IN THE HIGH COURT OF SOUTH AFRICA
(WESTERN CAPE DIVISION, CAPE TOWN)

Case Number: 9777/2018

In the matter between

ADV BRENDON BRAUN NO

CURATOR AD LITEM TO TATENDA EDWIN TIRIPANO

PLAINTIFF

and

PASSENGER RAIL AGENCY OF SOUTH AFRICA

DEFENDANT

JUDGMENT

Date of scheduled hearing: 17 March 2025

Date of judgment: 26 March 2025

BHOOPCHAND AJ:

1. The Plaintiff is the Curator Ad Litem to the Patient, Tatenda Edwin Tiripano, who is 40 years and 11 months old. The Patient fell after being pushed through the open doors of a train at Stikland Station, Western Cape Province, on 15 September 2017. The Defendant, the Passenger Rail Agency ('PRASA'), provides rail passenger services in the province. The Defendant has accepted eighty percent liability for the Patient's proven damages. This judgment deals with the quantification of the claim. The parties agreed to submit their respective expert reports, supported by affidavits, as per Rule 38(2). The Court determined the matter based on the papers and the written arguments provided by Counsel for the parties under Rule 39(20).

2. The Patient struck his head on the station platform as he fell and suffered a traumatic brain injury, an occipital skull fracture, and haemorrhagic brain contusions in the frontal lobes and left temporal lobes. The Plaintiff had claimed the following damages.

2.1. Past hospital and medical expenses: R100 000
2.2. Future medical and related expenses: R674 740
2.3. Loss of earnings: R7 073 000
2.4. General Damages: R2 500 000

3. The Plaintiff appointed a Neurosurgeon, a Psychiatrist, a Plastic and Reconstructive Surgeon, an Ophthalmologist, a Clinical Psychologist, an Occupational Therapist, an Industrial Psychologist, and an Actuary. The Defendant appointed an Orthopaedic Surgeon, an Occupational Therapist, an Industrial Psychologist, and an Actuary. The Industrial Psychologists compiled a joint minute.

4. Neurosurgeon Dr. Z. Domingo assessed the Patient on August 3, 2020. He reviewed the hospital's clinical records. The Patient's brain injury was assessed on admission to the hospital as a severe traumatic brain injury. A traumatic brain injury (TBI) is damage to the brain caused by a sudden blow, bump, or jolt to the head or by something that penetrates the skull, like a sharp object. Think of it as the brain getting shaken up or bruised inside the skull. These injuries can range from mild (like a concussion, where someone might feel dazed or have a headache) to severe (causing long-term changes in thinking, movement, or emotions). They often result from

accidents, such as falls, car crashes, or sports-related impacts. It's important to take head injuries seriously, as the brain is incredibly delicate, and even what seems like a mild injury can have lasting effects if not treated properly.

5. The CT brain scan done on admission to the hospital after the injury revealed multiple pathologies. The skull fracture line extended from the occipital area into the foramen magnum (the hole at the posterior part or base of the skull where the spine and blood vessels enter), and occipital condyle. The condyles are bony structures on either side of the foramen magnum. They articulate with the first vertebra of the spine and thus facilitate movements of the head on the neck.

6. There were bilateral frontal lobe contusions. The latter means that there was bruising of the tissue situated in the anterior aspect of the brain. The frontal lobes are responsible for higher-level functioning in humans. These include, firstly, executive functioning, like planning, decision-making, problem-solving, and reasoning. The second is emotional regulation, which enables us to manage and express our emotions appropriately. The third is behaviour control, which modulates impulse behaviour and maintains focus. The fourth is motor function, which controls voluntary muscle movements. The fifth relates to language and speech production, and the sixth to personality. Many aspects of personality and social behaviour are shaped by the frontal lobes. The frontal lobes are often referred to as the command centre of the brain as they coordinate so many critical functions.

7. The Patient also suffered left temporal lobe haemorrhagic contusions, meaning that there was bruising of the brain tissue situated along the sides of the brain, just above the temples and the ears. Its main function is auditory processing, i.e. how we hear sounds. It has other functions, such as long-term memory, the ability to understand spoken and written language, emotional responses, and the capacity to process what we see and subsequently recognise.

