REPUBLIC OF SOUTH AFRICA

IN THE HIGH COURT OF SOUTH AFRICA,
GAUTENG LOCAL DIVISION, JOHANNESBURG

CASE NO: 01470/2013

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

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DATE SIGNATURE

In the matter between:

D. J. C. J. A.
obo D. J. B. ,
K. C. L. Plaintiff

and

ROAD ACCIDENT FUND Defendant

SUMMARY

Delict – negligence – motor vehicle accidents – damages claim under the Road Accident Fund Act 56 of 1996, as amended – 5 year old minor's claim for loss of earning and earning capacity – head injury – mild to moderate severe – expert witnesses – conflicting opinions – diverseness – approach of court – defendant not bound by its own expert witnesses' opinions but failure

to proffer counter-expert on factual evidence – actuarial calculations unopposed.

J U D G M E N T

MOSHIDI, J:

INTRODUCTION

[1] The plaintiff, in her representative capacity and mother of the accident victim, has instituted action against the defendant for damages as a result of a motor vehicle accident which occurred on 30 October 2004. In the accident, the plaintiff's minor daughter, K. C. L. B.t, then aged 5 ("*K.*"), sustained certain injuries, including a head injury, superficial abrasions and limb abrasions. More about the injuries later.

THE ONLY ISSUE FOR DETERMINATION

[2] At the commencement of the trial, the defendant had already accepted liability for 100% of the plaintiff's agreed or proven damages. In addition, the defendant had also agreed to pay to the plaintiff the sum of R700 000,00 (seven hundred thousand rand) in respect of general damages, and agreed to furnish to the plaintiff an undertaking or certificate in terms of section 17(4)(a) of the Road Accident Fund Act 56 of 1996, as amended ("*the Act*"). The certificate was in respect of the plaintiff's claims for past and future medical,

hospital and related expenses. Consequently, the only remaining issue in dispute is the plaintiff's claim for loss of future earnings and earning capacity.

[3] I must at the outset observe that, in determining the disputed issue during the trial, the Court gained the distinct impression that the manner in which the litigation was conducted by the defendant, left much to be desired. As a consequence, the trial lasted slightly longer than necessary. In the end, it turned out that the defendant's main gripe was the severity of the head injury sustained by K. as well as the *sequelae* thereof. More about this aspect later below.

THE EVIDENCE OF K.

[4] The plaintiff led the evidence of some six witnesses. When she testified, K. was 17 years old. At the time of the accident (October 2004), she was 5 years old and in Grade R but currently she is in Grade 11. Pursuant to the accident, she "*repeated*" Grade 3, but no other grades. She had no recollection at all about the accident save that it occurred when she was about to cross the road. The first memory after the accident was when she woke the following morning, and attempted to wake up from her bed to go to the bathroom, but could not walk, and collapsed. In the accident she sustained injuries to her knees, her left shoulder and the whole of her left side of her face. She also said her left eye was swollen which she could not open. Her current health problems included that she developed a short temper, mood swings, poor short-term memory, and that she "*blanks out*" occasionally. This occurs when her mother screams at her, and her mother would then shake

her to come around. It also happens at school from about when she was in Grade 5. K. also complained about poor concentration levels, headaches, and low energy levels. Her marks at school were currently about 50% and lower.

[5] In cross-examination, K. recalled attending various assessments by the defendant's experts and the instance of the defendant. In particular, she remembered the consultation she had with Ms M Olivier, the defendant's occupational therapist ("*Olivier*"). The assessment was carried out on 22 April 2015. In this regard, it was put to K. that according to Olivier's report, K. "*did not report any overt anxiety or mood swings …*". K. responded, *inter alia*, that she did not remember conveying such information to Olivier. K. was also cross-examined on whether she repeated or in fact Grade 3. The response was that her mother kept her back from proceeding to the next grade since her pass mark was not too good. K. could not recall when exactly her short temperedness commenced, however, the blackouts started when she was in Grade 5. K. undertook to make an attempt to look for her school reports in substantiation of her evidence that her school marks had dropped. I must later below comment about the nature of the cross-examination of K.?

THE EVIDENCE OF K. 'S MOTHER

[6] K.'s mother, also the plaintiff (Mrs C J D. J.) ("*the plaintiff*"), gave extensive evidence, and was also cross-examined. Her evidence extends over some 28 pages of the record of proceedings. She became unemployed since January 2016. She was previously employed as a debt collector by a

firm of attorneys for about 4 years. She held qualifications in financial management, business management, and marketing management. At the time of her evidence, the plaintiff was studying towards a BA degree fulltime. Her husband is self-employed as a carpenter.

[7] On her arrival at the Baragwanath hospital after the accident on 30 October 2004, the plaintiff found K. already badly injured. She could not readily recognise K. due to the injuries especially the scarring on her face, which was swollen. K.'s left eye was swollen closed. The plaintiff was unhappy that K. was discharged from the hospital immediately without any form of medication. That very same evening, the plaintiff went to a pharmacy where she bought bandages and pain medication, which she used to attend to K.'s injuries at home that night. K. started vomiting which became unbearable the Sunday thereafter.

