REPUBLIC OF SOUTH AFRICA

SOUTH GAUTENG HIGH COURT, JOHANNESBURG

CASE NO: 2007/6636

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

11/9/2012
DATE

SIGNATURE

In the matter between:

THOMAS, CRAIG FRANCOIS Plaintiff

and

B.D.SARENS (PTY) LTD Defendant

JUDGMENT

SUTHERLAND J:

Introduction

[1] The defendant was held to be liable in full for the damages suffered by the plaintiff resulting from an industrial accident whilst working for Expro, a transnational corporation, on 4 March 2004 at the T5 Temanic oil rig site in Mozambique. This trial concerns only the quantum of damages payable.

[2] The plaintiff was struck by a heavy metal pipe and injured.

[3] It is common cause that the injuries he sustained included:

3.1 a fracture of the left parietal skull,

3.2 a comminuted fracture of the left clavicle,

3.3 laceration of the left ear,

3.4 laceration of the left ear,

3.5 damage to the 4th cranial nerve, or trochlear, which regulates the left eye muscle, and which has permanently impaired his vision,

3.6 unconsciousness and post traumatic amnesia (PTA)

[4] Controversial issues about the injuries are:

4.1 Whether or not the plaintiff's present, common cause, frontal lobe cognitive deficits and cervical neck pathology are attributable to injuries he sustained in this accident.

4.2 Whether or not he suffered any form of brain injury.

4.3 Whether or not he suffered any neck injury.

[5] The plaintiff's initial claims were for:

5.1	Past medical expenses:	R54,920.32
5.2	Future medical expenses:	R1,207,300
5.3	Past loss of earnings and Future loss of earning capacity: R15,473,300	
5.4	General damages:	R800,000
Total:		R16,328,220

[6] Several experts were consulted. They are not wholly in agreement about either his present medical condition or the appropriate future treatment for which he must be compensated, and moreover they are not all in agreement about the causes of the present medical condition. Other related experts are not wholly in agreement about the appropriate factors that are to be weighed to calculate the plaintiff's pre-accident and post-accident income earnings capacity.

Experts and their evidence

[7] Controversy arose during the trial about what evidence was properly before the court and what scope existed to challenge or solicit expert evidence. I gave rulings from time to time. I do not recount here all the particular skirmishes, rather I set out what I view to be the appropriate strictures to which I have adhered in considering the body of evidence adduced.

[8] The very nature of this case dictated the extensive use of medical and related experts. The purpose of an expert witness is to put before a court facts that require specialist skill to ascertain them or to interpret facts adduced that are not readily susceptible to interpretation by a judge owing to that judge's absence of such specialist skill. In this regard what should appear, typically, from an expert's report is a set of facts and/or a series of opinions. Sometimes the 'facts' upon which opinions are based are contested and sometimes experts called by opposing litigants agree on those facts. Similar agreements or disagreements over a given opinion can occur.

[9] The general principle is that a decision on what constitutes the facts on any issue is the preserve of a court. (See: State v Harris 1965 (2) SA 340 (A) at 365C) There is only one category of exception: ie, when the parties agree on the facts. Even if a court might be sceptical about a set of agreed facts, there is no

licence to go behind the parties' agreement, at least in a civil matter, just as the admitted facts on the pleadings are not to be interrogated by a court.

[10] Where litigants in a damages dispute give due notice to call an expert who is to adduce facts and to give an opinion, such notice binds the litigant who gives that notice. It is not open to that litigant to impeach its own expert witness unless and until it clearly repudiates all, or some, of the expert's contribution.

[11] Where the experts called by opposing litigants meet and reach agreements about facts or about opinions, those agreements bind both litigants to the extent of such agreements. No litigant may repudiate an agreement to which its expert is a party, unless it does so clearly and, at the very latest, at the outset of the trial. It is self-evident that do so at so late a stage is undesirable because it may provoke delay, but that is a practical aspect not touching on any principle. It is conceivable that very exceptional circumstances might exist that allow a litigant to repudiate an opinion later than this moment, such as fraudulent collusion, or some other act of gross misconduct by the expert, but such considerations do not bear extrapolation for present purposes.

[12] Where experts are asked or are required to supply facts, either from their own investigations, or from their own researches, and an agreement is reached

with the other party's experts about such facts, such an agreement on the facts enjoys the same *de facto* status as facts that are expressly common cause on the pleadings or facts agreed in a pre-trial conference or in an exchange of admissions.

[13] Where two or more experts meet and agree on an opinion, although the parties are not at liberty to repudiate such an agreement placed before the court, it does not follow that a court is bound to defer to the agreed opinion. In practice, doubtlessly rare, a court may reject an agreed opinion on any of a number of grounds all amounting to the same thing; ie the proffered opinion was unconvincing. (Menday v Protea Assurance Co Ltd 1976 (1) SA 565 (E) at 669B-E.) The rationale for not affording a litigant the same free hand derives purely from the imperative of orderly litigation and the fairness due to every litigant to know, from the beginning of a trial, what the case is that has to be met.

[14] The upshot of these principles is that it is illegitimate to cross-examine an opponent's witness to undermine an agreed position on fact or on opinion unless, before the trial begins, the opinion of a party's own expert has been formally repudiated. No litigant shall be required to endure the risk of preparing for trial on a premise that an issue is resolved only to find it is challenged.

[15] Furthermore, an opinion may only be admitted into evidence on two bases. The first is that there is an agreement that it may be so admitted. The second is that the rules of court, especially Rule 35, have been complied with or compliance therewith has been excused by the adversary. It is therefore not permissible to refer to a letter or a report of a medical practitioner for the purpose of invoking and relying on an opinion expressed therein, if it was not the subject of proper notice in terms of the Rules. However, it may sometimes be permissible to refer to a fact recorded in such a document and any controversy about so doing falls to be decided in accordance with the rules of evidence as to the reliability of such evidence to establish the particular fact.

Whether the claim has pleaded a Neck Injury

[16] An objection was taken to the plaintiff adducing evidence about a neck injury on the grounds it had not been pleaded. The true grievance was not the unfairness of being taken unawares, because the plaintiff was invited to amend the pleadings without objection. In answer, it was argued that the report of Dr Versveld was attached as an annexure to earlier amended particulars wherein the issue of the neck injury was fully canvassed; hence no amendment was necessitated.

[17] The plaintiff's stance is not without substance, but is remains, in principle, an undesirable answer to have to say that buried in an annexure to the

particulars, the substance of the claim is mentioned and is thus well founded. A party who intends to rely on a fact or circumstance must shine a light on it, not take refuge in its mention in a less obvious spot.

[18] In this case it is not a matter of moment for two reasons: first, there was no prejudice as the defendant was alert to the issue, and secondly, the view I take of the matter is that the neck injury issue was on the probabilities in any event at least part and parcel of the clavicle injury complex of injuries as I have found and addressed hereinafter, and thus, is an indistinguishable aspect of what was undoubtedly pleaded.

Referring to documents in a bundle: what is their evidential status?

