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

IN THE HIGH COURT OF SOUTH AFRICA

GAUTENG DIVISION, JOHANNESBURG

CASE NO: 9257/2017

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

....
DATE

In the matter between:

M M obo N M **PLAINTIFF**

and

MEC FOR HEALTH, GAUTENG **DEFENDANT**

JUDGMENT

MAHALELO J:

Introduction

[1] The plaintiff instituted action against the defendant during March 2017 claiming delictual damages from the defendant for the injuries which her minor child suffered during birth as a result of the now admitted negligence of the medical staff at the Natalspruit Hospital. The matter came before court for the determination of quantum of the plaintiff's claim for general damages in her personal capacity and representative capacity for the past and future hospital and medical expenses and modalities, future loss of earnings and earning capacity and general damages for her minor child.

[2] The parties prepared a statement of facts and opinions on which they reached agreement in respect of the questions to be determined by the court i.e loss of earnings or earning capacity, past and future medical and hospital expenses and general damages and they elected not to call any witnesses but to argue those questions based on the statement of their agreed facts and opinions. It was further agreed between the parties that medico-legal reports of all experts from both sides be admitted as evidence and the undisputed report of the plaintiff's paediatric neurologist Dr Pearce also be admitted as evidence. The parties specifically agreed on the facts and findings of all experts as expressed in their joint minutes. The parties had agreed upon the appropriate contingency deduction to be applied to the child's loss of earning capacity, the appropriate amount for the plaintiff's general damages in her personal and representative capacity and the amount to be awarded for the child's future hospital and medical expenses. They have also agreed on the rate of 7.5% to be allowed for the creation and administration of the Trust. Furthermore, they agreed on a draft order which they handed up and wished it to be made an order of court.

[3] The evidence discloses that the plaintiff was admitted to the Natalspruit Hospital on 2 August 2006 with a history that her contractions started that morning at 9:00 and that her membrane ruptured at 16:00. According to the medical notes the plaintiff had mild contractions and the vaginal examination revealed a cervix that allowed “a tip of a finger”. Pethidine and hydroxyzine were prescribed and a CTG scan was performed which proved satisfactory. At 02:00 the plaintiff was received in the ward. She was in the latent phase of labour. The foetal heart rate was 156 beats per minute and her condition regarded as stable. According to the doctors/midwives notes at 06:00 the plaintiff’s cervix was 6cm dilated and the plaintiff was transferred to the labour ward. At 9:00 she was assessed and was found to have a big baby. Her cervix was 8cm dilated, she had blood pressure of 158/96 and pulse rate of 120 beats per minute. Foetal heart rate was noted to be 154 to 160 beats per minute.

[4] At 10:30 the plaintiff was waiting for theatre and according to the medical notes she had “a big baby ++” and “contractions ++”. Pethidine and hydrozynine were prescribed while the plaintiff was waiting for caesarean section. She had a fully dilated cervix and lying in the lateral position and receiving oxygen.

[5] At 11:10 the plaintiff was waiting for the theatre and by 11:40 she was in the theatre. According to the caesarian section note, a caesariarian section was performed at 12:35 and the time of delivery was noted to be 12:55. According to the neonate document the minor had a birth weight of 3.55 kg and the Apgar score were noted as 3,4 and 5 out of 10 respectively.

[6] According to the doctors/midwives notes at 13:40 the baby required incubation while naxalon was administered. Resuscitation continued for 30 minutes and after 20 minutes’ spontaneous breath occurred. According to the discharge summary

document the minor's head circumference was 34cm and the length 51cm. The minor was diagnosed with permanent neurophysical and intellectual impairment as a result of her intrapartum hypoxic ischaemic brain injury which manifested as mixed type cerebral palsy.

The experts and joint minutes

[7] The experts agree in their joint minutes in respect of the nature and extent of future medical treatment and modalities reasonably required by the child in future and the costing and frequency thereof.

[8] Dr Fine and Dr Visser, the psychiatrists appointed by the parties reached agreement as follows:

1.The minor physically suffers from cerebral palsy with severe limitations;

2. Immobility to perform and enjoy normal activities of daily living and life amenities;

3. Neuropsychiatric moderate mental retardation is applicable but where the minor is educable but to a limited degree and where she can feel emotional pain and suffering;

4. The minor's condition is largely permanent and irreversible, and she will require life-term care, control and supervision and has totally lost the ability to lead in independent

life;

5. The minor requires psychiatric treatment intermittently and probably throughout her

life;

6. Appointment of a curator ad litem is recommended;

7. The parents of the minor would be her main life-long caregivers and has suffered emotional shock and pain and it is agreed that the parents and the child's brother requires counselling.