8. The scan also revealed a right hemispheric subdural hematoma with extension into the falx cerebri and tentorium cerebelli. The brain is covered in three layers, namely the pia mater, the arachnoid mater, and the dura mater, from the outer to the inner. The pia mater hugs the surface of the brain and the spinal cord. 'Mater' is the

Latin word for ‘mother,’ a fitting metaphor that relates to their protection and nurturing of the soft, gelatinous-like brain tissue lying beneath them. There are potential spaces between the dura and arachnoid maters as well as between the arachnoid and pia maters. Cerebrospinal fluid in these spaces cushions the brain tissue against movement and protects it from bruising against the tough skull bones. These spaces can fill with excessive cerebrospinal fluid or blood in brain injuries. The blood collection can expand against the soft brain tissue and displace it. The soft gelatinous tissue of the brain needs to be kept in place. Think of the falx cerebri as a vertical wall that runs down the centre of the brain, separating the left and right halves or hemispheres. The tentorium cerebelli runs horizontally, separating the upper cerebrum from the lower part of the brain, known as the cerebellum. These structures or partitions are made up of a tough layer of dura mater. They can be described as the scaffolding that keeps the different parts of the brain from damaging each other as the head moves. The right hemispheric subdural haematoma means that the impact of the Plaintiff’s head injury caused internal bleeding in the brain, and blood seeped into the space between the dura mater and the arachnoid mater. The scans also showed small left frontal and temporal subdural haematomas.

9. Finally, the scan revealed a subarachnoid haemorrhage in the interpeduncular cistern, the sylvian cistern and within the sulcal markings. A subarachnoid haemmorhage is bleeding into the space between the arachnoid mater and the pia mater. The cisterns of the brain are like little pockets or reservoirs within the space surrounding the brain, where cerebrospinal fluid (CSF) gathers. CSF is the liquid that cushions and protects the brain and spinal cord. These cisterns act as storage areas for this fluid, ensuring the brain is well-supported and shielded. They are protective fluid-filled cushions in specific parts of the brain and act as a source of nutrients for the brain as well. The interpeduncular cistern is situated near the brainstem, and the Sylvian cistern is a fluid-filled space in the brain located around the Sylvian fissure, which separates the frontal and parietal lobes from the temporal lobe. The sulci, or sulcal markings, referred to in the scan, are grooves or troughs visible on the brain's surface, giving it its characteristic wrinkled appearance. The elevated areas between the sulci are known as the gyri. This design provides the brain with a larger surface area, thus packing more brain into a confined space of the skull.

10. In summary, the Patient suffered extensive injury to his brain involving both the right and left hemispheres. A computed tomography (CT) brain scan identifies structural brain damage and its sequelae, such as bleeding, swelling, restricted blood flow, and tissue damage. CT scans are usually performed routinely following brain injuries. It is ordered following the clinical assessment of the patient and serves as an essential marker of the severity of brain injuries. An understanding of the clinical assessment on admission and the results of the CT scan is crucial in the legal assessment of brain injuries.

11. Dr. Domingo categorised the brain injury as being moderate to severe in extent. The Patient lost consciousness after falling and had no recollection of subsequent events until about three weeks after the accident. The Patient required surgical intervention three days after admission to the hospital to reduce the pressure inside his skull. The surgical procedure performed required the removal of a part of the left and right frontal skull bones to allow space for the underlying swelling brain to expand. The bone flap removed was subsequently replaced. The Patient underwent rehabilitation before being discharged home.

12. The review of the clinical notes relating to the ongoing medical assessment of the Patient's brain injury on admission and during his hospitalisation was consistent with the severity of the Patient's brain injury. The clinical findings shall not be examined in detail for the purposes of this judgment. Dr Domingo's examination did not reveal any focal neurological deficit. The doctor concluded that the Patient had made a good physical recovery from the brain injury. His opinion on the mental recovery was less optimistic.

13. The Patient also developed bilateral haemopneumothoraces, which required drainage. This injury was not expected to have any long-term sequelae.

14. Once at home, the Patient experienced headaches. Family members noted that he was aggressive and confused, requiring assistance with his daily activities. His condition gradually improved and stabilised when Dr Domingo assessed him. The Patient was divorced two years after the accident. The divorce occurred, in part, due to his behavioural problems following the accident.

15. The Patient complained of poor vision in his left eye. He is conscious of the surgical scar that runs across his scalp from ear to ear. He tends to be emotionally labile, and angers easily but is neither verbally nor physically aggressive. He suffered his first generalised seizure in 2019. He commenced anti-convulsant medication. He has mild intermittent headaches, which respond to simple analgesia. The Patient manages his daily activities and has no problems with routine household chores.