[8] When the medication prescribed by a private doctor could not help, and the swelling on her face did not subside, and K. could still not walk, the plaintiff took her to the Coronation hospital (now Rahima Moosa) where she was referred for certain scans. After the accident, K. could not attend her Grade R graduation ceremony.

[9] In regard to the *sequelae* of the injuries, as opposed to pre-accident, the plaintiff testified that: prior to the accident, K. attended a day-care at the Feed My Hands Day-Care Centre ("*the day-care centre*"), from the age of 2½ onwards. She was an active, busy, talkative child. She was plaintiff's '*angel and joy*'. K. was remarkable and catched up on everything. She had an

excellent vocabulary and could easily comprehend instructions. She had perfect listening skills, there was no negative feedback from the day-care centre. This was confirmed by a school teacher, as well the Grade R teachers in whose care K. was prior to the accident. The accident in question occurred when K. was almost completing Grade R.

[10] The plaintiff, however, testified that post-accident, there was a drastic and palpable change in the personality of K. . As a consequence, the plaintiff was called to the school, and asked what went wrong with K. . The teacher/s complained that K. stared at them but could not register. She blanked out. K. would not talk at all, was no longer sociable and behaved like a recluse. Her school marks lowered.

[11] In reference to K. 's school results from Grade 1 to Grade 7, at Elridge Primary School, the plaintiff testified that, although K. passed Grade 3, the teachers advised that it would be better to keep K. back as she would encounter difficulties in Grade 4. K. performed better in Grade 3, the second time. Whilst in the process of repeating Grade 3, for the reasons stated above, and at age 9, K. was admitted at the Coronation hospital (now Rahima Moosa). There, the plaintiff requested a psychologist to evaluate K. . The doctors advised that K. should be given medication and referred to a remedial school, instead. However, the plaintiff declined the medication, and could also not afford the cost of a remedial school. This was in 2008.

[12] In 2010, K. was admitted again at the Rahima Moosa hospital. This was after K. had fainted twice at school. The plaintiff testified that K. had in

fact had fits, and was vomiting and it was thought that she had developed epilepsy.

[13] The plaintiff and her husband (Mr D. J.) had two further children, namely K. (aged 11) and K. (aged 4), ("*K.*"). K.'s school performance was very good. She was a top grade achiever, and always obtained various diplomas in all seven subjects from Grade 1 up to Grade 5. K. was extremely clever, and her school had no problems at all with her. The plaintiff's aspirations for her children's career were that they should obtain the highest possible qualifications. For example, K. aspired to do psychology. However, the school teachers advised against this since K. 's grades were too low. The plaintiff conceded that she attended the various medico-legal assessments with K. , and that the latter responded to the various questions asked by the experts honestly and to the best of her ability. The plaintiff testified that the high school informed her that it was impossible to now obtain K.'s school reports.

[14] In cross-examination, the plaintiff remained adamant, persistent, and indeed, extremely knowledgeable about the circumstances of her child, pre-accident, and thereafter. This was expected of any mother who cared for the best interests of her child. I must point out that at that stage of the speculative cross-examination, I gathered the impression that the cross-examination was no longer concentrated at the severity or otherwise of the head injury. Instead, it was something else. This was the common cause fact that, when at eight months of age, K. was involved in a separate motor vehicle accident, during which she suffered no notable injuries. In this regard the plaintiff was referred

to the medico-legal report of her own specialist psychiatrist, Dr Z Mahomedy, dated 9 February 2015. In the report, Dr Mahomedy recorded that:

> "*Medical records of Coronation hospital indicate that Ms Bezuidenhout suffered with prolonged neonatal jaundice. She was a pre-mature baby at 34 weeks with a birth weight of 2,5 kg.*"

The report of Dr Z Mahomedy also referred to K. vomiting and had infections, and have been in another motor vehicle accident, when K. was eight months old. The plaintiff testified that the above condition of K. was unrelated to the present accident in any manner. The same applied to the hospital notes that K. had stress due to "*family issues*", which was disproved by a CT scan of the brain. The further cross-examination of the plaintiff revealed that: K.'s younger sister, K., received certificates of excellence at school which could be proved by documents; that K. was very active prior to the accident in question, interacted well with other children, was a bubbly child, laughed, played a lot outside her home, and was talkative. However, all of this changed after the accident, resulting in K., *inter alia*, no longer watching TV, no longer being remarkable at the day centre, and not returning to school after the accident where she was in Grade R. In regard to K.'s other younger sister, K., the plaintiff testified that this child was a busy baby. In the motor vehicle which occurred when K. was eight months old, K. was not injured at all. The plaintiff's in-laws took care of K. when the accident happened, and the plaintiff was unsure whether K. was hospitalised after this 2008 accident.