[9] Dr APJ Botha and Dr G Promnits, the physicians appointed by the parties agreed that the child has mixed spastic/dystonic quadriplegic cerebral palsy, intellectual impairment, is toilet trained, with head control, able to partially roll and with some sitting ability. In accordance with Dr Promnits the life expectancy of the minor is 45 years and in accordance with the plaintiff's physician Dr Botha the life expectancy is 47 years.

[10] Ms T Kaltenbrun and K J Thokoane the dieticians appointed by the parties have reached agreement as follows:

1.The minor appears to be of normal weight and that the minor's body mass index indicates that she does not present as underweight or wasted;

2. The minor has a good appetite however her intake remains limited due to financial constraints and limited nutritional education;

3. The minor has inadequate dietary variety and daily vitamin and mineral supplementation is recommended;

4. The minor does not consume adequate fluids during the day and therefore an increase in fluid intake is recommended;

5. The minor is unable to feed herself;

6. The minor does not have severe swallowing difficulties;

7. Treatment and maximising of the minor's intake orally would be ideal;

8. The minor would require a complete supplemental drink as well as fibre supplement and dietetic consultations;

9. The minor will require complementary feeds and supplementation as well as dietetic consultations and they also agree in respect of the costs of these.

[11] The Architects, Mr Ceronio and Mr A Retief appointed by the parties have reached agreement as follows:

1. Costs of additions and alterations to existing dwelling;

2. Constructions costs;

3. Strengthening of timber trusses for hoist installation;

4. Costs of internal alternations;

5. Costs of external alterations;

6. Costs in respect of site works and security;

7. Costs in respect of professional fees.

[12] Ms B L Eybers-Purchase and Dr G Prag, the educational psychologists appointed by the parties reached agreement that:

1. There are areas of satisfactory intellectual skills, particularly with regard to non-verbal learning processes of the child. According to them this indicates that but for the injuries at birth the child was of average intelligence and would probably have completed grade 12 (NQF 4) as both her parents did.

2. A further qualification at NQF level 5 was also a possibility.

3. Post-morbidly the child's significant verbal learning delays will make it difficult for her to continue with an academic curriculum;

4. She would be better suited to a practical vocational curriculum with special endorsements;

5. The minor will require:

5.1. continued support in the classroom as well as at home with regards to her learning;

5.2. the appropriate equipment (computer with joystick and adapted software, iPad tablet, communication device and so forth) at home;

6. The minor require ongoing occupational therapy, speech and language therapy;

7. The minor would be best suited to a vocational curriculum (with special endorsements) and subsequently will require placement in a centre for young adult and/or and adult care residence;

8. There is a significant loss of amenities.

[13] The physiotherapists, Ms P Jackson and A Joseph appointed by the parties agreed that:

1. the minor is a GMFCS level IV;

2. therapy is recommended in respect of the following:

2.1. Paediatric physiotherapy for neurological stages;

2.2. Therapy for childhood management and neurological stages;

2.3. Physiotherapy for neurological status and adulthood;

2.4. Therapy for adulthood management of neurological stages;

2.5. Post-operative physiotherapy in childhood;

2.6. Post-operative physiotherapy in adulthood;

2.7. Post incident physiotherapy.

3. Agreement and recommendations with regards to wheelchairs and other assistive devices inclusive of hoists, car seats and walking equipment as set out in their joint minute (the experts could however not agree on the costs and frequency of the treatment and assistive devices suggested).

[14] The Speech and Language Therapists, Drs K Levin and C L Dikobe appointed by the parties agreed that:

1. the minor child presents with:

1.1 normal hearing;

1.2 adequate development of her listening skills;

1.3 adequate structure but severe neurological involvement of the control of the musculature required for speech and for feeding;

1.4 with severe dysarthria and that her speech is unintelligible much of the time and that the rating of her speech production on the Viking scale is level IV;

2. the minor's unintelligibility is a primary motivator for the use of alternative and augmentative communication devices and systems;

3. The minor presents with delayed language development;

4. The minor's speech intelligibility and dysarthria affect her speech of language because she is not able to say more than 2 to 3 words because of her poor breath support but acknowledge that her expressive language is probably equivalent to her receptive language if not slightly lower;

5. The minor:

5.1. has developed many of the basic concepts underpinning communication and is beginning to grasp higher order abstract language, but that her level of abstraction is more than likely limited for her age;

5.2. requires better seating and positioning in relation to the AAC system and better means of access because she is slow and thus inefficient at present;

5.3. presents with dysphagia and agree that her feeding and swallowing is rated at level II on the EDACS;

5.4. would benefit from the services of a speech therapist to assist with her communication as well as her feeding by a speech and language therapist;

6. There are currently no prescribed tariffs for speech therapist and audiologists and that these tariffs will vary according to the therapist's level of expertise and the geographical location of the practice and that these may vary between R617.32 and R1 092.50 per hour.

