HIGH COURT OF SOUTH AFRICA
GAUTENG LOCAL DIVISION, JOHANNESBURG

Case No: A5093/2014

(1) REPORTABLE: Yes
(2) OF INTEREST TO OTHER JUDGES: No.
(3) REVISED.

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DATE SIGNATURE

In the matter between:

PM **obo** **TM**
Appellant

and

MEC FOR HEALTH, GAUTENG PROVINCIAL GOVERNMENT Respondent

Case Summary: **Delictual damages – medical negligence - Appeal against certain parts of trial court's assessment of damages ensuing as a result of hypoxic brain injury sustained during the perinatal period leaving the child severely disabled by quadriplegic cerebral palsy. The appeal concerns the estimation of life expectancy, claims that had been settled but not awarded, the contingency deduction percentages applied and the downward adjustment of 50% in respect of the award for loss of earnings. The latter is based on the findings that the provincial government is obliged to maintain the child for the rest of her days and that she would never be able to utilise any such damages, if awarded. The appeal also deals eith the dismissal of the claim for general damages based on the finding that her condition precludes any compensation for non-pecuniary damages, the disallowance of the costs of administering a trust for the benefit of the child, the disallowance of certain items of the claim for the costs of suit and the dismissal of certain of the appellant's claims in her personal capacity, including her claims for past and future caregiving beyond the scope of duties of 'normal' parenthood. The respondent's cross-appeal raises the financial constraints of the Department of Health, Gauteng and everyone's constitutionally entrenched right of access to health care services, which is alleged to be compromised by lump sum awards. The respondent utilizes this as the basis for courts, in matters such as these, to**

develop the common law, and, instead of awarding a lump sum in respect of future medical and related expenses, to order the payment or provision of the required medical services and assistive devices by a defendant, such as the respondent, as and when they are required in the future.

JUDGMENT

MEYER J (WEINER and MONAMA JJ concurring)

INTRODUCTION

[1] This is an appeal and cross-appeal against certain parts of the judgment and order of the Gauteng Local Division of the High Court sitting in Johannesburg (Mayat J) assessing the *quantum* of damages that ensued because of a hypoxic brain injury sustained by the appellant's daughter, TM, during the perinatal period, which left her severely disabled by quadriplegic cerebral palsy. TM, who was born at the Chris Hani Baragwanath Hospital on 17 March 2005, has very little voluntary functional movement and is dependent on others for all activities of daily living. She has no use of words and appears to have profound mental retardation. She requires constant and permanent care, a variety of therapies, assistive devices and medical interventions and treatment of a general and specialist nature. She was nine years and five months old at the time of the trial, and is now almost twelve.

[2] The appellant instituted the action in her personal and representative capacities against the respondent, the Member of the Executive Council for Health, Gauteng Provincial Government. The negligence of certain members of staff at the Chris Hani Baragwanath Hospital, that TM's brain injury was caused by the negligence and that the respondent is liable for the ensuing damages have been admitted. The trial, accordingly, proceeded on the question of the *quantum* of damages only, from 12 to 29 August 2014. Judgment was delivered on 3 November 2014 and a revised judgment on 14 November 2014. The appeal and cross-appeal are with the leave of the trial court.

[3] The appeal concerns the estimation of TM's life expectancy, claims that had been settled between the parties but not awarded, the contingency deduction percentages applied, the downward adjustment of 50% to the award for loss of

earnings (based on the findings that the respondent is obliged to maintain the child for the rest of her days and that she would never be able to utilise any damages awarded her for loss of earnings), the dismissal of the claim for general damages based on the finding that her condition precludes her from being compensated for non-pecuniary damages, the disallowance of the costs of administering a trust for the benefit of TM, the disallowance of certain items of the claim for the costs of suit and the dismissal of certain of the appellant's claims in her personal capacity, including her claims for past and future caregiving beyond the scope of duties of 'normal' parenthood. The respondent's cross-appeal raises the financial constraints of the Department of Health, Gauteng and everyone's constitutionally entrenched right of access to health care services, which is alleged to be compromised by lump sum awards, such as the one that was made in this instance. The respondent contends that this is the basis for courts, in matters such as these, to develop the common law, and instead of making lump sum awards, to order the payment or provision of the required medical services and assistive devices by a defendant, such as the respondent, as and when they are required in the future.

[4] The appellant's appeal aims at having the award of damages made by the trial court increased and the respondent's cross-appeal to have the trial award reduced. The approach to be followed by this court of appeal to the trial court's award of damages is this:

'It is settled law that a trial Court has a wide discretion to award, what it in the particular circumstances, considers to be fair and adequate compensation to the injured party for his bodily injuries and their sequelae. It follows that this Court will not, in the absence of any misdirection or irregularity, interfere with a trial Court's award of damages unless there is a substantial variation or a striking disparity between the trial Court's award and what this Court considers ought to have been awarded, or unless this Court thinks that no sound basis exists for the award made by the trial Court.'

AA Mutual Insurance Association Ltd v Maqula 1978 (1) SA 805 (A), at 809B-D. Also, *Singh v Ebrahim* (413/09) [2010] ZASCA 145, para 148.

LIFE EXPECTANCY

[5] Life expectancy refers to the additional years which a person is expected to live, as from the person's age at the date of calculating the person's expected additional years. A person's expected death age is arrived at by adding the

additional years to the person's age at the calculation date. (See *AD and Another v MEC for Health and Social Development, Western Cape Provincial Government* (27428/10) [2016] ZAWCHC 181 (7 September 2016), para 87.) Prof Strauss, a mathematician and statistician who has worked as a medical researcher in the sphere of life expectancy for many years, and Prof Cooper, a paediatrician specialising in neonatology, were called as expert witnesses by the appellant and the respondent respectively to assess TM's likely life expectancy. They differed in their estimations. Prof Strauss estimated her life expectancy at 29.2 additional years and Prof Cooper at about 18 years. This issue is of considerable importance because of the effect it has on the calculation of much of the appellant's damages claims.

Prof Strauss

[6] Prof Strauss was a professor of statistics at the University of California for almost 30 years, and a fellow of the American Statistical Association. He has published more than 100 peer reviewed articles in the scientific and medical literature, most of these on life expectancy or related topics. He has been Director of the Life Expectancy Project in California since 1994, an internationally recognised research team based in San Francisco, who since 1980 had been focussing on statistical and epidemiological studies on children and adults with developmental disabilities (the California Group).

[7] Prof Strauss was instrumental in developing a database, the Californian Disability Services Register, relating to individuals who suffer from cerebral palsy and other disabilities (the California database). That database, which falls under Prof Strauss' authority, is by far the largest database of individuals with cerebral palsy in the world. It comprises about 300 000 individuals from California with childhood related disabilities, particularly cerebral palsy, but many other conditions too, such as down syndrome, autism and acquired traumatic brain injury. The California database includes more than 50 000 children with cerebral palsy, with very detailed information regarding their abilities, disabilities, the severity of their disabilities (*inter alia* in respect of walking, feeding, speech and mobility), psychiatric problems and social issues. Prof Strauss and his co-researchers are essentially statisticians who estimate life expectancy for individuals with cerebral palsy based on the information and data extracted from the California database. A pool or cohort is selected of similar disabled persons of the same age, gender and similar functional

abilities and disabilities (a stratified cohort) for comparison in the estimation of life expectancy. The assessments of the persons forming part of the California database are updated approximately annually and it is therefore possible to compare an individual, such as TM, with children of the same age who currently have the same pattern of disabilities as hers.

[8] The following description by Rogers J in *AD* (supra) of the methodology followed by Prof Strauss is concise and accords with the evidence in this instance:

'[88] There is no mortality data on South African CP (cerebral palsy] sufferers. The most extensive foreign data is from the Life Expectancy Project ('LEP') in California, spearheaded by Dr Strauss and his colleagues. The LEP has been tracking a large cohort of CP children in California since 1983. The data currently includes CP children up to age 29. The LEP receives annual information on each participant by way of a Client Development Evaluation Report ('CDER') submitted by the relevant caregiver or social worker.

