Reportable:	YES / NO
Circulate to Judges:	YES / NO
Circulate to Magistrates:	YES / NO
Circulate to Regional Magistrates:	YES / NO

"IN THE HIGH COURT OF SOUTH AFRICA"

NORTH WEST DIVISION, MAHIKENG

CASE NUMBER: 303/16

In the matter between:-

J. R. PLAINTIFF

And

THE MEC FOR HEALTH DEFENDANT

JUDGMENT

GUTTA J.

A. INTRODUCTION

[1] J. R. (plaintiff) in her capacity as a mother and natural guardian of O. O. E. R. (O.) claims damages from the Member of Executive Council for Health, North West Provincial Government (defendant), cited as nominal defendant in terms of the State Liability Act No. 20 of 1957 and as the nominal head of the Department of Health, North West Province, arising from the alleged negligence of the medical personnel employed at the Job Shimankane Thalane hospital (JST Hospital) in the North West Province.

B. PLEADINGS

[2] Plaintiff in her particulars of claim alleged *inter alia* that:

"2.1 On or about November 2008, plaintiff took O. to the JST hospital as he had diarrhea and weakness of the body.

2.2 O. was admitted at the hospital and a drip was inserted on his forehead.

2.3 The following day the plaintiff noticed that O.'s left ear and left side of his scalp where the infusion had been inserted had gone black.

2.4 The black spot was gangrenous skin which was caused by infiltration of the tissues by the infusion. The infiltration of the tissues, and the sequelae thereof, was caused by the failure of the nurse who inserted the drip into O.'s forehead *alternatively* the nursing and/or medical staff employed at the hospital, to:-

2.4.1 properly and carefully insert the infusion; and

2.4.2 properly monitor and take care of the infusion.

2.5 As a result O. suffered a cerebral venous thrombosis and/or a left side brain infarct and/or left sided brain atrophy and weakness of his right and/or a paralysis of his right side and/or a right sided hemiparesis, and was unable to talk and is still unable to talk even today. His left ear is smaller than the right ear and there is a smelly discharge coming from the area where the needle for the drip was inserted in his forehead.

2.6 As a result of the negligence of the nursing personnel *alternatively* the medical doctors and support staff who were inserting the needle for the drip on O., O. is brain damaged.

2.7 O.'s body injuries, and damages as aforesaid was caused solely as a result of the negligence of the nursing personnel and/or the medical doctors of the defendant who were negligent in one or more of the following:-

2.7.1 They failed to take any and or all reasonable required steps to ensure proper and professional assessment of patient in the hospital including O.;

2.7.2 They failed to implement such steps as could and would reasonably be required to prevent the occurrence of the complication;

2.7.3 They failed to avoid complication when by exercise of reasonable care and diligence they could and should have done so;

2.7.4 They inserted the needle for the drip incorrectly and not according to the required standard;

2.7.5 They failed to insert the drip properly and monitor it with reasonable care, skill and diligence as required in the medical profession;

2.7.6 They failed to provide and/or render the requisite reasonable medical and surgical services with such professional skill and diligently as could reasonably be expected of medical practitioners in the particular circumstances.

2.8 In and as a result of the aforesaid negligence and particularly the breach of the legal duty referred to above, O. suffered the following injuries:-

2.8.1 Severe traumatic brain injury resulting in severe neuro-cognitive, behavioural and physical deficits.

2.9 As a result of the injuries sustained, O. sustained a traumatic brain injury and is impaired and it is anticipated that this will continue for the remainder of his life. The complications are as follows:

2.9.1 He is unable to speak;

2.9.2 He has poor executive functioning – poor memory (immediate, working and visual) functioning and incapacity to sustain and divide concentration, as well as poor problem solving skills;

2.9.3 He is unable to handle complex cognitive task as well as multiple task simultaneously;

2.9.4 His cognitive *sequelae* is likely to remain permanent;

2.9.5 He remains vulnerable and prone to develop debilitating emotional difficulties;

2.9.6 He suffered and will continue to suffer severe personality changes, mood swings and anger outburst due to the behavioural changes he suffers from".

[3] Plaintiff claimed damages in the amount of R37 400 000.00 which amount is made up as follows:

3.1	Future hospital, medical and related expenses	R20 000.00
3.2	Future loss of income and earning capacity	R10 000.00
3.3	General damages	R4 000 000.00
3.4	Costs of protection on monetary award	R3 400 000.00

[4] Defendant in its plea alleged *inter alia* that:

"4.1 Defendant pleads that O. ("the minor child") was initially admitted at the Job Shimankana Tabane Hospital ("JST Hospital") on 2 October 2008 with complaints of vomiting.

4.2 The minor child was admitted at JST Hospital from 2 October 2008 and discharged on 8 October 2008 with a final diagnosis of urinary tract infection and retroviral disease at stage III and was not on any treatment and/or had defaulted on treatment prior to his admission.

4.3 The minor child was once again admitted on 10 November 2008 with complaints of convulsion and vomiting.

4.4 Upon assessment and examination by attending medical staff, the minor child was diagnosed with tuberculosis meningitis, retroviral disease and delayed milestones.

4.5 The minor child was admitted in hospital from 10 November 2008 and discharged on 11 December 2008 whereat he was diagnosed with retroviral disease at stage IV, tuberculosis meningitis and septic and/or necrotic left ear around the pinna area.

4.6 During the period of the minor child's admission at JST Hospital, the minor child was attended by the different nursing and medical staff who treated his condition with the reasonable care, skill and diligence expected of them and in accordance with the acceptable standards in the medical profession.

4.7 Defendant pleads that the minor child was severely ill upon his admission and the attending medical staff indicated that a blood transfusion drip be inserted on him.

4.8 The intra-venous drip was duly inserted without any complications throughout the duration of the minor child's admission at hospital and no reaction was ever recorded resulting from the insertion of the drip.

4.9 Save as aforestated, the defendant has no knowledge of the remainder of the allegations herein contained, cannot admit same and accordingly puts plaintiff to the proof thereof.

4.10 Defendant pleads that as a result of the minor child's RVD stage and that he was born with hydrocephalus condition, his immune system was compromised with various opportunistic diseases, like tuberculosis meningitis and septic and/or necrotic left ear around the pinna area set in and resulted in the further treatment of the minor child.

4.11 The septic and/or necrotic left ear was not as a result of the insertion of the drip needle as alleged.

4.12 In amplification of its denial, defendant pleads that the minor child's delayed milestones and apparent brain damage is as a result of a birth condition, hydrocephalus that cannot be attributed to any of the medical and/or nursing staff at JST Hospital.

4.13 Defendant further pleads that the minor child was diagnosed with RVD stage VI, tuberculosis meningitis and septic and/or necrotic left ear around the pinna area which diseases have further compromised his central nervous system.

4.14 The birth defect which the minor child was diagnosed with, together with its *sequelae* cannot be attributed to the said nursing staff and/or medical practitioners of JST Hospital".