7. Communication assessment as well as AAC one-on-one intervention and AAC occupational and physiotherapy as well as training and collaboration is required but they differ in respect of frequency and costs;

8. A communication passport is required (but disagreed on the costs in respect thereof);

9. The minor should be provided with an AAC device and AAC software;

10. Given the profound nature of the minor's communication impairments its highly likely that she will have to receive care 24 hours per day.

11. It would be preferable for the minor to attend a school that can provide her with at least part of the speech therapy that is recommended and it Is also important that this school is familiar with AAC systems and that it can support the use of the minor's AAC system in the classroom for as long as the minor is able to attend school;

12. A case manager be employed for the rest of the minor's life to manage the complex arrangements that need to be made once funds are allocated to this matter;

13. Because of the minor's profound communication impairment and her lifelong dependency on an AAC system in combination with the severity of her other impairments its highly unlikely that the minor would be employable in any capacity in her life in the competitive open labour market;

14. The minor is a vulnerable individual and will remain so for the rest of her life and it is strongly recommended that any funds awarded be protected for the minor's exclusive use for the rest of her life.

[15] The dentists appointed by the parties, Dr P J Lofstedt and Dr Galatis reached agreement on their clinical findings as well as treatment and modality and place of treatment in respect of the dental requirements of the minor (the causation of the costs by the condition of cerebral palsy and the costs in respect of the dental treatment differ).

[16] The mobility experts Mr D Rademeyer and L Patterson appointed by the parties reached agreement as follows:

1. The minor:

1.1. current weighs more that 30kg;

1.2. is of a cerebral palsy rated GMFCS level IV;

1.3. crawls but cannot sit unaided, stand, walk nor transfer;

2. The minor's global mobility is severely compromised and requires:

2.1. Caregiving, relevant domestic mobility related assistive devices as well as special transport arrangements; lifelong provision for a privately-owned entry level MPV costing no more than R295 000.00 with a trade in value of R120 000.00 after 8 years together with adaptions costing no more than R160 000.00 to be replaced with vehicle;

2.3. Additional vehicular running costs at R1.66 per km and not to exceed 6 000 km per annum for compensation;

2.4. Alternatively, that should the parents be able to manage vehicle ownership, annual provision to be made to hire private or ambulance type special transport estimated to presently cost on average R4 750.00 per month over

rest of life;

3. They are unaware- of any suitable state transport that is provided on a national basis

[17] Dr Van Der Merwe and Dr Fletcher the ophthalmologists appointed by the parties reached agreement as follows:

1. The child's ophthalmological system is within normal limits;

2. The visual system and visual acuity could only be assessed objectively due to the minor's brain injury. Subjective visual acuity testing was not possible, and the minor does not suffer from any visual impairment related directly to her eyes;

3. The minor has cortical visual impairment related to the severe nature of her cerebral palsy and there is no available method to clinically quantify the visual impairment of the minor.

[18] H Grimsehl and M Cox the Orthotist and Prosthetists appointed by the parties reached agreement as follows:

1. The minor should receive bilateral ankle foot orthoses every year until skeletal maturity and thereafter it should be replaced every 2 years for the rest of her life and that straps should also be replaced every six months;

2. Provision should be made for:

2.1. annual maintenance on all assistive devices and orthotic equipment at

10% of the value of the device per annum;

2.2. biannual consultation and laboratory fees;

2.3. an electric hoist with a sling every 10 years for the rest of her life;

2.4. left and right static wrist hand orthoses every 2 years for the rest of her life;

2.5. orthotic footwear which will be replaced every 2-3 years for the rest of her life;

2.6. one full length night splint for her right leg every 2 years for the rest of her life;

2.7. a pair of soft knee and elbow splints every 3 years for the rest of her life;

2.8. a manual wheelchair consisting of the following components:

2.8.1. Otto Bock Discovery Tmax Outdoor Base;

2.8.2. Mygo Seat.

2.9. A Mygo standing frame for the rest of her life;

2.10. A 7-point harness to be replaced every 10 years for the rest of her life;

3. The costs and the replacements times of the above assistive devices has also been agreed upon.

[19] Dr S Bouwer and Dr L Friedman the Ear, Nose and Throat Surgeons appointed by the parties reached agreement that:

1. The minor has to be under supervision for the rest of her life;

2. Any future medical expenses regarding ENT will be the same as for a normal person.

[20] The Orthopaedic Surgeons Dr A H Van den Bout and Dr Eltringham appointed by the parties reached agreement as follows:

