⁶³ Thirdly, insofar as the public healthcare defence is concerned, and insofar as this part of the dictum may be related thereto, it is accepted that it was an *obiter dictum*.

[129] The difficulty which I have with the statement that *Ngubane* is indeed authority for this contention, is that Kumleben JA in *Ngubane* did not say that the evidence in rebuttal by a defendant should establish that medical services

⁶³ *DZ* (note 4 above) at paras 20-21.

“of the same or higher standard” will be available to the plaintiff in the future. He said that the respondent was required to produce evidence in rebuttal:

“.....in support of its contention, that is to say, that for the next 35 years, or for some shorter period, medical services of the same, or an acceptably high, standard will be available to the appellant at no cost or for less than that claimed by him.”

[My underlining]

[130] Indeed, during the course of reaching this conclusion, Kumleben JA stressed the question of reasonableness in this regard particularly by reference⁶⁴ to the cases of *Erasmus*⁶⁵ and *Janeke*.⁶⁶ On my reading of *Ngubane*, the underlying premise relating to the standard required was one of “reasonableness” which is in harmony with section 27(2) of the Constitution and its jurisprudence as dealt with earlier. When Froneman J summarized this aspect of the *Ngubane* judgment, he did not say that he differed therefrom and thus, because of his reliance on that case, one can assume that he intended to accurately restate the law as set out in *Ngubane*. Thus, one can conclude on this aspect that Froneman J intended to say that the standard required was that of a standard equating to that in the private sector, “or an acceptably high, standard” which, in my view, and because of the reasons I have set forth above, translates into his saying that the standard of “reasonableness” is what is required.

[131] I am further fortified in this view by the practicalities involved in comparing a vast private healthcare sector in the country with that of an equally vast, if not greater, public healthcare sector. As submitted by the defendant, a number of geographical factors will play into this and in particular the fact that

⁶⁴ *Ngubane* (note 12 above) at 784F-785D.

⁶⁵ *Erasmus v Davis* 1969 (2) SA 1 (A).

⁶⁶ *Janeke v Ras* 1965 (4) 583 (T)

each separate province has its own health department. A requirement that the courts should reach a conclusion as to whether the public healthcare in a particular province, or indeed in a particular locality, is the same or of a higher standard than the private healthcare in that province or locality would be very difficult. On the other hand, a requirement that such medical services are available at a reasonable standard, whilst at first blush may seem to be a case of ‘lowering the bar’, does, in my view, allow the courts more leeway to examine the exigencies of each particular case and to reach a reasoned and logical conclusion on the evidence before them. In this regard it is so, as testified to by various witnesses, that the standard of healthcare in the private sector itself is not universal.

[132] Furthermore, there is much merit in the contention that it would be better for the plaintiff to have the best of the strengths of both sectors which a “reasonable standard” would accommodate, and it allows for consistency with section 28(2) of the Constitution and it’s imperative that a child’s best interests are of paramount importance in every matter concerning the child.

[133] For these reasons I conclude that a “reasonable standard” is the standard against which this court must assess the future medical services available in the public sector, in the event that the common law is developed.

Assessment of the evidence led regarding development of the common law

[134] The evidence summarized earlier in this judgment has reference to this part thereof. Regarding the evidence of the defendant’s witnesses, namely Mr Donaldson, Mr Frachet, Mr Howes and Dr Wagner, it is so as submitted by the

defendant that there was no real direct evidence presented by the plaintiff to contradict the factual assertions contained therein. In any event, having listened to these witnesses I am satisfied that they gave evidence in a forthright and direct manner, were thoroughly truthful in their factual assertions and tried their best to give the court a full and complete picture of the situation pertaining in the public sector. In this regard, I am fully alive to the fact that Mr Frachet, Mr Howes and Dr Wagner may be imbued with a degree of self-interest as they are employed by the defendant department. However, throughout their evidence I perceived no sign of bias in favour of the defendant. In fact, I was most impressed with the way each of these witnesses strove to assist the court and, in particular, made concessions where such were warranted. They were also alive to the fact that the public healthcare sector in the Eastern Cape has not, over the years, been a model of virtue and efficiency. In this regard, they readily conceded deficiencies in administration and, in some instances, maladministration in the department over the years. I am accordingly satisfied that I can accept their evidence as being both sincere and truthful.

[135] Indeed, the cross examination of these witnesses was, in the main, predicated on the various reports of the plaintiff's witness, Prof. Van den Heever, and the criticism of their evidence stemmed directly from his reports together with the evidence of the professor himself. It is therefore necessary to examine the evidence of Prof. Van den Heever and to consider whether it, in its totality, undermined the case put up by the defendant through the aforementioned witnesses.

[136] At the outset, it is necessary to state that Prof. Van den Heever's credentials are beyond reproach. As foreshadowed in the earlier summary of his evidence, he is a highly qualified economist particularly in the field of health. Not only this, but his experience in the field of governance and, again,

particularly in the field of health governance, is very extensive. His expertise in this regard is beyond question and he impressed me with his immense knowledge of the economics relating to both the private and public health sectors within the country. He also impressed me regarding his knowledge of, and retention of, facts and figures pertaining thereto.

[137] However, despite this, there are several aspects of his evidence which are of concern. It is necessary in this regard to observe that his evidence amounted to an extraction of words and figures from various reports pertaining to the health department of the country in general, and in particular to the health department of the Eastern Cape. His analyses relied almost exclusively on such facts and information as he gleaned in this regard. At no stage did he tender evidence in direct rebuttal of the defendant's witnesses. In my view, his evidence was akin to the evidence of an accident reconstruction expert attempting to undermine the evidence of eyewitnesses to the event in a motor vehicle accident case. Having made these observations, it is necessary to deal with further aspects of his evidence which are troublesome.

[138] In his first report he argued that compensating victims of medical negligence other than through a lump sum pay-out would result in an unjustified transfer of risk and a departure from the principle of social solidarity which underpins both the public and private health systems, and that, because he viewed the defendant department as being poorly managed, the DZ remedies would transfer the risk of that poor performance into a vulnerable household. In this regard, he claimed that the department "endemically lacks the systems and leadership to competently run a health department".

[139] A difficulty I have with this contention is the simple fact that he came to this conclusion without a consideration and analysis of the actual remedies, their nature and in particular the finely tuned draft order which has been proposed by the defendant. It has been accepted that this draft order, in essence, amounts to the heart of this case as it sets out in precise detail how the proposed remedies would operate in a manner to ensure BN's rights are fully protected.

[140] In my view, had the professor considered the defendant's proposed remedies and in particular the nature of the draft order, he may well have changed his view in this regard. He accepted that both the public and private healthcare systems fall within a formal system of social protection but did not consider that the proposed remedies involve provision of the required medical services for free. On this basis, it does not seem to me that the argument that there is a transfer of risk back to a vulnerable household can hold any water as via these remedies, BN would remain within a system of social protection.

[141] A further difficulty with this contention is the fact that the defendant has described a number of serious risks which have arisen from, and are thus attendant upon, the grant of a lump sum in a case such as this. By way of example, the evidence discloses in fine detail how many millions of rands have been misappropriated by lawyers and trustees who have not administered funds properly. Indeed, the professor conceded that there exists a transfer of risk to the families of injured parties if it remains possible for such funds awarded to a claimant to be misappropriated when damages are awarded on a once and for all basis. Furthermore, he conceded that significant amounts paid out in compensation are lost in contingency fees paid to lawyers, disbursements and costs of administering trusts. By contrast, the public healthcare remedy in operation with the undertaking to pay remedy would provide entirely for the

plaintiff's future medical needs and not only 75%, or less, as is the case when 25% or more is extracted from the award.