[89] The CDER contains patient information on a wide range of symptoms and conditions and their severity. The data has enabled the LEP to determine the relative impacts of various CP symptoms and conditions on LE. In order to determine the LE of a specific CP boy (X), Dr Strauss selects from the LEP database a subset of male CP participants with more or less the same symptoms and conditions as X. The creation of the subset involves experience, expertise and judgment of a kind which Dr Strauss is pre-eminently qualified to bring to bear.

[90] If X were a Californian boy, it would not be necessary to travel beyond the Californian data to determine X's LE. More particularly one would not need to concern oneself with the ordinary male LE of Californian boys. However because ordinary LE differs from country to country the LE of CP children may also differ from country to country. One thus cannot apply the Californian data to a child in another country without adjustment. Since ordinary LE in South Africa is lower than in the United States, an adjustment is needed. The approach adopted by Prof Strauss, which is reasonable and has not been challenged, is to assume that CP LE in California and South Africa will differ in the same ratio as ordinary LE does.'

[9] Prof Strauss' main assumptions regarding TM for purposes of his assessment were that she was female, 9.3 years of age, suffered from cerebral palsy and: (i) was not tube fed, did not feed herself and must be fed completely; (ii) lifted her head in prone, rolled to either side and did not consistently roll over from front to back and back to front; (iii) did not sit without full support; (iv) had little if any functional hand use; (v) did not crawl, creep, scoot, stand, or walk; (vi) was

completely dependent in all activities of daily living; (vii) did not use words; and (viii) appeared to understand simple commands. These factors, according to Prof Strauss, are known to be predictive of survival/mortality. Her immobility and inability to self-feed were strongly adverse factors for her life expectancy. Positive factors were her abilities to lift her head in prone, roll from side to side and feed orally.

[10] The comparison group used by Prof Strauss to assess TM's life expectancy consisted of children of her age who have cerebral palsy and: (i) were not tube fed and were fed completely by others; (ii) lifted their heads in prone and had at least some rolling ability, but did not sit independently; (iii) had little if any functional hand use; (iv) did not crawl, creep, scoot, stand or walk; (v) were completely dependent in all aspects of their care; and (vi) did not speak but had at least some understanding of speech. Prof Strauss noted that overall this group captured TM's pattern of abilities and disabilities well and provided a much closer match to her than any of the groups considered in the published literature on life expectancy in cerebral palsy and was tailored to her specific age.

[11] There were some positive and negative clinical factors that Prof Strauss could not take into account, because suitable actuarial data was not available. The positive clinical factors, in the opinion of Prof Strauss, were that TM: (i) enjoyed reasonable general health; (ii) had a satisfactory weight (above the average for girls of her age with comparably severe cerebral palsy); and (iii) she had no problems with hearing. The negative clinical factors, according to Prof Strauss, were that: (i) she suffered from severe scoliosis, which might require surgery; (ii) her epilepsy had resumed after a two-year period (2011 to 2012) without seizures; (iii) she had dysconjugate eye-movement, even after she had undergone corrective squint-surgery, and was near sighted; and (iv) she had excessive drooling, which indicated an inability to handle secretions and therefore might represent some risk of aspiration. Prof Strauss expressed the view that some adjustment to his assessed life expectancy might be required if the balance of positive and negative factors were considered more or less favourable than average among children with comparable disabilities.

[12] Research by the California Group showed that there was improved survival in persons suffering from cerebral palsy from 1983 to 2002. Specifically, improvements

were found amongst children under the age of 15 who were immobile and fed by others and for adults who were dependent on gastronomy. Recent follow-up research by the California Group indicated that the previously observed trends of improvement had continued for all children, though at a slower rate, through to 2010. This trend was taken into account by Prof Strauss in estimating TM's life expectancy.

[13] Based on United States data, Prof Strauss determined that a similarly placed 9.3-year-old Californian girl suffering from cerebral palsy would have a life expectancy of 42.4% for that country (the normal U.S. figure being 71.9 additional years). He arrived at a life expectancy of 29.2 additional years (to age 38.5) by applying the same percentage to the ordinary life expectancy of a South African female at age 9.3, which is 68.8 additional years (to age 78.1) in accordance with Life Table 1 in the 2011 edition of Robert Koch's Quantum Yearbook. Prof Strauss determined that TM's median survival time is 26.8 additional years.

Prof Cooper

[14] Prof Cooper is professor and academic head of Paediatrics and Child Health at Charlotte Maxeke Johannesburg Academic Hospital and the University of the Witwatersrand. He explained that there were no South African experts equivalent to Prof Strauss. Prof Cooper, however, had studied the literature on the effects of cerebral palsy on life expectancy. He was also of the view that an estimation of the life expectancy of handicapped children needs to be based on large databases of such children who have been followed for a sufficient length of time. The two commonly used databases that have been used to provide estimates of survival for individuals with cerebral palsy, according to Prof Cooper, were the Californian Disability Services Register (Strauss *et al*) in the USA, which is by far the largest database, and the Mersey Cerebral Palsy Register (Hutton *et al*) in the UK. The data from Hutton *et al*, according to Prof Cooper, were difficult to apply when children have already got well beyond two years of age and were thus difficult to use in this case where TM had already reached 9.3 years of age. Prof Cooper considered Prof Strauss' calculation of TM's life expectancy as 42% of the general population to be a reasonable estimate.

[15] Prof Cooper referred to an article entitled '*Survival of Individuals with Cerebral Palsy born in Victoria between 1970 and 2004*' by Reid *et al* (the Reid study). The

Reid study reported on a data pool of 3 507 persons with cerebral palsy born in the Australian state of Victoria between 1970 and 2004 of whom 418 were known to have died by 31 May 2010 (the Victoria database). The Reid study gives survival probabilities at various ages, for various groups and TM fitted into the most unfavourable group as far as mortality was concerned.

[16] Prof Cooper expressed the view that, although the Reid study was based on a much smaller sample than the Californian database, the data were based on medical records rather than information obtained by non-medically trained people as, according to him, was the case with the California database, and were thus likely to be of a better quality. The Reid study, according to Prof Cooper, was more applicable to TM's condition, because her condition arose from the perinatal period. The Reid study was based on those children whose disability dated from the neonatal period, whereas the California database includes all those with cerebral palsy at the age of 9 years regardless of age of onset. The Reid study found that those born at term had a lower survival rate than those born preterm, given the same degree of handicap. It did not find a trend towards increased survival over the four decades during which the study had been conducted.

[17] The data from the Victoria database are presented according to the severity of disability and TM would fit into the group with the most severe motor disability and at least three to five additional impairments, namely epilepsy, profound intellectual impairment and lack of speech. Figure 2 from the Reid study shows that around 80% of those with this degree of disability from birth would survive to 9 years of age whereas only 40% would survive to 25 years of age. The median survival for a 9-year-old in that category would be an additional 16 years. Prof Cooper agreed that median survival is not the same as life expectancy and that an actuary needed to translate that figure into life expectancy. He noted that the difference between median survival and life expectancy on Prof Strauss' calculation was only 2.4 years longer. On that basis, according to Prof Cooper, the data from the Reid study would predict a life expectancy of around 18 additional years for TM. Prof Cooper was, however, also of the opinion that because TM had been born at term, her life expectancy would even be less than his estimated 18 years.

Prof Strauss' response

[18] Prof Strauss took issue with certain of the comments and views expressed by Prof Cooper. He disagreed that the Victoria database was likely to be of a better quality than the California database. He explained that the medical information in the California database had been obtained from medical specialists. The functional information – such as the ability to walk without support – had not, but these functional items had been specifically designed to be simple observations that can be assessed without medical training.

[19] Prof Strauss disagreed that the Reid study was more applicable to TM's condition, because her condition arose from the perinatal period. First, according to him, the vast majority of cases of cerebral palsy were early onset. Second, the research data indicated that the difference between perinatal injury and slightly later onset was not a significant one for the estimation of life expectancy. Thirdly, one major advantage of the California database over that of the Hutton and Reid studies was that assessments were available at the child's current age rather than at a single and much earlier point in time.