[19] Controversy also arose about reference to documents in the bundle. The almost universal practice of preparing a bundle of all the documents that might be referred to in evidence is a boon to orderly litigation. However, it invariably occurs that not all the documents in a bundle are traversed in evidence. In my view, a document not traversed in evidence is not before the court, unless a prior agreement exists that it be admitted in a fashion other than through legitimate reference in evidence by a witness competent to comment thereon. The customary mantra that 'all documents in the bundle are what they purport to be without any admission to the truth of their contents' confers no evidential status on a document unless it is introduced through a witness capable of addressing

the contents, called by one or other of the opposing parties. (See, eg: Howard & Decker Agencies & Fourways Estates (Pty) Ltd v De Sousa 1971(3) SA 937 (T) at 940 F – G) The problems that arise for a litigant who itself cannot adduce evidence about a document can sometimes be addressed by compelling, when competent, a person under a subpoena to appear and address the document. Accordingly, no reliance may be placed on such documentary material, however relevant, in the absence of these two methods of adducing it.

[20] Therefore, where for example, a mine of data is contained in the bundle that would be most useful in the cross-examination of a given witness who might testify for the adversary, but that witness is not called, thereby depriving the cross-examiner of the chance to advance the case by challenging the absent witness with the data, it is not open to a party, later in argument, to allude to such material, however relevant it might be to any issue in dispute.

Absence of early medical records

[21] The trial was bedevilled by a lack of important immediate post accident medical data. Almost all the medical evidence presented was garnered in 2011 or 2012, some 7-8 years after the accident.

[22] Some 'accident reports' exist by ambulance staff and other co-workers about the incident and the immediate post - accident happenings. The authors were not called. The reports are in certain respects contradictory of facts established by reliable later medical evidence. As a result, reliance thereon, except where corroborated by other evidence or at least consistent with the inherent probabilities, is unsafe.

[23] Even more troublesome was the total lack of the records of the treatment administered to the plaintiff at the Milpark hospital. It is accepted that upon the accident happening, the crew took the plaintiff to a first aid post, and that from there paramedics cared for him and airlifted him to Johannesburg.

[24] At Milpark, he underwent surgery to try to repair the fractured clavicle and his wounds were treated. Self evidently, X rays would have been taken and clinical examinations would have been carried out. Apparently, at the time when a request was made for these records, they had already been destroyed in line with the hospital routine policy. It was therefore necessary for all current medical opinions to be based on present clinical and recent X- ray and Scan data, and to infer from such data, among other evidence, what injuries would on the probabilities have been the cause of the plaintiff's present medical condition. The information given by the plaintiff, even if assumed by the experts to be accurate,

was self evidently an inadequate technical account of his medical treatment and status.

[25] Ancillary to this absence of documents was the defendant's grievance about the failure or tardiness of the plaintiff to disclose documents demanded. As was self evident, critical data was missing but no convincing basis was advanced to criticise the plaintiff for not sharing what it admits that he had.

Failure of the plaintiff to testify

[26] The plaintiff did not testify. It was argued that an adverse inference should be drawn because his ostensible reason not to testify was to escape the rigours of cross examination. Moreover, in certain respects, it was argued that in the absence of the plaintiff's evidence, there was no evidence adduced about his condition insofar as his subjective experience of symptoms was relevant, and that there was no evidence of his total actual earnings during the period between 2006 when he left Expro, and 2009, when he joined his present employer.

[27] Counsel for the plaintiff contended that the plaintiff's evidence would have added nothing to what has already been adduced; arguing that the medical experts were agreed about his present condition and that in respect of the actual earnings during 2006-2009, the parties respective experts were both mandated

to enquire into that issue and in a joint minute agreed on what the earnings were. I agree with these submissions up to a point; it is incorrect to say, literally, that the plaintiff could have added nothing. However, it is a fair contention that this case did not rely on the plaintiff evidence for any of the material issues in dispute; in every instance only experts could resolve the differences of opinion or of underlying fact. In the main, the experts gathered input from the plaintiff in the ordinary course of several interviews. The plaintiff was criticised for telling different things to different experts, omitting some complaints to some experts, and in general giving an inconsistent account of himself. However, the common cause diagnosis of frontal lobe deficit which includes poor memory and distractibility is a complete answer to the pattern of inconsistent reporting. Moreover, on every critical issue, as shall be illustrated, his contribution was marginal. If the facts gathered by the experts from the plaintiff and others, including his wife, and agreed by them was to be subjected to challenge by the defendant, then the agreements between the experts on those matters ought to have been repudiated in accordance with the approach addressed above.

[28] The plaintiff's wife, Shirley Thomas, was called to testify about their home life circumstances and his difficulties with his weakened left arm, his poor memory, his fumbling retrieval of familiar words, his proneness to distraction, his black moods, his depression, and the contrast between the man he is now and the person he used to be. Some of these matters could as well have been related

by him. However, some could not and the perspective of his spouse of twenty years was plainly preferable overall.

[29] Accordingly in the circumstances of this case, I am of the view that no adverse inferences are warranted.

The plaintiff's present medical condition and its probable causes

[30] In large measure the experts are in agreement, although serious differences on certain aspects exist. The controversies were about these questions:

30.1 Can plaintiff's present cognitive deficits, which are frontal lobe in origin, be linked to a brain injury, if any, sustained in the accident?

30.2 Is the cervical spine degeneration attributable to an injury sustained in the accident or to a predisposition to naturally occurring osteo-arthritic degeneration?

30.3 Is the acromio-clavicular joint the site of pathology linked to the clavicle injury?

The brain injury question

[31] It is common cause that plaintiff exhibits cognitive deficits. These are:

31.1 Poor short term memory

31.2 Word retrieval.

31.3 Inattention and distractibility.

31.4 Incoherent babbling.

31.5 Slowing physchomotor responses to problem solving

31.6 Mood swings exhibiting anger outbursts and violent gesticulations.

[32] It is common cause that these symptoms indicate a brain frontal lobe abnormality.

[33] There is no agreement about why the frontal lobe is in such condition and whether it could be related to the accident injuries or another cause. The sensible place to begin an assessment is with the objectively established facts.

[34] In my view, the appropriate starting point is plaintiff's vision deficit, about which there is complete unamity. He cannot align his two eyes to see normally because he has double or blurred vision images, unless he tilts his head to the right. The cause of this condition is damage caused by the blow to the 4th cranial nerve which is responsible for regulating the eye muscle. This nerve, together

with the 7 other cranial nerves are laid out over the surface of the cranium. The evidence does not indicate exactly where along the thread of the 4th cranial nerve the damage occurred. It is indisputable that the damage incurred as part of the injuries caused by the blow to the head, and is an important indicator of the severity of the blow.

[35] Together with that injury, the other specific head injuries were:

35.1 A cut and fracture of the skull over the left parietal region, ie the upper mid section of the head.

35.2 A cut over the left eyebrow.

35.3 A cut over the left ear.

35.4 A broken tooth on the right side of the mouth.

35.5 The blow caused an acceleration/deceleration effect. This means, as I understand it, that the contents of the skull were violently shaken.

35.6 He was unconscious for a time and he experienced PTA for a time. The duration of the unconsciousness is estimated at 30 minutes and the PTA at a duration in excess of an hour, placing it by all accounts in the moderate head injury range according to the Jennett nomenclature. Reference was also made to the plaintiff, soon after the incident, registering on the Glasgow Coma Scale a reading of 12/15 improving within an hour to 15/15 which similarly

supports the opinion of a moderate brain injury. The ostensible difference between Dr Marus and all others who commented about whether the head injury was 'mild' or 'moderate' was a difference of nomenclature not a difference of opinion about the severity.

