THE SUPREME COURT OF APPEAL OF SOUTH AFRICA

JUDGMENT

Non-Reportable

Case no: 1270/2018

In the matter between:

ROAD ACCIDENT FUND **APPELLANT**

and

S M **RESPONDENT**

Neutral citation: *Road Accident Fund v S M* (1270/2018) [2019] ZASCA 103 (22 August 2019)

Coram: Leach, Wallis, Mathopo and Molemela JJA and Weiner AJA

Heard: 24 May 2019

Delivered: 22 August 2019

Summary: Delict – damages – whether the respondent sustained a mild or moderate traumatic brain injury – expert evidence – approach to their evidence restated – expert

opinions must be based upon facts that have been established by way of admissible evidence.

ORDER

On appeal from: Eastern Cape Division of the High Court, Mthatha (Nhlangulela ADJP sitting as court of first instance):

1. The appeal succeeds with costs, including the costs consequent upon the employment of two counsel.
2. The order of the court a quo is substituted with the following:

'(a) The plaintiff's claim for loss of income is dismissed with costs, including the costs of the hearing from 21 October 2015 to 18 July 2016.

(b) The defendant shall furnish the plaintiff with an undertaking in terms of s 17(4) of the Road Accident Fund Act 56 of 1996, for the costs of the future accommodation of the plaintiff in a hospital or nursing home for the treatment or the rendering of a service or the supplying of goods to him after each of such costs have been incurred and on proof of payment thereof.'

JUDGMENT

Weiner AJA (Leach, Wallis, Mathopo, Molemela JJA concurring)

Introduction

[1] This case demonstrates the perils parties face when they rely exclusively on the opinions of experts without laying any factual basis for such opinions. In a trial action 'It is fundamental that the opinion of an expert must be based on facts that are established by the

evidence and the court assesses the opinions of experts on the basis of "whether and to what extent their opinions advanced are founded on logical reasoning". It is for the court and not the witness to determine whether the judicial standard of proof has been met.'[1]

[2] Adapting the approach taken by this court in *MV Pasquale*: '[T]he court must first consider whether the underlying facts relied on by the witness have been established on a pri333ma facie basis. If not then the expert's opinion is worthless because it is purely hypothetical, based on facts that cannot be demonstrated even on a prima facie basis. It can be disregarded. If the relevant facts are established on a prima facie basis then the court must consider whether the expert's view is one that can reasonably be held on the basis of those facts. In other words, it examines the reasoning of the expert and determines whether it is logical in the light of those facts and any others that are undisputed or cannot be disputed. If it concludes that the opinion is one that can reasonably be held on the basis of the facts and the chain of reasoning of the expert the threshold will be satisfied.'[2]

[3] In *PriceWaterhouse Coopers Inc v National Potato Cooperative Limited*[3] the court said:

'The basic principle is that, while a party may in general call its witnesses in any order it likes, it is the usual practice for expert witnesses to be called after witnesses of fact, where they are to be called upon to express opinions on the facts dealt with by such witnesses.'[4] Similarly, Wessels JA, in dealing with the nature of an expert's opinion, in *Coopers (South Africa) (Pty) Ltd v Deutsche Gesellschaft für Schädlingsbekämpfung MBH*[5] said '. . . an expert's opinion represents his reasoned conclusion based on certain facts or data, which are either common cause, or established by his own evidence or that of some other competent witness. Except possibly where it is not controverted, an expert's bald statement of his opinion is not of any real assistance. Proper evaluation of the opinion can only be undertaken if the process of reasoning which led to the conclusion, including the premises from which the reasoning proceeds, are disclosed by the expert'.

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[1] *MV Pasquale della Gatta; MV Filippo Lembo; Imperial Marine Co v Deiulemar Compagnia di Navigazione Spa ZASCA* 2012 (1) SA 58 (SCA) paras 25-27. See also *Michael & another v Linksfield Park Clinic (Pty) Ltd & another* 2001 (3) SA 1188 (SCA) paras 34-40.
[2] *MV Pasquale* fn 1 above para 26.
[3] *PriceWaterhouse Coopers Inc & others v National Potato Cooperative Ltd & another* [2015] ZASCA 2; [2015] 2 All SA 403 (SCA) para 80.
[4] *PriceWaterhouse* fn 3 para 80.
[5] *Coopers (South Africa) (Pty) Ltd v Deutsche Gesellschaft für Schädlingsbekämpfung MBH* 1976 (3) SA 352 (A) at 371F-H.