[142] A further pertinent aspect relating to the transfer of risk is the possibility of BN's future medical needs exceeding the sum awarded, particularly in the event of his living beyond his life expectancy. On the other hand, the DZ remedies would ensure that BN receives continued future medical care even if he were to outlive his estimated life expectancy or were he to experience unanticipated medical complications.

[143] Mr Donaldson differed with the contention that lump-sum awards resulted in the risk effectively being passed back to the individual, vulnerable families of the claimants for various valid reasons, some of which I have already dealt with. He further pointed out, as accepted by the professor, that should the funds awarded to a particular claimant run out (either by effluxion of time, misappropriation of funds or unanticipated medical expenses) this would result in the state effectively paying twice for that claimant's damages as such claimant would in that event be entitled to approach public healthcare for assistance. One way of eliminating such risk would be the application of the DZ remedies. Furthermore, whilst Mr Donaldson agreed with the professor that if the state failed to minimize the risk of medical negligence, this would not be a saving but a departure from the principle of social solidarity, he noted that the state had extensive efforts underway to address the underlying causes of similar medical negligence cases which, according to Mr Donaldson, was an important part of the response of the state. Such efforts are being coordinated nationally under the direction of a committee, and the Eastern Cape was moving in the

right direction in this regard. This evidence was supported to the hilt by that of Dr Wagner.

[144] Regarding the demeanour and presentation of his evidence, whilst I am hesitant of being critical of a person of his stature, qualifications and experience, it is of some importance to note that Prof. Van den Heever tended in evidence to become wedded to his propositions and/or arguments. On several occasions under cross examination, when contrary propositions or arguments of some merit were put to him, he refused to make any concessions. He also tended to ignore the question or proposition put to him and regaled the court with lengthy hypotheses unrelated thereto. This was, to my mind, epitomized by his production of several newspaper reports (some of which were attributed to him) which severely criticized the defendant department. Quite apart from the fact that many of these articles amount simply to hearsay upon hearsay and are unable to be tested in court, it appeared to me that he was determined to fortify his views in any way he could. In my view, had he indeed fully believed in his empirical analysis of what he perceived the facts to be, it would have been unnecessary to resort to the production of such evidence. I am accordingly not prepared to take into account any such articles from newspapers or other publications.

[145] An additional, and important, fact in this regard is that a substantial portion of the professor's evidence was contained in his supplementary report which, as indicated earlier in this judgment, was delivered after both Dr Wagner and Mr Donaldson had testified. They were accordingly not able to answer many aspects which he raised and dealt with in evidence based on that report, and I do not believe that much weight can accordingly be attached thereto.

[146] Much time during the professor's evidence, and in argument, was spent on the question of the failure to budget in advance for damages awards based on medical negligence of departmental employees. He went so far as to say that such failure had, for various reasons set out at length by him, criminal implications for Dr Wagner as head of the department. The defence, rightly in my view, spent much time in establishing the contrary. However, I do not believe that it is necessary to waste much time on this aspect as it is, in my judgment, largely a red herring vis-à-vis the proposed constitutional defences.

[147] It is an accepted fact that up until approximately 2010 large claims of this nature did not exist. Whilst there were a few medical negligence claims, the quantum thereof as awarded by the courts was a drop in the ocean compared to the awards which are made today. Additionally, for various reasons which were debated extensively during evidence and argument, there has been a vast increase in the number of such claims over the past 12 years, particularly CP claims. Their attendant damages awards have evolved dramatically and appear to average in the region of R25 million to R30 million, and in some cases more. Accordingly, in the earlier days such medical negligence claims formed a small drop in the ocean of the department's budget, and indeed of the national budget. In a relatively short space of time, as I have described, this drop has grown exponentially.

[148] Mr Donaldson described how international accounting standards have not accommodated such contingent liability and may well have to be adjusted in this regard. However, Parliament is unlikely to prospectively approve a health department anticipating its own negligence. Rather, the accounting convention

as it stands requires that government departments prevent and contain these costs and, if such costs do occur, the relevant parliamentary committee is able to review the settlements after the fact and, where appropriate, assign responsibility and recover costs. He testified that, in part, this accounting convention operates to disincentivise departments from simply settling claims without investigation. Indeed, this is how contingent liabilities are managed in the public administration system generally, including the police department and correctional services.

[149] Flowing from this, Mr Donaldson said that the instruction from National and Provincial Treasury not to budget for contingent liabilities is thus an incident of accountability and parliamentary oversight. It is an additional check and balance, and accounting officers are legally obliged to follow treasury's instructions and regulations. The system would fall apart otherwise.

[150] I have already mentioned how long it has taken for the legislature to consider legislation dealing with the endemic issue of medical negligence claims against the state. It seems to me highly unlikely that this accounting convention which the department faces annually is likely to be changed, and if it is, such change will only happen far in the future. This being so, it is a fact that the department must live with this issue and all the debates in that regard appear to me to be largely irrelevant. Indeed, it is the very existence of these vast claims and their effect on efficient governance coupled with this convention which, in my judgment, point ineluctably to the constitutional defences having to be granted.

[151] As regards the proxy indicators which the professor relied upon to conclude that the department is poorly managed and that this was a good reason not to depart from lump-sum awards, in my view Mr Donaldson's evidence was far more balanced and cautious. For example, Mr Donaldson's opinion was that Prof. Van den Heever's views were incautious in the way in which they abstracted general critiques based on such proxy indicators to determine a hospital's capability to meet particular needs or care for children with such needs. He stressed that if one takes a long-term view on health service delivery, there is marked improvement in performance represented by many indicators over time despite the existence of extraordinary stresses on the system.

[152] Mr Donaldson also said that whilst he accepted the professor's assertion that the management of health services is important in determining maternal mortality, a range of socio-economic circumstances beyond the control of the public health system are of importance, such as the vast distance to hospitals, nutritional levels, obesity, hypertension and the prevalence of tuberculosis. He testified that there has been a concerted effort at national level to address maternal mortality, and that the Eastern Cape has shown a steady decline in in-facility maternal mortality rates. The professor indeed conceded that there has been such a decline.

[153] Dr Wagner likewise presented cogent evidence pointing to problems with the use of these proxy indicators as a method of assessing the capability of the public healthcare sector. She also stressed that the Eastern Cape in particular carries a historically poor investment in healthcare infrastructure as a former "Bantustan" under the apartheid government. As regards the OHSC reviews, she acknowledged that their assessments focus largely on input and process measures and do not directly measure the outcomes of service delivery, which are of singular importance. Indeed, the professor himself expressed some doubt

as to the reliability of OHSC assessments in relation to the capability of the Gauteng Department of Health and questioned the logic underlying some aspects of the data.

[154] The third proxy indicator relied upon related to reports of the Auditor General. The professor testified that any qualification in an audit is suggestive of managerial fault which is systemic in a government entity. He testified further that these findings relating to health expenditure are consistent with the view that the public health system is in crisis.