[20] Prof Strauss agreed that the Reid study found that those born at term had a lower survival rate than those born preterm, given the same degree of handicap. Hutton, according to Prof Strauss, showed a similar result, but her comparison, in his view, did not take account of the severity of the disabilities. Prof Strauss was of the opinion that it seemed likely that amongst children with cerebral palsy, those who were full term births were on average more severely disabled. This, in his opinion, would explain why the mortality rate was higher amongst them. Reid's measures of severity of disabilities, in the opinion of Prof Strauss, were crude and did not fully adjust for the various degrees of severity. The California Group's research indicated that once one had taken the severity of disabilities fully into account, full term *versus* pre-term was not a significant factor for life expectancy.

[21] Prof Strauss agreed that the California database was the first to have shown a secular trend towards improved survival over time. It was likely, according to him, that the much larger database, detailed information on function, and more sensitive statistical methods used by the California Group could reveal a trend that had not been detected in the works of other groups. In the Reid study, it was concluded that

'[c]ontrary to expectation, no improvement in survival was seen over the 40 years of the study'. In this regard the following was stated:

'There are a number of reasons to expect survival to have improved over the past half-century. Vigorous treatment of infections, scoliosis surgery, advances in intensive care and ventilator support, better antiepileptic medication, and a trend away from institutional care would all be anticipated to improve mortality. Moreover, we now have a better understanding of the importance of appropriate nutritional status in individuals with severe disability, a greater appreciation of the risks of aspiration, improved surgical procedures for gastrostomy and fundoplication, and better gastrostomy feeding techniques. Despite those advances, most studies have reported no evidence of improved survival over the past two to three decades. Only the California group has provided evidence demonstrating significantly better survival for children who were largely immobile and fed by others, and adults dependent on gastrostomy feeding.'

[22] Prof Strauss testified that the use of the Reid study to determine TM's life expectancy was 'very questionable'. It, in his opinion, was 'not tailored to [TM's] particular pattern of abilities and disabilities'. The category in which she fitted, in terms of the Reid study, included children who had to be fed by a tube because of an inability to take food by mouth and to swallow. Children who need gastrostomy because they cannot feed safely by mouth, according to him, were more disabled than those who could feed by mouth and their life expectancies were shorter. Prof Strauss also pointed out that the Reid study did not make any distinction for a child who, although unable to walk, could lift her head in prone and roll from side to side.

[23] Prof Strauss agreed that, according to Reid's criteria, TM would fall into the group with severe motor disabilities and at least three of five additional impairments. Prof Cooper's analysis based on this classification was, in the opinion of Prof Strauss, 'roughly correct'. The figures given in Reid's Table 2, based on survival from age 10 to age 30, according to Prof Strauss, resulted in a median survival time of 16.7 additional years. But he pointed out that the data also extended to age 40, and Reid's figure for that age resulted in a median of 21.6 years. It was common cause that the median was generally less than the mean, which is life expectancy. Prof Strauss was of the opinion that the higher mortality rates in the group cited by Reid into which TM fell led to a larger difference between the median and the mean than 2.4 years, and would be about three to four years. Thus, the Reid study indicated a life expectancy for TM in the range of between 20 to 25 additional years,

which was a little lower than Prof Strauss' estimation of 29.2 additional years. Prof Strauss was of the opinion that the Reid analysis did not take account of two key positive factors that were present in TM's case: First, her ability to take her nutrition orally rather than by gastronomy (adjustment for this alone would, according to Prof Strauss, be enough to explain the difference between his assessment and one based on the Reid study), and second, TM's mobility through rolling. Prof Strauss was also of the view that a further adjustment should be made to the calculation based on the Reid study for improved survival in cerebral palsy in recent decades.

Trial court's findings on life expectancy

[24] In rejecting Prof Strauss' assessment of TM's life expectancy, the trial court found as follows:

'Given the fact that Strauss is not a medical expert, it is my view that his postulations based only upon statistical information cannot gainsay the medically substantiated research and inferences of the Reid study. Thus, the statistical analysis based on the California database cannot gainsay scientific research over four decades by the Reid study, merely by virtue of the fact that the Californian database is larger. Stated in another way, it was not established on a balance of probabilities that the variables identified by Strauss cumulatively or individually were causally connected to [TM's] life expectancy.'

The trial court accepted that the figures given in Table 2 of the Reid study led to a median survival time of 21.6 additional years for TM. It then found that-

'[i]f one further accepts Strauss' initial unqualified statement to the effect that the difference between the median survival time and the mean (for life expectancy) was generally 2.4 years, then it is my view that the additional years of [TM] can be more realistically, logically and probably postulated to be 24 years, without taking into account any of the positive or negative factors, referred to be Strauss.'

The trial court concluded by finding:

'Taking all the above factors raised by Cooper into account [that TM was born full-term] as well as the negative factors admitted by Strauss, it is my view that the above calculation of 24 additional years for [TM] must be adjusted downwards to 22 additional years. As such, [TM's] total life expectancy can be postulated to be approximately 31 years.'

[25] In my view, the trial court erred in its outright rejection of Prof Strauss' assessment of TM's life expectancy. His eminence and expertise in the field of life expectancy was acknowledged by the Supreme Court of Appeal in *Singh* (supra, paras 13 *et seq* of the majority judgment and paras 150 *et seq* of the minority

judgment) and by different divisions of the High Court (see *AD* (supra), paras 84 *et seq* and the *NM Mzima v MEC for Health* (unreported judgment of the South Gauteng Local Division delivered on 22 October 2015 (Case No. 29512/2012)) as well as in other jurisdictions (see *Whiten v St George's Healthcare NHS Trust* [2011] EWHC 2066 (QB), paras 18 *et seq* and *James Robshaw v United Lincolnshire Hospitals NHS Trust* [2015] EWHC 923 (QB), paras 39 *et seq*).

[26] Furthermore, as was remarked by Snyders JA in the minority judgment in *Singh* (supra), –

'[153] Before statistical evidence was available to make an estimate of life expectancy based on statistical calculation, the courts had to embark on making a round estimate of what seemed fair and reasonable in the circumstances. This is not such a case.

[154] Strauss' studies have shown which variables affect life expectancy. Voluntary motor function, for example, has been shown and is generally accepted as the key determinant of life expectancy. In the studies conducted, Strauss specifically controlled for the ability to consistently and typically lift the head in prone and roll. On key variables good statistical data which facilitates a more accurate calculation, exists. On variables like cognitive function statistical data does not exist, but they could and should be factored into the assessment as positives and negatives resulting in some adjustment.'

[27] Prof Strauss was careful to emphasise that it was for the court, with the help of medical professionals, to determine whether an adjustment should be made for the positive and negative clinical factors which he could not factor into the assessment, because of the unavailability of suitable actuarial data. He also emphasised that the appropriate South African Life Table to use was 'a matter for the parties and/or the Court to determine.' The opinions advanced by Prof Strauss, in my view, were founded on logical reasoning (see *Michael and Another v Linksfield Park Clinic (Pty) Ltd and Another* 2001 (3) SA 1188 (SCA), paras 34–40). His reasoning and the opinions advanced by him convincingly refuted the conflicting views that the Victoria database was likely to be of a better quality than the California database, that the Reid study was more applicable to the calculation of TM's life expectancy because her condition arose from the perinatal period, that her life expectancy would probably be less because she was born full term and that the secular trend towards improved survival over time as showed in the California database should not have been taken into account in estimating her life expectancy. Prof Strauss convincingly showed that the predictors of mortality used in the Reid

study were, in certain material respects, not tailor-made for TM's particular pattern of abilities and disabilities. By contrast, Prof Strauss had access to the much larger California database, detailed information on function, and sensitive statistical methods used by the California Group. His comparison included a large cohort of disabled children of the same age and gender and with similar severity profiles to those of TM.

[28] Furthermore, Prof Strauss did not express the view that the difference between the median survival time and the mean was always 2.4 years. He expressly pointed out that the higher mortality rates of the group cited by Reid, into which TM fell, led to a larger difference between the median survival time and the mean than 2.4 years, and would be about three to four years. The trial court was accordingly wrong in accepting that the difference between the median survival time and the mean in a calculation of TM's life expectancy based on the Reid study was 2.4 years.