16. The psychiatric evaluation revealed that the Patient suffered from mood swings, memory difficulties, stress, and depression. Dr Le Fevre diagnosed the Patient with a personality change due to traumatic brain injury. Ms Durra, the clinical Psychologist diagnosed with post-traumatic stress disorder ('PTSD'), and Major Depressive Disorder. Ms. Durra referred to symptoms of the neurocognitive disorder but correctly did not venture into providing a neuropsychological diagnosis. She, like all of the other experts recognised the need for a neuropsychological assessment of the Patient. It was not done.

17. The Plaintiff's appointed Occupational Therapist considered that the Patient would, from a physical perspective, be able to comply with the demands of his former sedentary job. She, however, expressed insecurity about the Patient's emotional cognitive, and behavioural difficulties resulting from the brain injury. She wondered whether it could have a negative impact on his vocational abilities. The Defendant-appointed Occupational Therapist expressed the view that the Patient would be able to work in his field of training, and accommodations in the work environment were not foreseen. The scarring on the Patient's head may cause minor loss of earning capacity.

18. The Defendant appointed Professor Vlok, who is an Orthopaedic Surgeon. The Plaintiff did not suffer any injury that required his expertise. The only link that Professor Vlok had to this case was that he was the Consultant in the ward where the Plaintiff was treated. He does not take the matter any further, and the appropriateness of appointing this expert is uncertain.

19. Dr. Cronwright, the Plastic and Reconstructive Surgeon, directed attention to the patient's prominent, elliptical surgical scar, extending from ear to ear with a curve

towards the forehead. The scarring could attract unwanted attention in the job sector the Patient worked in around the time of the accident. Dr. Cronwright did not recommend scar revision, as it would be difficult to achieve significant and meaningful improvement. Further surgery was expected to improve its appearance by 30-40%.

20. Dr Perrot, the Ophthalmologist, assessed the Patient on 23 November 2022. The examination showed a markedly reduced visual acuity in the left eye. Dr Perrot surmised that the blunt force to the Patient's head disrupted the normal anatomy of the central retina or macula of the left eye. The Patient was left with a traumatic maculopathy with a secondary lamella macular hole. Dr Perrot stated that the loss of vision in one eye had a significant psychological impact on the Patient.

21. As for the experts appointed, the Court notes that despite recommendations that the Plaintiff appoint a Neuropsychologist or a Clinical Psychologist with a special interest in Neuropsychology to provide objective testing and assessment of any cognitive fallout resulting from the accident, he did not. The Court thus has no objective evidence that the Patient suffered any cognitive fallout. At best for the Plaintiff, Dr. Domingo noted that the Patient reported no cognitive problems on specific questioning. Still, given the severity of the brain injury, he, like all the other experts, expected neurocognitive deficits to follow this type of brain injury. The clinical psychologist conducted an elementary neuropsychological assessment, which does not assist the Court in determining the neuropsychological sequelae in this matter. The Court needed guidance on whether there were long-term effects from the injuries that occurred in various parts of the brain, as identified in the opening paragraphs of this judgment.

PLAINTIFF'S CLAIMS

FUTURE MEDICAL EXPENSES

22. Dr Domingo referred to the single seizure the Patient suffered in 2019. The Patient was commenced on anti-convulsant medication after the seizure. At the time

of Dr Domingo's assessment of the Patient in August 2020, the Patient was no longer on anti-convulsant medication. Dr Domingo believed that the Patient required lifelong medication for post-traumatic seizures. The most recent report in the Court file was that of the Plaintiff appointed Industrial Psychologist. Her report of October 2022 confirmed that the Patient had just one seizure in 2018. He told the Occupational Therapist that the medication given to him for the seizure was a once-off prescription, and he no longer takes the medicine. There is no indication that the Patient was tested for seizures or had any further assessment after the 2018 seizure. Dr Domingo suggested that the Patient receive R450 000 for lifelong treatment of his post-traumatic seizures (of which he suffered just one). The written argument submitted on behalf of the Plaintiff omitted this item from the claim for past medical expenses. In the Plaintiff's undated supplementary submissions, an attempt was made to include this item under this head of damages. The Defendant submitted that the late inclusion of this item prejudiced it. Even if the Court were to consider this item, the evidence is that the Patient suffered just one seizure and had stopped his medication shortly after seeing a doctor for it. There is no evidence that the Patient was assessed or tested for his seizures. Expenses must be reasonable and necessary. The Court declines to make any award for this item.