[155] In this regard I must lean once again towards the view of Mr Donaldson. He testified that such findings are incapable of informing as to the capability and commitment of the department to meet particular needs of children in certain circumstances, and indeed to do so in terms of a framework to which the court will contribute in framing. Such audit findings, he said, are not necessarily a good indicator of service delivery capacity. In his experience, such performance assessment as reflected in the Auditor-General's reports is assessed by auditors and in many instances amounts to a mechanical accounting exercise as opposed to an ascertainment of the actual performance of an individual department. Moreover, South Africa sets comparatively high standards in public financial management. He disagreed with the insinuations made by the professor of corruption and maladministration against the department based solely on such audit findings.

[156] Dr Wagner also undermined the usefulness of such reports. Professor Van den Heever relied on the 2018 Auditor-General's report which showed poor current performance by the department. Not only is that report outdated, but the

qualification to the financial statements relates to the amount of the department's contingent liabilities arising from medicolegal claims. It is these very claims which she seeks to address.

[157] Having examined the evidence of Prof. Van den Heever, I am satisfied that it does not undermine the evidence and conclusions placed before the court by the various witnesses who testified on behalf of the defendant. In my view, the evidence of Mr. Donaldson in particular stands to be preferred. His written reports and his oral evidence were both measured and objective, and his reasoning process was not shown to be flawed. He also readily made concessions when such were necessary and appropriate. He was able to explain complex and technical issues in a simple and accessible manner and careful reasoning supported his opinions. Likewise, his experience in relation to public finance is extensive and unparalleled. There is little doubt that he has a deep understanding, based on his experience over many years, of the financial management of government departments from every perspective, including budgeting, planning, expenditure of public revenue, financial reporting and auditing.

Does such evidence support the development of the common law?

[158] Particularly regarding the public healthcare defence, this case is, in many respects, on all fours with *MSM*. Accordingly, the *dicta* of Keightley J in this regard are of equal application.⁶⁷ Having studied her judgment in this regard, I agree with her analysis particularly as the evidence led in this case is largely supportive of the evidence led in that.

⁶⁷ *MSM* (note 11 above) at paras 174-196.

[159] In *DZ*, Froneman JA's examination of the common law led to the obiter conclusion that neither the once and for all rule nor the money damages rule were in conflict with the constitutional value system.⁶⁸ He added that this problem (which he categorized *in vacuo* as it were, i.e. without any evidence as not being *prima facie* offensive to the Constitution), should be dealt with on a case-by-case basis. This is such a case. We now have evidence. In addition to what was said in *MSM*, the evidence in my view discloses at least two obvious bases upon which such common law rules offend the Bill of Rights.

[160] Firstly, it seems that all the witnesses ultimately accepted that the department is struggling financially for the various reasons which have been dealt with. That being so, heaping more "once and for all" claims on the department averaging approximately R30 million apiece, can only make the situation worse. This has the result that the department's ability to carry out its obligation of realizing access to health for everyone in terms of section 27(2) is increasingly under pressure. Dr Wagner and Mr Donaldson emphasized that the stress (and further potential for stress) on the department's finances has the result that 80 to 90% of the population of the Eastern Cape (the balance being serviced by private healthcare as they are insured) are not receiving the healthcare that they ought to be. As the situation is worsening year by year, in my view, this is offensive to the Bill of Rights.

[161] Secondly, as correctly pointed out by the plaintiff, whilst the Contingency Fees Act has not been found to be unconstitutional, in most run-of-the-mill cases where legal practitioners abide by the law, it has a salutary effect in that it

⁶⁸ *DZ* (note 4) at paras 44-5 and 53-4.

allows indigent people to have legal representation albeit that they have to give up a percentage of the award ultimately given. Where that award is not very high and does not represent an important component of damages such as extensive future medical services for a severely compromised claimant, the 25% deduction for legal fees (or, hopefully, a lesser percentage if the Act is applied to its full extent) will not make a great difference to the claimant's quantum of damages. However, when dealing with CP cases such as this, it is common cause that a huge component of the damages award is represented by future medical expenses. This can account for R20 million or more of the claim. In the once and for all situation, this amount is carefully determined by actuaries so as to provide future medical services for the compromised child on an ongoing basis, hopefully for his or her life span. When one looks at the tendency of legal practitioners (according to the evidence led in this case) to take 25% of such claims, and sometimes more, this represents in the region of R5 million or more which punches a significant hole in the capacity of the once and for all monetary award to provide fully for the complainant. Indeed, the evidence of Mr Howes disclosed that more than 40% in some cases is taken up by lawyers' fees.

[162] If the CP child claimant lives to his or her life expectancy as calculated at the time the award is made, he will, in theory at least, run out of funds to provide the necessary medical services some time before reaching that point. This is more so if the child lives beyond its calculated life expectancy. It is therefore so that in cases such as this where large awards are made in accordance with the common-law once and for all principle, large deductions are made for legal services. These deductions are much larger than in cases where smaller awards are made and represent a reduction in the ability of the award to sustain the child over his or her lifespan. This places the awards which

are consistently made in similar CP cases in a different category to the general run of the mill damages awards. This, to my mind, represents a further assault, if I may use the word, on the constitutional rights of such individual CP claimants and thus further offends the Bill of Rights, and the constitutional obligation imposed on the state under section 27(2) to “take reasonable legislative and other measures within its available resources, to achieve the progressive realization of [healthcare services]”.⁶⁹

[163] In this regard, it should be mentioned that the plaintiff has argued that the contrary would be true where a CP child does not live out its full lifespan. If he or she indeed were to live three quarters of his or her lifespan as ascertained at the time of the award, this would translate into him or her probably having enough funds therefrom to sustain the necessary medical services until the time of his or her death. However, in my view this argument is, to a degree, tautologous. The very purpose of ascertaining the longevity in advance is to try, insofar as is humanly possible, to ensure adequate compensation in the future. If it cannot be ascertained with any degree of accuracy, this is a further reason to consider jettisoning the once and for all rule in such cases. The purpose of such an award is to ensure that the child’s patrimony is restored to the position it would have been had the cerebral palsy not occurred and, based on the once and for all rule, an attempt is thus made to provide sufficient funds to sustain the child as best possible and in accordance with best medical practice, during its anticipated lifespan. It would be wrong in these circumstances to assume that its lifespan would be 25% shorter than that calculated by the experts to justify a large lump sum being paid in legal fees. Furthermore, once the funds do indeed run out sometime before the child’s anticipated lifespan is reached, it is almost inevitable that the child’s medical needs will be cast back upon the public

⁶⁹ *MSM* (note 11 above) at paras 178-179.

healthcare service. This, in turn, will place more stress upon the public healthcare service despite it having paid out a large lump sum to avoid this very situation. Again, this reduces the capacity of the department to carry out its responsibilities in terms of the Constitution, which is offensive to the Bill of Rights.

[164] Before leaving this aspect, it should be mentioned that the plaintiff argued that the introduction of the constitutional remedies would result in reduced interest on the part of legal practitioners to take up the cases of CP claimants which would, in turn, affect their right of access to the courts. I do not regard this as a valid argument. I say so because of many reasons, the more important of which is the fact that if such were to happen, it would be an indictment on the legal profession. Also, the introduction of such defences does not eliminate partial lump-sum awards. For example, in the present matter, the lump sum award will amount to almost R4 million. This is still a sizable sum for the calculation of contingency fees. RAF cases attracting similar quantum awards, and indeed less, are regularly handled by legal practitioners on a contingency basis. It seems to me that this argument is spurious in these circumstances.