C. ISSUES IN DISPUTE

[5] The following issues are in dispute:

5.1 Negligence

5.2 Cause of O.'s brain injury

5.3 General damages

5.4 Contingencies

D. JOINT EXPERTS MINUTES AND REPORTS

[6] The parties agrees that the following experts' reports and their joint minutes be accepted as evidence adduced at the trial:

6.1 Plaintiff's speech and hearing therapist's report, Mrs Masoka and the joint minutes of Mrs Masoka and VP Madima.

6.2 Plaintiff's clinical psychologist's report, Dr Moshanyana and the joint minutes of Mrs Modipa and Ms Phake.

6.3 Plaintiff's occupational therapist's report, Mr Malatse

6.4 Plaintiff's physiotherapist's report, Stacey Aires.

6.5 Plaintiff's specialist's report, Dr Botha with specific reference to the life expectancy of O..

6.6 Plaintiff's educational psychologist's report, Dr Kumalo, including the addendum report.

6.7 Plaintiff's plastic surgeon's report, Dr Saul Braun.

6.8 Plaintiff's industrial psychologist's report, Dr Talmund.

E. PLAINTIFF'S WITNESSES

J. R.

[7] The plaintiff, is the biological mother and guardian of O.. She said O. was admitted to JST hospital on the 10 November 2008, with vomiting, dehydration and diarrhea. He was referred to the JST Hospital by Kana Clinic. A nurse at JST hospital inserted an infusion needle into the scalp vein, on the left side of O.'s forehead. She was asked to sleep elsewhere in the hospital and left O. in the ward. The following day, 11 November 2008, she noticed a black spot around the site where the needle had been inserted. She enquired from the nursing staff about the cause of the black spot and did not get an answer. A doctor was called who refused to speak to her. The nurse, in her presence, removed the drip from O.'s forehead, and threw it on the ground. She telephoned her husband and told him what she had observed.

[8] O. was later during his stay at the hospital referred to the George Mukhari Hospital for plastic surgery but same could not be done because he was too young. According to plaintiff, O. had no delayed milestones and was developing well until after the admission. After O. was discharge, they tried to consult with a physiotherapist at the JST hospital but gave up after the third attempt when they could not find a physiotherapist. Since then, she has not taken O. to any hospital due to lack of funds and O. is not attending any remedial school.

M. C.

[9] Mr M. C. is O.'s biological father. He received a telephone call from plaintiff during the afternoon of 11 November 2008. She told him that O. had developed a black spot/mark on the left side of his forehead where the drip had been inserted. He visited O. the next day and confirmed that there was a black spot on his forehead. He described it as if the skin had been burnt. Mr C. corroborated plaintiff's evidence, that O. is not attending any remedial school and that since the last attempt at finding a physiotherapist, O. has not been to a physiotherapist for treatment.

DR ROSMAN

[10] Dr. Rosman is a highly qualified and experienced neurologist who is a fellow by peer review of the college of neurologists of South Africa. He was registered as a medial practitioner in 1977 and holds an M.D, degree. His thesis was titled "The epidemiology of stroke in an urban black population". He has written numerous articles which were published in peer review journals.

[11] Dr Rosman, relied on the history given to him by plaintiff. He said plaintiff informed him that she saw a black spot on O. on 11 November 2008, the second day after his admission. He said O.'s brain damage and right sided hemiparesis, were caused ultimately by the infusion – either the way in which the infusion needle was inserted, or else the care of the infusion in the left side of O.'s head. He said gangrene occurred, as there was cerebral venous thrombosis as a result of the scalp problems. He noted that the area of brain damage lies immediately beneath the area of the gangrene. He said that because veins penetrate the skull, and these veins do not have valves, the infective process with its complications, such as thrombosis, would very easily enter the cranium, causing the current problem.

[12] Dr Rosman said that it was apparent from the hospital records, and from plaintiff's history, that O. had suffered seizures prior to the insertion of the drip, but he was of the opinion that the seizures were probably caused by dehydration. He said the seizures were successfully treated with an IV drip, and diazepam and O. has not had seizures since. Under cross examination he stated that the underlying neurological cause of the seizures were not known.

[13] Dr Rosman examined the MRI scan as well as the report dated 5 September 2016, of O.'s brain. He said the scan shows atrophy of the entire left side of the brain and was not confined to any particular arterial territory, in other words the entire left side of the brain had shrunken. He said that this picture, on a balance of probabilities, rules out cerebral insult from arterial pathology. The MRI picture excludes arterial stroke as a cause of the O.'s right side weakness. He also ruled out a possibility of virus encephalitis as in his view, it would have resulted in the damage to the entire brain and not only the left hemisphere. He conceded that O. had [...], but stated that O.'s retro viral disease (RVD)

would not result in "half of his brain shrinking". He said if the entire brain injury was as a result of atrophy, it would be difficult to blame the events of 10-11 November 2008. In this regard, he stated that the damage to the brain would have started with swelling of the brain for a period between 6 days and 6 weeks after the event. He concluded that the scan supports the diagnosis of cerebral venous thrombosis.

PROF PANTANOWITZ

[14] Prof Pantanowitz is a specialist surgeon, and vascular surgeon. Prof Pantanowitz has over 40 years of experience as a vascular surgeon. He is an emeritus professor at the University of the Witwatersrand.

[15] Prof Pantanowitz, testified that in his experience, it was common for drips to leak but it was unusual that such leakage would result in complications. He said the leaking drip caused decreased perfusion of the left scalp, and O. developed scalp necrosis and gangrene. Septicemia occurred which resulted in a vascular thrombosis of the cerebral supply, and thereafter right-sided weakness and the inability to speak.

[16] He said the right sided hemiparesis was a vascular event which occurred over a very short period of time. He said that it may have exacerbated what was there before, but it was 100% a venous event. He said "…. once vessels thrombose the venous infarct can happen in minutes". Under cross examination he said that, "The gangrene was noticed the day after admission. The mother noticed the changes on the scalp". Prof Pantanowitz explained that the venous system draws blood from the body to the heart and any infection which passes through this system will take a matter of hours to affect the brain. In the present case, it was quicker and

more severe as O. was susceptible due to his compromised immune system. In his view O.'s compromised immune system and his [...] status did not play any role in the resultant brain injury, which he described as venous thrombosis.

DR MAPONYA

[17] Dr Maponya is an expert paediatrician. She gave evidence that no tests had been done to diagnose TB meningitis. In her opinion, the medical staff at JST did not check O. drip regularly and this resulted in the tissuing of the drip and thrombosis. She said the nursing staff could have prevented the scalp necrosis, and its *sequelae*, had they monitored the drip properly and had they recorded their observations hourly. She testified that the nurses have to be extra vigilant when dealing with a very sick child, especially a dehydrated child who most probably would have been given a higher flow of intravenous liquid. She said it was not sufficient to monitor the drip every 5 hours.

[18] Dr Maponya, testified that there were no delayed milestones. O. was admitted at one year and two weeks and milestones at that age were appropriate. She disagrees with the suggestion that O.'s RVD status had any role to play in the resultant brain injury and its *sequelae*.

F. DEFENDANT'S WITNESSES

DR KGANANE

[19] Dr Wandile Kganane, a paediatrician testified that according to the records O. was slow in attaining expected milestones and only walked properly at 3 years of age. He has never displayed coherent speech. On 10 November

2008, O. was seen at a local clinic with signs of growth failure and seizures and upon O.'s admission, the abnormal neurological condition was diagnosed and treated before the drip infiltration complications.