[29] The question now is whether an adjustment should be made for the positive and negative clinical factors which Prof Strauss could not factor into the assessment of TM's life expectancy. Dr Lippert, a paediatric neurologist, furnished written comments on the positive and negative clinical factors raised by Prof Strauss and some of them were addressed in his oral evidence. The fact that TM had no problems with hearing was in his opinion 'a very minor point in estimating life expectancy'. Much weightier was the commitment of her parents to nurse and tend to her and her access to quality medical care. Dr Lippert was of the view that her epilepsy was unlikely to influence or affect life expectancy 'much' in her case, if attended well. Regrettably, no reasons for his opinion were advanced nor was epilepsy as a predictor of mortality in individuals with cerebral palsy canvassed with him when he testified. He expressed the view that TM's near sightedness was unrelated to her condition and brain damage. She also had abnormal eye movements, even after she had corrective squint-surgery, and central or cortical visual impairment because of damage to her brain. Dr Lippert was of the opinion that the possibility of her visual impairments affecting her life expectancy was remote. In regard to excessive drooling, he agreed that this might be a negative factor in terms of life expectancy if it was caused by tongue thrusting and by weakness of the ability to clear the throat and swallow well (her tongue did not have

the coordinating ability to interiorise food, it was inept), but that it would have less of an impact if it was caused by an inability to close her mouth or seal her lips because of a motoric disability. He placed TM in the 'moderate to better category' as far as the risk of aspiration pneumonias was concerned.

[30] Dr Versfeld, a specialist orthopaedic surgeon, was of the opinion that TM's scoliosis was 'somewhere between moderate and severe'. If untreated, in his opinion, it would adversely affect her life expectancy: First, from a functionability point of view; and, second, if the spinal curve gets too large, it would ultimately negatively impact on her respiratory function. She required surgery to correct her spine. Surgery, according to him, would improve the functionability of both her upper and lower limbs, she would be better off with sitting and standing and her lung function would be protected. Surgery, in his opinion, 'would be somewhere between a small and medium size intervention' and TM 'would sustain the surgery well', the chances that the surgery would be successful 'are very high' and the 'risk of complications is low here'. The respondent did not lead any evidence to contradict the medical opinions of Dr Lippert or Dr Versfeld in relation to the positive and negative clinical factors raised by Prof Strauss.

[31] The Reid study found epilepsy to be amongst the predictors of mortality for individuals with cerebral palsy and it found respiratory causes (pneumonia, respiratory failure, influenza or lower respiratory tract infection, pneumonitis due to food and vomit, obstruction/asphyxiation from a foreign body, and other respiratory causes such as asthma and acute bronchiolitis) to be the most common direct causes of death.

[32] In his medico-legal report, Prof Strauss stated the following regarding scoliosis as a predictor of mortality:

'A potential concern here is the severe scoliosis, which in some cases becomes a life-threatening condition. The research literature suggests that if successful surgery occurs then the long-term excess mortality rate is minimal, but if for some reason the needed surgery does not occur then the mortality risks are very high. It may be that this issue deserves further consideration.'

[33] I have no reason to doubt that TM will receive the required surgery for her severe scoliosis and that the surgery would probably be successful with a low risk of

complications. The adverse impact of scoliosis on her life expectancy, therefor, seems minimal. But her epilepsy and her risk of aspiration indicate that a downward adjustment should be made to the life expectancy of 29.2 years estimated by Prof Strauss. The unanimous decision of the Supreme Court of Appeal in *Singh* (supra), paras 65 and 199, was that the South African 1984/1986 life tables, although out of date, were still the best available and they were thus applied to the assessment of the life expectancy of the child in that case. Therefore I propose to apply the 1984/1986 life tables to the assessment of TM's life expectancy, which results in a further downward adjustment of Prof Strauss' estimation, and to follow Rogers J in *Du Toit* (supra), paras 176-197, in making a further downward qualitative adjustment based on the more recent information and data that became available after the 2010 census and Statistics South Africa (SSA) in 2015, producing male and female life expectancies at birth for persons not at risk of HIV/AIDS.

[34] Thus, my assessment arrives at a life expectancy of about 26 additional years for TM. The difference of four years between my assessment and the trial court's estimate of 22 additional years does not warrant interference in a matter that is essentially speculative. (See *Singh* (supra), para 66.)

SETTLED ITEMS OF TM's CLAIM FOR FURURE MEDICAL AND RELATED EXPENSES NOT AWARDED

[35] During the course of the trial the parties settled numerous items included in the appellant's claim for TM's future medical and related expenses, in most instances subject only to a calculation based on the life expectancy of TM as determined by the court and the defence raised by the respondent in respect of the lack of financial resources. The parties recorded the settled items in a list of some 60 pages, which they submitted to the trial court (the compromise). The trial court, however, despite its determination of TM's life expectancy and its rejection of the respondent's defence of lack of financial resources, excluded many items that were settled between the parties from the award it made in respect of TM's future medical expenses. The items which were agreed, but not awarded (items 5, 7-9, 13, 15-18, 20.1-20.3, 22-23, 51-52, 54-55, 72-90, 91.1-91.29, 92-97, 99 and 101 listed in the compromise), can be grouped roughly into items relating to psychiatric treatment, urological treatment, orthotics, speech therapy and occupational therapy up to the

age of 18 (the agreed but excluded items). The undisputed total cost of the agreed but excluded items, actuarially calculated on a life expectancy of 22 years, is the sum of R3 002 748.00.

[36] The parties also agreed that TM should be awarded a 'Rodeo' mobile positioning chair, to be replaced in four years for the next size up, and thereafter in eight years for the next size up, and for its upholstery to be replaced every two years, except in the years of replacement of the Rodeo mobile positioning chair (the Rodeo wheelchair). (This aspect of their agreement is listed in items 67 and 68 of the compromise.) The trial court accepted the evidence that TM would require the Rodeo wheelchair, which provides good pelvic and spinal posture, and for it to be replaced twice. The court then awarded a rounded off amount of R30 000.00. However, the undisputed total cost of the Rodeo wheelchairs, including the upholstery replacements, actuarially calculated on a life expectancy of 22 years, is R179 186.00.

[37] *Hlobo v Multilateral Motor Vehicle Accidents Fund* 2001 (2) SA 59 (SCA) concerns a compromise agreement that was made an order of court. Therein, Plewman JA said the following:

'[10] The proper approach to the question, in my view, should have been as follows. A compromise (or *transactio*) arrived at between litigants is a well-established measure. Our courts encourage parties to deal with their disputes in this way and the rules decree that compromises must be sought. When concluded such a compromise disposes of the proceedings. *Estate Erasmus v Church* 1927 TPD at 23.'

[38] *Slabbert v MEC for Health and Social Development, Gauteng* (432/2016) [2016] ZASCA 157 (3 October 2016) also concerns a compromise agreement that was made an order of court. Therein, Potterill AJA said the following:

'[7] An agreement of compromise creates new rights and obligations as a substantive contract that exists independently from the original cause. The purpose of a compromise is twofold: (a) to bring an end to existing litigation and (b) to prevent or avoid litigation. When a compromise is embodied in an order of court the order brings finality to the lis between the parties and it becomes *res judicata*. The court order changes the terms of a settlement agreement to an enforceable court order – through execution or contempt proceedings. Thus, litigation after the consent order will relate to non-compliance with the consent order and not the underlying dispute.

[8] This being said, a *transactio* (compromise) is made by consent between parties and like any contract or order of court made by consent, it may be set aside on the ground that it was fraudulently obtained. It may also be set aside on the ground of *justus error*, 'provided that such error vitiated true consent and did not merely relate to motive or to the merits of a dispute which it was the very purpose of the parties to compromise.' A compromise agreement may also be set aside if the parties to the agreement laboured under a common mistake. However, a unilateral mistake on the part of one party that does not flow from a misrepresentation by the other does not allow for the former party to resile from a consent agreement. The question thus is whether one of these grounds exists for the MEC to resile from the compromise agreement.

. . .