23. Dr Domingo also recommended R5000 for simple analgesia over the Patient's lifetime. There is no evidence about the Patient's life expectancy.[1] Future medical expenses extending over a patient's lifetime should, of necessity, have evidence relating to this aspect. As the Plaintiff is receiving this amount now, a 15% deduction must apply, considering that the amount is intended to cover the Patient over his lifetime. The Court awards R4250 for this item.

24. The Defendant-appointed Occupational Therapist recommended that the Patient receive 4-6 hours of occupational therapy to address education related to pain management and the implementation of reasonable accommodations in the workplace, should the Patient obtain employment again. The expert suggested that the therapist should be compensated for her traveling time at a rate of R650 per hour.

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[1] The Court had to search for this evidence, which referred to tangentially in the Defendant-appointed actuarial report where the comment is made that "We have assumed that the Claimant's life expectancy is normal."

The expert does not explain why a therapist should be paid for her traveling time. The Actuary costed these items at R8750. The expert states that the Patient occasionally takes analgesic medication for headaches. What type of education would a patient require to take a Panado? The Occupational Therapist did not justify this expense. The expert also stated that on testing, the Patient did not present with any limitations for tasks requiring sitting, standing, walking, climbing stairs, crouching, squatting, and kneeling. The expert fails to explain why the Patient should require the implementation of reasonable accommodations in the workplace. The Court declines to make any award for this item.

25. The Clinical Psychologist recommended twelve sessions of Eye Movement Desensitisation and Reprocessing therapy (EMDR) to reduce the symptoms of PTSD. She also recommended weekly supportive psychotherapy followed by psychotherapy on a need basis. The actuary costed this item at R80 680. The Court awards this amount. As the Patient is expected to avail himself of the treatment immediately, no contingency deduction would be applied to this item.

26. Dr Perot recommended that R80 000-R100 000 be ‘apportioned’ to cover ‘possible’ macular hole surgery if the partial defect in the Patient’s eye progresses to a full-thickness hole. The Actuary costed this item at R72 530. Dr. Perot provides no indication as to when the partial defect is expected to become full-thickness. The Court has considered the nature of the recommendation, and as there is some doubt as to whether the Patient’s condition would deteriorate and he would require surgery, a contingency deduction of 20% is appropriate on the cost of this item. The Court awards a rounded-off figure of R58 000 for this item.

27. Dr Cronwright’s recommendation for the future management of the scalp scar is even more problematic. The Plastic and Reconstructive expert considered how a scar revision might be done if the patient desires the surgery. Dr Cronwright does not advise the surgery, as it is difficult to achieve significant, meaningful improvement. The expert stated that he would only be hopeful of a 30-40% improvement in the scar's appearance. The Actuary costed this item at R62 780. The Actuary noted that they had allowed for this cost, even though the expert had advised against it. They deferred to the attorney (about whether it would be pursued). Considering the expert’s reluctance

to advise surgery for scar revision and the poor prospects of obtaining improvement, the Court declines to make an award for this item.

28. Plaintiff argued that as Defendant did not file an actuarial calculation in opposition to Plaintiff's instructed actuarial calculation, the future medical costs, as detailed and calculated, should be accepted as uncontested. The Plaintiff suggested that the Court award a revised amount of R679 740 under this head of damages. It is apparent from the motivation provided on behalf of the Plaintiff that his legal representatives did not thoroughly review the reports they submitted, nor have they ensured that the claims are properly supported by evidence. The Defendant fares no better. It has also accepted the costs of the interventions suggested by the Plaintiff-appointed experts without evaluating the context wherein the recommendations were made. Where the Defendant suggested contingency deductions, they bore the hallmark of sheer guesswork. In the premises, the Court awards R142 930 for future medical expenses.

GENERAL DAMAGES

29. General damages are awarded as compensation for non-financial losses or harm that cannot be easily quantified. It includes pain and suffering, loss of amenities of life, and disfigurement. Each case has to be evaluated under these headings. Pain and suffering encompass both physical and emotional distress. Loss of amenities pertains to the reduction in the quality or enjoyment of life, and disfigurement includes permanent scarring or physical changes flowing from the injuries.