[20] Dr Kganane opined that the drip infiltration complications were not the cause of O.'s irreversible neurological condition. She testified that the findings of the CT scan done on 12 November 2008 which indicated an atrophy on the left side is significant when one considers the cause of the brain injury, especially since O. presented with focal seizures on admission. In her view, the natural progression of an infiltrated drip would be surrounding skin necrosis with and/or without local tissue sespsis. According to the medical records, the necrotic scalp and ear lesions occurred almost 20 days after the diagnosis of hemiplegia. In her conclusion, the plausible cause of the hemiplegia is the [...] neuropathy.

[21] In cross examination she said the nurses taking care of O. ought to have checked the drip site every 15 to 20 minutes. She said that drip infiltrations happen frequently especially in children. If the nurses has properly monitored the drip as an aforesaid they would have been able to detect the infiltration early enough to prevent harm to O..

DR MANYANE

[22] Dr Dikeledi Manyane, a neurologist testified that she relied on O.'s history from plaintiff and verified same with the hospital records in her possession. She said on admission to the hospital O. suffered from [...], and was on HAART. She opined that O. presented with status epilepticus and right focal motor seizures involving both right arm and leg. O. has right hemiparesis due to left

hemiatrophy of the cerebral cortex which are possibly caused by infarct and focal enciphalistis. She further explained that since O. had risk factors that may lead to a stroke, such as [...] infections, these may cause infarcts.

[23] She stated that the latest MRI report described a hemiatrophy of the left side of the brain. In her opinion O. suffered an arterial infarct as a result of his pre-existing [...] pathology or focal encephalitis. She said that it is possible that the infarct affected the left internal carotid artery, which led to all the vascular territories supplied by the middle, and anterior cerebral arteries.

[24] Dr Manyane conceded under cross-examination that the MRI scan shows atrophy of the entire left side of the brain, not confined to one arterial area. She further conceded that an infarct through the carotid artery would not show atrophy on the MRI scan to that part of the brain supplied by the basilar artery, leading to the vascular territories supplied by the posterior artery. She agreed that this picture would be highly unlikely if the cerebral insult was from arterial pathology. She also said that another cause of hemiatrophy of the cerebral cortex was focal encephalitis, which is the inflammation of the brain. She, however, conceded that there was no evidence to prove that O. was suffering from focal encephalitis.

[25] Dr Manyane conceded that, therefore, the injury to the brain could not have been caused by a stroke resulting from O.'s pre-existing [...] pathology or from focal encephalitis. She agreed that plaintiff's case, which is based on the evidence of Dr Rosman, Prof Pantanowitz and Dr Maponya, that O.'s right sided weakness was caused directly by the drip infiltration, which caused necrosis to the skin surrounding the drip site, and then sepsis to the area of the cranium just below, resulting in a venous thrombosis, was possible. She

explained that plaintiff's theory was possible as emissary veins allow blood to freely flow between the brain and the cranium making it likely that the infection would spread from the cranium to the brain..

[26] During further cross-examination Dr Manyane conceded that, should the court accept the plaintiff's version that she saw a black spot on the child's forehead on 11 November, the Dr Rosman's evidence of how the paralysis occured is the most probable version.

DR MONARENG

[27] Dr Taalib Monareng, a vascular surgeon testified to the effect that the plausible cause of the neurological insult on O. is likely [...] associated neuropathy complicated by meningitis. The duplex ultrasound findings of normal carotid and vertebral arteries rule out extra cranial carotid disease as a cause of O.'s neurology and the drip infiltration complications are unlikely the cause of the neurology. He conceded that O. was not diagnosed with meningitis and that he was started on treatment for TB meningitis as a cautionary step.

[28] Dr Monareng relied on the medical records that there was a colour change of the ear on 1 December 2007. He said the neurological disease was first diagnosed at the third admission and at the time O. had presented with focal seizures which likely suggest a neurological insult.

DR DIKGANG

[29] Dr Dikgang, a medical practitioner employed by the JST Hospital, confirmed the authenticity of the medical records that were placed before the Court and said that the records reflect what the different medical care practitioner recorded with regard to O.'s treatment.

DR UERGO

[30] Dr Uergo, an employee of JST Hospital, testified that she attended to O. during his admission on 20 June 2008 and October 2008 respectively and confirmed that O. was diagnosed with various opportunistic disease that appear on the records.

MRS KHUNOU

[31] Mrs Khunou, the nursing sister who attended to O. at Kana Clinic on 10 November 2008 testified that she recorded the history as told to her by plaintiff. She did her own assessment and recorded same on the hospital referral form.

G. WRONGFULNESS

[32] In order to establish liability in delict the conduct of the defendant must have been wrongful, being the conclusion of law that a court draws from the facts before it[1]. The wrongfulness issue is logically anterior to the fault enquiry and only when it is established that defendant acted wrongfully does the question arise as to whether the objectively wrongful conducted can be imputed to

[1] Indac Electronics (Pty) Ltd v Volkskas Bank Ltd 1992(1) SA 783(A) at 797

the defendant[2]. In *casu*, it is common cause that a duty of care was owed by the doctor and nurses to O. and that a breach of the duty for the purpose of liability is wrongful[3].

H. NEGLIGENCE

[33] The inquiry as regards professional negligence is whether a reasonable practitioner in the circumstances would have foreseen the likelihood of harm and would have taken steps to guard against its occurrence, and whether the practitioner concerned failed to take such steps to guard against its occurrence.

[34] In ***Sea Harvest Corporation (Pty) Ltd v Duncan Dock Cold Storage (Pty) Ltd***[4] the appeal court reiterated that the benchmark for negligence is what a reasonable person would have done in the same circumstances the defendant experienced. The most usually quoted test is that set out in ***Kruger v Coetzee***[5] reformulated in ***Mukheiber v Raath***[6], namely that the ultimate analysis is whether in the particular circumstances the conduct complained of fell short of the standard of a reasonable person, or in this matter, the appropriate standard for the relevant medical personnel applicable. In respect of medical practitioners and nurses this is a profession that demands special knowledge, skill and care and the measure is the standard of competence that is reasonably expected of a member of that profession[7].

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[2] Minister of Safety and Security v Van Duivenboden 2002(6) SA 431 (SCA) at para 12
[3] Minister of Law and Order b Kadir 1995 (1) SA 303 A at 317
[4] 2000(1) SA 827 (SCA) at paragraph 21
[5] 1966(2) SA 428(A) at 430 E – F
[6] 1999(3) SA 1065 (SCA) at 1077 E –F
[7] See Mukheiber (supra) at 32

[35] The relationship between doctors, nurses and the patient treated, involves the duty to act with reasonable care and skill and is a duty imposed by the law of delict[8]. The *onus* of proving negligence rests on the plaintiff as Wessels JA in ***Van Wyk v Lewis***[9] *supra* said:

> "This brings us to the question of the burden of proof in such cases. Does the fact that a surgeon leaves a swab in the body after an abdominal operation performed in a hospital and with qualified nurses in attendance, throw throughout the case upon him the burden of showing that he was not negligent or does the burden of proofing negligence rest on the plaintiff to the very end of the trial? If the surgeon is only liable for reasonable skill and care and if the question of whether he acted reasonably or not depends upon all the accompanying circumstances it seems to me that in as much as the term 'reasonable' is relative, the onus of proof must necessarily lie upon the plaintiff all the time. The *maxim res ipsa loquitur* cannot apply when negligence or no negligence depends upon something not absolute but relative. As soon as all the surrounding circumstances are to be taken into consideration there is no room for the maxim. The plaintiff asserts negligence and bases his claim upon it and this can only be determined by an examination of all the circumstances".