[16] The court a quo was correct that a court cannot ignore facts placed before it, but these facts must sustain one of the established grounds on which a compromise agreement can be rescinded. Although a High Court has inherent discretion, it can never exercise it against recognised principles of substantive law. Our constitutional dispensation does not afford courts a carte blanche to ignore substantive law and grant orders couched as being in the 'interests of justice'. Moreover, certainty and finality are key elements of justice. Parties to a compromise agreement accept an element of risk that their bargain might not be as advantageous to them as litigation might have been. This element of risk is inherent in the very concept of compromise. It, however, does not afford parties the right to go back on the bargain for unilateral mistakes. Settlement agreements have as their underlying foundation the benefit of orderly and effective administration of justice. Courts cannot allow for consent orders to be set aside for reasons not sanctioned by applicable legal principles.'

[39] The trial court, therefore, exercised its discretion against recognised principles of substantive law. It did not have a discretion to exclude the agreed items from the award for TM's future medical and related expenses in circumstances where there was no justification in law to set aside the compromise. No facts were placed before the trial court to sustain one of the established grounds on which a compromise can be rescinded.

[40] The additional sum of R2 702 473.20 (the total cost of the agreed but excluded items in the sum of R3 002 748.00 minus a 10% contingency deduction in the sum of R300 274.80, which contingency deduction counsel for the appellant agreed would be fair in all the circumstances and counsel for the respondent did not argue otherwise) plus the additional sum of R131 267.40 (the total cost of the Rodeo wheelchairs, including the upholstery replacements, in the sum of R179 186.00

minus a contingency deduction of 10% in the sum of R17 918.60 and minus the sum of R30 000.00 awarded by the trial court) must be added to the sum of R12 470 738.00, which the trial court awarded in respect of TM's future medical and related expenses. The total sum to be awarded in respect of TM's future medical and related expenses, therefore, is the sum of R15 304 478.60.

CONTINGENCIES

[41] The trial court applied contingency deductions to TM's future medical and related expenses. The deductions were 10%, 15%, 25% (in a few instances) and 40% (in one instance). The trial court did not furnish reasons for its application of contingency deductions and the different percentages. We were informed by counsel for the appellant (and counsel for the respondent did not take issue with him on this), that the relative average is 14.8%. The appellant appeals the contingency deductions of 25% and the one of 40%. The appellant does not contend for nil contingency deductions (except in the instance where the trial court applied the 40% deduction to the award for house adaptations to make it wheelchair accessible and to accommodate a live-in carer and a therapy room), but that the contingency deductions of 25% should be reduced to 10%.

[42] The application of contingency deductions '. . . is essentially a matter of judgment resting on the judge's view of the likelihood of the expenses allowed actually being incurred' (*Singh* (supra), para 74). The trial court in *Singh* (*Singh and another v Ebrahim (1)* [2010] 3 All SA 187 (D), para 107) held that-

'[a]djustment should be made as part of a suitable contingency for the following:

(a) that the maximum tariff may have been applied in some instances;
(b) that the effectiveness of some of the therapies may be questioned;
(c) whether the therapies will continue for the full proposed program, also in view of the relative lateness with which some of the therapies have been commenced with N;
(d) the concern whether some of the therapies will be carried out with the diligence with which they have been claimed (although this might require merely a minor adjustment);
(e) the difficulties of fitting in all the therapies as N's position might change from time to time;
(f) the possible interruption of certain therapies if no benefit is to be gained from the continued application thereof;

(g) to make allowance for some break (but not 12 weeks) per year;

(h) It must also be remembered that N's performance fluctuates from day to day which will enable him to fit in less therapy in some days and more in others. Miss Hattingh testified that what he can do one day he will not necessarily be able to do the following day (balancing therapy which is of a physical nature with therapy of a more academic nature could possibly go some way in addressing this difficulty).'

[43] The Supreme Court of Appeal did not interfere with the discretionary decision of the trial court in *Singh*. In this regard Conradie JA, para 74, said the following:

'Judging by the therapeutic aids he has been given thus far, there is a distinct prospect that Nico will not be given all the aids for which provision has been made. I also share the judge's view that Nico will probably not have the time or energy to fit in all the many therapies provided for and moreover he is now four years older and some of the therapies will no longer assist in improving his condition.'

[44] I am of the view that interference by this court with the discretionary decision of the trial court to apply a 25% contingency deduction to some of the items comprising its award for TM's future medical and related expenses, is not warranted. The factors that were taken into account in *Singh* in making the adjustment as part of a suitable contingency also apply in this case. TM has been given a multitude of therapeutic aids and there is also a distinct prospect that all the expenses allowed will not actually be incurred.

[45] In support of the claim for house adaptations in the sum of R1 250 900, the appellant relied on the report of an architect, Mr Len Eybers, which report was admitted by the respondent. The respondent also admitted liability for the reasonable costs of house adaptations, subject to the defence relating to the lack of financial resources. The trial court held as follows:

'As regards the future costs of adapting a notional home, specifically tailored for [TM], it appeared from all the evidence that [TM's] parents are comfortably settled in their present home with [TM] as well as her brother. Her parents do not suggest moving out of the family home, which they have purchased and their home is also conveniently located near Pathways [the care centre TM attended]. However, I also appreciate that the family home may possibly require certain adaptations as [TM] grows. As such, I intend to grant damages for the estimated costs of a future notional, ideal home recommended, subject to a large contingency deduction of 40%. Both actuaries computed this amount to be R750 000, after deduction of the stated contingency allowance as directed by me.'

[46] Although not said in so many words, it seems that the trial court applied a much higher contingency rate to the claim for house adaptations because of its view of the real likelihood of the expense or a great part thereof, if awarded, not actually being incurred. I do not believe that this court should interfere with that discretionary decision. Furthermore, the amount claimed was based on costing that was estimated by an architect and not calculated by a quantity surveyor. In his report Mr Eybers designed a notional house to which he added the additions for the requirements of TM and he estimated the costs of the additions. His estimates were based on 'an architectural square meter basis' and he stated that '[i]f more detailed and specialised costs calculations and estimates are required on a measured basis, deference is made to a quantity surveyor.' The amount claimed also does not seem to me to be reasonable in its entirety. (See the judgment of the trial court in *Singh* (supra), paras 135-148, where an amount of R61 500.00 was allowed for house adaptations.) It would be unreasonable to expect the respondent to pay for items, such as the 'overhead track system' at an estimated cost of R219 863,81, which is included in Mr Eybers' total estimated cost. The overhead track system, according to Mr Eybers, is a system-

'. . . that allows one person/helper to lift or lower [TM] by operating a keypad attached to the motor hoist. When [TM] is at the correct height in the sling, she can be conveniently pushed to any position between the fixed beams in the Therapy room, Bedroom 4, and Bath 3. Once she is in the correct position above the bed, toilet, bath, basin, shower and even her wheelchair, she then can be conveniently lowered with the motor hoist.'

LOSS OF EARNINGS

[47] The industrial psychologists, Ms Donaldson and Mr Marais, who were called as expert witnesses by the appellant and the respondent respectively, were *ad idem* that, but for her disabilities, TM would probably have achieved matric and a three-year diploma or degree qualification. According to Ms Donaldson's postulation, TM would have entered the work force at a lower salary than that commanded by her qualifications, to get a foot in the door. She postulated an entry level salary commensurate with the Paterson C4 job grading, with straight line increases to the C4 level, reaching a peak in her career at age 45 and thereafter inflationary increases until retirement at age 65. Mr Marais postulated an entry level salary commensurate with the Paterson job grade level B2/B3, moving upwards every four

years to the 50th percentile of each level, reaching a ceiling at the C4 level at age 45 and thereafter inflationary increases until retirement at age 65.

[48] The trial court, correctly in my view, considered a median between the postulations of Ms Donaldson and Mr Marais appropriate for the quantification of TM's loss of earnings. Based on a diminished life expectancy of 22 years and the assumption that TM would not have been promoted during her expected working life of a few years, the trial court awarded the sum of R1 500 000 for TM's loss of earnings, less a 50% contingency deduction, resulting in a net award of R750 000. In arriving at the percentage of the contingency deduction, the trial court said the following:

'The relevant contingencies in this respect are the hazards of life including unemployment, illness, errors in the estimation of earnings and life expectancy, early retirement as well as other hazards of life. In addition, for reasons already given I am of the view that a further downward adjustment must be made to take account of the fact that the defendant is obliged to maintain [TM] for the rest of her days in an amount far in excess of any salary, which [TM] would probably have earned for the duration of her expected life time. A relevant consideration in relation to my discretion in this respect, as already stated, is the reality that [TM] will never be able to utilise any damages awarded her for loss of income, either directly or indirectly. This is particularly so as her needs and requirements, as set out above, will be paid by the defendant.'