[165] In addition to the foregoing, in my view the evidence overwhelmingly establishes that there are other areas in which the common law rules conflict with the constitutional value system. In this regard reference is made to the rights of everyone under section 27(1)(a) and (2), together with the rights of all children under section 28(1)(c) and (2), and the right under section 9 (1) to equality before the law and to the equal protection and benefit of the law. In my judgment, the limited and incremental development sought in this case is therefore justified in terms of section 39(2).

[166] Section 173 also empowers the superior courts to develop the common law, taking into account the interests of justice. I am satisfied, based on the evidence led in this case, that it is also in the interests of justice that the common law be developed so as to provide courts which adjudicate medical negligence claims with a broader remedial framework, including the remedies pleaded in this case.

[167] It seems self-evident that both the public healthcare and the undertaking to pay remedies should be developed together as they operate in tandem. The evidence discloses that the most expensive items inflating lump-sum damages awards are those such as caregivers which the state is unable to provide in kind. If the undertaking to pay remedy is not granted in tandem with the public healthcare defence, this will serve to substantially reduce its efficacy.

[168] The draft order proposed by the defendant in which development of the common law in this regard is articulated is in line with the Constitutional Court's direction in *Makate* which requires that changes to existing law be articulated with the same clarity as the rules and principles that they seek to replace.⁷⁰ I thus conclude that a case has indeed been made out for the development of the common law as set out in the proposed draft order.

Does the evidence establish a reasonable standard in public healthcare at the relevant hospitals?

[169] In this part I intend to deal briefly with the evidence led for and against the ability of the department to provide the medical services and supplies at the required standard, together with an analysis and conclusion in that regard.

⁷⁰ *Makate v Vodacom Ltd* 2016 (4) SA 121 (CC) at para 160.

[170] Dr Wagner's qualifications and experience have already been dealt with. In essence, she testified that:

170.1 There is extensive interaction between public and private healthcare in the province.

170.2 Both Frere and CMH are accredited academic hospitals falling within the East London Academic Complex and are the exclusive practical training grounds for both undergraduate healthcare workers and specialist doctors irrespective of whether they end up in the public or private sectors.

170.3 There are certain benefits which the public sector enjoys in contrast to the private sector. An example she gave was the question of economies of scale. In the private sector doctors and specialists work as independent contractors whereas a large number of healthcare workers are employed by the public sector. Thus, a single specialist employed in the public sector is able to treat many more children with greater efficiency as profit margins are built into the cost of care in the private sector. Economies of scale also assist in procurement.

170.4 The public sector enjoys higher utility from capital investments such as MRI machines.

170.5 In the public sector the employment structure makes it easier to arrange and implement multidisciplinary platforms which has benefits for the patients such as the review of complex cases and in ensuring the continuity of care.

170.6 Dr Wagner also testified that the public sector is better able to take advantage of the collegiate environment and relationships that the public sector employment structure enables. In this regard, she used the word “collegiate” to convey both the continuing professional development and training that is built into daily practice, such as during ward rounds with specialists, and continuity of care that is promoted by having specialists and clinical staff under the same umbrella, and physically under the same roof.

170.7 She was supported in her evidence by Mr Donaldson to the effect that the trajectory is towards improvement and expansion of healthcare services throughout the public healthcare system. In her view, the likelihood would be that the services available to all CP children in the public healthcare system, including both those who have and those who do not have medico-legal claims, will improve and expand over time. Additionally, despite the huge burden of servicing the vast majority of the population, there has been considerable progress in the availability and effectiveness of healthcare services during the past two decades.

170.8 During her time as CEO of Frere Hospital, Dr. Wagner implemented a turnaround plan which improved operations and leadership in the hospital. This led to measurable improvements in mortality and morbidity and to the hospital winning an international award for improvements in quality of care. She has also instituted a turnaround strategy for the entire department since she has become the head thereof. She testified that the need for this strategy arose, amongst others, because of the approximately R4.5 billion budget deficit largely caused by medicolegal claims as well as increasing demands caused by the pandemic. While in its early stages, this turnaround strategy has already made significant progress.

170.9 She emphasized that BN will receive priority treatment and that a budget has been ring fenced for this purpose. This budget will be incrementally enhanced should the court grant the constitutional defences to cater for further CP cases.

[171] Prof. Cooper, who is both a paediatrician and a neonatologist, examined the hospitals concerned with a clinical eye. It was his opinion that both CMH and Frere hospitals are able to cater for BN's clinical needs at a standard equivalent to that which is available in the private sector. In this regard, he dealt with all the disciplines which may be required by BN and, except for child psychiatry, concluded that they satisfy the necessary test. As regards child psychiatry, there appears to be no indication that BN requires this. Prof. Cooper added that CMH is a newly built hospital which has attractive and spacious paediatric wards whilst those of Frere are smaller and in poorer condition.

However, he was satisfied that the hospitals have always been able to accommodate children in the wards of one or other of the hospitals. As regards intensive care, he conceded that the beds in the paediatric section are usually at a premium. However, ICU care for children with CP is rarely needed but, should it occur and no accommodation be available, they could be sent to the private sector.

[172] Dr Saloojee who is a physiotherapist in private practice, and a researcher, has an extensive and impressive CV. Not only is she highly qualified academically, but she has had considerable experience with CP children and in particular in dealing with their rehabilitation. In brief, she testified as follows:

172.1 At the two hospitals concerned, children with CP are seen monthly in a group setting by a multidisciplinary therapeutic team. This offers several advantages over individual therapy.

172.2 In addition thereto, both hospitals have a number of therapists with postgraduate training in working with CP children.

172.3 As fortified by the evidence of Dr Wagner and Prof. Cooper, she considered that it was possible that all of BN's therapy needs could be accommodated in the public sector.

172.4 She was satisfied that the department is actively training its therapists to provide the type of specialist care required by BN whereas, as there is no regulation limiting therapists working with CP children, therapists in the private sector can treat children with CP without necessarily having the postgraduate specialization to do so. She added that there were relatively few practitioners in East London and even fewer, if any at all, at Mdantsane, who are experienced in working with children with CP.

172.5 She was happy with the rehabilitation department at CMH describing it as “beautiful” and “fairly new” with plenty of space. She was also happy with the equivalent centre at Frere.

172.6 She commended the CP clinics run at the two hospitals as being multidisciplinary and providing a teamwork and one-stop shop approach to such rehabilitation together with psychological support.

172.7 A variety of dietary supplements are provided at CMH at no cost for children with gastronomy tubes such as BN.

173.8 She indicated her neutrality by testifying that the biggest limitation of the services available at the hospitals was the caseload of children with CP and the ratio of staff available. She however was of the opinion that because BN would receive

prioritized treatment he would not be affected by such limitations. She also identified certain shortcomings in the rehabilitative facilities, which concerns were communicated to Dr. Wagner. In turn, Dr. Wagner testified that the department has taken note of these concerns and has already made substantial progress in addressing the shortcomings.