[36] It is common cause that:

36.1 the nursing staff at JST inserted an infusion needle into O.'s scalp vein on the 10 November 2008;

36.2 the drip leaked into the tissue surrounding the drip, resulting in infiltration of the tissue;

36.3 On the 12 November 2008, O. presents with right sided paralysis;

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[8] 1924 AD 438 at 456
[9] 1924 AD 438 at 462

36.4 the infiltration resulted in scalp sepsis occurring on the left side of the head; and

36.5 As a result, O. developed scalp necrosis and gangrene to this area and to his left ear.

[37] The question arose whether the gangrene developed soon after the drip infiltration. Plaintiff observed the black mark on O.'s forehead on the 11 November 2008 that is the day after his admission to JST hospital and Ms R. observed it on the 12 November. It was neither put to plaintiff that she did not see any black mark on O.'s forehead nor that any mark on O.'s forehead was gangrene. Nor was it put to her that she must have been mistaken on the basis that the defendant's expert will testify that it could not be possible.

[38] Furthermore Prof. Pantanowitz was questioned whether the gangrene could have developed in the time frames suggested in evidence, to which question he answered in the affirmative. He said the hemiparesis occurred over a short period of time and that the damage was done in hours, that any infection which passes through the venous system will take a matter of hours to affect the brain. It was furthermore not, put to Prof. Pantanowitz that Dr. Monareng would give evidence that this was not possible, and what the basis of his opinion was. This opinion was not in any event contained in Dr Monareng's report. This issue will be dealt with in more detail *infra*.

[39] Counsel for defendant's put the following proposition to Dr Rosman, that the development of the facial necrotic lesion, 20 days after the finding of the clinical signs, makes no logical sense. Dr Rosman replied that the statement

was not factually correct as plaintiff had seen the necrosis the day after O.'s admission to hospital.

[40] Defendant failed to call the attending doctor, Dr Dungwa, who cared for O. when plaintiff noticed the gangrene on his forehead. Defendant also did not call the nurses employed at the hospital and on duty during the period from the admission of O. until the right sided weakness was observed by plaintiff. Although Dr Dikgang testified that the medical records reflect what the medical practitioners recorded, the medical practitioners were not called to verify their reports and as such, the medical records pertaining to the above period constitute hearsay evidence. These records include the CT scan purportedly taken soon after the hemiparesis was discovered, the report of the radiologist relating to the CT scan, and the observations recorded by the nurses.

[41] In the circumstances this court cannot place much weight on the evidence of Dr Kganage that the suggested onset of the necrosis on the second day is not supported by the medical records and that in her assessment of the records, the necrosis was only recorded some 20 days after the right hemiplegia was diagnosed by Dr Dungwa.

[42] Plaintiff's evidence was largely unchallenged. The proven undisputed facts is that plaintiff observed the black spot around the site where the needle was inserted on the 11 November and Mr R. observed it the next day, on the 12 November. The experts who testified on behalf of the plaintiff relied on the history as told to them by plaintiff. Most of the expert witnesses regarded the dark pigmentation on O.'s forehead as gangrene. Prof Pantanowitz's evidence lends credence to plaintiff's evidence as he said the gangrene

could have developed in a short time frame. Counsel for the defendant submitted that as the medical reports do not prove a black spot or gangrene the day after O.'s admission, that plaintiff's evidence should in the circumstances be approached with caution. As stated supra, the medical reports constitute hearsay evidence. I am of the view that plaintiff was a credible witness and her evidence was corroborated by Mr R. and there was no evidence presented by defendant to gaingay plaintiff's evidence. For the reasons stated *supra*, I accept that gangrene developed soon after the drip infiltration.

[43] Defendants paediatrician, Dr Kganane said the nurses taking care of O. ought to have checked the drip site every 15 to 20 minutes and if they had properly monitored the drip they would have been able to detect the infiltration early enough to prevent harm. Similarly plaintiff's paediatrician, Dr Maponya said the nursing staff could have prevented scalp necrosis and its *sequelae* had they monitored the drip properly and had they recorded their observations hourly. Both paediatricians gave evidence that the leaking of the fluid into the tissue surrounding the drip site was caused by improper insertion of the needle and/or improper management of the intravenous drip.

[44] As stated supra, there was no medical records presented or evidence from the nurses how frequently the drip was monitored or whether it was properly inserted and managed. Further Dr Maponya testified that the nursing staff should have been more vigilant with O. who was very sick and was also dehydrated. Defendant failed to lead any evidence of the steps it took to prevent harm to O.. However this court draws an inference that as the drip infiltrated and that gangrene was detected the next day, that reasonable nursing staff in the position of the nurses taking care of O. would have:-

a) reasonably foreseen that their failure to properly insert the intravenous drip and/or prevent the intraveous fluid from infiltrating the surrounding tissue would cause him harm which they failed to foresee; and
b) would have taken reasonable steps to prevent the harm from occurring, which they failed to take.

[45] Defendant failed to lead any evidence to rebut plaintiff's *prima facie* case that the nurses employed at the JST hospital were negligent. In the premises plaintiff has proven, on a balance of probabilities, that defendant was negligent.

I. CAUSATION

[46] Plaintiff must allege and prove the casual connection between the negligent act relied upon and the damages suffered. It is for the plaintiff to allege and prove his damage[10].

[47] The legal test for causation has been formulated in a number of cases. In ***ZA v Smit***[11] the court at paragraph 30 held that:

> "The criterion applied by the court a quo for determining factual causation was the well-known but-for test as formulated, e.g by Corbett CJ in International Shipping Co (Pty) Ltd v Bentley[12]. What it is essentially lays down is the enquiry – in the case of an omission – as to whether, but for the defendant's wrongful and negligent failure to take reasonable steps, the plaintiff's loss would not have ensued. In this regard this court has said on more than one

[10] Minister of Police v Skosana 1977 (1) SA 31 (A); Blyth v Van den Heever 1980 (1) SA 191 (A) at 208
[11] 2015(4) SA 574 (SCA) at paragraph 30
[12] 1980 (1) SA 680 (A) ([1989] ZASCA 138) at 700E – H

occasion that the application of the 'but for test' is not based on mathematics, pure science or philosophy. It is a matter of common sense, based on the practical way in which the minds of ordinary people work, against the background of everyday life experiences. In applying this common-sense, practical test, a plaintiff therefore has to establish that it is more likely than not that, but for the defendant's wrongful and negligent conduct, his or her harm would not have ensued. The plaintiff is not required to establish this casual link with certainty".

