FREE STATE HIGH COURT, BLOEMFONTEIN
REPUBLIC OF SOUTH AFRICA

Case No. : 2155/09

In the matter between:-

MICHAEL MOLETE Plaintiff

and

MEMBER OF THE EXECUTIVE COUNCIL FOR HEALTH, FREE STATE PROVINCE Defendant

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HEARD ON: 2 MARCH 2012

JUDGMENT BY: RAMPAI, J

DELIVERED ON: 21 JUNE 2012

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[1] The hearing of evidence was completed on Friday, 2 March 2012. There was no sufficient time for the parties to present their closing legal argument. The two counsels were not local advocates. I was about to go on long leave. The parties were reluctant to have the matter postponed to a date during the third court session for argument.

[2] In view of the aforegoing factors it was agreed to dispense with oral argument. I was given the green light to use written heads of argument instead. The last dates on which such

heads were to be filed by the defendant and the plaintiff were 4 April 2012 and 30 April 2012, respectively (*vide* court order 3 March 2012). The underlying purpose for the filing of the written heads of argument was to expedite the finalisation of the matter. To this end I undertook to craft the required judgment soon after 30 April 2012.

[3] The plaintiff's written heads of argument were filed on 19 April 2012. The defendant's written heads of argument which were supposed to have been filed on 4 April 2012 were still outstanding as on 14 May 2012, more than five weeks since they became due. By then there was no explanation whatsoever for the defendant's default. At long last the outstanding heads were eventually filed on 25 May 2012. I say no more.

[4] The plaintiff sues the defendant for the payment of compensation in the sum of R21 000 000,00. He sues in his representative capacity as the biological father and natural guardian of his minor son, Moahlodi Daniel Molete. The minor was born on 5 June 2001. He was injured when he fell out of a tree at Odendaalsrus on Christmas day, 25

December 2007.

[5] From the scene of the accident the child was rushed to Thusanong Hospital, a public hospital at Odendaalsrus, on 25 December 2007. He was not admitted. He was not x-rayed. A doctor applied a plaster back slab to the injured left arm and advised the plaintiff to bring the injured child back on 28 December 2007. The plaintiff did so. The plaster cast was removed and the child was x-rayed on 28 December 2007. He was diagnosed with a fractured forearm. In spite of the angulation of the forearm, no corrective surgical procedure was performed. The child was again sent back home. On 15 February 2008 the child was called back as a result of the plaintiff's complaint to the department of health. On his third visit to the hospital, Dr. Mahlatsi caused the child's left arm to be x-rayed one more time. A dislocation of the left elbow was diagnosed.

[6] The child was taken to Bongani Hospital, a regional hospital in Welkom, on 7 March 2008. There he was examined by Dr. Mohamed. The elbow dislocation was confirmed by the latter. The next day Dr. Mohamed referred the child to

Pelonomi Hospital in Bloemfontein. On 14 March 2008 the child was booked for surgery. Three days later he was admitted. An operation was performed by Dr. Smith, an orthopaedic surgeon.

[7] The defendant was sued in his representative capacity by virtue of the provisions of the State Liability Act, 20 of 1957. The plaintiff alleged that during December 2007 certain medical doctors or nurses or both who were employed by the defendant's department performed medical services in a manner which was professionally negligent. The essence of their alleged negligence, the plaintiff averred, consisted of their failure to properly diagnose a fracture of the child's left arm and dislocation of his left elbow and to treat those injuries accordingly.

[8] On 31 August 2010 the defendant conceded the merits in favour of the plaintiff and admitted fully liability on certain specified grounds of professional medical negligence.

[9] The version of the plaintiff's claim was narrated by the following five expert witnesses:

Mr. J.R. Domingo, an orthopaedic surgeon

Mr. F.G. de Kock , an industrial psychologist

Ms J.C. Bainbridge, an occupational therapist

Ms F.A. van Vuuren, an educational psychologist and remedial therapist

Ms H.G. Hughes, a registered physiotherapist

[10] The version of the defendant was also narrated by five expert witnesses, namely:

Mr. B. Moodie, an industrial psychologist

Ms L. Janse van Vuuren, a physiotherapist (hospital chief)

Ms V.T. Alexander, an occupational therapist

Prof. J.A. Shipley, head of department of orthopaedics - UFS

Prof. R.Y. Seedat, specialist ear-nose-throat

[11] The plaintiff sued the defendant for damages under the following heads of compensation: future loss of earning capacity, future medical expenses and general damages.

[12] In the first place, I deal with the child's claim for future loss of earning capacity. This is but one segment of special damages claimed. The plaintiff claimed R10 million under

this head. The inquiry requires the leading of medical evidence concerning the effects which the medical negligence is likely to have on the child in the long run. Of particular significance is the effect, if any, of such professional negligence on the child's ability to earn an income in the future.