[15] Possibly the two most important and relevant witnesses to testify for the plaintiff, and in regard to the defendant's alleged defences, were Dr C M

Lewer-Allen, a neurosurgeon ("*Dr Lewer-Allen*"), and Ms M A Gibson ("*Gibson*"), a neuropsychologist. It must be recalled that the defences of the defendant on the disputes issue, was that the head injury was not serious (mild); that the injuries sustained by K. when she was eight months old could still have certain *sequelae* in K. 's present complaints; and that the stress based on "*the family issues*", could also be a contributory factor.

[16] First, Dr Lewer-Allen. Not only did Dr Lewer-Allen prepare a report after he assessed K. during February 2015, but he also compiled a joint minute with his counter-part, Dr Jaap Earle (Dr Earle) on 17 April 2016.

[17] The divergence in the opinions of Dr Lewer-Allen, and Dr Earle, was based firstly, on whether there was a head injury, and if so, whether it can be classified as mild or moderate. Secondly, whether such head injury could have any detrimental effect on K.'s further career progression, and earning capacity. In arriving at the conclusion that K. has in fact suffered a significant head injury which would affect her future career progression, and earning capacity, Dr Lewer-Allen, properly also deferred to the expert opinions of neuropsychologists and educational psychologists.

[18] The conclusion of Dr Lewer-Allen, when he testified, was based on the following aspects of the evidence: that according to the plaintiff and K., K. could not recall anything about the accident even the morning thereafter when she woke up in bed at home; K. 's teacher in the year following the accident, in Grade 1, observed absence seizures; that K. had to re-do Grade 3 for reasons advanced by the plaintiff; that K. was referred for an assessment at

the Coronation hospital during August 2008 (the year in which she repeated Grade 3), and which assessment revealed that K. 's IQ fell within the borderline range, and that she would benefit from psychiatric medication to alleviate concentration and attention deficits, and a recommendation that K. be placed in a remedial school instead; that K. was also admitted to the Rahima Moosa Mother and Child Hospital during April 2010 after she had fainted at school for the second time, where she was admitted overnight for observation followed by a diagnosis of epilepsy; that the diagnosis made in the casualty department would amount to the classification of the severity of the head injury as probably moderate; Dr Lewer-Allen unequivocally criticised the classification of the severity of the head injury on the basis of the hospital records only (as opposed to Dr Earle's opinion), since such basis excluded any reference to the long-term *sequelae*, such as neurocognitive and neuropsychological deficits; in the opinion of Dr Lewer-Allen, the reliable degree of the severity of brain injury is to be measured against the severity of the neurocognitive and neuropsychological deficiencies ultimately proven to be present after maximum medical improvement, and his opinion is endorsed by the following: the AMA Guides to Impairment Rating; NHS Personnel in the UK by NICE; Dr Lewer-Allen opined that the severity of a brain injury should be divided into (a) the severity of the injury or injury diagnosis, as against (b) the severity of the outcome, or outcome diagnosis; Dr Lewer-Allen contended for the formal neuropsychological assessment in order to determine the outcome diagnosis, at the time of his assessment of K. , Dr Lewer-Allen had at his disposal the reports of Ms Gibson, and that of Dr R Hovsha, a clinical psychologist (for the defendant); and finally, in evidence-in-

chief, Dr Lewer-Allen confirmed his assessment of the extent of the brain injury sustained by K. during the accident, as a significant one.

THE JOINT MINUTE OF THE NEUROSURGEONS

[19] Prior to dealing with the cross-examination of Dr Lewer-Allen, it is useful to refer to the contents of his joint minute with Dr Earle. The joint minute noted the history of K. having sustained a head injury pursuant to the motor vehicle accident in question; although it was agreed that it was unclear whether K. was unconscious or not at casualty, it was noted that according to the hospital records, K. had no recollection of the accident a day thereafter. The experts also noted and recognised the casualty department's diagnosis of the severity of the head injury was interpreted as being mild (Dr Earle) or mild to moderate (Dr Lewer-Allen). Finally, the experts agreed that the psychometric report, which was done some four years post the accident, was done apparently because of K. 's poor academic performance. The psychometric assessment determined that K. was in fact performing below her age group, and had decreased concentration levels.