[48] The above test was applied in ***Lee v Minister of Correctional Services***[13], where the Constitutional Court said:

"In the case of "positive" conduct or commission on the part of the defendant, the conduct is mentally removed to determine whether the relevant consequence would still have resulted. However, in the case of an omission the but-for test requires that a hypothetical positive act be inserted in the particular set of facts, the so-called mental removal of the defendant's omission. This means that reasonable conduct of the defendant would be inserted into the set of facts. However, as will be shown in detail later, the rule regarding the application of the test in positive acts and omission cases is not inflexible. There are cases in which the strict application of the rule would result in an injustice, hence a requirement for flexibility. The other reason is because it is not always easy to draw the line between a positive act and an omission. Indeed there is no magic formula by which one can generally establish a causal nexus. The existence of the nexus will be dependent on the facts of a particular case".

[49] The issue of causality, especially in medical negligence cases, should be approached on the basis that it is not simply a "common sense" approach as suggested in *Lee v Minister of Correctional Services*[14]. The human body and its

[13] 2013(2) 144 (CC) at paragraph 41
[14] 2013(2) SA 144 (CC),

reactions are of such a complex nature that it is imperative for a plaintiff to provide expert medical evidence regarding the issue of causality.

[50] The next important issue for consideration is whether the aforesaid negligence caused O.'s brain damage, that is the nexus between the necrosis, and the hemiparesis suffered by O.. For this, the expert evidence was particularly helpful as set out more fully hereinbelow:

[51] In ***Michael and Another v Linksfield Park Clinic Ltd and Another***[15] the court said the following:

"[36] ….. what is required in the evaluation of such evidence is to determine whether and to what extent their opinion advance are founded on logical reasoning. That is the thrust of the decision of the House of Lords in the medical negligence case of Bolitho v City and Hackney Health Authority [1997] UKHL 46; [1998] AC 232 (HL(E) with the relevant dicta in the speech of Lord Browne – Wilkenson were respectfully agree. Summarised, they are to the following effect.

[37] The court is not bound to absolve a defendant from liability for allegedly negligent medical treatment or diagnosis just because evidence of expert opinion, albeit genuinely held, is that the treatment or diagnosis in issue accorded with sound medical practice. The court must be satisfied that such opinion has a logical basis, in other words that the expert has considered comparative risks and benefits and has reached "a defensible conclusion" (at 241 G - 242 B).

[38] If a body of professional opinion overlooks an obvious risk which could have been guarded against it, it will not be reasonable, even if almost universally held (at 242 H).

[39] A defendant can properly be held liable, despite the support of a body of professional opinion sanctioning the conduct in issue, if that body of opinion is not capable of

[15] 2001(3) SA 1188 (SCA), Lourens v Oldwage 2006 (2) SA 161 (SCA) summary

withstanding logical analysis and is therefore not reasonable. However, it will very seldom be right to conclude that views genuinely held by a competent expert are unreasonable. The assessment of medical risks and benefits is a matter of clinical and it would be wrong to decide a case by simple preference where there are conflicting views on either side, both capable of logical support. Only where expert opinion cannot be logically supported at all will it fail to provide "the benchmark by reference to which the defendant's conduct falls to be assessed" (at 243 A-E)".

[52] At para 40 the court in ***Michael and Another v Linksfield Park Clinic***[16] *supra*, specifically emphasized the fact that expert witnesses sometimes fail to differentiate between what is possible as to what is probable. The following was stated in this regard:

"[40] Finally, it must be borne in mind that expert scientific witnesses do tend to assess likelihood in terms of scientific certainty. Some of the witnesses in this case had to be diverted from doing so and were invited to express the prospects of an events occurrence, as far as they possibly could, in terms of more practical assistance to the forensic assessment of probability, for example as a greater or lesser than 50% chance and so on. The essential difference between the scientific and the judicial measure of proof was aptly highlighted by the House of Lords in the Scottish case of Dingley v The Chief Constable, Strathclyde Police 200 SC (HL) 77 and the warning given at 89D – E and the warning given that:

> "one cannot discount the risk that by immersing himself in every detail and by looking deeply into the minds of the experts, a judge may be seduced into a position where he applies to the expert evidence the standards which the expert himself will apply to the question whether a particular thesis has been proved or disproved – instead of assessing, as a judge must do, where the balance of probabilities lies on a review of the whole of the evidence".

[16] (361/98) [2001] ZASCA; {2002] 1 All SA 384(A) (13 March 2001)

[53] Regarding the roll of an expert witness, the SCA in ***Jacobs and Another v Transnet Limited t/a Metrorail and Another***[17] held that:

> "It is well established that an expert is required to assist the court, not the party for whom he or she testifies. Objectivety is the central prerequisite for his or her opinions. In assessing an expert's credibility an appellate court can test his or her underlying reasoning and is in no worse a position than a trial court in that respect. Diemont JA in *Stock v Stock*" said
>
> 'An expert …. Must be made to understand that he is there to assist the court. If he is to be helpful he must be neutral. The evidence of such a witness is of little value where he, or she, is partisan and consistently asserts the cause of the party who calls him. I may add that when it comes to assessing the credibility of such a witness, this court can test his reasoning and is accordingly to that extent in as good a position as the trial court was'.

[54] Also in ***Schneider NO and Others v AA and Another***[18]**,** Davis J said at 211J – 212B:

> "In short, an expert comes to court to give the court the benefit of his or her expertise. Agreed, an expert is called by a particular party, presumably because the conclusion of the expert, using his or her expertise, is in favour of the line of argument of the particular party. But that does not absolve the expert from providing the court with as objective and unbiased an opinion, based on his or her expertise, as possible. An expert is not a hired gun who dispenses his or her expertise for the purpose of a particular case. An expert does not assume the role of an advocate, nor gives evidence which goes beyond the logic which is dictate by the scientific knowledge which that expert claims to possess".

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[17] (803/13)[2014] ZASCA 113; 2015(1) SA 139 (SCA) (17 September 2014)
[18] 2010 (5) SA 203 (WCC)

[55] In the unreported judgment of ***Mathebula v RAF***[19] the following was stated:

> "An expert is not entitled to, any more than any other witness, to give hearsay evidence as to any fact, and all facts on which the expert witness relies must ordinarily be established during the trial, except those facts which the expert draws as a conclusion by reason of his or her expertise from other facts which have been admitted by the other party or established by admissible evidence". See *Coopers (South Africa) (Pty) Ltd v Deutsche Gesellschaft FÜr Schädlingsbekämpfung Mbh* 1976(3) SA 352(A) at 371G; *Reckitt & Colman SA (Pty) Ltd c SC Johnson & Son SA (Pty) Ltd* 1993(2) SA 307 (A) at 315E; *Lornadawn Investments (Pty) Ltd v Minister of Landbou* 1977(3) SA 618 (T) at p623 and *Holtzhauzen v Roodt* 1997(4) SA 766 (W) at 722I.