[13] On behalf of the plaintiff it was contended by Mr. Dutton that the child would suffer substantial loss of the capacity to earn income as a result of the said negligence. In support of his claim under this segment, the plaintiff relied on the expert evidence of Mr. F.G. de Kock, an industrial psychologist, Ms F.A. van Vuuren, an education psychologist and remedial therapist, as well as Ms J.C. Bainbridge, an occupational therapist.

[14] The collective thrust of the evidence tendered by those experts sought to establish that the injury or rather the professional negligence to make a medically correct diagnosis of the full extent of the child's injury, would have an adverse impact on his ability to compete for work on the labour market in the future.

[15] On behalf of the defendant it was contended by Ms Norman that the child would not suffer as much severe loss of capacity to earn income as a result of the medical negligence associated with the misdiagnosis as the plaintiff contended. In support of the defendant's contention the expert opinion of Mr. B. Moodie, an industrial psychologist, in particular was heavily relied upon. So too was the opinion of Ms L. van Vuuren and Ms V.T. Alexander. The cumulative essence of the evidence given by the aforegoing expert witnesses was intended to establish that the child's injury exacerbated, as it was, by the medical negligence did not radically compromise his ability to earn income in the future as was suggested by his father, the plaintiff.

[16] Before I proceed any further, it is perhaps necessary to comment about the child. The child, Moahlodi Daniel Molete, was born on 5 June 2001. He was delivered at full term after normal pregnancy. He was delivered by way of a caesarean section. There was nothing unusual about his developmental milestones. He had no prior surgical history or accident before the fateful day. He lived at Odendaalsrus

at all times material to this dispute. He was the first child in a family of two siblings. He began his school career at the tender age of five years and seven months at Icoseng Primary School at Kutloanong. In 2007 he was a grade 1 learner. On Christmas day of the same year he met his disaster while playing in a tree with a friend. He fell out of a tree on a neighbouring property. In that freak accident he sustained a fractured left upper arm and a dislocated left elbow.

[17] He was medically treated at three public hospitals. He went back to school in January 2008, his injuries notwithstanding. He has never failed a grade at school. Last year he was in grade 5. This year he is probably in grade 6. His school performance seemingly was not negatively affected by the tree accident. He and his father were still living at Odendaalsrus at the time of the hearing. His mother and the younger brother were living at Rustenburg where she was working. His father has passed grade 10 and his mother grade 12.

[18] Given the aforegoing historical background, I consider it

advisable to deal with the evidence given by Ms F.A. van Vuuren, the educational psychologist. In a detailed educational assessment report the psychologist thoroughly assessed the intellectual strengths and deficits of the child. She identified certain areas of major concern in the child's educational functioning. When his knowledge and logic of mathematical operations were put to the test, his abilities were found to be wanting. As regards numeracy his bonds were considered to be below both age and grade level. Although he was in grade 5 at the time he was assessed, his bonds were, at best, at par with those of a grade 3 learner. The psychologist opined that underlying problems with complex listening and attention skills, adversely affected the child's performance on the test for arithmetical logic and knowledge of operations. She found that when the child was scholastically tested, it became apparent that he had not mastered simple arithmetical bonds.

[19] Apart from the child's numeracy handicaps, the psychologist also found that he suffered from inadequacies relative to vocabulary, creative written expression and reading comprehension. After administering arithmetical test, the

psychologist commented:

> "The results of the educational screening confirm that he is not functioning at grade level in literacy or numeracy skills although decoding reading skills are sound. The results are inconsistent with his school reports which suggest that he is a competent pupil."

[20] In assessing the child's intellectual disabilities and abilities, the education psychologist made use of what is known as TEST WISC-IV. Of importance in the use of this particular testing tool was that it allowed a pattern of latent strengths and weaknesses of an individual to emerge. Ms Van Vuuren identified the following deficits in the child:

- limited expressive understanding of word meanings, which negatively affects his communication and would increasingly disadvantage him in the higher grades;
- quite slow mental processing speed on a whole range of tasks;
- slight difficulties with perceptual skills;
- somewhat limited reasoning abilities with noticeable gap between the actual level of functioning and the potential

level of functioning;

- poor mathematical skills despite the contrary first impression created by his school reports;
- some problems with complex attention as well as lack of sustainable concentration;
- emotional factors and symptoms of underlying anxiety and over-sensitivity.

[21] The strength of the child included:

- adequate copying skills;
- sound non-verbal inductive reasoning under optimal conditions;
- responsiveness to positive feedback and encouragement and capacity for concern and empathy for others.
- His visual memory for designs was considered to be very good as was his auditory memory.

[22] The bright pre-accident scenario suggested that the child had the potential to progressively perform well on the scholastic front. On the strength of his available grade 1 track record it was expected that he would become a learner

of average intellectual ability; that he would reasonably cope in the mainstream class with the option of further education and training either by short course study or on the job training.