1. The minor was born with brain damage resulting in cerebral palsy type GMFSC V with no real use of her arms and hand, and that the minor is unable to independently maintain an erect posture and has severe spastic legs with contracture of hips and knees;

2.The minor is totally and permanently disable and will never be able to earn any income;

3. The minor will require future medical treatment that will also include tendon lengthening of the hip and knees.

[21] The occupational therapists Mr L Wheeler and A Ndabimi appointed by the parties reached agreement as follows:

1. The minor:

1.1. is classified as level IV according to the MACS (handles a limited selection of easily manages objects in adapted situations. Performs parts of activities with effort and with limited success. Requires continuous support and assistance and/or adapted equipment for even partial achievement of the activity).

1.2. presents with severe developmental delay and is maximally dependent for her needs in various occupational performance areas to be met;

1.3. will require ongoing occupational therapy for the rest of her life;

1.4. is currently attending a special needs school;

1.5. will benefit from individual occupational therapy sessions;

2. That the therapist should have experience/training in neurodevelopmental therapy;

3. Occupational therapy will be required and that they agree on the periods of occupational therapy required and the costs with regards thereto;

4. Costs of adjusting of clothing is required and the costs thereof;

5. A case manager be appointed to oversee the minor as well as her therapeutic, medical accommodation and other intervention and caring needs;

6. The minor will benefit from case management and they agree on the hours in respect of the case management (they differ in respect of the costs involved);

7. Allowance should be made for transport for the minor in respect of medical appointments and other therapy appointments and that due to the minor's limited mobility and vulnerability she will always have to be accompanied by family members;

8. The minor will require assistive devices in respect of transport needs, mobility, specialized beds and bathing devices as well as hoist;

9. The current school (an LSEN- school) is suitable however the minor requires further therapeutic input, and additional AAC systems in the school environment;

10. The minor will require continence care, hygienic care as well as therapy and apparatus, schooling or stimulation centers for children with disabilities and that the minor will ideally benefit from continuing in this type of schooling system until the age of 18 – 20 years of age;

11. The minor after the age of 18 – 20 years be likely to be at home with specialized caregivers structuring her entire day into meaningful activities.

12. The minor should be allowed an Eyegase system such as can be provided by Inclusive Solutions;

13. The minor will require a fulltime facilitator and a fulltime caregiver when at home;
14. Domestic assistance will be required as well as alternative accommodation;

15. The minor will never be able to reside on her own and will always need to reside with an adult and in this case with her parents in a suitably adapted house;

16. The future residence will have to meet minimum requirements as set out in their joint minute and that caregiving should ideally be provided through a nursing agency;

17. That allowance should be made for a separate therapy room where a therapist will be able to carry out their therapy during home visits;

18. Both agree that the minor will continue attending a special school;

19. The minor will not be employable in the open labour market in any form.

[22] Dr F Van Wijk and Dr P Steyn the urologists appointed by the parties reached agreement as follows:

1. The minor:

1.1. is continent with a balanced bladder, can tell her mother when she wants to go to the bathroom;

1.2. has not had any urinary tract infections;

1.3. has normal bladder and kidneys.

2. No meaningful change in her condition over the rest of her lifespan is foreseen;

3. The minor will just always have to wear protection, for example a pad or nappy that would not affect her life expectancy or quality of life and will require a yearly examination by a specialist urologist.

[23] The gastroenterologists Professor D B Bizos and Dr D Pretorius appointed by the parties reached agreement as follows:

1. The minor has no feeding problems;

2. The minor is potty trained;

3. There is an agreement that no surgical treatment specific to this case is required or foreseen.

[24] The economists appointed by the parties Mr M Schussler and Dr E Ndou reached agreement as follows:

1. The minor's future medical expenses must be discounted at a rate of 1.1%;

2. While there might be different outlooks for health inflation these differences are not significant and therefore it is agreed that a medical discount rate of 1.1% is recommended.

[25] The industrial psychologists, Mr L Linde and Mr L Marais appointed by the parties reached agreement as follows:

1. Pre-incident the minor would probably have completed a matric with endorsement for higher certificate NQF level 5 studies;

2. Pre-incident the minor would possibly have completed a NQF level 5 qualification;

3. Post-incident the minor has been rendered unemployable in all sectors of the open labour market and has suffered a total loss of earnings and earning potential.