[56] The SCA's decision of ***Pricewaterhousecoopers Inc v National Potato Cooperative Ltd***[20] where the court examined when expert opinion is admissible, and the duties and responsibilities of an expert witness in civil cases:-

> "[97] Opinion evidence is admissible „when the Court can receive "appreciable help" from that witness on the particular issue". That will be when: „… by reason of their special knowledge and skill, they are better qualified to draw inferences than the trier of fact. There are some subjects upon which the court is usually quite incapable of forming an opinion unassisted, and others upon which it could come to some sort of independent conclusion, but the help of an expert would be useful." As to the nature of an expert's opinion, in the same case, Wessels JA said: „… an expert's opinion represents his reasoned conclusion based on certain facts or data, which are either common cause, or established by his own evidence or that of some other competent witness. Except possibly where it is not controverted, an expert's bald statement of his opinion is not of any real assistance. Proper evaluation of the opinion

[19] (05967/05) [2006] ZA GPHC 261 (8 November 2006) at para 13
[20] 2015 JDR 0371 (SCA), Also see Nicholson v Road Accident Fund (07/11453) [2012] ZAGPJHC 137 (30 March 2012)

can only be undertaken if the process of reasoning which led to the conclusion, including the premises from which the reasoning proceeds, are disclosed by the expert. (Own emphasis)

[98] Courts in this and other jurisdictions have experienced problems with expert witnesses, sometimes unflatteringly described as „hired guns". In The Ikarian Reefer43 Cresswell J set out certain duties that an expert witness should observe when giving evidence. Pertinent to the evidence of Mr Collett in this case are the following: Gentiruco AG v Firestone SA (Pty) Ltd 1972 (1) SA 589 (AD) at 616H. This statement it derived from Wigmore on Principles of Evidence (3 ed) Vol VII para 1923. 41 Coopers (South Africa) (Pty) Ltd v Deutsche Gesellschaft für Schädlingsbekämpfung MBH 1976 (3) SA 352 (A) at 370G-H. 42 At 371F-H. 43 National Justice Compania Naviera SA v Prudential Assurance Co Ltd ('The Ikarian Reefer') [1993] 2 Lloyd's Rep 68 [QB (Com Ct)] at 81 – 82. Approved in Pasquale Della Gatta, MV; MV Filippo Lembo; Imperial Marine Co v Deiulemar Compagnia Di Navigazione Spa 2012 (1) SA 58 (SCA) para 27, fn 12 and Schneider NO and Another v AA and Another 2010 (5) SA 203 (WCC) at 211E-I. 61 „The duties and responsibilities of expert witnesses in civil cases include the following:

1. Expert evidence presented to the Court should be and should be seen to be the independent product of the expert uninfluenced as to form or content by the exigencies of litigation …
2. An expert witness should provide independent assistance to the Court by way of objective unbiased opinion in relation to matters within his expertise … An expert witness in the High Court should never assume the role of advocate.
3. An expert witness should state the facts or assumptions on which his opinion is based. He should not omit to consider material facts which detract from his concluded opinion. . . .
4. An expert witness should make it clear when a particular question or issue falls outside his expertise." These principles echo the point made by Diemont JA in Stock that: „An expert … must be made to understand that he is there to assist the Court. If he is to be helpful he must be neutral. The evidence of such a witness is of little value where he, or she, is partisan and consistently asserts the cause of the party who calls him. I may add that when it comes to assessing the credibility of such a witness, this Court can test his reasoning and is accordingly to that extent in as good a position as the trial Court was.

[99] Lastly when dealing with the approach to an expert witness I have found helpful the following passage from the judgment of Justice Marie St-Pierre in Widdrington: 45 „Legal principles and tools to assess credibility and reliability [326] "Before any weight can be given to an expert's opinion, the facts upon which the opinion is based must be found to exist" Stock v Stock 1981 (3) SA 1280 (A) at 1296 E-G. See also Jacobs and Another v Transnet Ltd t/a Metrorail and Another 2015 (1) SA 139 (SCA) para 15. 45.

[327] As long as there is some admissible evidence on which the expert's testimony is based it cannot be ignored; but it follows that the more an expert relies on facts not in evidence, the weight given to his opinion will diminish".

[328] An opinion based on facts not in evidence has no value for the Court.

[329] With respect to its probative value, the testimony of an expert is considered in the same manner as the testimony of an ordinary witness. The Court is not bound by the expert witness's opinion.

[330] An expert witness"s objectivity and the credibility of his opinions may be called into question, namely, where he or she: • accepts to perform his or her mandate in a restricted manner; • presents a product influenced as to form or content by the exigencies of litigation; • shows a lack of independence or a bias; • has an interest in the outcome of the litigation, either because of a relationship with the party that retained his or her services or otherwise; • advocates the position of the party that retained his or her services; or • selectively examines only the evidence that supports his or her conclusions or accepts to examine only the evidence provided by the party that retained his or her services."

[57] Dr Rosman discounted O.'s pre-existing [...] as a cause of his neurological insult due to the fact that no singular arterial part of the brain was damaged, but the entire left hemisphere, which hemisphere was directly below the tissue necrosis on O.'s forehead. Dr Manyane agreed with this opinion. She conceded further that, should the court find that the necrosis developed the day after O.'s admission, and prior to the detection of the right sided weakness, then Dr Rosman's explanation of how O. suffered the right side

hemiparesis would be the most probable cause of O.'s brain damage and right sided weakness.

[58] It was submitted by counsel for plaintiff, which submission I agree with, that Dr Monareng did not have sufficient experience to be qualified as an expert in a medical negligence trial as he was admitted to practice medicine 5 years ago, and only received his admittance to the fellowship of vascular surgeons during 2014, while Prof Pantanowitz had over 40 years experience as a vascular surgeon. This court did not attach much weight to Dr Monareng's evidence for reasons set out hereinbelow. Dr Monareng refused to make any concessions, and in my view was clearly advancing the case for defendant in instances where he did not have the requisite expertise, Dr Monareng refused to accept that he was not qualified to give an opinion on the status of O.'s [...] disease, nor was he qualified to opine on the neurological consequences of [...] relevant to this matter. Dr Monareng did not properly explore plaintiff's theory of the cause of O.'s brain damage and consequent right sided hemiparesis. He rejected this theory out of hand without any reasoning process. Dr Monareng also failed to include his reasoning process in his expert report. His inexperience was further highlighted by his introduction of further facts, reasoning and opinion proferred at the trial which were not included in his expert report, and could not be tested against plaintiff's experts' evidence.

[59] The factual basis for Dr Monareng's opinion, and in fact the opinions of defendant's expert paediatrician and neurologist, was that the septic necrosis of O.'s forehead and left ear was only detected days, if not weeks, after he was diagnosed with right sided paralysis. This is incorrect as the scalp necrosis was observed by plaintiff the day after O.'s admission to the hospital.

The neurologists, Dr Rosman and Dr Manyane in their joint minutes also agree that:-

"3. In the course treating the seizures, the patient was given a scalp vein drip. As a result of this drip, scalp sepsis occurred on the left side of the head.

4. Sepsis on the left side of the head is compatible with a lesion in the left hemisphere which could the cause a right-sided hemiplegia.