[36] What is known of the effect on brain tissue itself? The Scan copied in the bundle at [C25] (2012/04/18) reveals two facts of importance. First, over the left posterior parietal zone there is an area of hyperdensity of the soft tissue. Secondly, it was observed that the sulci, ie the familiar pattern of grooves that covers the whole of the brain, exhibited widening, and to the radiologist, 'more so, on the left, than the right'. The radiologist added that there were no definitive 'hypodensities' noted, which I understand to mean the opposite of dense; ie flaccid.

[37] The interpretation of the results about the sulci is controversial. However, the hyperdensity area found corresponds to the site of the fracture. It seems plain that an inference can be drawn about the injury resulting from the blow also involving some affect on the brain. As the data is just more than eight years post-accident it must follow that there could have been bruising even though that is not now visible. Common sense informs one that, given the list of injuries and their nature as tabulated above, the absence of bruising would have been remarkably unlikely.

[38] However, in this investigation in search of an explanation for the frontal lobe condition, what is significant is the absence of any clues to be derived from the Scan about damage specifically to the frontal lobe; eg, hyperdensity, as in respect of the parietal region. Therefore, is there a well grounded basis to infer that, in the absence of such radiological indications, the left frontal lobe was not damaged in the accident?

[39] The contention that no other explanation has been advanced is not helpful; that merely leaves the question unanswered. Rather, attention ought to be given to the following:

39.1 The acceleration/deceleration effect of the blow.

39.2 The severity of the blow that caused unconsciousness of about half an hour and PTA of some 1-2 hours

39.3 The severity of the blow that damaged the 4th cranial nerve.

39.4 The eyebrow injury as a site of severe impact.

39.5 The ear injury as a site of severe impact.

[40] In tabulating the impact spots that reveal themselves by visible and tangible injuries, the danger of compartmentalising them must be avoided; the implications of the head injury must be assessed holistically. A fierce blow to the left of the head by a large metal pipe must, on this evidence, have extended from the top of the head across the ear and the eyebrow, a large sweep. One can test

this by merely placing a finger on each of those spots; it forms an extensive zone, which transects part of the left frontal lobe. Moreover, the 4th cranial nerve is exposed throughout this area. It cannot be seriously in doubt that the frontal lobe escaped the impact of the blow, albeit tangentially.

[41] To this appreciation must be added the acceleration/deceleration effect of the injury. Though obviously such an effect is axiomatically of a diffuse character, the wobble caused would not require an exact direct contact with every part of the brain with the instrument delivering the blow to cause an ill-effect. Lastly, the unconsciousness and PTA speak to the overall severity of the blow.

[42] There was considered expert opinion about the source of the deficits and whether it could be linked to a brain injury. Dr Marus, the neuro-surgeon was of the view that the Scan results about the sulci were 'non-specific' even though there was a concentration over the left parietal area corresponding to the skull fracture. This evidence was pertinent to rebut the evidence of Ms Coetzee, the neuro-physcologist, who construed the Scan data on the widening sulci, with a left-side emphasis, to corroborate her evidence that the cognitive deficits had an organic origin. On the basis of the expertise required to interpret the data, deference is due to Dr Marus on this point. However he confirmed other data about a hyperdensity over the parietal region and that it indicates injury.

[43] Dr Marus does not offer an alternative theory for the cognitive deficits, nor is it his role to do so; his evidence however warns against piecemeal reliance on any given symptomolgy. In my view, having regard to the evidence of a skull fracture, the area of hyperdensity at that site, the bias of sulci widening over the left at that site, the probable extensive zone of impact encompassing much of the left side of the head, including at least part of the frontal lobe and the improbability of there being no soft tissue damage to the head, all of which must be weighed holistically, an inference of brain injury is justified.

[44] Added to that view is the presentation of clinically observable cognitive deficits and the results of psychometric testing showing cognitive deficits whose origin is frontal lobe, makes it a conclusive inference that brain injury occurred. The testing by Ms Coetzee a neuro-psychologist and Mr Mostert, a counselling Psychologist and the testing by the occupational therapists Ms Bester and Ms Greef, in my view all point in this direction.

[45] Their more significant test findings relevant to these aspects showed a low average score, and included:

45.1 Psycho- motor slowing.

45.2 Inattentiveness.

45.3 Unstable memory; poor encoding strategies relevant to prioritising activities.

45.4 Verbal deficiencies; ie, word retrieval, phonemic fluency, lapses into silence, poor prospective memory capacity.

45.5 Poor executive functioning.(ie planning, decision–making, flexibility of thinking)

[46] Particular clinical observations of significance included:

46.1 A flat affect in conversation. (Dr Marus)

46.2 Passive aggressive disposition. (Ms Greef)

46.3 Talkativeness, often directionless. (Mr Mostert)

[47] To that body of evidence must be added the personal testimony of Mrs Thomas, the plaintiff's wife of twenty odd years that the cognitive deficits did not exhibit before the injury. (The subjective reports of the plaintiff to the experts are likewise to the effect that the cognitive defects did not exhibit before the injury.) She mentioned these significant changes and current personality traits:

47.1 difficulty in multi-tasking.

47.2 poor concentration; in conversation he drifts off the topic being addressed, forgetfulness.

47.3 difficulty with spelling words.

47.4 easily stressed, short temper, anger outbursts involving physical gesturing and banging on tables.

47.5 childishness.

47.6 loss of confidence.

47.7 loss of libido.

47.8 unusually deep sleep patterns

[48] In my view, the available evidence is such that the thesis that the frontal lobe was damaged as part and parcel of the injuries sustained in the accident is sound and is supported by the probabilities.

[49] What remains is to assess whether any evidence exists to displace this thesis, as the most probable explanation.

[50] The alternative explanations are dealt with in turn:

50.1 That a pre-existing learning problem exists, perhaps undiagnosed: -

50.1.1 Mr Mostert, a counselling psychologist, alludes to the idea of a pre existing leaning disability as a speculative origin of the deficits, but does not substantiate why it is more likely than the accident.

50.1.2 The absence of reliable objective data about the period pre-2004 is regrettable. The reporting by plaintiff has

furthermore been inconsistent and often downright contradictory, but that is consistent with his diagnosed condition.

50.1.3 However, his wife who has been married to him since he was 23 years old discounts any such notion.

50.1.4 Moreover, the post school vocational education recorded by Ms Coetzee [56-57/4.3] is inconsistent with the difficulties he now experiences.

50.1.5 I must find that no basis to take this thesis seriously has been advanced.

50.2 That the psychometric test results have been influenced by the plaintiff's mood disorder: -

50.2.1.1 There were different results found evidencing different deficits. However there are no tests which produced contradictory results or which invalided others.

50.2.1.2 The mood disorder is in any event a result of at least the orthopaedic injuries.

50.2.3 The correspondence of the particular deficits to frontal lobe pathology rules out mood disorder as a primary suspect.