Undisputed Reports

[26] The report by the plaintiff's paediatric neurologist (Dr Pearce) is undisputed. Dr Pearce reported that: Although not suffering from seizures, the child remains at risk of seizures for the rest of her life; the child usually wakes up 3 to 4 times per night; upon neurological examination it was found that, the minor is Microcephalic; drooles moderately; suffers from choreo-athethoid posturing and intermittent tongue thrusting; had two café au lait lesions, being on the left lateral thigh and the anterior chest; had two abrasions associated with a recent fall from her wheelchair; was severely dysarthritic and very difficult to understand; was able to count to 100, identify colours and able to follow single step instructions such as open your mouth; receptive language was significantly better than her expressive language, has moderate-severe intellectual disability; has increased tone in all her limbs, predominantly dystonic, with her upper limbs worse than her lower limbs and right side worse than her left side. This is in keeping with a superimposed right hemiplegia. Intermittent phasic spasticity was elicited in her lower limbs. Her power graded at least 4/5 globally; is unable to reach for objects due to her inability to

coordinate her movements and unable to hold objects even if placed directly in her palm. She has fixed contractures of her knees. Her right knee was unable to extend beyond 170 degrees and her left knee beyond 160 degrees; In 2019 her contractures had worsened. He right knee was unable to extend beyond 150 degrees and her left beyond 130 degrees. Her left ankle was unable to passively dorsiflex beyond neutral. Her upper limbs had developed contractures in the interim. Her right elbow was able to extend fully but her left elbow was unable to extend beyond 110 degrees. Her left hand was fisted with her thumb adducted and early contracture formation noted. Her reflexes were pathologically brisk and graded as 3/4 globally with clonus at her ankles and crossed adductors bilaterally. Upgoing plantars were evident bilaterally. Her muscle bulk was globally decreased with relative preservation of her biceps. Is able to sit in a “w” formation and able to crawl on her knees; is unable to walk, even with maximal assistance; has a scoliotic spine on sitting. This appears compensatory in nature. Her truncal tone is poor but no head lag is evident. Her sensation appeared grossly intact;

[27] Dr Pearce was unable to: assess her cerebellar function due to lack of cooperation and motor fallout, however she has no suggestive features. Her cranial nerves were intact. She was able to follow light and according to her mother is able to see well; perform fundoscopy, however her pupils were equal and reactive, direct and consensual. During assessment the child responded to loud sounds but Dr Pearce was unable to test her hearing at more subtle frequencies. The child is toilet trained and able to communicate her toileting needs. She does however need assistance to get to and use a toilet. Fine motor ability: The child is unable to: perform fine motor skills; wash, feed or dress herself; reach for or hold objects even if placed directly into her palm. Vision: The child was able to follow light and her

vision appeared grossly normal, but subject to further formal assessment Hearing: The child responded to loud sounds. According to the plaintiff she is able to hear. She requires formal assessment; Speech: The child is able to communicate in limited sentences; Her speech was noted to be dysarthric and very difficult to understand; Her receptive language was significantly better than her expressive; Personal/Social: The child is severely limited in her communication and interaction, unable to perform even limited activities of daily living and requires around the clock care. The child: has a severe mixed-type cerebral palsy, predominantly dystonic, with a superimposed right hemiplegia. She is classified as GMFCS IV (Gross motor functional classification scale. Her comorbidities include moderate/severe intellectual disability, compensatory scoliosis, microcephaly, contractures and severe developmental delay; is completely dependent on others for activities of daily functioning; unable to attend a normal school as a result of her disability and will need the benefits provided by a specialised centre for the rest of her existence; will never be able to care for herself and her employment options will be non-existent; has forfeited normal childhood play and suffered ridicule and hardship as a result of her disability; The plaintiff has been burdened with an immense, full time care load far exceeding that of normal parenting. This: will persist as long as the child lives; imposes significant restrictions on career choices, family dynamics, vacations etc; causes significant emotional strain and pain endured to the plaintiff and her family.

Quantification of plaintiff's claim in her personal capacity: General Damages:

[28] The quantification of any claim for general damages is an exercise which is not an easy one. It is trite that each case must be decided on its own merits though guidance must be sought from precedent. With regard to the plaintiff's claim for general damages in her personal capacity the psychiatrists agree in their joint minute

that "*the parents of the minor would be her lifelong caregivers and have suffered emotional shock and pain……".* They recommended awarding a sum of R40 000 for counselling service of her parents and brother.

[29] In Mngomeni obo EN Zangeve vs MEC for Health Eastern Cape Province 2018 (7A4) QOD 94 (ECM) to which I was referred by both parties an award was made of R300 000 for emotional shock and severe depression due to cerebral palsy of a child. The current value thereof being R355 000. The parties are *ad idem* that an award of R350 000 is a fair and reasonable compensation for the plaintiff's general damages. Having considered past awards in comparable cases and the facts of the present case I am in agreement with the parties.