[23] The bleak post accident scenario suggested that the child would not optimally function as he progressed higher and higher in his school career. It was noted that there were factors retarding the level of his actual functioning and limiting him from achieving the potential level of his innate intellect. It was found that there were neurological signs – *vide* p. 9 exhibit "C" for Ms F.A. van Vuuren's complete assessment report.

[24] Ms J.C. Bainbridge, the occupational therapist gave evidence. The purpose of her assessment report was to describe the child's physical and cognitive abilities and to determine the effects his injury related disabilities would have on his functional performance of tasks in his work environment in particular.

[25] The occupational therapist observed that the child was right

hand dominant. He used his right hand to hold a spoon for the purpose of eating and drinking. He bathed, dressed and toileted independently in spite of his bodily injuries. He occasionally wetted his bed at night. Although his personal management appeared reasonably satisfactory, certain difficulties relative to such managements were observed. He could not properly wring water out of a facecloth and he could not carry a dish of water without spilling. The occupational therapist was of the opinion that the child's difficulties evidenced that he did not have adequate strength in his left hand.

[26] The child spent his leisure time playing with his friends. He has a lot of them. He played street soccer. He liked playing as a goal keeper. Although he could put his arms up to catch a ball, he experienced pain in his left elbow. He did not take part in any organised sporting activities at school before and after the disaster of falling out of a tree.

[27] Ms Bainbridge made certain findings following her assessment of the child. She found that he was right hand dominant; that he had an obvious surgical scar on his left upper arm; that the left arm strength was weaker than that of

his right arm; that he demonstrated reduced endurance and stamina in sustained heavy duty tasks; that his left arm had restricted ranges of motion for pronation and elbow extension; that he resorted to compensatory mechanisms to make up for the deficiency of pronation of the left arm; that he displayed a grossly clumsy approach to functional tasks of a fine motor nature requiring bi-manual function and that his below average scores suggested that he had cognitive and perceptual deficits residual to concussion or head injury.

[28] The formal testing she carried out highlighted that the child visual motor integration was weak; that certain aspects of his visual perceptual processing were weak; that his mathematical processing was weak; that his writing speed was slow; that his upper limp speed and dexterity were retarded and that he physically presented with a postural asymmetry about the shoulder girdle with the left shoulder riding higher than the right during bilateral upper limb physical activities. The left upper limb, in other words, the non-dominant limb has diminished sensation. The loss of sensory abilities was detected on the lateral aspect of the humerus adjacent to and including the 18 centimetre railroad

operative scar. The lateral aspect of the elbow and the forearm slightly reduced the extension of the left elbow with a residual flexion deformity, was noted.

[29] Concerning the child's future education, the occupational therapist commented:

> "His assessment results suggest that he has underlying difficulties in several core areas of function; the etiology of such difficulties is not clear and could well have predated his accident. Equally, were he to be found to have had a concussional injure, (sic) core areas of fall out could be identified and/or attributed to such an injury. Whatever the case, it is anticipated that Daniel will have difficulties negotiating his way through the more demanding requirements of higher grades at school in which self directed study and increased volumes of work are inherent. Deference is made to the Educational psychologist regarding his aptitude for mainstream schooling, and/or the necessity for remedial support in future years at school. Future training options will be determined by the level of schooling attained; opportunities for skills training in which bimanual tasks are (sic) inherent are likely to be narrowed."

[30] My take of the aforesaid witness' expert opinion was that the child's ability to do basic things such as shopping, reading, lifting, carrying or performing other functional activities integral to daily human living, would worsen with the passage of time. As a result of his surprising low cognitive functioning and perceptual functioning his scholastic and occupational opportunities would be adversely curtailed – *vide* p. 52 exhibit "C" for Ms J.C. Bainbridge's full report.

[31] Mr. Gideon de Kock testified. The purpose of his industrial psychological assessment was to evaluate the child's psychological functioning from an industrial psychological perspective to determine the extent to which the injuries he sustained may have affected him educationally and vocationally.

[32] The post morbid scenario was examined. The industrial psychologist alluded to the child's severe injury of the left forearm. The injury consisted of a fracture of the ulna which was displaced and was associated with the elbow dislocation of the head of the radius. He now has a permanent disability in the left elbow and forearm. There is now loss of extension

and of flexion in the impaired arm.

[33] There is loss of pronation. The loss of protation of the arm is permanent. Therefore, the industrial psychologist was of the firm opinion that such permanent restriction of rotation would affect the child's employment choices in the future. According to him the greatest sequilae of the injury was loss of pronation. Such physical limitation drastically prevented the child from rotating his left palm to face down.

[34] The psychologist said that the child would find it physically difficult to execute double-handed tasks where the left hand is used a great deal. Playing a goalkeeper, driving, using a computer or a typewriter are some of the examples of double-handed tasks that readily come to mind.