[4] An opinion of an expert must therefore be based on facts which have been proven before the court. An opinion based on facts not in evidence has no value for the court.[6] A court has to ascertain whether the opinions expressed by the experts are based upon facts proved to it by way of admissible evidence. It is with this principle in mind that the facts of the matter, as well as an analysis of the experts' evidence, must be considered.

Appealability and Condonation

[5] On the day preceding the hearing of this appeal, the respondent raised the point that the order was not appealable, because the quantum of damages had not yet been determined by agreement or by the court. Therefore it was submitted that the order was not final. The order granted by the court a quo fits the test set out in *Zweni v Minister of Law and Order*[7] that a judgment or order is a decision which 'has three attributes: first, the decision must be final in effect and not susceptible to alteration by the court that made it; second, it must be definitive of the rights of the parties; and, third, it must have the effect of disposing of at least a substantial portion of the relief claimed in the main proceedings'.[8] The order was a declaration of rights determining the RAF's liability. All that remained was the assessment of the quantum of damages. As such, it is clear that the judgment and order were appealable.[9]

[6] The appellant also sought condonation for the late filing of the record and for the filing of a supplementary affidavit. The appellant tendered the costs of such applications. The granting of condonation is dependent, inter alia, upon the merits of the appeal. The appellant has tendered an explanation as to the difficulties in obtaining the record and has shown good cause for the condonation to be granted. Condonation is therefore granted.

Background

[7] The respondent, S M (Mr M) was 12 years old when he was a passenger in a motor vehicle collision on 10 July 2006. The claim against the appellant (the RAF) was originally

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[6] *PriceWaterhouse* fn 3 above para 99.
[7] *Zweni v Minister of Law and Order* 1993 (1) SA 523 (A) at 532I-533A.
[8] *HMI Healthcare Corporation (Pty) Limited v Medshield Medical Scheme & others* [2017] ZASCA160; *Pitelli v Everton Gardens Projects* [2010] ZASCA 35; 2010 (5) SA 171 (SCA) para 27.
[9] *SA Eagle Versekeringsmaatskappy Bpk v Harford* 1992 (2) SA 786 (A) at 792C-H.

instituted by his mother, P M (Ms M) in 2009. M attained majority in 2012, and was substituted as plaintiff. When summons was issued, it was alleged that, as a consequence of the collision M suffered 'a ragged laceration on the lateral aspects of the left eye; small cuts on the left parietal area of the head; tender medial to the lat, border left scapula; and a Splenic laceration'(the injuries).

[8] In the original particulars of claim, it was alleged that as a result of the injuries sustained, he experienced shock, pain, discomfort and suffering, and underwent a splenectomy. R6 million was claimed as damages. Initially, the claim was based only upon the injuries referred to in the particulars of claim. An amendment was later introduced in terms of which Mr M based his claim for general damages on three medical legal reports, being that of Dr Repko, a neurosurgeon (now deceased), Dr Hardy, a neuropsychologist, and Ms Gowa, an occupational therapist. Dr Repko in his report[10] stated that the only complaint which M reported was abdominal pain. A full neurological examination found no abnormalities. Dr Repko diagnosed the head injury as a concussion, with no neurological signs and said that Mr M expressed no complaints relating to a head injury. Dr Hardy's report related to the sequelae of a mild to moderate brain injury, which she opined resulted in neurocognitive deficits. However, this was obviously dependant on Dr Repko finding that such injury had occurred, which he did not. These reports formed the basis of Mr M's amended claim.

[9] There is no indication as to when the particulars of claim were amended to include the reports referred to. It appears that the complaints and deficits complained of were not present at the time Dr Repko assessed M in March 2013. Such complaints were, however, identified by Dr Hardy, only a few months later, in June 2013. This date seems to correlate with when M's university results declined. His case at the hearing was conducted solely on the basis that he had suffered a mild to moderate traumatic brain injury (TBI),[11] which manifested in deficits many years after the collision and which appeared to still be present

[10] There was some debate as to the admissibility of Dr Repko's report, as he was deceased and therefore could not testify. However, it was accepted that Dr Kieck could refer to it as it was one of the reports, which he considered in compiling his report. In any event, the report of Dr Repko was incorporated into M's particulars of claim.