THE CROSS-EXAMINATION OF DR LEWER-ALLEN

[20] I revert to the cross-examination of Dr Lewer-Allen. Numerous questions and versions were put to him. However, at the end thereof, he remained adamant and well-steeped in his opinion. In the opinion of Dr Lewer-Allen, the abrasions meant that the skin was rubbed until it became raw, and that is what was recorded in the casualty department of the hospital;

the emotional assessment on which the defendant based some of its contentions, was carried out in 2008, which was some four years pursuant to the accident; the investigations in April 2010, which resulted in the prescription of epilepsy medication, occurred some 6 years after the accident; the running nose symptoms displayed by K. , created the possibility that it may have been caused by a base of skull fracture;

[21] In his assessment of K., and during the interview, Dr Lewer-Allen, at paragraph 5, p 6 of his report, noted as follows:

> "*The plaintiff was fully conscious and orientated. She appeared to have a blunted affect and she did not strike a rapport with the interviewer. She was however dominated by her mother in the interview and her answers appeared guarded.*"

The cross-examination delved into this aspect. Dr Lewer-Allen testified that his observation of K. in court (as he was in court during the plaintiff's evidence as well as K.'s evidence), while she was giving evidence was that she was also not readily forthcoming and pervasive. In regard to K. not recalling the accident, he testified that this showed that K. was not fully conscious. If she did not have such memory, it meant that the brain was not functioning normally. She suffered a moderate brain injury. However, in his view, and based on certain literature, the loss of consciousness/post-traumatic amnesia is not the crux of the enquiry, a patient can have brain damage without any loss of consciousness. In short, the severity of a brain injury cannot be determined by merely looking at the loss of consciousness and the Glasgow, Coma Scale ("*GCS*"). One has to look at the outcome of the maximum

medical improvement after the incident. At the conclusion of his cross-examination, he also answered certain questions put to him by the court.

[22] Ms Gibson testified. Not only did she corroborate substantially the opinion of Dr Lewer-Allen, but she went further. For example, for her view, and based on the tests, the assessment, collateral information, and the fact that K. physically injured her head, justified the conclusion that K. sustained a serious brain injury, with permanent *sequelae*. More about this later.

[23] Ms Gibson also prepared a joint minute with clinical psychologist (with special interests in neuropsychology) Dr R Hovsha ("*Dr Hovsha*"), of the defendant. In the joint minute, there was agreement: that K. would probably have been of average intellect, if not for the accident; a strong factor in K. 's background, is that her parents were supportive and both had made positive progress in their occupations; whilst Ms Gibson expressed the view that K. had the potential to complete matric and progress to tertiary education and be fully employable, Dr Hovsha deferred to Ms Gibson in this regard; it was also agreed that the head injury was assessed as minor on the statutory medical form, but agreed that the assessment of head injury is a complex matter in this case because (a) K. was only 5 years of age when injured, (b) brain injury can occur even in the absence of evidence of loss of consciousness and (c) that even if there is loss of consciousness and more specific indication of brain injury, the outcome of the brain injury is highly individual and variable. It was also agreed that the best assessment of the outcome of brain injury is long-term post-morbid functioning. More significantly, it was agreed that in

the case of K., there were numerous neurocognitive deficits consistent with brain injury identified. These included, auditory attention, concentration and mental tracking, working memory, sustained attention, recall, mental control, motor speed, initiation of activities, self-monitoring and learning, as well as dyscalculia as found by Ms Gibson. It was further agreed that K. presented with personality and behavioural changes consistent with traumatic brain injury, and that neuropsychological tests profile were consistent with at least moderate diffuse brain injury, or brain injury involving the left, temporal and frontal lobes. The joint minute noted the reports of continuing difficulties, such as headaches, blackouts and dizziness. Indeed, the concluding paragraph of the joint minute was also crucial. For therein it was agreed that the neuropsychological difficulties presented by K. post-accident, are permanent, and that as a sub-adult, are likely to continue to manifest in abnormal or slow brain development, in particular with regard to executive functioning, and the ability to cope with abstract conceptional information, as well as more complex academic demands. It was agreed that the identified deficits will have specific effects on K.'s functioning, educability and employment. More relevant too, it was agreed that K. is likely to find educational limits early (i.e. she is unlikely to pass Grade 12) and she will therefore be excluded from many areas of study and development, and that K. is likely to be trained for employment at a low level. Finally, and of some relevance here, it was agreed that K. has suffered substantial loss of amenities.

[24] In cross-examination, Ms Gibson testified that: there was no evidence of a connection between the 2008 motor vehicle accident, and the accident under discussion. She gave credible reasons for this view; in regard to the

alleged family social and stress issues, there was no basis of any unusual family circumstances, and that family stresses are endemic by nature, all have them; it is possible that K.'s mother may not have recognised the neurocognitive deficits that Ms Gibson found on testing if they had been present before 2004, but with a child of 5 years, the best source of information about the functioning of the child, is the mother.