5. A brain scan done shortly after the initial admission should atrophy of the left brain hemisphere".

[60] Dr Monareng contended that O.'s underlying pre-existing conditions, namely [...] neuropath was the possible cause of the brain injury. As stated *supra*, the medical records constitute hearsay evidence as neither the doctors nor the nurses were called to confirm the correctness of the content and their evidence could accordingly not be tested. Dr Monareng did not consider, that O. did not have right sided weakness when he was admitted on the 10th of November 2008. He also did not take into account that the seizures were successfully treated by means of IV therapy and diazepam and that O. did not have any seizures after being discharged from hospital. This suggests that any neurological abnormality as the source of the seizures has been corrected as opined by Dr Rosman. The final conclusion and opinion arrived at by Dr Monareng was based on inadmissible hearsay evidence.

[61] Dr Manyane relied on the medical records and found that there were pre-existing neurological conditions and RVD which were risk factors which may lead to strokes. Dr Manyane did not give an opinion as to the probable cause of O.'s brain damage, and right sided weakness. She confined herself to possible causes only. Accordingly the court does not place much weight on her evidence. It was also suggested by Dr Kganane that O.'s pre-existing

conditions, the focal seizures and delayed milestone were all indicative and/or confirmation of what the CT scan results and medical records reveal namely, a possibly left atrophy. There is no evidence to support this contention.

[62] Dr Rosman's opinion in my view is based on logical thinking. He referred to what he calls the laboratory of life, "He was well [did not have right sided weakness] before [the drip calamity], therefore what was present before [RVD status and seizures] not reason for current problem [brain damage and right sided hemiparesis]". Thus when considering the expert evidence as to the cause of O.'s brain injury, I am of the view that the answer to this question falls squarely within the expertise of the neurologists and Dr Rosman's opinion as stated *supra* was based on logical reasoning. He

reasoned that O.'s right leg and arm were normal prior to admission, and in fact that he was right hand dominant and after the drip infusion incident intervened, O. now has hemiparesis. Of importance is plaintiff's evidence that O. used his right hand initially, i.e prior to the admission on 10 November 2008 but since after the discharge, O. uses his left hand. Once again there was no evidence to gainsay the probabilities and plaintiff's experts relied on plaintiff's report in arriving at its finding.

[63] Both Dr Rosman and Prof Pantanowitz acknowledged that there were pre-existing neurological conditions, but were of the view that it did not have an impact on O.'s brain injury. Professor Pantanowitz conceded that the pre-existing neurological conditions found on O. could not be ignored but stated that the venous thrombosis would account for the majority of the *sequelae* that have befallen O.. Accordingly, I am of the view that Dr Rosman opinion was founded on logical reasoning, and not on hearsay evidence. Dr Rosman

considered all the possible causes and arrived at the most probable cause which opinion also found favour with Dr Manyane.

[64] I am accordingly of the view that, as a result of the impairment of perfusion to the left frontal temporal scalp O. developed scalp necrosis and gangrene to this area, and to his left ear. That O. became systematically ill due to septicaemia, the *sequelae* of which was cerebral vascular thrombosis (venous) of the left cerebral hemisphere of the brain. This resulted in permanent brain damage, and a right sided hemiparesis.

[65] As a result of the aforegoing, O.:

a) Presents with impaired speech, receptive, and expressive language skills. He has some elementary aspects of communication and sometimes uses gestures to communicate and to make his needs known.

b) Presents with psychological *sequelae*.

c) Presents with middle ear problems.

d) Requires speech language and AAC intervention.

e) Is severely cognitively and intellectually compromised. His neurocognitive deficits are permanent and will severely compromise the quality of his life. He will not be able to execute activities of daily living.

f) Needs permanent care givers and supervision.

g) Neuro-cognitive deficits will have a significant impact on his capacity to learn, and on his future employability.

h) Is unemployable in the open labour market due to his physical and neurological limitations.

i) Should be placed in a special school.

[66] When applying the but-for test, plaintiff established that it is more likely than not that but for the nurses wrongful and negligent conduct referred to *supra*, harm to O. would not have ensued. Accordingly plaintiff discharge the *onus* to prove the casual connection between the nurses negligent act and the damages suffered.

J. QUANTUM

[67] Plaintiff claims damages under the following heads:

a) General damages for pain and suffering, and for loss of amenities of life;
b) Damages for loss of earning capacity; and
c) Future medical expenses.

The only issue in dispute regarding the quantum is the award for general damages and the percentage for contingency deduction.

FUTURE MEDICAL EXPENSES

[68] At the commencement of the trial the parties agreed on the quantum of plaintiff's claim for future medical expenses, namely R7 774 795.00 which is made up as follows:

Future costs

a)	Dr Saul	-	R105 140.00
b)	N Masoka and VP Madima	-	R604 040.00
c)	N Masoka	-	R238 430.00
d)	Stacey Aires	-	R2 852 320.00
e)	W M Khumalo	-	R637 120.00
f)	Dion Rademeyer	-	R54 675.00
g)	James Brummer	-	R250 000.00
h)	Department of Labour	-	R2 195 960.00
i)	Dr Rosman	-	R742 800.00
j)	Medicane Moshanyana	-	R57 660.00
k)	L Modipa and M Phake	-	R36 650.00
	Future medical expenses	-	R7 774 795.00

LOSS OF EARNING

[69] The parties also agreed to the basis of the plaintiff's claim on behalf of O. for future loss of earnings as follows:

a) Pre-accident - scenario 2 of the industrial psychologists joint minutes, O. would have completed Grade 12 level of schooling at the age of 18 and obtained a certificate.

b) Post-accident – O. is unemployable in the open labour market.

c) Parties agreed on Basis 11B of defendant's actuaries report in the amount R2 530 842.00 before contingencies.

[70] Counsel for plaintiff, Mr Shepstone submitted that a contingency deduction of 10% should be applied to this claim, being 0,5% per year for his working life. In other words the amount of R253 085.00 must be deducted from R2 530 842.00.

[71] Counsel for defendant, Mr Chwaro submitted that the court should have regard to factors like the unknown possibilities in life, especially of children such as O. who is presently 10 years of age. He relied on ***Southern Insurance Association Ltd v Bailey***[21] and ***Van Drimmelin v President Versekeringmpy***[22], where a 10% - 30% contingency deduction was made.

[72] A court exercises a wide discretion when making allowance for contingencies. I have relied on the guideline provided by Robert Koch in the *Quantum Yearbook 2017* where the learner author said the following:

> "When assessing damages for loss of earnings or support it is usual for a deduction to be made for general contingencies for which no explicit allowance has been made in the actuarial calculation. The deduction is the prerogative of the Court. However, most matters do not go to Court so the relevant deduction becomes a matter of negotiation. Even when matters do go to Court some judges seek advice from expert witnesses as regards the appropriate deductions to make. General contingencies cover a wide range of considerations which vary from case to case and

[21] Southern Insurance Association Ltd v Bailey 1984(1) SA 98(A) at 113F – 114A
[22] 1993(4) C&D E2 – 19 (T)

> may include: taxation, early death, save travel costs, loss of employment, promotion prospects, divorce, etc. There are no fixed rules as regards general contingencies. The following guidelines can be helpful:
>
> Sliding scale: ½% per year to retirement age, i.e. 25% for a child, 20% for a young and 10% in middle age. (see *Bailey v Southern Insurance* 1984 1 SA 98 (A))
>
> . . .