[11] The description of the injury as 'traumatic' indicates only that it was occasioned by trauma. It says nothing about the severity of the injury, the matter that lay at the core of the dispute between the parties.

at the time of the trial in 2016, some ten years later.[12] Notwithstanding the absence of any clinical evidence in regard to the nature and extent of Mr M's injury, the case was conducted on the basis that the essence of the dispute was whether he had suffered a mild or a moderate TBI.[13]

[10] In terms of the Road Accident Fund (Transitional Provisions) Act[14] (the Transitional Provisions Act), the right of a third party to claim compensation for non-pecuniary loss is limited to R25 000, unless the third party submits a serious injury assessment report as contemplated in regulation 3 of the Road Accident Fund Regulations 2008, indicating a serious injury. In terms of s 17(1) of the Road Accident Fund Act[15] (the Act), the RAF's obligation to compensate M for non-pecuniary loss is limited to compensation for a serious injury as contemplated in s 17(1)A. Ms M submitted a serious injury assessment report to the RAF on behalf of her son. The RAF rejected the serious injury assessment report, on the ground that the injuries were incorrectly assessed as serious. It ruled that he did not qualify for compensation, even on the narrative test.

[11] The RAF accepted that it was liable to compensate Mr M for any damages he had suffered arising out of the motor accident and tendered a certificate in respect of his future medical expenses In terms of rule 33(4), an application was made for separation of the issues relating to quantum. The court made an order by consent that:

'1 The RAF was liable to pay to M all such damages as may be proved at the trial on quantum, or as may be agreed.

2 The issues relating to quantum of (a) loss of income and past and future medical expenses and (b) general damages, was (sic) separated. The matter would proceed only on the issues of loss of income and past and future medical expenses.'

[12] Neither Mr M nor his mother gave evidence. The case was based purely upon the expert reports and the medical and hospital records, which served before the court, none

[12] Although some of the experts testified that these deficits only manifested a decade later, if regard is had to the timing of Dr Hardy's report, it appears therefrom that the deficits manifested in 2013, some seven years later.
[13] It appears that although no amendment was made to M's pleadings, the reliance on the reports, which were incorporated for the claim of general damages, extended to his claim for loss of future earning capacity.
[14] Road Accident Fund (Transitional Provisions) Act 15 of 2012.
[15] Road Accident Fund Act 56 of 1996 as amended by Act 19 of 2005.

of which were proven or agreed to. The court a quo found that Mr M had suffered a more severe TBI, which had resulted in the deficits complained of and ordered that the RAF pay damages to Mr M, which would be calculated and agreed by the parties' actuaries, based upon the court's directions. The appeal to this Court is with the leave of the court a quo.

Common cause facts

[13] Mr M was 12 years and 6 months old when he was involved in the collision. He was a student doing Grade 7. After the accident, he was transported to Umtata General Hospital, where he was admitted and treated, until discharged on 21 July 2006.

[14] Mr M's school and university results were as follows:

(a) In 2005, in Grade 6 he obtained a 68% average. Comments on his reports indicated that he had the potential to do better and excel. His mathematics mark was 85,2%, a fact which assumed great significance in the evidence of the experts.

(b) In 2007[16], in Grade 8, after eleven months of hospitalisation and other medical treatments, he passed with a 58,4% aggregate. He did very well in Mathematics and Accounting and was awarded half-colours for Mathematics.

(c) His performance improved when he had more choice over his learning areas. In Grade 9 in 2008, he averaged 60%, with his best marks being Mathematics and Technology.

(d) In 2009 he passed Grade 10 with a 69% aggregate, scoring 84% for Mathematics. He was once again awarded half-colours for Mathematics.

(e) In 2010, in Grade 11, he scored a 72% average. He obtained 88% for Mathematics and 89% for Accounting. He was awarded certificates for effort in four or more subjects in terms 2 and 3.

(f) In 2011, in Grade 12, his June results displayed further improvements in Mathematics and Accounting, and he was again awarded certificates in terms 2 and 3 for effort. He passed matric with a 78% aggregate. He obtained 5 distinctions in Mathematics, Life

[16] There are no records for 2006, as M was receiving treatment for the injuries sustained in the collision.

Sciences, Physical Science, Accounting and Life Orientation. He also wrote an additional subject: Mathematics: probability data handling, for which he achieved 80%.