[173] Mrs Caga, an occupational therapist in private practice, testified on behalf of the plaintiff in rebuttal of the defendant's evidence on this aspect. She said that she had noted that BN had recently lost weight which, whilst in many respects was a positive attribute, indicated that his growth was stunted from undernourishment. She however admitted that she was not a dietitian. She also indicated that he had not been properly cared for by the state as she considered his PEG tube to be infected, and his epilepsy to be poorly managed. Again, she conceded that she was not an expert in diagnosing such infections or problems. She was also re-called after the defendant had closed her case. It was this evidence which was objected to as foreshadowed earlier in this judgment. During this subsequent evidence, she referred to her experience in case managing two children as a basis for her opinion that as far as occupational therapy is concerned, CMH and Frere hospitals were not able to deliver therapy to BN at the required standard.

[174] The plaintiff herself also testified in rebuttal. In the main, she testified as to emotional difficulties when having to take BN to hospital, and that she felt traumatized in doing so. With due respect, and empathy, for her state of mind, it is so that the psychotherapists for both parties agreed that Ms N[...] has been severely affected by BN's condition and has developed a mood disorder.

Indeed, the defendant has agreed to provide her with psychotherapy to assist in coping with her son's condition as recommended by the psychotherapists. This was done even though her claim had prescribed. For these and other reasons, I cannot accept her evidence as undermining the purport and effect of the evidence in this regard as tendered by the defendant.

[175] The only other evidence tendered by the plaintiff in this regard was that of Ms Moni-Tsawu. Once again, I do not take her evidence into account as it was shown to be unreliable and plainly wrong in several respects. Furthermore, none of it was put to Dr Wagner or Dr Michaelis for them to answer thereto.

[176] Dr. Wagner, as alluded to earlier in this judgment, was a most impressive witness. She is energetic and enthusiastic about her work and has both the mental ability and managerial capability to put her ideas into place, and to improve the quality of medical care in the province. Indeed, on her evidence, this is already well on its way. Prof. Cooper was not cross-examined, and his evidence clearly falls to be accepted. Dr Saloojee was extensively cross-examined. I am constrained to state that she was an extremely impressive witness with an extensive list of credentials. Her passion, her concern, her experience and her ability with regard to CP children is considerable and palpable. Her neutrality and objectivity shone through during her evidence in many respects, but particularly in the way she not only expressed positivity relating to the department, but also highlighted the negative aspects.

[177] Regarding the evidence of Ms Caga, it seems from the hospital records that BN is indeed receiving sufficient treatment from a dietitian at Frere Hospital. Prof. Chitnis, the head of Department of paediatric surgery at Frere

and CMH hospitals, and who also operates in private practice, testified with regard to the gastrostomy tube fitted to BN. He is clearly fully *au fait* with the problems relating to BN and was satisfied that he had correctly treated all the problems that had arisen. Indeed, during the trial, a problem arose in this regard and the case had to be stood down to the following day whilst the hospital immediately treated BN without demur. Furthermore, the plaintiff herself testified that whenever BN has experienced significant leakage from this tube, it was immediately treated at Frere Hospital. This evidence, in my judgment, demonstrates once again that the department is fully capable of implementing the public healthcare remedy, and the high quality of services available for the paediatric surgical needs of BN.

[178] Dr Michaelis, a paediatric specialist at Frere Hospital, also testified regarding the neuro-developmental clinics at both hospitals and the nature of BN's epilepsy care. Her qualifications and experience indicate that she is more than qualified to do this. She was satisfied that BN had been receiving sufficient therapy in this regard.

[179] As regards the rebuttal evidence of Ms Caga when she subsequently testified, it is so, as argued by the defendant, that no expert summary had been filed in this regard and that it was not put in cross examination to the plaintiff's witnesses. This, to my mind, serves to reduce its veracity. However, not only this, but her evidence in criticizing the department relied largely on hearsay and speculation and, in my view, must be accorded a low probative value.

[180] In the final analysis, it is my view that the defendant has tendered extensive and valuable evidence which points ineluctably to the conclusion that

both hospitals, working in tandem, are capable of providing BN with the medical services and supplies he requires at a reasonable standard or above. This is even more so in view of the fact that funds have been ring fenced specifically for this purpose. Having studied the evidence closely and in particular that tendered in this regard on behalf of the plaintiff, I am of the view that it does not undermine the strength of the evidence tendered by the defendant. I accordingly conclude that the defendant has established that the hospitals concerned are able to provide these services and supplies at the required standard.

The remaining issues

[181] In summary, the remaining issues for determination are: caregiving requirements, occupational therapy, physiotherapy, home alteration costs, a transporter buggy and case management.

[182] As regards the question of the transporter buggy, it seems to me that no real challenge has been put forth in this respect. In my view, a case has been made out for the provision thereof.

[183] Additionally, the question of the cost of protection and administration of the award will also fall away because the constitutional remedies are to be preferred. This being so, the relatively small lump sum award will not justify this.

Caregivers

[184] The parties are poles apart in this regard. The plaintiff claims that five caregivers are required for the care of BN whereas the defendant maintains that one is sufficient, together with a relief caregiver whilst the primary caregiver is on annual leave.

[185] Extensive evidence was led, and arguments made, in this regard. The defendant's prime submission motivating her claim that only one caregiver is needed is the contention that the plaintiff, having been BN's primary caregiver for his life thus far, should continue to play an important if not a primary role in his caregiving which would reduce the necessity for more than one caregiver.

[186] In developing the argument, the defendant relied on the case of *De Jongh*.⁷¹ It is so that De Jongh's case does to a degree support the argument made on behalf of the defendant in this regard but, in my view, that case is distinguishable. As mentioned earlier in this judgment, the plaintiff has already suffered extensively from a psychological point of view as a consequence of BN's incapacity. Indeed, she is receiving therapy to assist her. Whilst I accept that it is of vital importance for her to remain in the loop as it were in pursuing the normal functions required of a parent, I do not believe that in the circumstances she should be visited with the formal, additional, responsibilities of a caregiver.

[187] Having come to this conclusion, and accepting that one caregiver in the circumstances would be insufficient, the question remains as to the number of caregivers required to assist BN. It is common cause that BN is totally dependent on a caregiver to help him with the activities of daily living such as

⁷¹ *De Jongh v Du Pisanie* NO 2005 (5) SA 457 SCA at paras 22-40.

dressing, undressing, eating, drinking, going to the toilet, and turning him at night when he sleeps. It is also so that the parties have agreed that he should attend a day care centre⁷² every day. The plaintiff contends that even when he is at the day-care centre, he should have a caregiver available in addition to the caregivers employed by the centre. I do not agree. In my view, the evidence establishes that he is properly cared for whilst at the centre (which he has been attending for some time) and that an additional caregiver in this regard is not required.⁷³

[188] In considering the number of caregivers required, it is also important to note that the court is bound to ensure that its decision is fair not only to the plaintiff, but also to the defendant. It is further of importance to ensure that the employment of such caregivers will result in compliance with the Basic Conditions of Employment Act.⁷⁴

[189] In her initial report, Ms Caga recommended the employment of two full-time caregivers in addition to BN's attendance at the day care centre. She also submitted that a full-time domestic worker was required while he was under 18 years of age. In subsequent reports she changed her mind and recommended a minimum of three caregivers currently, which should be increased to five when BN reaches the age of 19. In argument before me, five caregivers were contended for.

[190] I have considered all the evidence and arguments in this regard. In my view, two caregivers will be sufficient taking into account the full-time care on weekdays during the day at the care centre, and the fact that an alternate

⁷² The parties have agreed upon the Canaan Centre in East London.