[35] The child also displayed pronounced cognitive deficits. It could not be conclusively determined whether the aetiology of such deficits was emotional or neurological in nature. Mr. De Kock aligned himself with the expert opinion that the child was likely to progressively struggle in the higher grades of his school career and that he was unlikely to achieve the

same result but for the trauma. Since the accident had happened experts were of the opinion that he was unlikely to pass matric. In the future he would thus be destined to compete at the unskilled level of the open labour market.

[36] On the one hand his physical shortcomings were seen as an obstacle likely to narrow the scope of his future career choices to limited jobs of a light duty nature to those of medium duty nature at the unskilled level of the open labour market. He would therefore be physically unable to choose and perform jobs of a heavy duty nature. On the other hand his intellectual shortcomings were regarded as obstructions likely to narrow the scope of his future career choices in much the same way to limited jobs of a light duty nature to those of medium duty nature at the same unskilled level in the open labour market.

[37] In view of the aforesaid physical difficulties as well as cognitive difficulties, the future of the child appeared bleak from the occupational perspective. Implicit in those distinctive types of difficulties taken together, is that he would not be able to compete with his peers on the physical grounds at the unskilled level of the open labour market and

also that he would not be able to compete, on cognitive grounds, at the skilled level of the open labour market. He would therefore have to walk a tight-rope post-morbidly.

[38] I have already alluded to the opinion of the industrial psychologist to the effect that the child would have limited scope of vocations to choose from in the future. Due to such narrow choice of suitable jobs, the expert witness was of the opinion that a higher than normal contingency rate for unemployment should be applied in quantifying the claim. The witness expressed the opinion that the child would probably be impelled to retire early at approximately the age of 58 years. His retirement would be expected to be preceded by a gradual decline in the capacity to cope with the demands of unskilled employment. The envisaged early retirement and the deterioration of his capacity to work would be associated with significant reduction in his future earnings.

[39] Now the ante morbid scenario. Had it not been for the accident, the child would have successfully completed grade 12 level of formal education, according to the expert

witnesses. In that scenario he would be able to favourably compete at either the unskilled level or semi-skilled level in the open labour market. He would be able to remain in gainful employment until the normal retirement age of 65 years. There were no pitfalls, such as early retirement or deterioration in his capacity to work, looming on the horizon. His future capacity to earn an income and his future prospects to gain progressive promotions were not in jeopardy. In a nutshell in the previous pre-morbid state the future was bright in contrast to the currently bleak post-morbid state of affairs.

[40] The witness' forecast was that, after achieving matric, the child would probably have embarked on a two year post matric course of study at a further education and training college. He would have completed matric as earlier stated. The industrial psychologist made a decrimental contingency allowance that the child would probably have been unemployed for a certain period of time subsequent to the completion of his college study. During such an initial post college period, he would be looking for a job.

[41] The industrial psychologist also made an incremental contingency allowance in the child's future income earning capacity in staggered series of steps from the third to the seventh year of the child's gainful employment. The adjustment to the prospective earning would apply or kick in as the child progressively rose up the employment ladder during the course of his vocational lifespan. The witness predicted that the child's last promotion would have been at the age of 55 years and that he would have remained at that salary ceiling until he retired at the age of 65.

[42] The industrial psychologist's further evidence was that he applied the figures as set out in the actuarial manual known as Robert Koch: **Quantum Year Book 2011** to quantify the child's future loss of income earning capacity. He explained that he made provision for the child's future employment either in the corporate sector or in the non-corporate sector. The evidence of the industrial psychologist considered together with the actuarial assessment report by Dr. R.J. Koch basically boiled down to this: During the entire course of his working life the child stood a reasonable chance of earning R885 504, 00 or R1 717 204,00 if he were employed

in the non-corporate sector or the corporate sector respectively.

[43] Obviously it could not be determined with absolute certainty in which sector the minor would have earned his livelihood in the future. The correct approach to be adopted in these circumstances is to use a figure midway the two extremes: the high estimate is the corporate sector on the one hand and the low estimate is the non-corporate on the other side. Applying such a method brings me to the reasonable assumption that the child as a future worker stood a chance of earning a sum of R1 301 354,00 had the accident not occurred.

[44] This then disposes of the one component of the claim in respect of future loss of earning capacity.

[45] In the second place I deal with the child's claim for future medical expenses. This too is another segment of special damages. The plaintiff claimed R10 million under this head. Here the inquiry again required the leading of medical evidence concerning the prospective financial loss which the child is likely to incur on account of his injury and the long-

term impact of the costs of his future medical treatment on his financial resources.

[46] On behalf of the plaintiff, Mr. Dutton argued that the child would suffer substantial prospective financial loss in the form of future medical expenses as a result of the injury. In support of his claim under this head the plaintiff relied on the expert evidence of the following three witnesses:

Dr. J.T. Domingo, an orthopaedic surgeon

Ms J.C. Bainbridge, an occupational therapist

Ms G. Hughes, a physiotherapist

and the expert opinion of the following two doctors whose reports were admitted as per exhibit “e”.