(g) In 2012 he enrolled at the University of Pretoria to study for a BSc degree in Actuarial and Financial Mathematics. His cumulative average for the first year was 57,07%. He obtained two distinctions for Academic Literacy. He passed 14 out of 16 modules.

(h) In 2013 he continued to second year and passed his two remaining first-year subjects, but failed all his second-year subjects but one. His cumulative average was 52,73%.

(i) In 2014 he passed only three second-year subjects with a cumulative average of 44,8%.

(j) In 2015, he undertook a combination of second and third-year subjects, achieving a cumulative average of 44,18%.

[15] Although there was no agreement as to the accuracy of the hospital records, there was no real dispute, after the evidence of the neurosurgeons was heard, that on admission, Mr M was fully conscious and orientated with a Glasgow Coma Score (GCS) of 15/15. His pupils were normal and reactive. His blood pressure and pulse were in the normal range and stable.

[16] The issue thus boils down to whether Mr M suffered a mild and uncomplicated brain injury, as submitted by the RAF; or whether it was a mild to moderate brain injury which resulted in neurocognitive, intellectual, physical and emotional deficits, as Mr M contends. The underlying premise was that based upon his mark in mathematics in 2005, in Grade 6, prior to the collision, he was capable of qualifying as an actuary. His case was that his academic difficulties which he experienced when he was studying actuarial science had to be ascribed to a more serious injury leaving him with various deficits that would prevent him from achieving this goal. His claim for loss of earnings was based upon this premise.

[17] Although the neuropsychologist, Dr Hardy testified before Dr Wilkinson, the neurosurgeon, both her and Dr Loebenstein, her counterpart, deferred to the

neurosurgeons' opinions. Dr Wilkinson testified for Mr M, and he, conceded that it appeared that Mr M had been fully conscious, orientated and responsive on admission. Although, no evidence was led by any of the medical staff at the hospital, it appeared from the hospital records that later in the day, Mr M's GCS had apparently dropped to 11/15, his blood pressure had dropped, his haemoglobin had been below normal, he had been very pale and cold, and had scanty urinary output. The RAF did not concede that the records in this regard were accurate. Dr Wilkinson, however, said that this showed that Mr M fell behind with IV fluid therapy and he was in hypovolemic shock due to his spleen injury. This, Dr Wilkinson, stated, was when a secondary (anoxic) brain injury, adding to the injury on impact, might have occurred. This could change the injury from mild to moderate or severe. He found a facial palsy and conduction deafness in Mr M's left ear which could also indicate some injury to neurological tissues.

[18] He referred to this condition as a 'silent epidemic brain injury'. Even after a mild brain injury the patient and doctors and families do not recognise the secondary effects. He referred to an article called 'Mild TBI: Silent Epidemic in our Practices[17]: 'Survivors of mild TBI are addressed for a range of psychosocial and psychiatric issues that arise from the neurological and the social elements of trauma. Research indicates that mental health issues often arise following a mild TBI with symptoms of clinical depression in 15 to 50% of survivors.'[18]

[19] Although not proved by any admissible evidence, or admitted by the RAF, Dr Wilkinson recorded that Mr M complained of frequent headaches and poor concentration. He slept a lot during the day, which Dr Wilkinson referred to as daytime somnolence which he frequently saw as a result of brain injuries. Mr M also reported decreased endurance mentally and physically. Dr Wilkinson was of the opinion that a moderate brain injury would lead to the psychological problems that had been set out in the reports and evidence of Dr Hardy and Ms Van Vuuren. If these deficits were manifesting now, they were due to what had been a moderate, and not a mild, brain injury. It was Dr Wilkinson's view that low self-esteem, depression, anxiety and other psychological effects would hamper functioning and Mr M would not reach his potential as he would be functioning at a

[17] P W Buck 'Mild Traumatic Brain Injury: Silent Epidemic in our Practices' (2011) 36 *Health & Social Work* 299 at 299.
[18] Ibid.

lower level. Dr Wilkinson attributed Mr M's academic decline at university solely to a moderate brain injury.

[20] It was difficult to ascertain from Dr Wilkinson's evidence whether his conclusion was that the injury must have been moderate because the alleged problems had manifested so many years later, or because they were still present so many years later. If the former, Dr Wilkinson did not explain how these deficits lay dormant for so many years. If the latter, he did not explain how Mr M scholastic results improved up until 2012.