Quantification of plaintiff's claim in her representative capacity: General Damages:

[30] I now turn to the quantification of the plaintiff's claim for general damages on behalf of her child. With reference to past awards for general damages in comparable cases of cerebral palsy children, inflation and CIP and GMFSC level the parties have agreed that general damages should be quantified at an amount of R2 000 000. This amount is comparable to the award in *MSM obo KBM vs The Member of the Executive Council for Health, Gauteng Provincial Government* Case: 431/15 handed down in this Court on 18 December 2019 and other cases where general damages awarded were R2 000 000 for a cerebral palsy child.

[31] General damages for personal injuries are not meant to penalise the defendant but to achieve some form of compensation for the plaintiff. The court must ensure therefore that the damages awarded are reasonable fair and just. It is relevant to

refer to the observations made by WATERMEYER JA in *Sandler vs Wholesale Coal Suppliers Ltd* 1941 Ad 194 at p 199:

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

[32] I agree with what the court held in *AD and IB V MEC for Health and Social Development, Western Cape Provincial Government 2016 (7A4) QOD 32 WCC* that:

> *"[618] Money cannot compensate IDT for everything he has lost. It does, however, have the power to enable those caring for him to try things which may alleviate his pain and suffering and to provide him with some pleasures in substitution for those which are now closed to him. These might include certain of the treatments which I have not felt able to allow as quantifiable future medical costs (eg NMES therapy, SPIO suits, psychotherapy and physiotherapy in excess of the allowances I have made, e-books and the like)."*

[33] Taking all things into account and that the child in this case is GMFCS level iv I consider that R2 000 000 is a fair award for the child's general damages in all circumstances of this matter.

Future loss of income:

[34] The parties also agreed on the actuarial calculations obtained by the defendant. They agreed that the amount for the child's future loss of income should be

quantified on the median of the two scenarios predicted by the defendant's industrial psychologist and quantified by the defendant's actuary and a contingency deduction of 20% be applied to the pre-morbid scenario. They both referred me to the SCA-judgment in the matter of Khoza v MEC for Health, Gauteng (Case no.: 216 /2017) and the full bench judgment in the Gauteng Local Division in the case of PM obo TM v MEC for Health, Gauteng Provincial Government [2017] ZAGPJHC 346, where the courts applied a 20% contingency deduction. The parties also referred me to Kriel NO obo S v Member of the Executive Council for Health, Gauteng Provincial Government (9407/2017) [2020] ZAGPJHC 273 (4 November 2020) where the court held that a 20% contingency deduction was appropriate.

[35] The defendant's actuary determined the loss of earnings on the following permutations: **Pre accident**: The child would have completed grade 12 in December 2024. The following earnings paths are then considered: Scenario 2: With only matric qualification- Per Mr Lance Marais • 1 January 2025: Median quartile for semi-skilled worker i.e. R88 000 per annum, July 2021 money terms; • Age 45 years (1 September 2051): Upper quartile for semi-skilled worker i.e. R193 000 per annum, July 2021 money terms. Uniform linear real increases are assumed between the above earnings Salary inflationary increases are then assumed every July to a normal retirement age of 65 years thereafter. Scenario 4: With post-matric certificate- Per Mr Lance Marais • 1 January 2025 to 31 December 2026 (Two years): Complete postmatric certificate qualification; • 1 January 2027: Paterson A1 (basic salary) lower quartile i.e. R74 465 per annum, February 2019 money terms; • Three years later (1 January 2030): Paterson B2 (Guaranteed Annual Package) median quartile i.e. R197 885 per annum, February 2019 money terms; • Assumed age 45 years (1 September 2051): Paterson C1 (Guaranteed Annual Package) median quartile i.e.

R377 731 per annum, February 2019 money terms. Uniform linear real increases are assumed between the last two above earnings Salary inflationary increases are then assumed every July to a

Summary of Results:

[36] Value of income uninjured: **Scenario 2 -** R2 241

Scenario 4 - R3 726

Median of the 2 Scenarios- R2 984

Less 20 % Contingency- R596 810

Total gross loss- R2 387 242

[37] The parties are *ad idem* that the calculation of the child's gross future loss of income in the amount of R2 984 000 is fair and reasonable. They also agree on a 20% contingency deduction. In my view and given the above cases and the guidelines provided by them, a contingency deduction of 20% is fair and reasonable and an amount of R2 387 242 in total is fair and reasonable compensation for loss of earnings/ earning capacity in all circumstances of this case.