Dr. L. Dumas, a plastic and reconstructive surgeon

Dr. R.J. Koch, an actuary.

[47] According to Dr. Domingo, the plaintiff complained that the child had a long surgical scar on the left arm; that there was loss of movement of the left elbow; that the child endured occasional pain and that the child was scared to normally use the left arm. The doctor then physically examined the movement of the elbow and the hands. As regards the

elbows he discovered that the left elbow could not extend at all. The measured reading of its extension movement was zero. As regards the hands he discovered that the left hand could not pronate at all. The measured reading of its pronation movement was zero. However, the supination movement thereof was normal. The range of its movement was measured as 0º to 90 º.

[48] When a person's hand is placed, say on a desk at a 90 º with a thumb pointing upwards, is turned in such a way that its palm faces downwards on a desk, its inwards movement from 0 º to 90 º is termed pronation. However, when a person's hand is placed in the same perpendicular position on a desk, but is turned away from the body so that its palm faces upwards on a desk, its outwards movement from the upright position to a horizontal position is termed supination.

[49] Dr. Domingo investigated the aforesaid physical restrictions of the child's left arm movement and found that the child had sustained a severe injury of the left arm. The injury consisted of a fracture of the ulna which was displaced and was associated with a dislocation of the head of the radius – medically described as monteggia fracture dislocation.

[50] The plaintiff's experts were agreed that the child would require future medical treatment. Their various inputs concerning estimates of probable future medical expenses were used by Dr. R.J. Koch to quantify the child's future medical expenses. In doing so, the actuary also took into account the medical opinions by the defendant's witness, Dr. Shipley, the orthopaedic surgeon. In the final analysis the actuary came to the conclusion that the total figure of R871 583,00 represented a fairly reasonable estimate of the future medical expenses. The assumptions he made about the rates of mortality, interest and inflation were apparent from the actuarial assessment report – *vide* p. 128 exhibit "C".

[51] Ms Gowa, the defendant's expert witness, recommended that provision be made for a washing machine. The costs thereof she estimated at R3000,00. It was the witness' opinion that the functional duration thereof would be five years. According to Dr. Koch the child's life expectancy was 55 years. Therefore, the plaintiff calculated the total costs of the washing machine(s) as follows: R3 000,00 x 5 years x 11 years (sic) = R33 000,00. That brought the total sum

claimed for the future medical expenses to R904 583,00, being the sum of R33 000,00 + R871 583,00.

[52] I have to make two comments on the total sum claimed for future medical expenses. The first is that no contingencies were taken into account in the actuarial assessment report. The second is that the method used in the separate costing of the washing machine was flawed.

[53] The pre-morbid projections by the experts were that Moahlodi was destined to obtain matric pass at the end of his secondary school career. His mother has achieved that milestone. His father came close to attaining that same goal. The boy had innate intellectually potential to reach that goal (accosting to the expert witnesses). Not so long ago Majiedt J, as he then was, correctly observed that its is a generally accepted phenomenon that children normally surpass educational levels achieved by their parents, in particular parents from the previously oppressed backgrounds – *vide* **ARTHUR RENS v MEC FOR HEALTH: NORTHERN CAPE PROVINCIAL DEPARTMENT OF HEALTH** Case No 799 (2006) par. [24] delivered 2009.04.17.

[54] Despite his encouraging post-morbid school performance, credible and reliable evidence by the educational psychologist, Ms F.A. van Vuuren, indicated that there was a pathological trauma, not associated with the accident, which inhibits his cognitive functioning. That alone would impair his chances to pass matric. Dr. Domingo said at some stage in the future the wheel would fall off and the school performance would drop quite remarkably.

[55] Ms Norman submitted that a 15% decremental contingency would be appropriate in the matter. I do appreciate that there are uncertainties concerning the child's pre-morbid career path. However, I do no accept that, on the facts, such uncertainties taken into account together with normal vicissitudes of life warranted such a high rate of contingency. It is always difficult to be precise when projecting what the future possibly holds for a claimant injured so early in his childhood. In my discretion, I would allow a conservative of 7,5%.

[56] As regards the second comment, the mathematical method

used did not take into account the fact that the child was already over five and a half years at the time of the misdiagnosis and that he was already ten and a half years old at the time he was actuarially assessed. The methods used erroneously suggested that the child was entitled, from birth, to look up to the defendant for the provision of a washing machine. Certainly he had no such entitlement before the misdiagnosis.