[22] Dr Kieck testified for the RAF. He discounted both conclusions of Dr Wilkinson. He did not detect, nor was he pointed to any palsy or conduction deafness experienced by Mr M. Having regard to the school and university results which Mr M had achieved, he was of the view that there were no neurocognitive deficits. The loss of consciousness (LOC) appeared to be of very short duration and the post traumatic amnesia (PTA) was at most two hours. Had these two elements been of a longer duration, those deficits would have manifested themselves within a few weeks or months, and not so many years after the injury. He based his findings on the medical records, and also referred to the American Medical Association Guides on Impairment (AMAG) 6th ed,[19] in dealing with the effects of a mild brain injury. Mr M's difficulties with his studies could not be attributable to the head injury he suffered in 2006. Any such injury would have manifested itself in symptoms that were perceived much earlier, not so many years after the injury was suffered. He concluded that there were many other explanations for the academic problems which appeared to now have manifested, but that the literature and his experience show that these symptoms would not manifest so many years after an injury and could not be attributed to such injury.

[23] Based on the hospital records on admission, no neurocognitive deficits were found post-accident. Dr Kieck's neurological examination of Mr M revealed no deficits. He referred to the report of Dr Repko, who similarly found no neurocognitive deficits on his examination. Dr Kieck recorded that Mr M informed him that he was struggling emotionally and had memory and concentration problems. However, Dr Kieck could not attribute these

[19] Robert D & Rondineli MD *AMA Guides on Impairment* 6th ed Published by the American Medical Association (2007).

to the injury sustained nearly 10 years before, more particularly having regard to his academic history post the accident. He noted that Dr Wilkinson had glossed over Mr M's academic results in 2008 to 2012 and only commented on the decline in 2013/2014. He could not accept that the neurocognitive abnormalities found by Dr Hardy were the result of a mild TBI. He described the condition of post-concussion syndrome, which included headaches, poor concentration, initial lack of memory, insomnia, and dizziness. These, he stated, would start immediately after the injury, but by the end of the first week they would normally resolve. By the end of three months, the symptoms would disappear completely. If symptoms remained, it was usually associated with other causes, such as previous depression, anxiety or ADHD.

[24] Dr Kieck referred to the Diagnostic and Statistical Manual of Mental Disorders (DSM 5),[20] which he stated is accepted universally. It described both qualitatively and quantitively the characteristics of the different traumatic brain injuries. The first determinant was loss of consciousness which should be less than 30 minutes. That would satisfy the first criteria. The second criteria is the PTA, which in Mr M's case probably not exceed one or two hours. This is confirmed by the fact that he had a GCS of 15/15 and was fully orientated and able to lay down memory on admission. According to DSM 5[21]:

'8 Overall the natural history of MTBI in children and adults is characterised by a gradual full recovery and symptoms, cognition and general functioning within several days to weeks of injury and the true incidence of persistent symptoms or impairments that negatively affect the patient's general functioning, is very low.

9 In uncomplicated MTBI persistent symptoms and poor functional outcome are often associated with non-injury-related variables including demographic, psychosocial, medical, motivational and other situation or factors'.

[25] Dr Kieck stated that the AMAG is regarded as the 'Bible' in relation to the assessment of impairment and disabilities in patients. These guidelines are developed as a consensus by many highly regarded institutions involved in this field. The committees of the American Academy of Neurology and the American Association of Neurological

[20] Diagnostic and Statistical Manual of Mental Disorders 5th ed (2013) American Psychiatric Publishing 2013.
[21] Ibid.

Surgeons, two pre-eminent organisations in their fields, evaluate all the literature and then come to a consensual decision before they put out a guide. The AMAG says the following in relation to mild TBI:

'Special mention should be made of mild TBI which has been the subject of extensive research in the last ten to twenty years. In contrast to the previous belief the symptoms of mild traumatic injury generally resolve in days to weeks and leave the patient with no impairment. Patients with persistent post-concussion symptoms generally have non-injury-related factors which complicates the clinical course. Post-concussion syndrome is rare and may be seen in 1 to 5% of all patients of mild TBI.'[22]

[26] The three main parameters that are used in determining the seriousness of a TBI are: was there a loss of consciousness, how long did the post-traumatic amnesia last and what was the GCS at the end of the period of unconsciousness. He distinguished between unconsciousness and PTA. One could have a blow to the head, be dazed and not remember for twenty minutes or so, but still be conscious. If the TBI was moderate, the symptoms and the signs would have been present as soon as the patient was functioning and back in society. This would happen within a week and Mr M was assessed approximately six weeks later. No deficits were detected. Dr Kieck could not reconcile the deficits referred to by Mr M with his scholastic and first year university results and the long period of delay before the deficits apparently manifested.