50.3 That the behaviour pattern is the result of the side effects of medication: -

50.3.1 The plaintiff is and has been for some time a habitual medicine drug taker for hypertension, pain and depression.

50.3.2 The contention was advanced that the presentation of memory problems and the like might have been precipitated by the taking of painkillers, hypertension medicines and anti-depressants. The thesis is not implausible, but such evidence as there is, is limited to the suggestion that certain symptoms are also experienced as a result of the taking of these drugs. Evidence derived from one drugs internet website about a medicine, taken by the plaintiff, suggested that these behaviours are a risk side effect; however, the inference of this as a proven cause is not made by such evidence; merely that a coincidence of symptomolgy exists.

50.3.3 It was suggested that the poor test scores were supportive of a drug induced effect. While that is a possible explanation it is not the most probable. As explained, by Ms Coetzee, the unevenness of the scores in the set of test results performed both by her and by Mr Mostert, shows that it is frontal lobe malfunctioning that is the likely cause, because the effect of the drugs would be to diminish scores in all tests not only some.

50.3.4 Sheer fatigue also does not explain the unevenness of the results pattern for the same reason.

50.3.5 Therefore, this explanation is less likely than a brain injury.

[51] In summary therefore, I find that the most probable explanation for the cognitive deficits is indeed an injury sustained in the accident

The orthopaedic injuries: The clavicle, the acromio-claviclar joint and the Neck Injury question

[52] It is common cause that the plaintiff had certain medical conditions that manifested themselves prior to March 2004. These were:

52.1 Hypertension; the plaintiff weighed about 91 kgs or 101 kgs according to different sources in March 2004 and in 2012, weighed about 128 kgs. He takes medication. The photographs of him suggest a large big boned man, and his height although not specifically measured is estimated by Dr Schepers to about between 180- 185cms.

52.2 At about age 23 he had carpal tunnel syndrome in both hands; ie an impingement of nerves running from the wrist into the palm, and this problem was resolved by a surgery to release the tension.

52.3 He had manifested lumbar spinal disc degeneration.

52.4 There is no evidence that these conditions could be linked to any of the plaintiff's present conditions which are alleged to have had an origin in the accident. Moreover, no evidence was adduced about the source or cause of the two osteo-arthritic conditions in the hands and back and whether they might be congenital or induced by work related strains. Prior to 2004 the plaintiff had worked in several occupations all involving heavy manual labour.

52.5 In about late 2011 - 2012 he manifested right arm shoulder pain which was provisionally diagnosed as a possible rotator cuff impingement, but as no definitive examination has been conducted this is speculative. Ostensibly, it has no link to the accident–injuries save that it was suggested by counsel that the favouring of a weaker left arm might mean a disproportionate use of the right arm. This is not implausible but is unsupported by any medical evidence.

[53] The serious left clavicle fracture and subsequent failed surgery is common cause. The clavicle fracture was of a comminuted type in the mid third of the bone, closer to the shoulder than to the neck. An attempt to mend it was carried out at Milpark. Regrettably, the surgery was unsuccessful and the join did not knit. Sepsis set in. A second join was attempted. It failed too. Ultimately the infection was cleared up, but he remains at continuous and permanent risk of a recurrence of sepsis. The loss of bone tissue resulted in a 'septic non-union', and the gap between clavicle and acromium; ie the shoulder cap bone, is about 2 cm laterally and 6 cms from point to point, in part the result of the unsupported shoulder and arm drooping below the natural line of the clavicle. Deep post-surgical scarring remains across the front of the clavicle area, some 13x4 cms in extent with corresponding depression of the flesh.

[54] Since that time he has had to make do with a left arm that is detached from the shoulder cradle that ordinarily would support it. This condition has self

evident consequences, both for the use of the arm and to the shoulder region extending to the neck.

[55] As alluded to above, the absence of evidence on the immediate post accident period has robbed the parties of the opportunity to ascertain with certainty what happened to the neck. The plaintiff was transported in a neck brace or collar. It must be accepted that this action by paramedics cannot give rise to an inference other than a prudent precaution. However, on what evidence is presented, there is no evidence of any neck problem that existed before the accident.

[56] It is nevertheless highly unlikely that no soft tissue damage occurred to the neck. If the head suffered an acceleration/deceleration injury and if the 4th cranial nerve was damaged a whiplike injury is probable. There is radiological evidence of degeneration in the cervical spine at C7/C7, ie towards the base of the neck. Such pathology is premature in a man of the plaintiff's age.

[57] In addition, the traction on the nerves system, specifically the bracial plexus, a concentration of nerves in the crook of the neck and clavicle, as diagnosed by Dr Versfeld, the orthopaedic surgeon, must have had an effect on the neck no less than on the arm. In any event, even if no specific injury to the neck occurred then, the probable development of the condition during 8 years of

tilting the head and a drooping arm putting stain on the shoulder and neck is a probable cause.

[58] As alluded to elsewhere, the danger of a piecemeal appreciation of the injuries diverting attention from a holistic understanding must be guarded against. Importantly, the information about how the blow was delivered, albeit sketchy, suggests the pipe fell onto him rather than swung across him. If that is so, the blow must be understood to have come downwards, and impact occurred accordingly. The question of what areas of the head and body were affected by the blow is answered, it seems to me, by conjuring an image of the pipe, breaking loose, falling, striking the side of the head (the left parietal area - ear - eyebrow zone) causing the acceleration/deceleration injury to the head, and further striking the area between neck and shoulder. The head injuries suggest the point of impact was broad and would have extended over a zone that was near to the neck/clavicle area no less than near to the clavicle/shoulder area. The clavicle was fractured near to the acromium, ie the top of the shoulder.

[59] Eight years later, there is no reliable data to inform us about the extent and nature of soft tissue injury in the shoulder and neck region but axiomatically, there simply had to be some injury of such nature.

[60] It was Dr Versveld's diagnosis that a neck injury had occurred. Dr Schepers did not enquire into this aspect. His reason was that plaintiff did not complain of neck pain. Further, Dr Schepers also did not consider the shoulder joint. It is remarkable that no enquiry was initiated by him about the neck, given what was known about the clavicle injury and the unsupported arm. It was later contended in argument that the absence of a complaint by plaintiff about pain to Dr Schepers supported the thesis that there was no real symptomatic problem with the neck or shoulder, despite radiological evidence. This is an unrealistic approach to the evidence.

[61] There is no rebuttal of Dr Versveld's findings and opinion which in my view, accord with the probabilities. The effect of the drag, owing to there being no clavicle attached to the shoulder to support the arm, would place tension on the nerves passing through the arm up and through the shoulder joint into the neck through the bracial plexus. The result of this is chronic pain in the arm and shoulder including a sensation of pins and needles. Dr Versveld's diagnosis of an impingement in the left acromio-clavicular joint; ie the shoulder joint explains, in consequence, why the plaintiff uses the left arm as little as possible to avoid pain. The arm is weaker than the right, and the left shoulder is wasted according to most experts. Activity above head height and level with the shoulder are seriously uncomfortable.

[62] The defendant sought to reject wholly his view on the basis that there was no evidence of pathology in joint. However, Dr Versveld diagnosis of an impingement, associated tenderness and wasting of the shoulder muscles mudt prevail. He said the absence of radiological evidence could not displace the clinical evidence. There was no contradiction by Dr Scheepers who did not apply his mind to these issues during his examination of the plaintiff. In my view, Dr Versveld's opinion accords with the probabilities.