⁷³ Ms. Krige (the defendant's expert occupational therapist) testified convincingly that this was unnecessary, having visited the centre herself.

⁷⁴ Act 75 of 1997.

caregiver will be made available when the full-time caregivers are on annual leave. In this regard, as is self-evident, the full-time caregivers should not be given annual leave at the same time. Once he turns 18, a mechanism will be provided for in the order for agreement as to caregivers from that age onwards.

Physiotherapy and occupational therapy

[191] This has been another hotly contested issue. However, I do not intend to enter that debate as I believe that there is a better way forward. As is clear from this judgment, the constitutional defences will be introduced. The focus in terms of these remedies is away from the determination in advance of the actual requirements vis-à-vis medical services. Without in any way impugning the highly competent expert witnesses who testified before me on behalf of the plaintiff in this regard, I am satisfied that Dr Saloojee has suggested a regime based on her many years of experience which will, in all probability, suit BN's unique situation. However, the order which I intend to grant will allow for an increase (and indeed if necessary, a decrease) in the extent of the therapy to be provided. Paragraphs 13, 14 and 15 of the order will provide for a mechanism in terms of which, were it to be necessary in the future, this regime can be altered by agreement or, if absolutely necessary, by the court including a clause to the effect that the defendant is to pay the costs thereof. It is thus, lest there be any doubt, the intention of this judgment and its concomitant order, that the regime which I intend to order regarding physiotherapy and occupational therapy will be subject to potential variation in terms of the clauses of the order to which I have referred.

Alterations to house

[192] Both parties led the evidence of architects in this regard, it being common cause that there is a necessity for alterations to be made to any residence that BN may in future live in, to accommodate his disability. On the one hand, the plaintiff's expert maintained that it was necessary for a completely new house to be built elsewhere with many bedrooms and allied accommodation for an extended family. On the other, the defendant's architect took a conservative approach indicating that it would be possible to renovate a house in which the plaintiff and BN used to live with her parents. This would cost in the region of R795,242.00.

[193] I am not satisfied that the plaintiffs architects' contentions in this regard are reasonable or comply with the existing common law in restoring BN's patrimony. On the other hand, considering inflationary pressures and the fact that the plaintiff and BN are at present living in rented accommodation in East London, it seems to me that the amount tendered by the defendant in this regard is on the low side. In my view, an amount of R1,100,000.00 would serve to compensate BN in this regard.

Private case manager

[194] It is common cause, in the event of the constitutional defences being granted, that both the public case manager and a private case manager are required. There is however a residual dispute regarding the number of hours that should be provided for the private case manager to be paid for by the defendant. However, the plaintiff's expert in this regard, Ms Caga, did not appear to challenge the assertion under cross examination that the tendered regime with regard to the private case manager in the event that the constitutional defences are granted, is reasonable, especially bearing in mind that there will also be a public case manager who will procure the provision of services and supplies at

the hospital. To my mind, this is a reasonable concession and the regime suggested by the defendant cannot be faulted.

Costs

[195] In the event of the constitutional defences being granted, and pursuant to *Biowatch*,⁷⁵ the defendant does not seek costs.

[196] In the circumstances, the following order will issue:

LUMP SUM AWARD

- 1. The Defendant shall pay to the Plaintiff the sum of R2,136,146-00 as set out in Annexure “D”.**

PUBLIC HEALTHCARE REMEDY

- 2. The Defendant is directed to provide free of charge to B[...] N[...] (“BN”) –**

- 2.1 All of the services, consultations, therapies, surgeries and other procedures itemised in annexure “A” (‘the medical services’); and**

⁷⁵ *Biowatch Trust v Registrar, Genetic Resources, & Others* 2009 (6) SA 232 (CC) at para 56.

2.2 All of the supplies, supplements, medicines, devices, and other equipment itemised in annexure “B” (‘the medical supplies’),

at one of the following hospitals, in order of priority, depending on where the particular medical service or supply is available at the time that it is required:

2.2.1 the Cecilia Makiwane Hospital, Mdantsane (“CMH”); or

2.2.2 the Frere Hospital, East London (‘Frere’); or

2.2.3 a public hospital nominated by the public case manager (referred to in paragraph 18 below) in consultation with BN’s private case manager appointed in terms of annexure “C”,

for the duration of his life, or such other duration as may be specified in any particular instance in annexures ‘A’ and ‘B’ to this order, provided that if the service or supply is to be made available in terms of paragraph 2.2.3, the Defendant will provide appropriate transport between CMH or

Frere and the hospital nominated in terms of paragraph 2.2.3 free of charge.

3. The Defendant shall ensure that all of the medical services and medical supplies will be of a reasonable standard, provided that where any particular medical supply is –

3.1 available on a standing government tender; or

3.2 identified by brand and model in annexure “B”; or

3.3 a generic equivalent medicine,

as the case may be, it shall be deemed to be of the required standard.

4. In the event of the Plaintiff, or any person responsible for BN’s care, failing to arrive with BN at a scheduled appointment for a medical service identified in annexure “A” or failing to collect a medical supply to be provided in terms of annexure “B”, the Defendant will be deemed to have complied with her obligations in terms of this order in respect of the medical service for which the appointment was scheduled or the medical supply to be provided.

5. In the event that an item in annexure “B” is in reasonable working order at the scheduled time for replacement, the Defendant will be exempted from replacing the item until such time as the item is no longer in good working order, and the scheduled dates for further replacement will be delayed accordingly.

6. In the event that an item in annexure “B” is no longer in reasonable working order prior to the time scheduled for replacement, the Defendant shall replace it unless the condition of the item is manifestly the result of unreasonable use or neglect.

7. In order to access all the medical services and medical supplies itemised in annexures “A” and “B” to this order at the hospital as and when they become due, the public case manager will act as liaison person.

8. The public case manager shall notify the Plaintiff and BN’s private case manager in writing of –
 - 8.1 his or her contact details, including cell phone number, landline number, email address and

office location within the hospital, immediately upon appointment; and

- 8.2 any change of the incumbent public case manager within 14 (fourteen) days of such change; and**

the plaintiff and the private case manager must notify the public case manager of their contact details, including cell phone numbers, landline numbers, email addresses and office or home addresses, upon notification in terms of paragraph 8.1 and 8.2 or upon any change in such contact details.

UNDERTAKING TO PAY REMEDY

- 9. The Defendant shall in respect of the medical services and the medical supplies listed in annexure “C” at the Defendant’s election-**

- 9.1 procure the medical service or medical supply required in the private healthcare sector so as to be provided timeously whenever it is required in terms of annexure “C”; or**

- 9.2 reimburse the Plaintiff, or any trust established for the benefit of BN, for their expenses reasonably incurred in procuring the medical service or medical supply in the private healthcare sector, within 30 days of presentation of an invoice for these.**
- 10. By no later than 30 June of each year, BN's private case manager and the public case manager shall jointly submit to the Chief Financial Officer of the Department of Health, Eastern Cape, a care and management plan for the following financial year setting out the medical services and supplies to be provided to BN in terms of annexure "C" during the next financial year and the estimated cost of each item.**
- 11. Within 30 days of this order and, in subsequent years, by no later than 31 August in each year, the public case manager shall communicate to the Plaintiff, or any trust established for the benefit of BN and BN's private case manager, the defendant's election referred to in paragraph 9 above.**
- 12. In order to access the medical services and medical supplies referred to in paragraph 9.1 and to claim**

reimbursement in terms of paragraph 9.2 the public case manager will act as liaison person.