[27] Dr Kieck commented on Dr Hardy's evidence that the reason for the alleged deficits manifesting so much later was that prior to this he was in a protective school and family environment, where he had all the support systems around him. Dr Kieck stated that such deficits do not lie dormant for ten years and suddenly appear. He commented that it was common knowledge that actuarial science is a very difficult course and only the very brightest complete it. He referred to statistics provided by the University of Cape Town (and not disputed) that 45,8% of the initial intake graduated after three years, 33,66% of the initial intake were currently registered for a fourth academic year, 22,5% of the initial intake have not graduated and are no longer in the system and only 33,8% of the initial intake proceeded to an honours degree.

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[22] Ibid fn 19.

[28] Dr Kieck also referred to the article 'Mild Traumatic Brain Injury and Post-Concussion Syndrome: The New Evidence-Base for Diagnosis and Treatment'[23] as well as the 'Summary of the WHO Collaborating Centre For Neurotrauma Task Force on Mild Traumatic Brain Injury[24] which listed the same criteria referred to by the AMAG and in DSM 5.

[29] Dr Kieck commented on the impairment listed on the RAF 4 form, which was categorised as Class 2, which is a 20 percent impairment. Referring to AMAG, Dr Kieck stated that such impairment involved an alteration in his high mental cognition which would interfere with his ability to perform his activities of daily living. Dr Kieck stated that this relates to someone who is obviously mentally impaired. However, he found Mr M to be exceptionally bright, forthcoming, and normal. He described the difference between a mild traumatic BI, which is a neurometabolic condition of dysfunctional neurons, and a more severe injury which involves neuron disruption.

[30] In commenting on Dr Wilkinson's 'silent epidemic', he testified that with a TBI a certain cascade of events can occur that change the condition to something more serious. Low haemoglobin could mean internal bleeding. Although pale and cold, with low urine output and a relatively lowish BP, this would not result in a patient going into hypovolemic shock. With a secondary event, such as an anoxic brain injury, there would be a cerebral perfusion. The blood pressure would be very low, the patient would become unconscious and there would be a noticeable deterioration in neurological status. The patient would be neurologically depressed, confused for many days, and on recovery there would be many neurocognitive deficits. Throughout his stay in the hospital, despite this episode, Mr M's neurological condition remained stable. He commented "there is no way" he could have achieved those results if he had suffered an anoxic brain injury.

[31] In reference to the many alleged deficits which Dr Hardy identified as affecting Mr M, Dr Kieck opined that a TBI is not the only cause of major neurocognitive or mental and

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[23] M A McCrea 'Mild Traumatic Brain Injury and Post-Concussion Syndrome: The New Evidence Base for Diagnosis and Treatment' (2011) 39(1) *The Journal of the American Academy of Psychiatry and the Law* 133-134.

[24] L Holm et al 'Summary of the WHO Collaborating Centre For Neurotrauma Task Force on Mild Traumatic Brain Injury' (2005) 37 *J Rehabil Med* 137 at 137-141.

behavioural disorders. There are multiple factors and in adolescence and young adults there are many other causes. A mild TBI is not the cause of major neurocognitive dysfunction. Whilst he could not dispute Dr Hardy's test results (although they were contradicted by Dr Loebenstein), as a neurosurgeon he looked at what he was presented with. In drawing from the literature, a mild TBI is distinct from a moderate and severe one where there would be significant neurocognitive *sequelae*. Thus if Mr M exhibited symptoms of depression, anxiety and lack of concentration it was more probably as a result of him undertaking a very difficult university course. What he may be experiencing now was most probably due to the difficulties he was having with his course, as well as being away from his protective environment.