[63] What are the permanent consequences of these orthopaedic injuries? What kinds of work can he perform? All the experts agree that with a detached arm he cannot undertake heavy work of any kind and is confined to light manual work and sedentary occupations.

[64] Despite this agreement, the defendant sought to throw doubt on the very diagnosis. Reliance was placed on the facts, derived from the plaintiff's reports to the experts of his work between 2006 and 2009 of a heavy nature; eg at Well Wise in West Africa, and on other projects. It was argued that this evidence shows he can do the work of that nature. The contention misses the important point. The probabilities suggest that the plaintiff undertook this work rather than be unemployed, a stark choice that put him at risk. The medical evidence is plain that he ought not to expose himself to such risks.

Summary of the findings on the plaintiff's present medical condition and the causes

[65] Accordingly I find as follows:

65.1 The plaintiff suffered a brain injury which is responsible for his present cognitive deficits.

65.2 The plaintiff suffered a neck injury which is responsible, in part at least, for the cervical neck pathology together with the probable consequential strain resulting from the head tilting and the drag on the bracial plexus.

65.3 The plaintiff suffered a broken clavicle with serious consequences owing to a septic non-union of the bone tissue leaving an unsupported arm causing in turn strain on the neck, and in the acromio–clavicular joint.

Past Medical expenses

[66] At the outset of the trial Counsel for the plaintiff, in opening, announced that the past medical expenses were not an issue that I needed to decide, as that had been settled and an interim payment had been made. Despite inviting Counsel for defendant to comment, if necessary, he offered no rebuttal. Quite some time later, it emerged that, from the defendant's perspective, although it was not in doubt that the sum stipulated for medical expenses had been paid, the question of whether or not the plaintiff was entitled to be compensated for that expenditure was in issue. The sum paid of R 68, 907.60 was merely a payment on account so to speak to be set off against whatever the total damages award might be.

[67] The sharp end of this controversy was located in the idea that the plaintiff was the beneficiary of a policy that bore the costs of medical expenses related to the accident and also, by implication, would or should bear a liability to pay all future expenses too. The documents garnered from Expro make passing references to a policy. However, no such document came to light. Rule 35 notices served on the plaintiff received the reply that no such document was in the possession of the plaintiff. No attempt was made to subpoena the supposed originator of the policy. After all evidence had been adduced on the 8th day of the trial, the defendant sought to introduce an amendment alleging such a policy and invoking it as a bar to liability on its own part. It clearly amounted to pleading a new defence and to allow would have provoked a postponement. Fairness and orderly litigious practice forbade such an amendment. Moreover, as had already

been made plain, the defendant did not know whether or not a policy existed that could have such an effect, to say nothing of the mountain presented by the legal principle that seemed, in my view, to render such a defence *res inter alios acta.*

[68] Therefore, there being no challenge to the genuineness of the outlay, and there being no reason advanced to question the appropriateness of such expenditure as related to the injuries which I have found were related to the accident, this claim is established in the sum alleged, namely R54,920.32.

Future Medical expenses

[69] The recommendations were largely agreed; the agreed treatments are recorded and the controversies are addressed as follows: -

[70] Should there be further surgery to the clavicle?

70.1 The recommendation is that of Dr Versveld. Dr Schepers is strongly against further surgery. The initial unsuccessful surgery is described above in elsewhere.

70.2 The advantages of a successful re-union are indisputable. The stand-off is premised on the high risk of failure, recognised by both surgeons. Dr Schepers suggests the risk of failure is so high from

infection, poor bone quality, the need to import a foreign clavicle from a bone bank, and because of the degraded scar tissue which will react badly to incision.

70.3 Some weight was sought to be given to the plaintiff having rejected the option of such surgery some years ago. I accord that factor no weight. Fear of the prospect ought not to play any role in whether allowance should be made. The only criterion can be whether on medical grounds it is a prudent course of action.

70.4 In my view the surgery is demonstrably imprudent for the compelling reasons given by Dr Schepers, Therefore I make no allowance for it.

70.5 Both surgeons agree on conservative treatment of the clavicle symptoms. A sum at the rate of R1800 pa for life is appropriate.

[71] Should there be surgery for the acromio-clavicular joint; the shoulder?

71.1 Dr Versveld and Dr Schepers agree on conservative treatment. It seems proper that the conservative treatment should be for life.

71.2 The allowance made in respect of the clavicle encompasses this treatment too.

[72] Should there be surgery for the cervical neck?

72.1 Dr Versveld's recommended treatment includes :

72.1.1 conservative treatment at R4200 pa until age 63;

72.1.2 provision for a possible cervical fusion at age 62 at R116,000;

.1.3 post operative conservative care at a total of R3600.

72.2 Dr Schepers did not investigate this question because the plaintiff did not mention neck pain. There is no rebuttal of Dr Versveld's view on appropriate treatment. I allow these sums.

[73] What occupational therapy is required has been agreed as follows:

73.1 3 sessions at R420 per session: R1260

73.2 Total associated travel: R300.

[74] What standard of psychiatric care is appropriate?

74.1 The agreed diagnosis is that he suffers depression, secondary to his injuries.

74.2 Anti- depressants at R600 pm for four years is agreed:

74.3 Monitoring of medication and consultations at R1000 per consultation – 16 consultations quarterly over 4 years is agreed.

74.4 In respect of counselling, it was contended that it was cheaper to use a psychologist than a psychiatrist, and therefore the cheaper option should be allowed. Dr Shevel too suggests treatment by either professional. I agree that the cheaper option is appropriate. I allow 30 sessions at R800 ph with a psychologist.

[75] What technical aids and forms of human assistance are appropriate?

75.1 The suggestion that a bath hoist is required is in my view unsubstantiated. The sub-standard functionality of the arm does not

demonstrate an inability to cope with this manoeuvre of getting in or out of a bath, even when favouring one arm. No allowance is made.

75.2 Household help:

75.2.1 The premise was that such assistance would be necessary if the plaintiff found himself living alone. The evidence available is of a close knit stable family. However these circumstances can change once child caring is a thing of the past. Some contingency ought to be allowed. I would allow a contingency factor of a 30 % risk of being alone in the future, having regard to the current stable family dynamics revealed by Mrs Thomas; ie a deduction of 70%.

75.2.2 The Evidence of Ms Bester was said to indicate that a domestic servant at current prevailing market rates in the Cape, a daily wage of R150 plus R35 for travel and meals was the norm. There was no evidential challenge. Moreover, in my view the sum seems to a conservative estimate. The suggestion the cost of replacement helper during annual leave be included is inappropriate.

75.2.3 The recommendation is an allowance be made for 5 days per month. I allow such sums, subject the 70 % deduction for contingency.

75.3 A Gardener is recommended and it is common cause is appropriate.

75.3.1 A gardener at similar daily rates at R185 one day per week was recommended. I agree with that proposal. The allusion to a gardener being only used 'now and again' by Mrs Thomas should be understood in a context where the plaintiff's son undertakes some regular garden maintenance. That will end within a few years.

75.3.2 The suggestion that additional allowance be made for a replacement gardener when on annual leave is premised on a fanciful assumption; I make no allowance for that.