[73] One cannot ignore the fact that O. prior to his admission was [...] positive and on ARV and his growth and neurological status was affected. For this reason a higher than normal pre-morbid contingency should be applied. Although O., port-morbid will be unemployable, his neuro cognitive deficits and psycho-social problems are important considerations for which a higher post morbid contingency should also be applied. In the circumstances I am of the view that a 30% contingency deduction is appropriate. Thus the quantum for loss of earning is R2 530 842.00 less R759 253.60 which equals to R1 771 590.40.

GENERAL DAMAGES

[74] As set out in paragraph 65 *supra*, O. has serious and permanent brain damage. He has right sided hemisparesis, impaired speech, severely cognitively and intellectually impaired, neurocognitive deficts and requires permanent care givers. He has a reduced life expectancy. He is dependent on other for activities of daily living and he will need a care giver for the rest of his life. He will have to go to a special school. He has suffered a devastating loss of the normal amenities of life. He is able to, recognise his family members, and to play with other children. He will, thus, have insight into his problems and the fact that he is different to other children.

[75] Mr Shepstone relied on the case of ***PM obo TM v MEC for Health, Gauteng Province***[23] and submitted that the bar for general damage in cerebral palsy cases was set at R1 800 000.00. He conceded that the injuries in the PM obo TM case was greater than the injuries suffered by O. as the patient has scoliosis and severe spasticity of her muscles and would require surgical intervention in future. He submitted that compensation for general damage should be R1 500 000.00.

[76] Mr Chwaro submitted that, it is common cause that O. has multiple depressed healed scars on the frontal and parietal side of the scalp on the left hand side and that there is necrosis of the earlobe and the helical fold of the left ear. He said although the reconstructive procedures will improve appearance, O. will remain severely disfigured. It is also common cause that O. has been left paralysed on the right side, he struggles with function in his right leg, has no grip on his right hand, he hops on one leg, does not speak at all and struggles with hearing and is mentally retarded.

[77] Mr Chwaro submitted that having due regard to the injuries sustained by O. that an appropriate award for general damages should be an amount between R300 000.00 and R400 000.00. He relied on the following cases:

77.1 In ***Makupula v Road Accident Fund***[24] the court awarded an amount of R300 000.00 as general damages in respect of a 5 year old boy who suffered a mild to moderate defuse axonal concussive brain injury which resulted in neuro-cognitive deficit associated with attention

[23] Case no. A5093/2014 (Unreported)
[24] 2010 6 QOD B4 – 48 (ECM)

deficit hyperactivity disorder, memory dysfunction and behavioural problems. The present value of the said award is an amount of R441 000.00.

77.2 In ***Du Preez v AA Mutual Ansurance Association Ltd***[25] the court awarded general damages of R11 000.00 to a 8½ years boy for hemiparesis on the right side which later resulted in permanent imbalance of right leg, right sided limp and irritability, frustration and large measure of unhappiness. The present value of the award is R268 000.00.

[78] In ***Cordeira v Road Accident Fund***[26], a teenage schoolboy suffered a severe primary head injury with intra-cerebral haematoma, secondary brain injury from raised intra-ovarial pressure from brain oedema and intra-cerebral haematoma. Right side hemiparesis making walking difficult and affecting speech. Severe neurocognitive and neurobehavioural deficits associated with poor memory, lack of energy, lack of mental agility and flexibility, speech difficulties and inability to live independently at risk of developing epilepsy. Future employment limited to structured sympathetic environment. The court in 2010 awarded R800 000.00 general damages. The equivalent for 2017 is R1 176 000.00.

[79] In ***Van Zyl NO v Road Accident Fund***[27], a 19 year old law student sustained severe diffuse axonal brain injury, multiple lacerations of the head and face, fracture of the right tibia and fibula and injuries to the left arm. Neurophysical, neurocognitive and neuropsychological deficits associated with right hemiplegia, right upper limb weakness, ataxia, impaired balance,

[25] 1980 3 QOD 206 (E)
[26] 2010 6 QOD A4 – 45 (GNP)
[27] 2012 6 (6A4) QOD 138 (WCC)

headaches, fatigue, cognitive and executive impairment and neurobehavioural disorder. Plaintiff was rendered unemployable as a result of his injuries. The court awarded R850 000.00 general damages, the equivalent for 2017 is R1126 000.00.

[80] It is trite that awards made in earlier cases serve to guide the Court in determining an appropriate award, bearing in mind that each case should be considered on its own unique set of circumstances.

[81] I have taken all the facts and circumstances into consideration, as well as the awards granted in the cases referred by counsel and I am of the view that an amount that would be appropriate and reasonable for general damages is R800 000.00

[82] In the circumstances, the total amount payable by the defendant to the plaintiff is the amount of R10 346 385.00 which is made up as follows:

a) General damage	-	R800 000.00
b) Loss of earnings	-	R1 771 590.00
c) Future medical expenses	-	R7 774 795.00

Total		R10 346 385.00

K. ORDER

[83] In the circumstances, I make the following order:

1. The defendant is ordered to pay the plaintiff the amount of R10 346 385.00.

2. The defendant is ordered to pay interest on the above amount at the legal rate, calculated 30 days after date of judgment to date of payment.

3. The defendant is ordered to pay the plaintiff's taxed or agreed costs on the High Court scale as between party and party.

4. The aforementioned costs will include the travelling / reservation / appearance fee, if any together with the qualifying fees, if any, and the costs for preparation of the medico-legal reports and joint minutes, if any of the following expert witnesses:

4.1	Prof D Pantanowitz	-	Vascular Surgeon
4.2	Dr KD Rosman	-	Neurologist
4.3	Dr WJC Pretorius	-	Radiologist
4.4	National Radiologist Services	-	MRI Brain Scan
4.5	Dr Nomsa L Masoka	-	Speech and Hearing Therapist
4.6	Dr Medicane Moshanyana	-	Clinical Psychologist
4.7	Mr Baloyi Malatse	-	Occupational Therapist
4.8	Stacey Aires	-	Physiotherapist
4.9	Dr Nosipho K Maponya	-	Paeditrician
4.10	Dr A.P.J	-	Specialist
4.11	James Brummer	-	Architects Costing
4.12	Dion Rademeyer	-	Mobility
4.13	Dr Matome Kumalo	-	Educational Psychologist
4.14	Dr Saul Braun	-	Plastic Surgeon
4.15	Dr Talia Talmud	-	Industrial Psychologist
4.16	Munro Forensic Actuaries	-	Actuarial

5. In the event that costs are not agreed upon:

5.1 the plaintiff shall serve the notice of taxation on the defendant's attorneys of record;

5.2 the plaintiff shall allow the defendant 14 court days to make payment of the taxed costs.

_____

N. GUTTA
JUDGE OF THE HIGH COURT

APPEARANCES

DATE OF HEARING	: 13 JUNE 2017
DATE OF JUDGMENT	: 03 AUGUST 2017
ADVOCATE FOR PLAINTIFF	: ADV SHEPSTONE

ADVOCATE FOR DEFENDANT	: ADV CHWARO
ATTORNEYS FOR APPLICANT	: M E TLOU ATTORNEYS & ASSOCIATES (Instructed by: Dudula Attorneys)
ATTORNEYS FOR RESPONDENT	: STATE ATTORNEYS