UNFORESEEN DEVELOPMENTS

13. In the event of it becoming reasonably necessary for BN to receive any medical service or medical supply additional to that provided for in annexures “A”, “B” and “C” as a result of BN’s cerebral palsy at any point in the remainder of his life, the Defendant shall provide same at one of the hospitals referred to in paragraph 2.2.1, 2.2.2, or 2.2.3 if it is available at such hospital, or, failing that, in accordance with paragraphs 9 to 12 above.

14. Where it is reasonable to amend any provision of annexures “A”, “B” or “C”, whether for the purposes of paragraph 13 or otherwise, the parties may, by agreement between BN’s private case manager and the public case manager, provisionally amend annexures “A”, “B” or “C” without approaching a court, provided that an updated, amended court order shall be placed before a judge in chambers every second year at the end of the financial year, to be made an amended order of court.

15. Absent agreement on any proposed amendment to annexures “A”, “B” or “C” either party may apply to this court for the variation of annexures “A”, “B” or “C” on good cause shown and/or for the enforcement of this order, provided that –

15.1 upon instituting any such proceedings, the party commencing the proceedings must refer the dispute to mediation in terms of rule 41A of the Uniform Rules of Court and the parties must –

15.1.1 conclude the minute and agreement contemplated in rule 41A(4)(a) and (b) within five court days of service of the process commencing proceedings;

15.1.2 convene the first meeting in the mediation within ten court days of service of the process commencing proceedings;

15.1.3 address as the first item for consideration in the mediation, the interim provision of medical services and medical supplies pending the outcome of the mediation, or failing that, the litigation; and

15.1.4 conclude the mediation within 30 ordinary days.

15.2 the Defendant shall bear all the attorney and client costs of any such proceedings and mediation, regardless of outcome, save where the court finds that the proceedings were not reasonably commenced by the Plaintiff or any person or trust acting on behalf of or in the interests of BN.

ADULT CARE

16. BN's private case manager and the public case manager shall meet no later than his 17th birthday and endeavour to agree on his care arrangement from the age of 18.

17. Failing agreement, the matter must be resolved in terms of paragraph 15 above.

PUBLIC CASE MANAGER

18. The head of the Department of Health of the Eastern Cape Province shall appoint a suitably qualified person from the management of the hospital where BN receives the majority of his services and supplies, to

perform the functions of public case manager provided for in this order.

DEVELOPMENT OF THE COMMON LAW

19. The common law is developed –

19.1 so as to accommodate the public healthcare and undertaking to pay remedies provided for in this order;

19.2 so that the once-and-for-all rule and the rule that damages must sound in money, are neither the exclusive nor the primary rules for the determination of a just and equitable remedy in terms of sections 38 and 172(1)(b) of the Constitution, in a claim arising from harm negligently caused by a public healthcare practitioner, provider or institution;

19.3 so that no claim shall lie in respect of lumpsum money damages to the extent that –

19.3.1 any of the future medical services and medical supplies required by the Plaintiff (or the injured party) as a result of the injury are provided, by order of court, at a

reasonable standard at a public healthcare institution; or

19.3.2 where a court does not so order, the Defendant provides an undertaking to –

(a) procure the medical service or medical supply required in the private healthcare sector so as to be provided timeously whenever it is required; or,

(b) reimburse the Plaintiff, or any trust or other entity established for the benefit of the injured party, for their expenses reasonably incurred in procuring the medical service or medical supply in the private healthcare sector, within 30 days of presentation of an invoice for it.

**R E GRIFFITHS
JUDGE OF THE HIGH COURT**

COUNSEL FOR THE PLAINTIFF : **Mr Alberts SC with**
: **Mr Stemela**
INSTRUCTED BY : **S. Booï & Sons**

COUNSEL FOR THE DEFENDANT : **Mr Dodson SC with**
: **Ms Raw**
INSTRUCTED BY : **State Attorney**

HEARD ON : **15 NOVEMBER 2021 – 19 NOVEMBER 2021;**
22 NOVEMBER 2021 – 26 NOVEMBER 2021;
19 APRIL 2022 – 22 APRIL 2022;
25 APRIL 2022 – 29 APRIL 2022;
3 MAY 2022 – 6 MAY 2022;
29 AUGUST 2022 – 30 AUGUST 2022;
12 SEPTEMBER – 15 SEPTEMBER 2022.

DELIVERED ON : **07 FEBRUARY 2023**

ANNEXURE “A”

N[...] v MEC HEALTH EC

LIST OF FUTURE CONSULTATIONS, THERAPIES AND SURGERIES

1	DIETICIANS’ CONSULTATION	FREQUENCY
	1.1 Dietician	3 annually for the first year
	1.2 Dietician	2 annually until 18 years
	1.3 Dietician	1xAnnually-18 years for life
	1.4 Dietician consultations until age 12	3x Annually
2	CLINICAL PSYCHOLOGISTS	FREQUENCY
	2.1 Psychotherapy for mother	15 sessions over 15 weeks once off
	2.2 Psychologist support	5 sessions over 4 periods

2.3 Couple therapy 5 sessions over 5 weeks once off

3	PHYSIOTHERAPEUTIC ITEMS	FREQUENCY
3.1	Physiotherapy for complex CNS	35 annually until age 12
3.2	Physiotherapy for complex CNS	30 annually from 13-18 years
3.3	Physiotherapy for complex CNS	20 annually from age 18 for life
3.4	Domiciliary physiotherapy	4 visits per annum till 12
3.5	Domiciliary physiotherapy for	3 visits per annum 13 – 18
3.6	Domiciliary physiotherapy for	4 visits per annum 18 for life
3.7	Chest physiotherapy	8 per episode for life
3.8	Physiotherapy following orthopaedic surgery: in-patient	As and when needed
3.9	Physiotherapy following orthopaedic Surgery: out-patient	As and when needed
3.10	Physiotherapy following orthopaedic Surgery	As and when needed
3.11	Seating assessment/fitting and	8 hours per annum for the next 2 years thereafter as and when required
3.12	Modification of postural support	if and when required
4.	OCCUPATIONAL THERAPY ITEMS	
4.1	Multidisciplinary group therapy	35 hours annually (incl Physio and Speech)
4.2	Block therapy	5 days of block therapy once

		off (30 hours)
4.3	Occupational therapy	20 annually until age 13
4.4	Occupational therapy	12 hours annually 14 until 18
4.5	Occupational therapy	2 hours annually after 18 years for life
5.	ORTHOTIC CONSULTATIONS	FREQUENCY
5.1	Orthotic consultations	1 hour per annum for life
5.2	Laboratory	Annually for life
6.	ORTHOPEDIC CONSULTATION, SURGERIES	FREQUENCY
6.1	Orthopaedic consults	Annually for life
6.2	Bilateral abductor releases	if and when recommended by the senior orthopaedic surgeon of Cecilia Makiwane Hospital in consultation with the plaintiff's case manager
6.3	Fracture treatment	All fractures suffered as a result of cerebral palsy if and when they occur
7.	REHABILITATION CONSULTATIONS	FREQUENCY
7.1	Paediatric Neurologist	Once off immediately