[76] Risk of epilepsy:

76.1 It is agreed that there is a 4% probability of developing epilepsy.

76.2 It was agreed a sum of R11, 000 pa be allowed.

[77] It was agreed that a general contingency be applied to reduce total of the sums for future medical expenses by 7.5%.

Summary of the allowances made for future medical and related expenses to be actuarially calculated

[78] Clavicle and acromio-clavicular joint conservative treatment for life at R1800 pa.

[79] Cervical neck conservative treatment to age 63 at R4200 pa.

[80] Cervical Neck surgery at age 62: provision at R116, 000.

[81] Cervical Neck post surgical treatment: Provision at R3600.

[82] Occupational therapy and associate travel to consultations at R1560.

[83] Anti-depressant Medicines at R600 pm for four years.

[84] Monitoring of medication at R1000 per consultation quarterly for 4 years.

[85] Psychiatric counselling: R800 for 30 sessions.

[86] Epilepsy risk: Provision (subject to a 4 % chance) at R11.000 pa

[87] Household domestic helper: Provision at daily rate R185 for five sessions per month; subject to a 70 % contingency deduction.

[88] Home gardener: Provision at daily rate of R185 once per week.

[89] A general contingency deduction of 7.5% to be applied to this category of allowances.

The plaintiff's pre-accident earning capacity and career prospects (the but for the accident scenario)

[90] The positions of the parties in this regard were largely common cause.

[91] The agreed bases for calculation can be summarised thus:

91.1. In March 2004, the plaintiff, then 34 years old, was a trainee oil Well Test Operator earning USS$ 44,000 pa

91.2. Within 3 years he would have probably been a senior well test operator earning US$ 47,000 pa.(ie 2007)

91.3 Within 10 years he would have become a shift supervisor earning US$ 50,000 which would been his career ceiling both occupationally and in relation to earnings save for inflationary increases. (ie 2014)

91.4 A pension contribution equal to 3 % of basic pay was payable until final retirement.

91.5 He would have retired from this initial career path at age 55.

91.6 He would have continued to work in an employed position with Expro or a similar enterprise and retired finally at age 60 – 65. To settle the calculation I hold that the age 63 years be used.

91.7 His South African Tax liability would have to be factored into the quantification, having regard to the August 2012 tax regime.

[92] Three areas of disagreement exist:

92.1 Offshore allowances until age 55 years: that he would receive such an allowance is common cause, but the calculation is controversial.

92.1.1 The added sums apply to earnings between ages 34 years and 55 years.

92.1.2 At the time of the accident the plaintiff was offshore for 182 days per year.

92.1.3 He got a field bonus of GBP 25 per day.

92.1.4 Further, he received a "co-efficient bonus" (This fancy term is understood to mean an inconvenience allowance for having to live in rough conditions in remote or dangerous zones) equal to 30% of his basic pay.

92.1.4.1 It is plain that this ratio was not universal for every foreign spot. Caution, as advised by the industrial Psychologist, Mr Moodie in factoring in this dimension is wholly appropriate. Estimation is the only tool to hand.

92.1.4.2 An estimation founded on averages is proposed. In my view there is no fairer way to achieve a usable factor. The submission that it be 50% of what he got at the time of the accident means a 15 % phantom co-efficient bonus be allowed on the assumption of 182 days of entitlement per year.

92.2 The value of meals consumed whilst off shore until age 55 years:

92.2.1 Values have been suggested from R150 to R50 per day for or 182 days pa.

92.2.2 The figure is guess, premised on common-sense estimation, an approach which I endorse. Having regard to the meals being served in a mess for the crew rather than taking meals in eateries, a lower rather a higher figure is more likely to match reality. I allow for this purpose R100 per day.

92.3 The capacity in which he would be employed and level of his earnings post 55 years of age:

92.3.1 The contest of opinions is that Mr Moodie considers that the plaintiff, having lost his 'outwork' utility, would have had to drop his earnings expectations by, say, one Patterson level from D1 to C5. Ms Furnell, has the opposite view; she opines that according to her research into the oil and gas industry, mainly of a secondary nature, there is likely to be a shortage of skills by the time the plaintiff reaches 55 and his marketability will not decrease. The further contention is advanced by counsel that Expro would on the probabilities want to keep a man of 25 years experience, at least in a training role, and that a drop in pay is unlikely.

92.3.2 Quite frankly, these views are all guesses, and are as reliable as predicting next years' maize crop. On the authority of Nicholas JA, in Southern Insurance Association v Bailey 1984(1) SA 98 (A) at 113G, if a guess is the best that can be done, than so be it. The view I take is that, on balance, it is probable that he would have maintained his level of earnings. It is accepted that his work is unlikely to be offshore and the source of income would be the basic pay, pension

contributions and ordinary bonuses, premised on a home based post.

[93] I allow a 10 % contingency factor be applied to this scenario.

Summary of findings upon which to actuarially calculate the "but for the accident" amount.

[94] The calculation of this figure must be based on the following data and assumptions.

[95] The plaintiff would have worked for Expro or an equivalent employer as an offshore worker until age 55 years.

95.1 In March 2004 his rate of basic earnings was US$ 44,000

95.2 In March 2007 his rate of basic earnings would have been US$ 47,000

95.3 In march 2014 his rate of basic earnings would have been US$ 50,000

95.4 Thereafter the basic earning would rise with the rate of inflation.

95.5 A pension component of 3 % of this basic earnings should be added

95.6 In respect of duty time offshore for 182 days per year he would have gotten these further amounts:

95.6.1 A daily field allowance of GBP 25.

95.6.2 A co-efficient bonus of 15% of the basic rate of earnings.

95.6.3 In kind, the value of meals at a rate of R100 per day.

[96] After Age 55, the plaintiff would have worked in South Africa and earned at a rate equivalent to the basic rate referred to above, inflation linked until age 63.

[97] Liability for South African Income tax on all these sums should be factored into the calculation.

[98] A general contingency deduction of 10% be factored into the calculation.

The Plaintiff's Post-Accident actual earnings 2004 to August 2012

[99] A controversy existed about the period from leaving Expro in 2006 up to May 2009 when he joined SKF his present employer, as to whether any reliable evidence had been adduced to show his total earnings. This was based on the failure of the plaintiff to testify and the existence of several contradictions and anomalies said to exist in the documentation available to the litigants. This perspective emerged clearly and mainly in final argument, although some hints were apparent in a tangential manner from some of the cross examination. This contention was answered by the view that the parties' experts had investigated and collected facts on this subject, upon which they had agreed. As a result, upon the basis of the rulings referred to earlier in this judgment, it was not open to the defendant ventilate these points in the absence of a direct repudiation of the experts agreements. This, in my view, is the correct position.

[100] The industrial Physiologists indeed agreed on the earnings based on data supplied to them by the plaintiff and derived from their independent investigations. They set out those facts in their joint minute of 8 August 2012. [A1/para 14: 2] Those agreed facts are:

100.1 From April 2004 until June 2006 Plaintiff worked for Expro:

100.1.1 At GBP 750 pm and a pension allowance of GBP 22.50.

100.1.2 He forfeited the co-efficient bonus.

100.1.3 He forfeited the offshore bonus of about GBP 20 – 30 per day.

100.1.4 His exit payout was GBP 13,299.

100.2 From July 2006 until February 2007 plaintiff was unemployed. (About 7 months) His income was nil.

100.3 From February 2007 until July 2007 (6 months) he worked on several short term contracts and his income totalled R32,340.