[32] Dr Hardy and Dr Loebenstein gave evidence of the psychological and neurological deficits which can occur with a TBI. Dr Hardy was of the opinion that the injury was a mild to moderate brain injury because of a long period of LOC and resultant PTA. Neither of these factors appear from the hospital records. Dr Hardy suggested that the hospital records were inaccurate. She rather relied upon what Mr M's mother told her about his condition. However, this hearsay evidence was not confirmed by Mr M or his mother, or by any member of the nursing staff and it is flatly contradicted by the available hospital records. It was accepted that Mr M was conscious when he reached the hospital, which was approximately 30 minutes after the collision occurred. Dr Hardy referred to the GSC later dropping to 11/15, which to her indicated that the brain injury was more serious than a mild post-concussion syndrome. The neuropsychological test findings, according to her, demonstrate variable intellectual and executive functioning and a suboptimal ability to concentrate for a sustained period. This psychological fallout was consistent with his mother's reported complaints of his being more sensitive, anxious, stressed and withdrawn since the accident. These facts were not confirmed by evidence. She found inter test scatter, which was of concern and these difficulties would diminish his educational and vocational potential. Although Mr M had an average and, at times, an above-average set of skills, he lacked the level of excellence required to be successful as an actuary. All of these she attributed to the head injury sustained in the collision. She relied extensively on his grade 5 mathematics mark in stating that prior to the accident, he had the ability to become an actuary. She was unwilling to accept that this superficial

judgment was incorrect and that, like many others embarking upon a difficult course at university, he found himself out of his depth.

[33] Dr Loebenstein was of the view that Mr M sustained an uncomplicated mild TBI (concussion). This was confirmed by the hospital records. Dr Loebenstein tested Mr M's short-term memory functioning which revealed no deficits. He referred to the opinion of Ms Van Vuuren, the educational psychologist who found exceptional intellectual abilities in the areas of reasoning and integrating concepts which were at variance with the findings of Dr Hardy. Dr Loebenstein's own assessment revealed competent functioning in areas considered to be most vulnerable to the effects of brain injury. The tests and assessments showed that Mr M had undergone a complete recovery from a mild brain injury. His progress at school was indicative of his pre-accident potential and not influenced by any neuropsychological behavioural *sequelae* that could be attributed to the accident. Mr M's need to repeat certain subjects at university in one of the most demanding degree programmes offered by tertiary institutions could not possibly be attributed to a mild concussion sustained nearly a decade before. This all pointed to a mild TBI. In his view, Dr Hardy did not give due weight to the complexities involved in studying Actuarial Science and the high drop-out rate.

[34] Ms Van Vuuren, the educational psychologist, based her opinions upon the tests carried out by Dr Hardy. She did not deal in her report with the cause of the brain injury but only with what she considered to be the *sequelae* thereof. Thus her evidence does not assist the court.

[35] As is apparent from what is stated above, the reports given by Mr M and his mother to Dr Wilkinson and Dr Hardy, of his present difficulties, are hearsay and no reliance can be placed on them. In the absence of Mr M giving evidence as to the nature of his problems, which evidence could have been tested against other possible reasons for his academic difficulties, such as the difficulty of the course; the transition to university life; the difficulties of living in an unfamiliar environment away from familial support structures and the like, no conclusion could properly be drawn by the medical witnesses that such problems were attributable to a moderate TBI.

[36] The court a quo accepted the evidence of Mr M's witnesses and rejected that of the RAF and its witnesses. The judge stated simply that '[T]he best approach would be to assess the logical reasoning of the plaintiff's expert evidence against the probabilities emerging from the entire evidence that was adduced. I do not intend to recount the evidence adduced as that exercise has been conducted already. Suffice it to say that the evidence of Dr Wilkinson is acceptable as compared to that of Dr Kieck'.

[37] The judge based this conclusion upon Mr M's witnesses giving 'supportive facts' that Mr M sustained a mild to moderate head injury. He rejected the argument of the RAF that Dr Wilkinson's opinions are not supported by medical literature, on the basis that Dr Wilkinson's qualifications and experience were undisputed. He described Dr Kieck's examination of Mr M as 'superficial, shallow and unhelpful.' He rejected the evidence of Dr Loebenstein because he would not accept the results of the myriad of tests conducted by Dr Hardy. That appears to be the only basis upon which he preferred the evidence of Mr M's witnesses, to those of the RAF. This approach flies in the face of the requisites laid down in *Louwrens v Oldwage*[25] in relation to the approach to be adopted when there is competing evidence. The court in *Louwrens*, referring to *Michael v Linksfield Park Clinic*, [26] said the following:

'What was required of the trial Judge was to determine to what extent the opinions advanced by the experts were founded on logical reasoning and how the competing sets of evidence stood in relation to one another, viewed in the light of the probabilities.'[27]