[25] In reference to Dr Earle's opinion as expressed in the joint minute, namely that K. sustained a mild traumatic brain injury, which is of no significance at all, Ms Gibson disagreed, but instead agreed with Dr Lewer-Allen. She was adamant that the most likely cause of K.'s problems now is the brain injury. In her view, a neuropsychologist has as much authority and capability to diagnose brain injury. She criticised the reliance on hospital records only without reference to the long-term consequences of the injury. In her respectful opinion, Dr Earle omitted to look at this case in its entirety. For example, Dr Earle ignored the poor performance at school post-accident, the 2008 assessment, as well as the later assessments which were carried out. It is impossible to conduct similar tests pre- and post-accident, as it is not possible to have a pre-accident assessment. That both she and Dr Hovsha conducted the same tests, and came to the same conclusion that there is no *nexus* between the collision and the present profile of K.. In fact, there was no disagreement between the two neuropsychologists. This question of non-disagreement between the experts is significant in the light of the submissions made on behalf of the defendant in the written heads of argument, as discussed later. This is so, based on the several joint minutes presented in this case.

[26] Ms Gibson, on the contentious issue of whether or not K. was ever unconscious, testified that it is very difficult to assess a 5 year old child's level of consciousness in the circumstances of this case. It is necessary to have regard to what occurred before and after the accident. A normal electroencephalography ("*EEG*") shows electrical functioning of the brain at a certain point in time only. It is an adjunct test to assist the clinician to make a diagnosis. The EEG does not exclude epilepsy, as conceded by Dr Earle in his report. The diagnosis of epilepsy is a clinical one. A normal computed tomography ("*CT*") scan, similarly to an EEG, does not exclude the diagnosis as further investigation is required to identify the problem. A major function, as a neuropsychologist, is to investigate the severity of a brain injury where the first indication of a more severe injury follows later. The role of a neurosurgeon is more significant when the brain injury is apparent at the outset. The "*absences*" ascribed to K., appeared to be some form of epilepsy and not caused by the so-called family stress issues as the defendant seemed to suggest. There would be no cause for a referral for a CT brain scan for family stresses. The family stresses contended for by the defendant, would make no difference to her conclusion about the severity of K. 's brain injury.

THE EVIDENCE OF DR Z MAHOMEDY

[27] I deal briefly with the report of the psychiatrist, Dr Mahomedy. It is again significant for the observation made about the defendant's manner of conducting the litigation, and the final conclusion reached, that, in the third

day of the trial, the defendant agreed that the report of Dr Mahomedy be handed up unopposed, as evidence of the contents thereof. As a consequence, it became unnecessary for the plaintiff to call the witness. In her report, Dr Mahomedy recorded that K. had symptoms suggestive of epilepsy, which prompted her to carry out a more specific enquiry in order to determine further symptomatology. The doctor recorded that K. "*blanked out*" at some stage of the assessment when K. just stared into space and was obviously unaware of her surroundings. After calling her repeatedly, K. appeared to "*come back*" into the discussion. As a consequence, Dr Mahomedy concluded that K. met the criteria for a diagnosis of mild neurocognitive disorder due to traumatic brain injury. Dr Mahomedy also diagnosed K. with the following diagnosis according to the Diagnostic and Statistical Manual of Mental Disorders V (American Psychiatric Association): depressive disorder due to another medical condition with major depressive-like episodes; mild neurocognitive due to traumatic brain injury with behavioural disturbance; head injury; and post-traumatic epilepsy. Indeed, the unchallenged report of Dr Mahomedy remained a significant factor in favour of the plaintiff.

THE EVIDENCE OF DR O GUY

[28] Dr Odette Guy, a speech and language expert, testified for the plaintiff. The essence of his evidence, in brief, was that: K. presented with a speech, language and communication profile that had areas of inadequate and limited functioning; the discourse difficulties noted, are often detected in children who have suffered injuries prior to the age of 6 years; discourse difficulties often

become increasingly evident, as the demand increases; and that, the high level of language limitations, and cognitive linguistic expressive language concerns, would correspond with the findings of Ms Gibson. The cross-examination of Dr Guy was uneventful. This was not surprising in the absence of counter-expert evidence. In my considered view, the same observation should apply to the rest of the plaintiff's expert witnesses. These included, Ms Lindah Möller, educational psychologist; Ms Mariana Olivier, occupational therapist; Ms Christa du Toit, industrial psychologist; and Mr Wim Loots, actuary. There were joint minutes of the industrial psychologists (and an addendum); the neuropsychologists; educational psychologists; neurosurgeons; and actuaries.

[29] The only witness for the defendant was neurosurgeon, Dr Earle. He assessed K. on 21 September 2015. As stated above, Dr Earle also compiled a joint minute with Dr Lewer-Allen on 17 April 2016. Dr Earle testified on his report, assessment, and findings. In his view:

> "*This child suffered a very mild brain injury from which no ill-effects are expected or could be demonstrated.*"

The report went on to state that:

> "*The fact that she is not doing well at school although she has only once failed is not accident-related neither are blank spells which could be a form of petit mal and not the grand mal attack that one gets with brain injury. She should then be able to complete her schooling as she would have done without any injury whatsoever and her poor schooling which she reports is not due to the accident. By the same token she should eventually follow the career of which she would have been capable of in any case.*"