Future hospital and medical costs and expenses:

[38] The actuarial calculation of the defendant (quantified to the agreed life expectancy) is admitted by both parties. The specific treatment and modalities which cannot be rendered and those that can be rendered in terms of the public health care defence were identified, quantified and listed in the actuarial calculations and the agreed quantified value of separate treatments and modalities are summarised in Annexures "A": (Items not subject to the public healthcare defence) and "B" (Items

subject to the public healthcare defence). In respect of Annexure “A”: an order for payment in the amount of R13 000 000 is sought. In Annexure “B” an order for postponement and separation is sought for the later determination only of whether these items can be delivered in future in terms of the public health care defence.

[39] The parties took cognisance of Dhlamini v Government of the Republic of South Africa 1985 (3A3) QOD 554 (W), where it was held at 582: “*The test, as I understand it and which I intend applying in this case, is whether it has been established on a balance of probabilities that the particular item of expenditure is reasonably required to remedy a condition or to ameliorate it”*. The parties agreed that joint minute agreements on the nature, extent, frequency and costs of treatment and modalities required in future to reasonably treat/ameliorate the condition of the child are reasonable and they are admitted. The legal representatives also discussed the items individually and identified and agreed upon the items, cost and frequency of modalities and treatment reasonably necessary to treat /ameliorate the condition of the child in future. I am satisfied that the amount of R13 000 000 is a fair and reasonable compensation reasonably necessary to treat /ameliorate the condition of the child in future in the circumstances of this case.

Establishment of a Trust

[40] The experts have recommended that the funds awarded to the minor should be protected. To that end, the parties are *ad idem* that the plaintiff’s attorneys should cause a Trust to be established for and on behalf of the child in accordance with the provisions of the Trust Property Control Act 57 of 1988. As already stated they also agree that it would be reasonable that an amount equivalent to 7.5% should be allowed for the creation and administration of the Trust.

[41] In the result I make the following order

1. The defendant shall pay to the plaintiff:

1.1. in her personal capacity, the amount of R. 350,000 (three hundred and fifty thousand rand), in respect of general damages;

1.2. in her representative capacity on behalf of N M (hereinafter referred to as The Minor Child) the following: -

1.2.1. Future loss of income: R 2 387 242,00

1.2.2. General damages: R 2 000 000,00

1.2.3. Interim future hospital, and medical costs and related expenses: R 13 000 000,00

Subtotal: R 17 387 242,00

1.2.4. The interim costs in respect of the creation and administration of the trust created in terms of paragraph 6 below (Being 7,5% of the total amount currently awarded to the minor (R 17 387 242,00): R 1 304 043,15

Subtotal: R 18 691 285,20

2. Determination of whether the services in annexure B hereto in the agreed amount of R 2 906 514 (the agreed balance of the future medical and related costs and expenses of services which the defendant is purportedly able to render in the public health sector) can be rendered as such in the public health sector, is separated from the balance of the issues and postponed sine die;

3. The total amounts referred to in paragraphs 1.1 and 1.2. above being the total sum of R19 041 285,20 (Nineteen million and forty-one thousand two hundred and eighty five Rand and twenty cents) shall be paid in accordance with the provisions of

Section 3(3)(a)(i) of the State Liability Act 20 of 1957 as amended and shall be paid directly in the following trust account of the plaintiff's attorneys of record:

Account Name : Edeling Van Niekerk Inc

Bank : Nedbank Branch :

Business Banking Account number : 1286083516 Branch code : 128605

4. The aforesaid amounts shall be retained in an interest-bearing account in terms of the provisions of Section 86(4) and (5) of the Legal Practice Act 28 of 2014 for the sole benefit of the minor child.

5. To ensure that the monies awarded to the plaintiff in her representative capacity are suitably protected, as contemplated by the relevant experts, the attorneys for the plaintiff, EDELING VAN NIEKERK INCORPORATED of Block A, Clearview Office Park, Wilhelmina Avenue, Constantia Kloof, ROODEPOORT are ordered:

5.1. to cause a trust ("the TRUST") to be established in accordance with the Trust Property Control Act No 57 of 1988, such Trust to be a "special trust" as defined in Section 1 of the Income Tax Act, No 58 of 1962 (as amended);

5.2. to pay all monies held in trust by them for the benefit of the minor child to the

TRUST;

6. The trust instrument contemplated above shall make provision for the following:

6.1. That the minor child shall always be the sole beneficiary of the TRUST;

6.2. That the trustee(s) and their successors are to provide security to the satisfaction of the Master;

6.3. That the powers of the trustee(s) shall specifically include the power to make payment from the capital and income for the reasonable maintenance of the beneficiary, or for any other purpose which the trustee(s) may decide to be in the beneficiary's interest, and if the income is not sufficient for the aforesaid purpose, that the trustee(s) may utilize capital;