[38] Despite referring to the required approach as laid down in these two cases, the judge a quo did not follow this approach. His uncritical acceptance of the evidence of Dr Wilkinson and Mr M's other experts, and the rejection of Dr Kieck and Dr Loebenstein's evidence, thus fell short of the requisite standard. The judge a quo failed to give any logical reason for arriving at such a conclusion, as is evident from the portion of the judgment referred to above. As stated in *Michael v Linksfield Park Clinic*, '(I)t would be wrong to decide a case by simple preference where there are conflicting views on either

[25] *Louwrens v Oldwage* 2006 (2) SA 161 SCA; *BEE v Road Accident Fund* [2018] ZASCA 52; 2018 (4) SA 366 SCA para 22 - 25.
[26] Ibid.
[27] Ibid at 175H.

side, both capable of logical support. Only where expert opinion cannot be logically supported at all will it fail to provide "the benchmark by reference to which the defendant's conduct falls to be assessed" '.[28]

[39] The hospital records show that on admission, Mr M did not display any evidence of having suffered anything more than a mild concussion. The periods of LOC and PTA were of short duration and thus fitted the criteria relating to a mild brain injury, from which full recovery could be expected within three months. None of the complaints now referred to seemed to bother Mr M post-accident, until his academic results declined in 2013. His exemplary school record showed improvement, rather than decline, with him achieving five distinctions in matric and two distinctions in his first year of Actuarial Science.

[40] The evidence tendered by the RAF more than adequately rebutted the suggestion that such an injury could have been sustained in 2006, not been diagnosed, and then manifested itself in 2013. The considerable improvement in Mr M's academic performance in the years following the accident was an insuperable stumbling block to the conclusions drawn by Drs Hardy and Wilkinson. There was no basis for the judge's rejection of the evidence of Drs Kieck and Loebenstein.

[41] The probabilities weigh heavily in favour of the evidence presented by the RAF's witnesses that this was a mild brain injury from which he has recovered. There is no basis to find that the symptoms suddenly appeared some seven to ten years later. If the brain injury was more significant, the probability is that any such deficits would have manifested immediately or within days or weeks of the injury. The failure of Mr M or his mother to give evidence in relation to his present condition leaves a deficit in Mr M's case, which cannot be cured by the opinions of the psychologists.

[42] Mr M has failed to prove the causal link between the brain injury sustained in 2006 and the problems that he presently experiences.[29] In the circumstances, the appeal must succeed because there was no admissible factual evidence to support the conclusions that Mr M's medical witnesses drew. Their opinions lacked the requisite factual foundation

[28] *Michael v Linksfield Park Clinic* fn 1 above para 39.
[29] *Life Healthcare Group (Pty) Ltd v Suliman* 2019 (2) SA 185 (SCA) para 12.

that our courts have consistently demanded should be the basis for the expression of opinions by an expert.

Costs

[43] The RAF had tendered a certificate in terms of Section 17(4) of the Act and that order will stand. Mr M's counsel submitted that as the certificate still stands, the RAF should be liable for a portion of the costs. This cannot be acceded to. The certificate was tendered on the first day of the trial. The claim for general damages is standing over and the trial therefore proceeded only in respect of the claim for loss of income. In these circumstances only the costs in respect of the latter claim need to be considered at this stage. The normal rule that costs follow the result must apply. Mr M must therefore pay the costs associated with his claim for loss of income which will include the costs of the hearing in the court a quo from 21 October 2015 to 18 July 2016.

[44] The following order is made:

1. The appeal succeeds with costs, including the costs consequent upon the employment of two counsel.
2. The order of the court a quo is substituted with the following:

'(a) The plaintiff's claim for loss of income is dismissed with costs, including the costs of the hearing from 21 October 2015 to 18 July 2016.

(b) The defendant shall furnish the plaintiff with an undertaking in terms of s 17(4) of the Road Accident Fund Act 56 of 1996, for the costs of the future accommodation of the plaintiff in a hospital or nursing home for the treatment or the rendering of a service or the supplying of goods to him after each of such costs have been incurred and on proof of payment thereof.'

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S WEINER
Acting Judge of Appeal

APPEARANCES:

For Appellant:	H J Van der Linde SC (with him P T Marais) Instructed by: Mnqandi Inc, Mthatha c/o Maduba Attorneys, Bloemfontein
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