30. There are usually two phases to injury assessment for general damages; the acute phase refers to the period from the time the injury is sustained to the time the injury stabilises or its effects disappear. The chronic phase refers to the ongoing symptoms and sequelae of the injuries, which may sometimes endure for the lifetime of the injured person. The assessment of general damages has introduced terms such as maximum medical improvement and percentage of whole-body impairment to determine whether general damages qualify for compensation. Serious injuries usually elicit the most physical pain and suffering and loss of life’s amenities in the acute

phase. The outcomes in the chronic or ongoing phase of injuries may be variable. A serious injury with a good outcome may cause little pain, suffering, and loss of amenities, and the inverse may also apply. A mild injury may evolve into long-term difficulties as it progresses, e.g., injuries involving joints.

31. In the context of a brain injury, symptoms such as headaches, nausea, vomiting, memory loss, and dizziness typically peak soon after the injury occurs and then either resolve completely or persist at a reduced frequency once the injury stabilises. Each case must be evaluated for its effects on physical and emotional pain, suffering, and disfigurement. Whilst awards for general damages may be useful guides in determining general damages, it is the actual symptoms and effects of injuries on the injured person that should determine the award in each case.

32. The Plaintiff submitted that the Court make an award of R1 500 000 for general damages. The Defendant argued for an award of R450 000.

33. The Patient required hospitalisation for a prolonged period. He has no recollection of the three weeks after the incident. He suffered blurred vision in his left eye and headaches. He had to acquire and wear spectacles because of the injury to his eye. His major problem related to his mental functioning and the psychological symptoms he experienced. He struggled to control his mood and temper. He struggled with insomnia. The Patient exhibited aggressive behaviour that led partially to his divorce. He was separated from his young child and had to find alternate accommodation. He tends to anger easily and is easily provoked by minor things. The headaches have decreased in frequency, requiring occasional simple pain medication. He still struggles to contain his emotions. He experiences both anxiety and depression but takes no medication. The blurred vision in his left eye is permanent, and so is the scalp disfigurement.

34. What is apparent in this case is that the Patient’s main problems relate to his psychological functioning and the scar on his head. The extent of his pain and suffering and disfigurement does not justify an award of R1 500 000 for general damages. Neither does the Patient qualify for a meagre award of R450 000. This case illustrates the principle that a serious brain injury may not attract a high award of general

damages. The inverse may be true in certain cases. None of the cases submitted by the parties comes close to the injury and outcomes prevalent in this matter.

35. The Court considered the extent of the initial brain injury, the eye injury, and the scalp scar in assessing the award it should make for general damages in this case. Although the Court has alluded to the absence of a neuropsychological report, it has considered the general neuropsychological sequelae as a part of the award for general damages. These would include the effects of memory, attention, concentration, executive, personality, and emotional functioning as they would have affected the Patient during the acute and chronic phases of his accident-acquired injuries. Some of these higher-level functioning deficits were sourced from the collateral history and information obtained by the experts. The Court considers an award of R1 million to be a fair and just award in the circumstances.

LOSS OF EARNINGS

36. The Patient completed a bachelor's degree in Tourism and Hospitality Management in 2008. He was employed as a sales and marketing coordinator for a hotel group from 2015 until the accident occurred. His role was primarily administrative and office-based. He returned to working half days in December 2017 and then to full days. He was retrenched in December 2018. He obtained a job as a waiter. His first contract lasted two months, and the subsequent one, five months. In March 2022, he began working at Kingdom Blue Funerals.

37. Dr. G Loubser (‘Loubser’)and Mr. D Malherbe (‘Malherbe’), respective Industrial Psychologists appointed by the Plaintiff and Defendant, compiled a joint report on 31 July 2023. Their Rule 36(9)(b) reports were compiled two years apart, with Loubser providing the later assessment. The Patient was employed as a Sales and Marketing Coordinator for Radisson Hotels. Loubser considered the job to be at a skilled and academically qualified occupational level. Malherbe placed the position at the semi-skilled level. They agreed that the Patient could have advanced his career further if he was not injured. Their earnings projections are comparable up until the average career ceiling at age 45. Loubser then suggested that the Patient would have earned in line

and attained earnings of R645 195 per annum by age 45. Malherbe postulated that the Patient would have attained a skilled job level at age 45, with earnings corresponding to the C1 Paterson job grade. He suggested that the related earnings were to be sourced from Robert Koch's 2023 Quantum yearbook.