[30] From both his report and evidence, it was plain that Dr Earle's opinion is in direct contrast with those of both Dr Lewer-Allen and Ms Gibson on the nature and extent of the head injury. He was persistent that K.'s injury is a very mild brain injury, which is so minor with no significant *sequelae* of whatsoever nature. His opinion was based on the casualty department hospital records and his interview with the plaintiff and K.. He opined that in regard to the "*casualty diagnosis*" that there are two components. These are that, a patient's level of consciousness (GCS) and post-traumatic amnesia. In his opinion, K.'s GCS was normal in the casualty ward of Chris Hani Baragwanath hospital. Whereas Dr Lewer-Allen used the Russel criteria in determining post-traumatic amnesia, Dr Earle preferred the World Health Task Force criteria. In terms of the latter criteria, post-traumatic amnesia of less than 24 hours equates to a mild brain injury, which is applicable in the instant matter. He disagreed that the outcome diagnosis is the correct manner to diagnose the severity of a head injury. A pre-accident similar report must be available, but there almost never is such pre-accident similar report. It is extremely incorrect to base conclusions on causation on the basis of these reports. Once more, the opinion is in conflict with the opinions of Ms Gibson and Dr Lewer-Allen.

THE CROSS-EXAMINATION OF DR EARLE

[31] In cross-examination, Dr Earle made certain concessions. For example, he agreed with the general proposition that the outcome diagnosis is important to consider what the effects of a head injury are. He also agreed with the general proposition that an expert witness is expected to table the

facts or assumptions on which his/her opinion is based, and that an expert is not expected to stray outside his/her field of expertise, and ignore other relevant and collateral information.

[32] It was not in dispute that at the time of his assessment of K. , Dr Earle had available to him only, the EEG carried out at his clinic; the RAF1 and MMF1 forms; the Chris Hani Baragwanath hospital records; a 2008 psychometric report; Coronation hospital records relating to K. shortly after her delivery in the neonatal ward, and a 2009 note in regard to a urinary tract infection. Dr Earle, however, admittedly, did not make reference to any other medico-legal reports in this matter which were available to him at the time of his assessment. These reports included plaintiff's expert reports of Dr Lewer-Allen; Ms Gibson, Mr Lindah Möller, Dr Mahomedy; Dr Guy; Ms Mariana Olivier; and Ms Christa du Toit. In addition, Dr Earle did not have reference to the reports of the defendant's experts, which were also available at the time of his assessment of K.. Further in addition, the report of the defendant's educational psychologist, Dr Gumede, became available subsequently but Dr Earle again had no regard thereto. Dr Earle testified that the above reports were not given to him by the defendant's attorneys. He also did not enquire about other sources of information relevant to this case, or available at the time when he compiled his joint minute with Dr Lewer-Allen. Dr Earle, conceded in cross-examination that he in fact failed to take into account material facts in his reports. He also conceded, significantly too, that from the information at his disposal, it can be accepted that the normal EEG obtained at his rooms does not include the probability of brain complications, and that on the basis of the notes and reports available, to him, K., as a new born

baby, had not developed a systematic condition that could have led to secondary brain damage. He also conceded that there were various levels of consciousness stretching from between comatose, on the one hand, and fully consciousness, on the other hand.

[33] For his view that K. was certainly fully awake and aware when she arrived at hospital, Dr Earle said that the source of the recordal were the hospital records, only. He did not make the entries on any of those hospital records. He relied solely on the author or authors of those records. He made assumptions in this regard, and it is common cause that the author or authors of the records did not testify in the trial. It is equally clear that Dr Earle, for reasons not explained by him, refused to make other crucial concessions which he was expected to make in the circumstances of this case, in particular, that he failed, as an expert witness, to consider certain vital information for the purposes of his report.

[34] Again, for his view that, K. suffered no more than a very mild brain injury only with a facial abrasion and a normal skull X-ray, Dr Earle conceded that he relied completely on the correctness and reliability of the casual ward's hospital records for his opinion. In his opinion, a skull X-ray is a simple routine procedure when minors are injured in motor vehicle accidents, and that, it is not reasonable to opine that this is any indication of the severity of the brain injury sustained. Once more, for the view that K. suffered a mild traumatic brain injury with no significant intellectual or negative deficits at all, Dr Earle confirmed that he relied on the hospital records.