[49] The trial court's finding that the respondent is obliged to maintain TM for the rest of her days is factually and legally incorrect. The respondent is by virtue of the delict committed against TM obliged to compensate her for the damages she incurred, particularly her general damages, her medical and related expenses and her loss of income. There is no duty in law on the respondent to maintain her for the rest of her days. The trial court's finding that TM 'will never be able to utilise any damages awarded her for loss of income, either directly or indirectly', has no factual basis either. The damages awarded for her loss of earnings may well be used for her support, and will probably be so used beyond the years of parental responsibility.

[50] The trial court's large contingency deduction of 50% is also substantially out of general accord with the contingency deductions previously applied in comparable cases. In *Singh* (*Singh and another v Ebrahim* (8027/2004) [2008] ZAKZHC 112 (30 July 2008), para 9) diminished life expectancy was assessed, and, in awarding

damages for loss of earnings, Koen J applied a contingency deduction of 15%. In *AD* (supra), paras 586-599, Rogers J considered a number of decided cases and the factors to be taken into account, also that the child's life expectancy of 48 additional years was significantly longer than that of the child in *Singh*, and a contingency deduction of 17,5% was applied to the minor child's award for loss of earnings.

[51] I agree with counsel for the appellant that it would be fair and appropriate for this court to apply a 20% contingency deduction to TM's estimated loss of earnings. We requested the parties to furnish us with actuarial calculations *inter alia* on the basis of a life expectancy of 22 additional years from 14 November 2014 and in which the postulations of Ms Donaldson and of Mr Marais are averaged. The appellant obtained such actuarial calculations from the actuary, Mr GA Whittaker, and the respondent did not take issue with his calculations. TM's loss of income was calculated in the sum of R1 312 495 (R1 640 619 less 20% contingency deduction in the sum of R328 124), which is the amount I propose to award.

GENERAL DAMAGES

[52] TM is permanently disabled and has a diminished life expectancy. In short, she has severe and irreversible brain damage, very little voluntary functional movement and is dependent on others for all activities of daily living. She has no use of words and appears to have profound mental retardation. She has abnormal eye movements and visual impairments, is unable to feed herself, at risk of aspiration pneumonias, is doubly incontinent and an epileptic. She has scoliosis and severe spasticity of her muscles, which is painful and results in contractures for which surgery is required. She is prone to developing significant psychological and psychiatric disorders. She requires constant and permanent care, a variety of surgical interventions, medical treatments, therapies and assistive devices. It requires no elaboration that TM has suffered a devastating loss of the normal amenities of life.

[53] The trial court, however, dismissed the claim for compensation for TM's general damages, that is to say damages for pain and suffering and loss of amenities of life. In finding that TM was not entitled to compensation for her non-pecuniary damages, the trial court relied on the decision in *Collins v Administrator Cape* 1995 (4) SA 73 (CPD). The plaintiff in that case was the father of a baby of 16

weeks who was a patient in the paediatric tracheostomy unit of the hospital in question where she sustained irreversible brain damage as a result of the displacement of a tracheostomy tube on which she was dependent for ventilation. The duration of the cerebral hypoxia was such as to result in irreversible brain damage. The hospital staff was found to be negligent in failing promptly to replace the tube. After an initial prolonged coma the child passed into a permanent vegetative state, which would remain for the rest of her life, estimated at the time of the trial to be another two to seven years. The child was unable to see or to swallow; had no awareness of environmental stimuli or pain nor any apparent awareness of herself. She was found 'in every respect a "cabbage" case'.

[54] Scott J pointed out that '[t]he problem of how to compensate persons in such a condition (frequently referred to in the cases as the "unconscious" plaintiff) has been the subject of much debate and difference of judicial opinion' and he then reviewed the position in England, Australia, Canada, Germany, the Netherlands and in our law. Scott J *inter alia* said the following:

'Where, as a result of injury, a plaintiff is mentally retarded even to the extent that he may have no insight into his loss, provided only that he has awareness, an award of non-pecuniary damages can be utilised for his benefit even if the expenditure is frivolous and does no more than amuse him. Where the plaintiff is unconscious and all his physical needs have been taken care of, the truth of the matter is that it is not possible to compensate him for his loss. It is like paying a dead person money in order to compensate him for the loss of his life.'

Scott J held that the plaintiff in that case was not entitled to an award of non-pecuniary damages. In conclusion he said the following:

'In the circumstances of the present case, however, any award would not only serve no useful purpose, it would serve no purpose at all, whether useful or otherwise. The claimant, by reason of her condition, is in truth, incapable of being compensated by a monetary award.'

[55] But the present case does not concern an unconscious claimant. TM is not in a vegetative state nor would she, by reason of unconsciousness, not be able to derive any advantage from an award of non-pecuniary damages. I need only refer to the evidence of TM's mother and father as was correctly and concisely set out in the judgment of the trial court. Her mother testified-

'. . . that although [TM] is not able to communicate verbally, she appears to be aware of her surroundings. She has relatively good vision and her hearing is intact. She is capable of understanding some English, Southern Sotho and Zulu. She is also capable of making certain sounds, such as moaning. She can smile, laugh out loud, and become very excited on certain occasions, such as when she sees one of her parents. . . . When she is fed at home, she sits on the lap of one of her parents. At school she is fed whilst sitting in her buggy.'

And further:

'Despite her severe disabilities, the plaintiff indicated that [TM] is alert and able to recognise some objects and pictures. She is also aware of the functional uses of some objects and is able to convey certain choices to her parents, including her choice of food. She also cries when she is upset. She enjoys activities such as horse riding, swimming, swinging in a hammock, kicking her legs and being on the trampoline. She enjoys some music. She laughs if her parents laugh or gesture to her in a certain way.'

Her father-

'. . . also confirmed that he takes [TM] to school every day. He indicated that he generally arrives home from work by 6 pm about three times a week to assist with feeding [TM] and to play with her. He explained in this respect that [TM] had to be positioned properly, before she can be fed. It was also his testimony that as [TM] has grown, only he can effectively carry her. He also tries to make time to play with [TM] as well as her brother. He indicated in this regard that [TM] loved playing on the trampoline and that she also likes "playing soccer", if he held her up and "walked with her".'

[56] As was stated by Rogers J in *AD* (supra), para 618:

'Money cannot compensate Imaad for everything he has lost. It does, however, have the power to enable those caring for him to buy things which may alleviate his pain and suffering and to provide him with some pleasures in substitution for those which are now closed to him. These might include certain of the treatments which I have not felt able to allow as quantifiable future medical costs . . . .'

[57] Taking all things into account as well as the past awards for general damages in similar cases, such as *Singh* (Koen J awarded R1,2 million which would be more than R1,8 million today, if updated), *AD* (Rogers J awarded R1,8 million) and the authorities referred to by Rogers J (paras 614-617), I consider R1,8 million to be a fair award for general damages in this instance.

CREATION AND COSTS OF ADMINISTERING THE TRUST

[58] The trial court found that the establishment of a trust for the benefit of TM was necessary for the protection of TM's funds and that it was 'just and appropriate for a trust to be formed with [TM's] parents and a banking trust of a major bank as trustees.' The trial court's order in this regard reads thus:

'The plaintiff's attorney of record "Joseph's Incorporated" is directed to establish a trust from the award in terms of 1(b) above to a trust for [TM], less the attorney and own client costs of the said attorneys as well as disbursements relating to [TM's] claim. The said trust is to be created within one month of the date of this order, with [TM's] parents, the plaintiff and [NM] as well as the Trust Division of Nedbank Limited as trustees. The said trust shall have as its primary objective the maintenance of [TM] during her lifetime.'