38. For the injured scenario, Loubser firstly acknowledged that the Patient's retrenchment was unrelated to the accident. She then suggested that the sequelae of the accident-related injuries played a role in the Patient's inability to secure another job. Malherbe stated that the periods of unemployment experienced by the Patient could not be fully attributed to the accident. He referred to the COVID-19 pandemic and its effect on the tourism and hospitality industry. Loubser predicted, in line with the other expert opinions, that the Patient would not be able to pursue a position that required him to function at a higher level as he did in the uninjured state. She postulated that the Patient may be promoted to the position of a sales supervisor subject to psychiatric and psychological assessments. Malherbe capitulated from his initial opinion and agreed that the sequelae of the accident would impact the Patient's career. It was likely that the Patient would not attain the skilled levels of work he would have enjoyed in the uninjured state. He will remain on a semi-skilled level for the remainder of his working career.

39. It is perturbing for a Court to find that two experts who are presumably schooled in the same discipline and require registration with their professional regulatory body to practice their profession can classify a job so differently. The Patient obtained a tertiary qualification and had plans for academic improvement. Yet, one expert considers the same job to be semi-skilled, whereas the other considers it a skilled placement available to professionally qualified individuals. Fortunately, their differences were finally narrowed to this issue alone.

40. The Plaintiff filed the final actuarial calculation dated 27 February 2025. The Actuary calculated the capital value of the loss of earnings predicted by the Industrial Psychologists as follows:

DR LOUBSER			

	Uninjured earnings	Injured earnings	Loss of earnings
PAST	R2 092 900	R414 700	R1 678 200
FUTURE	R8 859 200	R1 934 400	R6 924 800
TOTAL LOSS			R8 603 000
MR MALHERBE			
PAST	R1 971 200	R414 700	R1 557 000
FUTURE	R7 089 100	R1 934 400	R5 154 700
TOTAL LOSS			R6 711 700

41. What is apparent from the above table is that the past and future earnings in the injured state yield the same monetary value. The calculation of future uninjured earnings yields a material difference, aligning with the expert's classification of the patient's employment level. The difference in past earnings is minimal. The Court shall use a rounded-off figure of R2 million as past uninjured earnings.

42. Malherbe predicted that the Patient would attain a skilled level of employment at Paterson C1 job grade at the peak of his career. Although Malherbe acknowledges that the Patient would have qualified for a skilled (Paterson C band) placement after graduating with a commerce degree, he regarded the role the Patient held when the accident occurred as 'likely still on a semi-skilled level'. The Patient earned approximately R16 847 per month, cost-to-company salary at the time the accident occurred. Loubser provides a fairer and more compelling assessment of the Patient's true uninjured potential. She recognised the patient's educational achievement, i.e., the commerce degree, and his intention to further his tertiary qualifications by enrolling in an MBA. She considered that the Patient held skilled positions. Loubser projected the Patient's career advancement along those lines. Malherbe's projections are too pessimistic for a person with a tertiary qualification. The Court has no hesitation in accepting Loubser's career predictions for the future uninjured state. It shall use the monetary translation of the projection to determine the total loss of earnings.

43. For past uninjured earnings of R2 million, the Court shall apply a contingency deduction of 5%. For past injured earnings, no deduction shall apply as there were periods of unemployment that could not be attributed to the Patient's accident-related sequelae. The Patient is 40 years old. He has 25 years to retirement. The normal contingency deduction for future uninjured earnings is 15%. The question is whether additional percentage points should be added to the deduction to cater to the possibility that the Patient would not have attained the more optimistic career projection predicted by Loubser. The Patient has changed jobs and countries in pursuit of employment, even venturing to Dubai for a job, whilst uninjured. The Court believes that a further 10% deduction would cater to this type of unpredictability. The future injured earnings should attract no more than the normal contingency deduction. It is predicated upon a customised projection, and it would be inequitable to apply a higher deduction, considering that the Patient has secured what appears to be a steady job in the funeral sector.