[35] Again on two crucial aspects, Dr Earle conceded not considering these aspects. The first is that K. was at the time of the accident in Grade R from which the plaintiff received no negative, but only positive feedback from the teachers. The second aspect is that, Dr Earle equally omitted to consider the available and collateral information in regard to K.'s performance and functioning post-accident on the occasion when the Grade 1 teachers called her mother to school in 2005, and enquired what since went wrong with K. . It will be recalled that at this enquiry, the teachers reported that K. had blank-outs which they never observed before the accident; that K. became a recluse, and no longer sociable; that her school marks in Grade 3 dropped to unsatisfactorily levels; that K. was referred to the Coronation hospital, in 2008; that her mother was hugely concerned about her lack of progress or regression at school, and the medical doctors recommended certain medication and placement in a remedial school; and that K. was again referred to the Coronation hospital two years later, i.e. in 2010. Indeed, there are other omissions of vital information by Dr Earle. Finally, Dr Earle was referred in cross-examination to the reports of other expert witnesses, who were all in agreement about the severity of the brain injury (not mild) sustained by K.. He, however, maintained that other explanations should be sought for K.'s fall outs and prior performance. He was not prepared to concede that K. may fall into the 4% of patients who suffer mild brain injuries, on his own criterion, and are left with significant *sequelae*.

[36] Prior to dealing with the actuarial or actuarial evidence, and the evaluation of the entire evidence, it is necessary to deal with some legal

principles applicable to the evidence of expert witnesses, in particular, the evidence of Dr Earle.

SOME APPLICABLE LEGAL PRINCIPLES

[37] The general trite principles are briefly that, an expert witness is employed to assist the court in deciding issues in which the court does not have the ordinary and requisite expertise; the opinion of an expert witness must be well-grounded and reasoned; the determination of the probable value and weight of an expert witness's evidence, is not always about credibility; and that judicial officers should be careful not to allow the opinion of an expert witness to take the place of their own finding of fact. In the present matter, the difficulty is compounded by the existence of conflicting expert opinions, i.e. that of Dr Earle on the one hand, and the opinions of Dr Lewer-Allen and Ms Gibson, on the other hand, as to the extent of the head injury. In addition, a large chunk of Dr Earle's opinion seemed to be based on either hearsay evidence or the omission to have had regard to relevant information.

[38] The case of *Buthelezi v Ndaba* 2013 (5) SA 437 (SCA), concerned the differences in opinion between medical experts in the determination of whether the operating surgeon was negligent or not. At para [14] of the judgment, Brand JA, said:

> "*… It is true of course, as the court a quo accentuated in its judgment, that the determination of negligence ultimately rests with the court and not with expert witnesses. Yet that determination is bound to be informed by the opinions of experts in the field which are often in conflict, as has happened in this case. In that event the court's*

determination must depend on an analysis of the cogency of the underlying reasoning which led experts to their conflicting opinions."

See also *Medi-Clinic v Vermeulen* 2015 (1) SA 241 (SCA) at paras [4] and [5], and *Schneider NO and Others v AA and Another* 2010 (5) SA 203 (WCC) at 211E. In regard to the undesirability of an expert witness relying on hearsay evidence, see *Nicholson v Road Accident Fund* 2012 JDR 0672 (GSJ) at para [4].

THE APPLICATION OF THE LEGAL PRINCIPLES

[39] In applying the above legal principles to the facts of the present matter, it is clear that the opinion of Dr Earle was not founded on logical reasoning, for a number of reasons as alluded in regard to both his evidence-in-chief and cross-examination. Dr Earle was unreasonably inflexible and rather dogmatic in his views. I almost gained the distinct impression that he was partisan which affected partly his credibility. As stated before, his opinion was based on limited information, and he omitted to have reference to material, collateral and available information. He relied on the contents of the hospital records, which were not proven in evidence. He was driven in cross-examination to make certain significant concessions which militated against the acceptance of his opinion on the disputed issue of the extent of the head injury. It was difficult to accept that the head injury, even of mild nature, cannot have negative effects on a minor of 5 years old. The evidence demonstrated that K.'s mother was extremely distraught at the fact that K. was discharged from hospital on the same day of the accident. This could only point to the inadequacy and unreliability of the hospital records, as proved later. Dr Earle's opinion was clearly not well-grounded, logical, reasonable and

properly reasoned. This is not a matter of the court simply preferring one expert opinion to the other. However, on the other hand, the views of Dr Lewer-Allen and Ms Gibson were not only complimentary, but were also well-founded, logical and well-reasoned. Ms Gibson, in particular, impressed as a knowledgeable and experienced expert witness in her field of expertise. She was objective and unbiased in her opinion. The criticisms levelled by the defendant's counsel against Ms Gibson's opinion, as well as Dr Earle's criticism of the neuropsychologists, educational psychologists, speech and language expert, and plaintiff's psychiatrist, were all without merit, in my view. These experts all considered the question whether there could be another plausible explanation for K. 's fall-outs, but then concluded by majority that the fall-outs is as a result of the brain injury. There is authority for the proposition that, in circumstances such as the present, the opinion of a neurologist, such as Dr Earle, may be overlooked or rejected by the court. I conclude therefore that the plaintiff has proved, on a balance of probabilities, that K. has suffered a significant head injury caused by the accident in question. I can put it no higher than a mild to moderate head injury.