6.4. That the ownership of the trust property vest in the trustee(s) of the TRUST in their capacity as trustees;

6.5. That the procedure to resolve any potential disputes, in respect of the interpretation of the trust deed and the execution of the spirit and purport of the trust, shall be subject to the review of this Honourable Court;

6.6. The exclusion of all benefits (income and/or capital) accruing to the minor child as beneficiary of the TRUST from any community of property and/or accrual system in any marital regime;

6.7. The suspension of the minor child's contingent rights in the event of cession, attachment or insolvency, prior to the distribution or payment thereof by the trustee(s) to the Plaintiff;

6.8. That the amendment of the trust instrument be subject to the leave of this Honourable Court ;

6.9. The termination of the TRUST upon the death of the minor child, in which event the trust assets shall pass to the estate of the minor;

6.10. That the trust property and the administration thereof be subject to an annual audit;

7. Until such time as the trustees are able to take control of the capital amount and to deal therewith in terms of the provisions of the trust, the plaintiff's attorneys are authorized and ordered to pay from the capital amount:

7.1. Any reasonable payments that may arise to satisfy any reasonable need for treatment, therapy, care, aids, equipment or otherwise that may arise;

7.2. Such other amounts as reasonably indicated and/or required for the wellbeing of the minor child and/or which are in his best interest ;

8. The Plaintiff's attorney shall be entitled to make payment of expenses incurred in respect of accounts rendered by:

8.1. expert witnesses as identified in paragraph 11 hereunder as well as counsel's fee from the aforesaid funds held by them for benefit of the minor.

9. The Plaintiff's attorney shall be entitled to payment, from the aforesaid funds held by them for the benefit of the minor child, of their fees in accordance with their written fee agreement.

10. The defendant shall pay the plaintiff's taxed or agreed High Court costs of suit as between party and party, such costs to include –

10.1. the costs of Counsel inclusive of the costs of Counsel for the preparation and drafting of the Schedules in respect of Future Medical Expenses and the actuary instructions the annexures hereto and the stated case/exhibit 1 ;

10.2. all costs in obtaining all medico-legal reports including:

1. Actuary Algorithm Consultants CC (Actuary);
2. Architect Mr D Ceronio
3. Dentist Dr PJ Lofstedt
4. Dietician Ms T Kaltenbrun
5. Ear, Nose and Throat Surgeon Dr S Bouwer
6. Economist Mr M Schussler
7. Economist (Medical) Prof Van Den Heever
8. Educational Psychologist Ms BL Purchase
9. Gastroenterologist / General Surgeon Prof D B Bizos
10. Industrial Psychologist Mr L Linde
11. Mobility Expert Mr D Rademeyer
12. Neurological Physiotherapist Ms P Jackson
13. Occupational Therapist Ms L Wheeler
14. Ophthalmologist Dr L van der Merwe
15. Orthopaedic Surgeon Dr A H van den Bout
16. Orthotist H Grimsehl
17. Paediatric Neurologist) Dr D Pearce
18. Psychiatrist Dr L Fine
19. Specialist Physician Dr APJ Botha

20. Speech Therapist and Audiologist Dr K Levin

21. Urologist Dr F van Wijk

10.3. the experts' qualifying, consultation, preparation, and participation in joint expert meetings in respect of the quantification of the plaintiff's claims in her representative capacity on behalf of the minor child;

10.4. In addition, the defendant shall pay to the plaintiff an amount equivalent to 7.5% of all future total amounts to be paid into the aforesaid trust in terms of future orders for payment of damages (being the further costs of creation and administration of the trust).

11. Should the defendant fail to make payment of any of the amounts referred to in this order, interest in terms of the Prescribed Rate of Interest Act 55 of 1975 will commence to accrue on the amounts payable from the due date at the applicable mora interest rate (currently 7%) until date of final payment.

12. The plaintiff shall, if the costs are not agreed, serve the notice of taxation on the defendant's attorneys of record.

13. The capital and costs shall be paid in accordance with the provisions of Section 3(3)(a)(i) of the State Liability Act 20 of 1957 as amended.

14. There is a valid contingency fees agreement in existence between the plaintiff and her attorneys of record.

MB MAHALELO

JUDGE OF THE HIGH COURT OF

SOUTH AFRICA, GAUTEN DIVISION,

JOHANNESBURG

Appearances

Plaintiff's Counsel Piet Uys

Instructed by: Edeling van Niekerk, Louw Kruger

Defendant's Counsel: M Khoza SC with L Mtukushe

Instructed by: State Attorney Johannesburg

W Mabaso

Date of hearing: 11 October 2021

This judgment was handed down electronically by circulation to the parties' legal representatives by email and by uploading to case lines. The time and date of delivery is 10H00 on 21 January 2022