[57] There was no evidence that since the accident the child had been dependent on a washing machine acquired at the expense of his parents. As a matter of fact the plaintiff did not claim anything from the defendant for past medical expenses. That would be the precise effect if the plaintiff's claim were to be allowed for the entire period of 55 years in respect of the costs of the washing machine. In my view the correct formula for calculating the costs of the washing machine and of replacing it at regular five year intervals from now and throughout the child's remaining portion of his expected lifespan is as follows: 55 – 10 years divided by 5 intervals multiplied by R3 000,00 equals R27 000,00. To sum up. The mathematical end result is: R904 583 – R33

000 + (R27 000) x 92,5% = R831 189. This disposes of the child's claim in respect of future medical expenses.

[58] In the third and final place, I deal with the child's claim for general damages. The plaintiff claimed R10 million under this head. Here decided caselaw is a useful source of reference. I am mindful of the general principles that comparison with earlier cases though not decisive is nonetheless instructive – **HULLEY v COX** 1923 AD 234 on p. 246; that comparative analysis of awards can only be undertaken where the circumstances of a matter at hand and those of an earlier decided case, are clearly shown to be broadly similar in all material respects – **CAPITAL ASSURANCE CO LTD v RICHTER** 1963 (4) SA 901 (AD) on p. 908; that regard should be given to a general idea of the sort of a figure which, by experience, is generally regarded as reasonable in the circumstances of a particular case – **SIGOURNAY v GILLBANKS** 1960 (2) SA 552 (AD) at 556B and that a court needs merely to draw on its own experience and does not require to be reminded of earlier awards by the citation of an array of earlier decided cases - **MARINE AND TRADE INSURANCE CO LTD v GOLIATH**

1968 (4) SA 329 (A).

[59] The accident occurred on 25 December 2007. The plaintiff's son was then five and a half years old. He was a school beginner at the time. He sustained a fracture of the left ulna and a dislocation of the head of the radius at the elbow. The orthopaedic surgeon, Dr. J.R. Domingo, considered the injury to be a severe one.

[60] The evidence was that as a result of the major injury, the child endured much pain and suffering. After the accident he was immediately rushed to Thusanong Hospital. He was attended to by the trauma physician on call. He was conscious but in a confused state. The extent of the injury was not properly ascertained. The areas of the pain were not x-rayed because the x-ray machine was in a state of disrepair according to the hospital staff. Although he received no adequate treatment, his injured arm was partially placed in a support slab. He was not admitted. Instead he was then sent home and advised to return to the hospital in three days time.

[61] Three days later, on 28 December 2007 to be exact, the child returned to the hospital. He endured a horrible pain while at home waiting for his next return to the hospital, according to the history obtained from his father. The support slab was removed. The arm was then x-rayed. The radiographs revealed that the arm was fractured and the elbow dislocated. The whole arm was encased in a plaster of paris by a doctor. The arm immobilisation treatment entailed the application of a kind of a cast around the arm which was then stabilised by means of a sling which connected the arm to the neck to hold it in a firm position. That done the child was again sent home and advised to return to the hospital after four weeks. During that period the arm was kept in that uncomfortable position for a month before the first surgical operation was performed.

[62] While the arm remained in a plaster, the child had to walk, sit lie and sleep in a guided manner. So immobilised, he could not freely move or sleep. He initially suffered acute pain and endured considerable physical discomfort as the displaced radial head was prominent. It pressed against the hard plaster.

[63] On 28 January 2008 the plaintiff once more took his son back to Thusanong Hospital. He was still in pains. The child was seen by another doctor. The first treating doctor had left the hospital by then. The child complained that he endured a great deal of pain all the time since his previous visit to the hospital. The second doctor removed the plaster of paris. It was evident, even to the plaintiff, that his son's left arm was crooked. The doctor caused the child to be x-rayed again. The radiographs revealed that the arm-bone was indeed angled. The child was left out of the plaster, advised to go home and to start using the arm as normal again. The plaintiff was not happy at all about the second doctor's advice. He lodged a complaint with the department of health through his lawyer.

[64] The hospital superintendent, Dr. Mahlatsi, subsequently called the plaintiff and secured an appointment. The superintendent examined the x-rays and determined that the left elbow was dislocated. He took the child to Bongani Hospital in Welkom where the senior doctor in charge, Dr. Mohamed, saw the child, examined the forearm, diagnosed a fracture and dislocation of the left forearm and elbow and

at once referred him to Pelonomi Hospital in Bloemfontein.

[65] On 7 March 2008 radiographs taken showed a mal-united fracture of the ulna and a dislocation of the radius. A week later the child was booked for an operation. Three days later, on 17 March 2008, Dr. Smith, an orthopaedic surgeon, did an extensive surgical procedure to correct the problem of the forearm. The fractured forearm and the dislocated elbow were surgically exposed. A section of the fractured bone was removed from the distal radius and the dislocated elbow was re-aligned. Some wires were inserted in the forearm in such a way that the fractured forearm and the dislocated elbow were internally supported and stabilised. The operation, like most surgical procedures, must have been painful.