7.2	Paediatric Neurologist	6 sessions annually until 11
7.3	Paediatric Neurologist	4 sessions annually 12 – 17
7.4	Mild Respiratory infections	if and when they occur
7.5	Major Respiratory infections	if and when they occur
8.	SPEECH THERAPY	FREQUENCY
8.1	Speech & language therapy	Twice a week for 12 months immediately
8.2	Speech & language therapy	once a week for 12 months in the second year
8.3	Speech & language therapy	Once a month from the third year for life
8.4	Feeding/Swallowing assessment	Once every 2 years
8.5	Annual meetings to determine progress	Twice a year at 6 hours each for 3 years only
9.	DENTAL CONSULTATIONS	FREQUENCY
9.1	Dental check-ups	Every 6 months
9.2	Decay/Caries	If and when needed
9.3	Extraction of teeth	if and when needed
9.4	Scale & Polish	Every 6 months
9.5	Radiographs	if and when needed

9.6	Infection control	if and when needed
9.7	Day stay in hospital & theatre	if and when needed
9.8	Anaesthetist	if and when needed
9.9	Dentist consultation in theatre	if and when needed
9.10	Periodontal surgery	if and when needed
10.	NURSING COSTS	FREQUENCY
10.1	Minor Pressure sore treatment	if and when needed
10.2	Major Pressure sore treatment	if and when needed
11.	CAREGIVER TRAINING	FREQUENCY
11.1	Caregiver training for Domestic worker, family members, caregivers	As and when required

ANNEXURE “B”

N[...] v MEC HEALTH EC

LIST OF FUTURE SUPPLIES, MEDICAL DEVICES & OTHERS

1	DIETICIAN’S ITEMS	FREQUENCY
1.1	Nutrimel/Pediasure/Ensure	Monthly until the age of 18 years
1.2	Nutrimel/Pediasure/Ensure	Monthly after age 18 years for life
1.3	MIC Key	3x annually for life
1.4	EXTSET/SECUR LOK	5 boxes annually for life
1.5	BOLUS	5 boxes annually for life
1.6	Measuring device	Once off

1.7	Silver nitrate sticks	Annually for life
1.8	Blood tests iron studies	Annually for life
1.9	Calcium tests	Annually for life
1.10	Parathyroid hormone test	Annually for life
1.11	Vitamin D test	Annually for life
1.12	Carnitine test	Annually for life
1.13	Vitamin D supplement	Every 7 months for life
1.14	Iron supplement	Every 7 months for life
1.15	Calcium supplement	Every month for life
1.16	Carnitine supplement	Every month for life
1.17	Mineral supplement	Every month for life
2	DENTISTRY ITEMS	FREQUENCY
2.1	Electric toothbrush	Every 2 years for life
2.2	Replacement heads	Every 3 months for life
2.3	Hand held brush	3 x annually for life
2.4	Toothpaste	Annually for life
3	ORTHOTIC TEMS	FREQUENCY
3.1	AFOs	Replaced every 2 years until the age of 18 years
3.2	AFOs	Replaced every 4 years after 18 years for life
3.3	AFO straps/strings	Annually for life
3.4	Ortho footwear to 18	Annually until 18 years

3.5	Ortho footwear 19+	Every 2 years from 19 for life
3.6	Footwear tuning	Once off and then if and when required
3.7	Leckey horizontal stander	Every 10 years for life
3.8	Splints to 18	Every 2 years until 18
3.9	Splints 19+	Every 4 years from 19 for life
3.19	Hydraulic Hoist	Once off
3.11	Sling	Every 5 years for life
3.12	Car safety chair	1 in childhood, 1 in teens, 1 in adulthood
3.13	Wproof bed sheet	Every 2 years for life
3.14	Shower chair	Every 5 years for life
3.15	Custom made elbow splints	Every 2 years until 18 years
3.16	Custom made elbow splints	Every 3 years from 19 years for life

4	PHYSIOTHERAPEUTIC ITEMS	FREQUENCY
4.1	wheelchair/buggy	Every 4 years
4.2	Transporter & buggy	Every 4 years if necessary
4.3	Posture support chair	Every 4 years
4.4	Sleeping and positioning system	Once off
4.5	Foam and cushion covers	Annually
4.6	Bobath therapy plinths	Once off
4.7	Recovering/repair/replacement	Annually
4.8	Portable home suction unit	Every 5 years
4.9	Accessories for the home	Annually to age 18 thereafter
	suction unit (saline & catheters)	biannually for life

	4.10 Nebuliser	Every 2 years
5	OCCUPATIONAL THERAPY ITEMS	FREQUENCY
	5.1 Bench	Every 5 years for life
	5.2 Table	Every 10 years for life
	5.3 Manual crank adjustable bed/ Hi Low bed	Twice over life
	5.4 Extra bed linen	Every 5 years
	5.5 Disposable Nappies	Monthly for life
	5.6 Bibs	Annually for life
6	NURSING ITEMS	FREQUENCY
	6.1 Skin care	Monthly for life
	6.2 Bed wedge	Every 3 years
	6.3 Vaseline	Monthly for life
	6.4 Lacson to 12	Monthly until 12
	6.5 Lacson 13+	Monthly from age 13
	6.6 Dulcolax to 12	Every month until 12
	6.7 Dulcolax 13+	Every month from 13
	6.8 KY Jelly	Monthly for life
	6.9 Disp. Gloves	Every month for life
7	REHABILITATION ITEMS	FREQUENCY
	7.1 EEG	Twice for life

7.2	Serum drug level testing	Twice annually for life
7.3	Epilim 1120 mg daily	Monthly until 3 years
7.4	Epilim 1400 mg daily	Monthly from 4 until 8
7.5	Epilim 1600 mg daily	Monthly from 9 until 13
7.6	Epilim 1750 mg daily	Monthly from 14 years for life
7.7	Baclofen 30 mg daily	Monthly until 6 years
7.8	Baclofen 50 mg daily	Monthly from 7 years for life

8	SPEECH & LANGUAGE THERAPY ITEMS	FREQUENCY
8.1	Specialised spoons and cups	Once off
8.2	Oro motor skills kit	Once off
8.3	Low technology and therapeutic toys	Annually

ANNEXURE "C"

N[...] v MEC HEALTH EC

LIST OF ITEMS IN RESPECT OF WHICH UNDERTAKING TO PAY APPLIES

SERVICE / SUPPLY	FREQUENCY
Day care facility	Every month until 18 years
Two caregivers ¹	Full time 6 days per week with Sunday work paid at 1.5 times in terms of S 16(1) of Act 75/1997
Alternative to two caregivers from 18 permanent residential facility	From 18 years for life

Washing machine	Every 10 years
Private case manager	8 hours at commencement
Private case manager	8 hours at 17th birthday
Private case manager	4 hours every June
Private case manager	Save for June, 2 hours monthly for the first 2 years
Private case manager	Save for June, 1 hour per month after the first 2 years for life
Private case manager home visits	2 visits in the first 2 years

¹Caregiver does not require a nursing qualification and would be a domestic worker or other person with required training in caring for a CP child, the training to be provided by the defendant.

ANNEXURE “D”

N[...] v MEC HEALTH EC

LIST OF ITEMS IN RESPECT OF WHICH LUMP SUM DAMAGES PAYABLE

ITEM	AMOUNT
Loss of earnings	R386,146
Adapted vehicle and transport	R650 000
Adaptations to home	R1, 100, 000
TOTAL	R 2,136,146