100.4 From August 2007 until August 2008 he worked for well wise, a labour broker who put him out on fixed term contracts with field operators in West Africa. (About12 months) He earned RGBP 26,400.

100.5 From September 2007 until May 2009, Plaintiff tried to conduct a canopy and gate manufacturing business. (20 months). The information to hand from Plaintiff was that the business failed and no income to speak of was received.

100.6 From May 2009 he has been employed by SKF; there no controversy about his earnings from this source.

[101]. It is true that there is a sketchiness about earnings for portions of the period. Both periods totalling about 27 months out of a total of about 90 months were periods of *de facto* unemployment, (about one third of the time) during which, in the later period, he tried to earn on his own account, albeit unsuccessfully. I am of the view that is nothing seriously suspicious about the absence of a comprehensive paper trail. The experts were justified in treating the data they had as adequate for their purposes. If a case in rebuttal of this data exists it should have been mounted fully and the counter evidence adduced along with a repudiation of the experts' agreement.

[102]. From May 2009 to August 2012 his earnings from SKF are recorded as follows:

102.1 Rate of earnings upon recruitment in 2009: R20,081 pm

102.2 Present rate of earnings in 2012 : R33,730.10 pm

102.3 A car allowance was included in these sums at a rate of R2641 pm until April 2012, and thereafter R12493 pm.

102.4 He received bonuses to 2012 of R7500, R4333, R10196 and R17873.

102.5 Liability for South African income tax must be factored into the calculation.

102.6 These figures are agreed.

Summary of findings on the post morbid earnings 2004-2012 to factor into an actuarial calculation of loss of earning capacity

[103] Accordingly, the calculation of this figure for the purposes of calculating damages shall be the total of the above mentioned sums and extrapolations from rates of earnings with SKF, taken up until August 2012.

The Plaintiff's Future earning capacity: August 2012 - to age 63.

[104] A single controversy besets this assessment: a difference of opinion about whether the plaintiff might be promoted to the post of manager. Other than on that point there is agreement as follows:

104.1 He is almost certain to be promoted to analyst by 2015 at a rate relative to the analyst's salary (in 2012 values) of R35,000 and other

benefits payable to an analyst of a cell phone allowance R79 pm and provident fund employer contributions of 9% of basic earnings.

104.2 Retirement age: 63 years

[105] A vigorous debate over the prospect of further promotion was canvassed. The Reliability department in which the plaintiff works has three tiers:

105.1 the manager, (one person)

105.2 the analysts (three persons)

105.3 the technicians (of whom, plaintiff is one of four)

[106] The thesis for the prospect of a promotion to manager is the effusive commendations of the plaintiff's superiors; ie, the plaintiff is a superb worker, destined to rise and has the capacity to go to the top. The facts to sustain this notion are hard to find.

[107] The reality is this:

107.1 Since 2009 the plaintiff has been the sole technician in the Western Cape. His role is to visit about 10 clients and perform technical testing on engineering equipment using specialist instruments. His test data is passed on via email to data analysts to process and diagnose any adjustments required. This information is then conveyed to the client whose artisans made the necessary adjustments or repairs. The plaintiff's true role is a data capturer. His performance in this role is exemplary.

107.2 He works from home in isolation from all his colleagues with whom he communicates on-line. The Manager is in Johannesburg. Even the senior analyst Mr Umar, who is in Cape Town, has no regular face to face contact with him.

107.3 He has yet to undergo all the training and testing to be elevated to an analyst, but that is merely a matter of time.

107.4 The defendant's industrial Psychologist, Mr Moodie reckons that there is no doubt he will become the manager. Ms Furnell, the plaintiff's Psychologist, believes that there are two main reasons why that is less, rather than more, likely:

107.4.1 First, the plaintiff's present highly regarded performance offers no obvious rationale for his promotion to a management position. Indeed the isolation from others and the utter absence of any managerial function in his present job is obvious. If this were not dispositive of the matter, she adds that the cognitive deficits which are common cause; ie memory lapses, word retrieval, and mood swings that accompany these difficulties would, in her view, impair such a prospect.

107.4.2 Secondly, the social dynamics of the workplace and the vagaries of the economic cycle mean that once he is an analyst, an advance taken for granted, he would have to compete with other more experienced and longer serving analysts for a single apex post, held by the incumbent who has only recently taken it up. In that competition the cognitive deficits would make him less competitive.

107.5 Moreover, at the time the prospect occurs with a vacancy in the apex post, the plaintiff's age and remaining active service life will be against him.

107.6 In my view the perspective of Ms Furnell is compelling; there seems to be no rational basis for believing such a promotion is likely. For these reasons I discount the prospect completely.

[108] There is an ancillary debate between the orthopaedic surgeons about the risk of early retirement as a result of symptomolgy in the arm at age 60 rather than 63. Dr Versveld thinks the plaintiff will run into difficulties early and be forced to stop work. Dr Schepers thinks that he can carry on in his present capacity without such risk. The view I take is that the differential in about three years of working is too narrow to make such a prognostication meaningful. Given the work ethic of the plaintiff and optimal suitability of the occupation to accommodate his arm disability the likelihood is that he will not retire early. Both occupational therapists were of the views that in his present occupation, or the like, a light sedentary job, he could work on until ordinary retirement age.

[109] There is no consensus on what contingency to apply to the loss of future earning capacity to calculate the damages for the period 2012 until retirement at 63 years.. The plaintiff suggests a 20% factor because of his supposed market vulnerability. The defendant reckons the 10% agreed to in relation to pre-morbid scenario ought to apply as agreed in respect of the uninjured scenario. In my view the market vulnerability owes more to the unpredictable state of the economy than to the limited abilities of the plaintiff, a problem afflicting all employed people. In my view a 10 % contingency is appropriate.

Summary of findings about likely future earnings upon which an actuarial calculation shall be made

[110] Accordingly, the figure is to be calculated on the following data and assumptions:

[111] The plaintiff will continue in employment with SKF until retirement at age 63.

[112] He will be promoted to analyst by 2015 at a rate of earnings of R35,000.

[113] The earnings includes a car allowance of R12493 pm.

[114] The rate of earnings will rise with the rate of inflation.

[115] Liability for Income Tax must be factored into the calculation.

[116] A general contingency deduction of 10% should be factored into the calculation.

General Damages

[117] It is plain that that the plaintiff has suffered seriously. The contentions of the parties as to the appropriate sum are wide apart: the plaintiff proposes R800,000 and the defendant proposes R350,000.

The relevant facts about his present condition and suffering since 2004

[118] The plaintiff, at the age of 34 was well able to undertake arduous physical tasks and work in an environment where robust strength was a given. In his personal life, he undertook home improvements, and other tasks involving hard Manual work, including gardening. He was energetic, resourceful and enjoying the success of his efforts to improve his lot in life.