[40] I now turn to the quantification of the plaintiff's claim for loss of earnings and earning capacity, as well as the applicable contingencies deductions to be applied thereto. Mr W Loots testified for the plaintiff. He, as an actuary, prepared an actuarial report on 15 April 2016. He had been provided with the joint minutes of the industrial psychologists dated 11 June 2015 and 17 June 2015, as well as a second addendum joint minute dated 18 June 2015. In addition, Mr Loots prepared a further report on 3 June 2016.

[41] In short, in regard to the pre- accident earnings information under the headings, "*SCENARIO 1*" and "*SCENARIO 2*", respectively, are in accordance with the information contained in the joint minute of the industrial psychologists. The post-accident earnings information on which Mr Loots based his calculations, accords with the contents of the addendum joint minute of the industrial psychologists. Mr Loots demonstrated results for contingency deductions of 20% to the pre-accident earnings scenario, and 30% to the post-accident earnings scenario, alternatively, 25% to the pre-accident earnings scenario, and 35% to the post-accident earnings scenario. The cross-examination of Mr Loots was uneventful. More about his calculations later below. The defendant's actuary was not called to testify since she was reported to be on maternity leave. In addition, in closing argument, and in its heads of argument, the evidence and calculations of Mr Loots were not seriously challenged, save to the extent of the divergence expressed in the original actuarial joint minutes. In any event, the defendant's actuary, as mentioned, did not testify.

[42] Based on Mr Loots' quantification, it was contended on behalf of the plaintiff, that it will be just and fair to both parties for the court, to accept, for quantification purposes, that it is equally likely that the plaintiff (K.), pre-morbidly, would have attained a degree as it is that she would have attained a diploma. On the same basis, it was submitted on behalf of the plaintiff that it will also be fair to both parties for the court to accept, for quantification purposes, that it is equally likely that the plaintiff, post-morbidly may now attain a Grade 12 (matric), without exemption as it is that she may attain only Grade 11.

[43] The calculations of Mr Loots, as encapsulated in Scenarios 1 and 2, were presented as follows:

Scenario 1A (CDT)		R 4 402 389,00
Scenario 1A (HTK)		R 4 279 373,00
Scenario 1B (Dipl/Grade 12)		R 4 126 976,00
Scenario 2A (CDT)		R 7 320 863,00
Scenario 2A (HTK)		R 7 194 868,00
Scenario 2B (Degree/Grade 12)		R 7 038 274,00
		R34 362 743,00
	÷	6
	=	R 5 727 123,83

[44] The average of the above calculation is about R5 727 123,83 (five million seven hundred and twenty seven thousand one hundred and twenty three rand and eighty three cents only), since it is not readily plausible to choose between the various scenarios.

[45] It was also submitted on behalf of the plaintiff that Mr Loots' above calculations should be used with the illustrative contingencies of 25% for pre-accident, and 35% for post-accident. The illustrative contingencies are indeed on the high side, in particular, in respect of the pre-accident scenario. This, the court debated with Mr Loots during his evidence. To him, the value of the contingency is important, and more particularly, the difference between the

pre-accident, and the post-accident contingency. The higher contingencies are more conservative. However, upon a careful consideration of all the circumstances of this case, I am of the view that the calculations are justified and fair. The amount of R5 727 123,83 ought to be awarded to the plaintiff in respect of loss of earnings and earning capacity. In this regard, the epilepsy condition of K., and the tender age, remain significant factors, to say the least.

[46] I revert to the manner in which the defendant ran the litigation, as alluded to above. The defendant raised the three basic defences, (a) that the head injury is insignificant, (b) that the previous accident contributed to the present *sequelae*, and (c) that "*family issues and stress*", contributed to K.'s post-accident problems. All these defences had no merit at all, and not proved. As a consequence, the plaintiff was compelled to call almost all of her witnesses, during which the so-called defences faded away, one after the after, in the face of the credible expert evidence. During the course of the trial, the report of one of the plaintiff's witnesses, Dr Mahomedy, was eventually admitted without the need for her to testify. It may indeed be so, as contended for by the defendant's counsel, that the defendant was not bound by the views of its own experts. However, to challenge the plaintiff's evidence, to compel the plaintiff to call all of her available witnesses, and thereafter, to present no countering factual and expert evidence, was not reasonable in the circumstances. I mention these issues simply since they have a bearing on the costs of the trial. In my view, and in the exercise of my discretion, a costs order on the scale as between attorney and client will be justified.

ORDER

[47] In the result the following order is made:

47.1 The draft order annexure “X”, as amended, initialled and signed by the court, and attached to this judgment, is hereby made an order of court.

47.2 It is specifically clarified that the defendant shall pay the costs of suit on the scale as between attorney and client.

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D S S MOSHIDI
JUDGE OF THE HIGH COURT OF SOUTH AFRICA
GAUTENG LOCAL DIVISION, JOHANNESBURG

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DATE OF HEARING	7 JUNE 2016
DATE OF JUDGMENT	16 SEPTEMBER 2016