[59] The trial court also ordered the respondent to pay the reasonable costs of establishing a trust. But no order was made in respect of the costs of administering the trust. The trial court proposed the Trust Division of Nedbank as one of the trustees on the assumption that Nedbank, being the appellant's employer, would render its trust services free of charge. There was, however, no evidentiary basis for the assumption. Also, the appellant and her husband did not and presently still do not wish to be trustees and I do not believe that it would serve the best interests of TM if they were compelled to assume the specialist duties of trustees of such a trust for the benefit of TM. The appellant proposed that Mr Wilsnach, who was called as a witness at the trial, administer the trust. He is an attorney who qualified in 1982 and he specialises in the administration of trusts and estates. The professional entity through which he practices was managing 281 trusts involving funds of about R370 million at the time when he testified before the trial court.

[60] That TM's award should be paid into a trust to be administered for her benefit, the appointment of Mr Wilsnach as the sole trustee and the wording of the revised trust deed proposed by the appellant and attached to her notice of appeal, are not in issue before us. Presently in dispute is whether the ten percent claimed by the appellant in her representative capacity from the respondent for the costs of creating and administering the trust should be calculated on the capital amount awarded to TM, as contended for by the appellant, or on the balance that is ultimately paid over to the trust, as contended for by the respondent.

[61] I am of the view that the ten percent claimed for the costs of creating and administering the trust should be calculated on the capital amount awarded to TM.

First, the ten percent claimed on the capital amount awarded to TM was calculated with reference to the fees charged by Mr Wilsnach, which, on his undisputed evidence, is lower than those charged by major banks. Second, the costs of furnishing security, which is included in the amount claimed by the appellant, is substantial. Third, as Conradie JA said in *Singh* (supra), para 100, a calculation of the trustee's remuneration on the balance that is ultimately paid over to the trust, would give rise thereto '. . . that the extent of a defendant's liability to pay a percentage of a trustee's fees would not be known until the amount paid over to the trust has been established . . .' and that '. . . the amount actually administered in the trust is likely to vary over the years of the trust's existence.' Fourth, in deciding on a fair and just order to be made in respect of the costs of administering the trust for the benefit of TM, I also bear in mind that there was no legal obligation upon the appellant to include the claw-back provision into the trust deed that she proposed for the repayment to the respondent of any portion of the ring-fenced 'medical fund', which benefits only the respondent without any concomitant benefit to TM, such as in the form of a top-up provision.

COSTS OF SUIT

[62] The appellant appeals the trial court's costs order to the extent that the costs of Dr Choonara's medico-legal report and attendance at court, the costs of Prof Strauss' return flight from San Francisco to Johannesburg and the costs of preparing heads of argument at the request of the trial court, were not included. The only dispute raised before us, as far as these three items is concerned, is whether the respondent should be liable for the costs of a business class or economy flight ticket for Prof Strauss. Although the decision to afford Prof Strauss the comfort of business class cannot be criticised, it would, in my view, be unreasonable to expect the respondent to pay for the luxury.

MOTHER'S PERSONAL CLAIMS

[63] The trial court awarded the sum of R313 190 as damages to the appellant in her personal capacity in respect of her past hospital and medical expenses (R261 190) and in respect of the expenses she incurred in employing a caregiver to look after TM (R52 000). In issue is the trial court's refusal to award damages to the appellant personally in respect of her claims for future medical expenses, general

damages for shock and trauma as well as loss of amenities of life (she claimed the sum of R350 000), for past caregiving beyond the scope of duties of 'normal' parenthood (she claimed the sum of R432 000 calculated at R4000 per month for nine years) and future caregiving and case management beyond the scope of duties of 'normal' parenthood (she claimed the sum of R600 000 calculated at R5000 per month for ten years during TM's adulthood).

[64] The appellant claimed the sum of R50 000 for psychological counselling, psychiatric care and the costs of anti-depressants. The trial court indicated that it intended 'to grant damages in the sum of R120 000 in another context for what is termed "directive therapy for both [TM's] parents at Pathways"' and concluded that 'damages for future psychiatric care as well as future psychological counselling for the plaintiff in the sum of R50 000 has not been established.' The trial court's reasoning was as follows:

'Whilst Grinaker reported a profound sense of sadness on the part of the plaintiff, and whilst the plaintiff gave moving testimony relating to her feelings about [TM's] circumstances, the plaintiff did not indicate that she was depressed at all. Therefore, even though the plaintiff poignantly described how she would never see [TM] pass the milestones normal daughters go through, (such as bringing home her first boyfriend or getting married), the plaintiff did not at any stage of her testimony suggest that she was permanently depressed. This was confirmed by Grinnaker's report, which merely indicated that there was a certain level of depression, which continued to wax and wane for both of [TM's] parents. It can of course be plausibly assumed in this respect that this level of depression is normal for most people. Therefore, Grinaker concluded that it did not appear to him that either parent was depressed to the point that psychiatric treatment with psychotropic medication, such as anti-depressive medication was required. His allowance for future psychological counselling for the plaintiff despite his conclusion in this respect is accordingly at odds with the evidence before the court relating to the admirable fortitude, dedication and commitment of both [TM's] parents, without any sign of depression.'

[65] I am unable to fault the trial court's reasoning in this regard and I agree that damages for future psychiatric care and psychological counselling for the appellant had not been established on a balance of probabilities.

[66] In rejecting the appellant's claim for general damages, the trial court found, in the first instance, that there was 'no evidence suggesting shock or trauma' on the part of the appellant. This finding is challenged before us based on the following

evidence of the appellant: That TM was immediately taken from the appellant after she had been born and not brought to her the next day when other new-born babies were taken to their mothers. The appellant suspected that something was wrong and, accordingly, spoke to a certain medical doctor, who explained to her that TM had suffered brain damage. The appellant thereafter experienced emotions of denial, then guilt, which turned into anger once it had become apparent that TM's condition had been caused by the negligence of members of staff at the hospital. The appellant testified that as time went by the situation had become worse and not better; TM grew taller and eventually only her father was able to carry her. She felt a deep sense of sadness for not always knowing what TM wanted and that the two of them would never be able to confide in each other. She expressed concern when TM reaches puberty and said that dealing with her was a 'continuous adjustment'.

[67] There is no evidence that the appellant, as a result of the negligence of the staff at the hospital, had sustained detectable psychiatric injury. Whether such an injury had been sustained is a question that falls to be answered through the expert evidence of psychiatrists. (See *Bester v Commercial Union Versekeringsmaatskappy* 1973 (1) SA 769 (A), at 776D-779H; *Barnard v Santam Bpk* 1999 (1) SA 202 (SCA), at 208H-217A; *Hing and Others v Road Accident Fund* 2014 (3) SA 350 (WCC), paras 14-30.)

[68] I accept that the evidence established that the accident and its consequences caused the appellant (and TM's father) much grief and sorrow. But, as was held by the trial court, such grief and inevitable bereavement is not actionable. Scott J in *Collins* (supra), at 94G-I, said the following:

'I have much sympathy for [Lee-Ann's parents]. The accident and its consequences must have caused them much grief and sorrow. But they do not claim damages for their grief and inevitable bereavement. Nor as a matter of policy, could such a claim ever, I think, be entertained. The social burden would be too great. Whatever the position may be in England or for that matter in any other country, the funds available in South Africa will not stretch that far. It is common knowledge that the hospital authorities are desperately short of money. Free medical treatment has recently been afforded to all children under the age of six years. . . . All this costs money. The same is true in the case of other public bodies which are defendants in actions arising out of bodily injuries. As sympathetic as I am to Lee-Ann's parents, I can see no justification for indirectly awarding them damages for their bereavement.'

[69] The trial court also held that the appellant did not suffer a loss of amenities of life that would entitle her to general damages. In this regard, it said the following:

'Notwithstanding the enormous sacrifices the plaintiff has made in her social life as well as other areas of her life, and notwithstanding the obvious heartache felt by her, it is my view that the evidence before this court has not established any loss of amenities of life in the way described by Hoexter J. Therefore, even though [TM's] mental and physical limitations (including severe limitations to her vital functions and faculties) have included a profound sense of sadness in the plaintiff, the plaintiff's own body and mind have, of course, not been directly compromised by [TM's] injury. Unlike her daughter, the plaintiff herself is able to walk, run, sit and stand unaided. She is also able to bath, dress and feed herself unaided.'