[119] When the pipe felled him in 2004, the immediate injuries, described exhaustively elsewhere, were treated as an emergency. He was ferried in a bakkie to a field station. Paramedics attended to him. The period of unconsciousness is estimated at half an hour. The PTA lasted for an uncertain time but probably not more than two hours at the outside. He was obviously confused, but would be sufficiently aware to experience pain. The helicopter ferry took him to the Milpark hospital. The duration of the trip is unknown.

[120] He was hospitalised for a week. The clavicle mend was attempted. The wounds were sutured. He was flown to Cape Town where his home was situated. However, extreme pain persisted in the shoulder. Sepsis was detected. Surgery was performed to address this problem. Further surgery was carried out. However, the non-union of the shoulder and clavicle remained. Throughout this period he was in pain, and on painkillers. He was hospitalised. The wounds and sepsis healed over a 6 week period. He was significantly scarred along the site of the surgery to the clavicle.

[121] Since then he has been permanently disabled as a result of the non-union of the clavicle and shoulder. His left arm is permanently drooped. The range of movement is restricted. He cannot use the arm for heavy work. Use of the arms at head height or above produces muscle tension with discomfort. He cannot sleep on his left side in comfort. When his right shoulder became symptomatic, he found it impossible to sleep on either side, and this led to a long period of interrupted sleep, including attempts to sleep upright to find a comfortable posture. The arm as detached is vulnerable to injury.

[122] The 4th cranial nerve damage caused profoundly intrusive consequences. His vision was upset and the need to compensate by tilting the head is a constant impairment that significantly diminishes his amenities of life in both work and personal spheres. The headaches and the neck pain he experiences are at least in part associated with this unnatural posture. He suffers from vertigo in

consequence of damage related to the vision impairment and possibly an ear injury.

[123] The neck pain, shoulder pain and pains down the arm are chronic. He needs painkillers regularly.

[124] The head injuries and brain malfunctioning *per se* are described fully elsewhere. His intellect, of average to high range, is unaffected and he is fully aware of his cognitive impairment, which is psychologically profound. His depression and mood swings are linked both to the organic roots and to the awareness of his loss of personhood. He has lost the demeanour of reliable companionability, an attribute of significance in maintaining family relationships, which have been under strain over the past 8 years, and sustained by loyalty.

[125] The effect of the impairment in the work environment is calculated to restrict his suitability for higher level managerial functioning, and render him suitable for positions of limited type, most poignantly illustrated by the current job, where in relative isolation and involved in repetitive data gathering work he performs well, because he is not rushed, nor under pressure, and is largely functioning in a non-verbal context.

[126] His role as handy man and the sense of independence, self sufficiency and pride that accompanies such self perception is largely been lost.

Comparable awards

[127] I was referred to several awards. The best to be achieved is to assess in the broadest terms whether a sum postulated seems to be in line with the range of awards for a theoretical comparable level of suffering. None are properly comparable.

[128] I was, if I understood correctly, invited to be generous rather than stingy. In this regard I was cautioned against a dictum of Wepener J who, so it was implied, apparently manifested a too enthusiastic a fidelity to the decisions of the SCA which in turn have cautioned against an award being extravagant. (Nicolson v RAF (Unreported) SGHC 2007/11453 (30 March 2012) and De Jongh v Du Pisani N.O. 2005 (5) SA 457 (SCA)). However, I decline the solicitation to embrace such presumption, and I concur with the approach endorsed by Wepener J.

[129] Jajbhay J, in Opperman v RAF (unreported) 2002/276816 SGHC,(2009) considered a young man who sustained fractures of hip, scapula and clavicle, and injuries to the knee and neck together with a brain injury resulting in behaviour not too dissimilar to the plaintiff. He was off work for about four to five months. He was then unemployed and finding difficulty in securing another job. His personality changes were causing his family to disintegrate. A sum of

R800,000 was awarded. Saldulker J in Gaxo v RAF (Unreported) 2009/18711(2012) considered a case where the injured plaintiff suffered a head injury, fractures of arms, ribs, and a lacerated cornea. The permanent condition that resulted was chronic headaches, diminished sight in one eye, and limited use of the arm, and shoulder. He has brain injury with similar behaviour patterns to the plaintiff in the present matter. An award of R900,000 was granted. I regret to have to say that I am unpersuaded that these examples assist me, and I am unable to grasp how such sums were computed other than that they appear to be part of a spiral of awards that feed off the momentum generated by ever more heartfelt generosity. They illustrate the very problem cautioned against in De Jongh's case.

[130] The plaintiff's circumstances, though self- evidently hugely distressing to him and to his family, do not amount to a tragedy, properly so called. His life has not been ruined, although it has been spoiled. This is due, in part, to his own strength of character. But it is appropriate to properly weigh the important fact that the effects of the injuries do not disenable him from living, in general, a normal life. His principal suffering is literal; the chronic pain he must endure from several sources. Secondly, there is the 'psychological' pain derived from his insight into his diminished mental acuity and flexibility. Many of those consequences can be addressed by suitable medical intervention and he will be compensated appropriately under that head of damages. His forfeiture of career opportunities will similarly be compensated under that head of damages.

[131] In my view the principal elements to weigh under this head of damages are the initial intense pain at the time of the accident, the trauma of the surgical interventions and the non-responsiveness of the clavicle to treatment, ongoing chronic pain likely to persist and worsen, the highly intrusive vision impairment, the frustrations experienced in the organisation if his personal life owing to poor memory, diminished verbal articularity and mental sharness, mood swings and mildly strained personal relationships both intimate and social.

[132] In my estimation the sum of R400,000 is an appropriate sum.

The order

[133] The defendant shall pay to the plaintiff:

133.1 For General damages, a sum of R400,000.

133.2 For past medical expenses, a sum of R54,920.32.

133.3 For future medical expenses, a sum to be actuarially calculated having regard to the findings and directives in this judgment.

133.4 For past loss of earnings for the period April 2004 – August 2012, a sum to be actuarially calculated having regard to the findings and directives in this judgment

133.5 For loss of future earnings capacity for the period August 2012 until age 63 years, a sum to be actuarially calculated having regard to the findings and directives in this judgment.

[134] The defendant's interim payment of R 68,907.60 must be set off against the sum calculated as due.

[135] The sums due as set out above and as calculated in accordance with this order shall be paid within 20 days of the final judgment and shall bear interest at the rate of mora interest as prescribed from time to time calculate from date of judgment.

[136] Upon the actuarial calculations referred to above having been prepared, the matter may be set down before me on 26 September 2012 for the formalisation of a final judgment, or if necessary, in the event of the parties not reaching agreement on the final figures to be awarded, for further determination before me on that date or another date to be arranged with me.

[137] The defendant shall pay the plaintiffs costs of suit, including-

137.1 The costs of one senior counsel.

137.2 The costs of the following experts:

137.2.1	Dr G. Versveld	(Orthopaedic surgeon)
137.2.2	Ms M.Coetzee,	(Neuro-pscholologist)
137.2.3	Ms E.Bester	(Occupational therapist)
137.2.4	Ms B. Furnell	(Industrial psychologist)

137.3 The reasonable costs of transport of the plaintiff for the purposes of examinations by the experts listed above.

Roland Sutherland

ROLAND SUTHERLAND
Judge of the South Gauteng High Court,
Johannesburg.
10 September 2012

Hearing: 8 August – 23 August 2012
Judgment Delivered: 12 September 2012

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