[66] The child was discharged from the Pelonomi Hospital on 19 March 2008 with the pins, screws and wires still *in situ*. Seemingly the forearm was once again placed in a plaster of paris. He went home to recuperate. He also returned to school. The child's healing was a gradual, painful and uncomfortable process. He visited the hospital a few times for scheduled checkups. On 5 August 2008 he returned to

Pelonomi Hospital. The wires were removed under ketamine sedation. There was no evidence as to exactly when the plaster was removed. Between those dates he obviously endured some pain and suffering.

[67] After the removal of the wires, the child had to undergo intensive physiotherapy. There was evidence gleamed from the hospital records which indicated that he attended three physiotherapy sessions at Pelonomi Hospital between 8 September 2008 and 1 October 2008, both dates exclusive. The elbow joint was manipulated in various ways in an endeavour to strengthen the joint muscles and to improve the drastically reduced pronation of the left hand associated with the left forearm fracture and elbow dislocation. The experts were agreed that such treatment was often vigorous and that it could be quite a painful exercise at each session. He finally returned to school and the community with a disabled elbow. Now he is a physically disabled child.

[68] On 14 October 2008 the child was x-rayed for the last time at Pelonomi Hospital. The comments of Dr. R.D. Scott on the radiographs were that the ulna osteotomy had united with

slight radial angulation. The head of the radius was 30% sublaxed.

[69] Dr. Domingo finally commented that the child now has permanent disability in the left forearm and elbow. The impairment manifested itself in the loss of extension and flexion. He commented:

> "More significantly there is total loss of pronation of the forearm i.e. the child cannot rotate the forearm such that the hand can be placed flat facing downwards e.g. on a table surface. In order to do this the child has to use secondary motions at the shoulder joint to place the upper limb in this position. This loss of rotation is life long."

[70] Although the corrective procedure substantially alleviated the pain, it could not be hailed as a tremendous success. The constructive procedure was belatedly performed, for reasons already alluded to, with the result that a rotational deformity developed. The particular surgical procedure greatly improved the impaired forearm and elbow, but did not completely restore the original flexibility of the elbow and normal pre-morbid functioning of the arm as a whole. The

last radiological picture taken, revealed an irregular and permanent impairment of the elbow joint and symptoms of mild osteoarthritis. There was a 30% chance that such condition would develop. The medical evidence was that such condition would deteriorate with the passage of time. Empirical evidence tended to show that such a condition was often characterised by frequent pain and suffering.

[71] There was persuasive evidence that as a result of the injury, the child was so disabled that he was deprived of certain amenities of life, such as playing soccer as a goalkeeper, a kind of recreation in which he showed early interest, using a computer, using a typewriter or manually doing his own washing or becoming a policeman, his preferred career of choice at this formative stage of his life.

[72] The aforegoing is a resumé of the factors I took into account in coming to an estimate of damages. The limitation of rotation has left him with permanently impaired arm. While the defendant was not to blame for the injury *per se* sustained by the child, the gross negligence of the first treating doctor coupled with the ordinary negligence of the

second treating doctor, both of whom were in the employ of the defendant, were entirely responsible for the permanently rotational deformity which developed and all the adverse sequelae associated with such permanent injury.

[73] It is my considered opinion that, in the light of all the aforesaid factors, an award of R400 000,00 would be a fairly reasonable general compensation for all the amenities lost, surgical disfigurement, rotational deformity, discomfort, pain and suffering – *vide* **MQUTWA v ROAD ACCIDENT FUND** 2011 (6D5) QOD 10 (ECG).

[74] In that case the minor patient, Malizo, was involved in a road accident on 5 August 2002. He was 11 years of age at the time. He sustained a compound fracture of the left hand. Almost eight years later on 7 May 2010 when he was 17 years of age the court made the award of R250 000,00 in his favour.

[75] In the present matter, we now know that the minor patient, Moahlodi, was injured on 25 December 2007; that he was twice misdiagnosed; that he was half Malizo's age at the

time; that he sustained a monteggia fracture of the left forearm and not hand; and that he is currently 12 years of age when the award is made.

[76] These then are the comparative features which set the two patients poles apart. The most significant feature which distinguishes the matter from that case is the age factor. Moahlodi met the crippling disaster much earlier than Malizo did. He will, therefore, theoretically endure the physical disability, the cosmetic deformity, loss of amenities, sporadic discomfort, occasional pain and suffering, plus the emotional distress associated with all these for almost an entire lifetime. Unlike Malizo, Moahlodi no longer has a normal lifespan. Having contextualised the two claims, I am of the view that a monetary differential of R150 000,00 is justifiable in this matter.