44. The following table reflects the capital values used by the Court and the contingency deductions applied.

	UNINJURED EARNINGS	INJURED EARNINGS	LOSS OF EARNINGS
PAST	R2 000 000	R414 700	
CONTINGENCY DEDUCTION	5%	0%	
	R1 900 000	R414 700	R1 485 300
FUTURE	R8 859 200	R1 934 400	
CONTINGENCY DEDUCTION	25%	15%	
	R6 644 400	R1644 240	R5 000 160
		TOTAL LOSS OF EARNINGS	R6 485 460

45. The application of the appropriate contingencies to the actuarial calculation of earnings in this matter emphasises certain principles. The first is that each case should be determined by its peculiar facts. There are normal deductions that apply to past and future earnings in the uninjured state for adults. These deductions are 5% for past earnings and 15% for future earnings. For a younger adult, such as a 25-year-old with approximately 40 years until retirement, a 20% deduction would be appropriate and consistent with a 0.5% annual deduction.[2] Contingency deductions are applied to earnings, not to the loss of earnings. In any given case, there are usually four deductions that need to be applied, and each should be considered on its merits. There are instances, such as *in casu*, where a higher-than-normal deduction is warranted for future uninjured earnings if the facts require it. The contingency deduction thus applied for future uninjured earnings may be higher than for future injured earnings, emphasising the need to consider the reasoning behind each calculation. Regarding injured earnings, no deductions are necessary for past injuries if they, as is usually the case, reflect actual earnings. There is a tendency to apply a higher-than-normal deduction to future injured earnings. The facts of a particular case should determine whether that is appropriate or not. If the career projection proposed is customised to the Plaintiff's injured condition, it will make no sense to apply a higher-than-normal deduction. Overall, the Court still maintains a discretion in applying or not applying contingencies.

46. Both Counsel mistook the second actuarial calculation as the combined calculation of capital values, whereas the Actuary clearly labelled it as the calculation based upon the Malherbe projection. The Plaintiff's Counsel did not apply any contingency deduction to future injured earnings. The Defendant's Counsel spoke of applying contingencies to past and future loss, and his arithmetic was out by R2 million. The Court finds no joy in raising these aspects. Ultimately, it must ensure an award that is fair and equitable to the Patient. Nothing further needs to be said about the submissions made by Counsel under this head of damages.

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[2] Road Accident Fund v Guedes (611/04) [2006] ZASCA 19; 2006 (5) SA 583 (SCA) (20 March 2006) at para 9

47. The Court then awards R142 930 for future medical expenses, R1 million for general damages, and R6 485 460 for loss of earnings. The total award is, therefore, R7 628 390. Once the twenty percent apportionment is deducted, the amount to be awarded to the Plaintiff is R6,102,712. The Plaintiff mistakenly, among a series of errors, relied on the actuarial calculation based on Malherbe's career projections. Coincidentally, the award sought by the Plaintiff, and fortuitously for the Plaintiff's Counsel, the computation of the figures as performed by the Court comes to a similar amount, give or take R40,000.

48. The Plaintiff submitted that the Defendant should pay the plaintiff's costs on the B scale. The Court assumes that Plaintiff seeks its party and party costs and Counsel's fees on the B scale. The Court shall allow the Plaintiff's party and party costs, but Counsel's fees on the A scale. This case was of a complex nature, but the manner in which it was handled does not justify awarding Counsel's fees above the A scale. The costs relating to the Plaintiff's supplementary submissions, the note, and the amendments to the orders sought are excluded from the Plaintiff's costs. The following order shall reflect these findings.

ORDER

1. The Defendant shall pay to the Plaintiff through the Plaintiff's attorney, the sum of R6,102,712 (six million, one hundred and two thousand, and seven hundred and twelve rand) in full and final settlement of the Patient's claim against it. As well as any costs incurred in obtaining the capital amount,
2. The Defendant shall pay the Plaintiff's party and party costs and Counsel's taxed or agreed fees on the A scale.
3. The Defendant shall pay the costs of the appointment of a Curator Ad Litem and, if deemed necessary, the costs of a Curator Bonis to protect the capital sum awarded,
4. The Defendant shall pay the reasonable and necessary fees and disbursements of the following expert witnesses:
    4.1 Dr Z Domingo,
    4.2 Dr K Le Fevre,

4.3 Dr K Cronwright,

4.4 Dr A Perrot

4.5 Ms L Durra

4.6 Ms L Kruger

4.7 Dr G Loubser

4.8 Munro Forensic Actuaries

Bhoopchand AJ

Judgment was handed down and delivered to the parties by e-mail on 26 March 2025