[70] The description of the amenities of life by Hoexter J to which the trial court referred, appears in *Administrator-General, South West Africa v Kriel* 1988 (3) SA 275 (A), at 288E-F:

'The amenities of life may further be described. I consider, as those satisfactions in one's everyday existence which flow from the blessings of an uncluttered mind, a healthy body, and sound limbs. The amenities of life derive from such simple but vital functions and facilities as the ability to walk and run, the ability to sit and stand unaided; the ability to bath, dress and feed oneself unaided; the ability to exercise one's control over one's bladder and bowels. Upon all such powers human self-sufficiency, happiness and dignity are undoubtedly highly dependent.'

[71] I am again unable to fault the reasoning of the trial court in this regard and the appellant's personal claim for general damages was, in my view, correctly refused.

[72] I now turn to the trial court's refusal to award damages to the appellant for past caregiving and future caregiving and case management beyond the scope of duties of 'normal' parenthood. The trial court said the following:

'I take cognisance of the fact that the plaintiff has made a number of sacrifices as a consequence of her dedication to [TM]. However, she also admirably completed a number of certificates, studied and secured full time employment, whilst fulfilling her parental responsibilities. [TM] is looked after by Pathways in the day as well as a caregiver, who lives with the family. The defendant correctly does not deny being liable for the costs of a caregiver for the past two years as well as the costs of [TM] attending Pathways (subject to my discretion). At a most fundamental level, it is my view that irrespective of the negligence of the defendant in this matter, and irrespective of the quantum of damages awarded to the

plaintiff, the plaintiff cannot be absolved of her parental responsibilities as defined by the law. As such, it is my view that the plaintiff cannot claim remuneration for past caregiving.'

And further:

'Apart from the notional difficulty I have with a parent being compensated for "rendering services" to a child, for the reasons already given, the plaintiff has a legal responsibility to [TM]. Thus, in the event that [TM's] impairments not being causally linked to negligence on the part of any person, then the plaintiff would have been legally obliged to "render services" to [TM]. Moreover, to the extent that the defendant has admitted liability for the costs of a full-time caregiver for [TM], as well as the costs of being looked after at a facility, this claim [for future caregiving beyond the scope of normal parenthood] appears to be duplicated to a certain extent.'

[73] I share the trial court's difficulty with a parent being compensated for caring for his or her own child, or as it was put by the trial court, for rendering services to one's own child, as well as with the concept of parental caregiving beyond the scope of 'normal' parenthood. The nature and scope of normal or usual parental obligations in any given situation, I dare to say, are determined by the particular circumstances, abilities, disabilities, and the like, of each individual child, irrespective of the cause of any disability or other condition, such as asthma, anorexia, obesity or substance dependency. The cause of any disability may be congenital, accidental, self-inflicted or the result of another's negligence or even intent. In substance, the appellant's claim for past and future caregiving beyond the scope of normal parenthood in this instance, appears to be rather one for non-pecuniary damages. I do not believe, as a matter of policy, that such a claim, without more, should be entertained. The social burden would also be too great. The trial court, in my view, correctly refused these two personal claims of the appellant.

COUNTER-APPEAL

[74] The respondent's cross-appeal - which essentially seeks the development of the common law due to the financial constraints of the Department of Health, Gauteng and the constitutional right that affords everyone the right to of access to health care services, which is alleged to be compromised by lump sum awards, such as the one that was made in this instance, and for the lump sum awarded to TM in respect of her future medical and related expenses to be substituted with an order for the payment or provision by the respondent of the required health care services

and assistive devices as and when they are required by TM in the future - is doomed to failure in the light of the recent decision of the Supreme Court of Appeal in *The MEC for Health and Social Development of the Gauteng Provincial Government v Zulu* (1020/2015) [2016] ZASCA 185 (30 November 2016), wherein it was made clear that such law reform should more appropriately be dealt with by the legislature, which was also the view taken by the trial court.

[75] In *Zulu*, Swain JA said the following in this regard:

[12] In any event, in exercising their power to develop the common law, judges have to be 'mindful of the fact that the major engine for law reform should be the Legislature and not the Judiciary'. 'The judiciary should confine itself to those incremental changes which are necessary to keep the common law in step with the dynamic and evolving fabric of our society'. The development of the common law sought by the appellant is not an incremental change, but one of substance and more appropriately dealt with by the legislature, being an issue of policy. Any legislated change in the common law rule could only be effected after the necessary process of public participation and debate.'

(Footnotes omitted.)

ORDER

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

(a) The appeal succeeds with costs, including those costs attendant upon the employment of two counsel and the costs of the supplementary heads of argument submitted in respect of the costs of the trust.

(b) The order of the trial court is set aside in part and reproduced below with substituted provisions and additions:

'1. The defendant is to pay the plaintiff in her personal capacity the amount of R313 190.00.

2. The defendant is to pay the plaintiff in her representative capacity, on behalf of the minor child, the amount of R18 416 973.60.

3. The defendant is to pay interest to the plaintiff on the aforesaid amounts (less any payments made) at the rate of 10.25% per annum *a tempore morae* from 3 November 2014 to date of payment.

4. The defendant is to pay the plaintiff's taxed or agreed costs on the party and party scale, such costs to include:

4.1 the costs consequent upon the employment of two counsel, including the preparation of written heads of argument;

4.2 the reasonable costs of obtaining medico-legal and actuarial reports from those experts who testified and whose qualifying fees are allowed;

4.3 the reasonable costs of those expert witnesses who attended joint meetings of expert witnesses;

4.4 the reasonable qualifying and reservation fees relating to attendance at court of the following witnesses: Miss A Crosbie, Miss B Donaldson, Miss P Jackson, Miss E Bubb, Dr MM Lippert, Dr G Marus, Dr D Strauss, Prof A van den Heever, Dr Versfeld, and Dr Choonara;

4.5 the travelling expenses of Professor Strauss (including economy class airfare); and

4.6 the costs of obtaining a transcript of the proceedings.

5. The plaintiff's attorney of record is directed to cause to be created within three months of the date of this order a Trust on behalf of the minor child, and, if it is not created within three months, to approach this court or a judge in chambers (as directed by the Judge President or Deputy Judge President) for a further direction or extension of time, which Trust:

5.1 shall be created in accordance with the revised draft Trust Deed and shall contain the provisions set out therein, a copy of which is annexed hereto, marked "X";

5.2 shall have as its Trustee Mr Constant Wilsnach, with those powers and duties as set out in the aforesaid Trust Deed.

6. The Trustee shall:

6.1 be entitled in the execution of his duties and fiduciary responsibilities towards the beneficiary of the Trust, to have the attorney and client costs and disbursements of the plaintiff's attorneys taxed, unless agreed;

6.2 be obliged to render security to the satisfaction of the Master of the High Court.

7. The plaintiff's attorneys of record:

7.1 are authorised, pending the creation and registration of the trust, to invest the award less such fees and/or costs to which they are entitled, in an interest bearing account in terms of section 78(2A) of the Attorneys Act, 53 of 1979 and to make payment of any reasonable expense or disbursement for the benefit of the minor child as a trustee would have been able to do should such expenditure or disbursement be regarded as reasonably necessary;

7.2 shall account fully to the trustee appointed, of all costs, fees, expenditure and/or disbursements paid from the award once the Trust had been registered and the balance of the award paid over.

8. The defendant shall pay the reasonable costs of creating the Trust and the amount of R1 841 697.36 in respect of the costs of administering the Trust.

9. All amounts payable in terms of this order shall be paid to the plaintiff's attorneys of record to the following account:

Josephs Incorporated Trust Account
RMB Private Bank
Account number: […]
Branch code: 261 251
Reference: M Joseph.'

(c) The cross-appeal is dismissed with costs, including those costs attendant upon the employment of two counsel.

P.A. MEYER
JUDGE OF THE HIGH COURT

I agree.

S.E. WEINER
JUDGE OF THE HIGH COURT

I agree.

R. MONAMA
JUDGE OF THE HIGH COURT

Date of hearing:	19 October 2016
Date of judgment:	07 March 2017
Counsel for appellant:	WP de Waal SC (assisted by WL Munro)
Instructed by:	Josephs Incorporated, Dunkeld, Johannesburg
Counsel for Respondent:	V Notshe SC (assisted by N Ntombela)
Instructed by:	State Attorney, Johannesburg