[77] There is no evidence to sustain the plaintiff's claim of R21 million. This much Mr. Dutton conceded during the hearing. At the end of the trial the respective submissions of the counsels, as regards the three quantum issues before the parties, were as follows:

As regards future loss of capacity to earn income, future medical expenses and general damages, Mr. Dutton scaled down and proposed R1 301 354,00, R904 583,00 and R500 000,00 respectively totalling R2 705 937,00 wereas Ms Norman proposed R285 070,00, R750 000,00 and R250 000,00 respectively totalling R1 285 070,00. The parties were therefore R1 420 867,00 apart. Eventually this is what the dispute was all about. To sum up, in my judgment the proven issues came down to these figures: R1 301 354,00, R831 189,00 and R400 000,00. This then disposes of the three issues.

[78] Before I hand down the order I have to comment briefly about a few aspects of the case.

[79] The collective crux of the evidence tendered by the defendant's credible and reliable witnesses was that the child did not suffer any head injuries; (Mr. Moodie and Ms Gowa's evidence) that he was not totally dependent; that he was still able to independently execute basic self-care activities (Ms Alexander's evidence and Prof. Shipley's) and that his nose bleeding was unrelated to his fall out of the tree

(Prof. Seedat). By and large the dispute between the parties as regards quantum was more apparent than real. This explains why I did not extensively deal with the evidence of the defendant's witnesses.

[80] The evidence of Mr. Moodie, the industrial psychologist, could not be seriously criticised. His evidence which concerned the child's future loss of earning capacity was credible and reliable in many respects. The only critique was that his approach was incomplete. For instance, he did not plot the minor's future career progression post-accident by reference to salary scales, figures and the likes.

[81] Ms Jansen van Vuuren and Ms Alexander correctly testified that in spite of the accident and the injury, the child still continued progressing well at school. However the further evidence that the injury would not have an adverse impact on the child's school performance in the future, was in sharp contras to that of Ms Van Vuuren. The educational psychologist's opinion was that cognitively the child would not be able to get matric. She was more qualified to express an opinion on matters educational than the physiotherapist. Moreover she was an excellent witness. She enormously

impressed me. To the extent that the evidence of the two physiotherapists deflected from hers, hers must be preferred.

[82] There remains one more aspect. The plaintiff has succeeded and therefore is entitled to the costs. The costs must follow success. Since there is an application for the appointment of curators which I still have to adjudicate, it is necessary to bear the costs thereof in mind. In **REYNEKE NO v MUTUAL & FEDERAL INSURANCE CO LTD** 1992 (2) SA 417 (T) the court held per Van Dijkhorst J that in an action for damages for bodily injuries which have necessitated the appointment of a curator *bonis* to the injured party, the costs of the application for the appointment of a curator *bonis* as well as the costs of the administration by the curator *bonis* of the injured party's affairs and the curator's remuneration should be quantified and included in the total award of damages. The learned judge stated that there was no reason why such costs should not form part of the total award in cases where the appointment of a curator *bonis* is a necessary result of the injury sustained by the claimant. If the appointment of a curator *bonis* is an unavoidable result of the injuries, then the costs of such

curator by which costs the damages will be diminished, must be taken into account in the award. Otherwise the award would not amount to fair compensation. I agree and I intend making an award to that effect.

[83] Accordingly I make the following order:

83.1 The defendant shall pay to the Master of the High Court, Bloemfontein the sum of R2 532 534,00 as compensation for the minor Moahlodi Daniel Molete, which award is to be paid into a trust account and invested in the Guardian's Fund on his behalf until such time as the court orders otherwise.

83.2 The defendant shall also pay interest on the capital amount of the award at a rate of 15,5% per annum from the 1st Augustus 2012.

83.3 The party and party costs of the action including the costs relative to the application for the appointment of a *curator litis* and the application for the appointment of *curator bonis*, should such application become necessary as well as the remuneration of the proposed *curator bonis* to the aforesaid minor, shall be borne and paid by the defendant.

83.4 The defendant shall also be liable to pay the costs and the qualifying fees of the following expert witnesses, together with interest thereon at a rate of 15,5% per annum from the 14th day after the formal taxation of the plaintiff's bill of costs, Dr J.R. Domingo, an orthopaedic surgeon, Mr. F.J. de Kok an industrial psychologist, Ms J.C. Bainbridge an occupational therapist, Mr. F.A. van Vuuren and educational psychologist and remedial therapist, Ms H.D. Huge the registered physiotherapist, Dr. R. J. Koch an actuary, Dr. A. J. Dumas a plastic and reconstructive surgeon subject to the *proviso* stated below.

83.5 The plaintiff shall not be entitled to recover from the defendant any costs or disbursements incurred in respect of the affidavits of Ms J.C. Bainbridge and Ms F.A. van Vuuren that were made in support of the answering affidavit.

obo M.H. RAMPAI, J

On behalf of applicant: Adv. T.V. Norman SC

Instructed by:
The State Attorney
BLOEMFONTEIN

On behalf of respondent: Adv. I.T Dutton
Instructed by:
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/sp