IN THE KWAZULU-NATAL HIGH COURT, PIETERMARITZBURG
REPUBLIC OF SOUTH AFRICA

CASE NO : 8051/06

In the matter between :

THANDEKA LYDIA NGEMA **Plaintiff**

and

THE ROAD ACCIDENT FUND **Respondent**

J U D G M E N T

Delivered on : 31/7/2009

K PILLAY J

[1] Plaintiff institutes action against the defendant for damages totalling R3 381 037.60 arising out of a motor vehicle collision that occurred on 1 September 1995 in the Kranskop area. Plaintiff, who was originally represented by her mother, was born on 12 December 1987. The damages, claimed under different heads, are set out in detail in the Particulars of Claim.

[2] At the time of the collision, she was 8 years old and had commenced Grade one.

[3] The defendant has already admitted liability for :

3.1 The physical injuries sustained by plaintiff as set out in paragraph 6 of her particulars of claim, and to this end had admitted facts, findings and opinions contained in the report of orthopaedic surgeon, Mr Michael Jelbert.

3.2 Any further injuries proved to have been caused by the collision.

[4] The parties also agreed that plaintiff's medical and hospital records correctly reflect what was recorded at the time they were recorded and that the said recordings are a true and correct reflection of what transpired at that time.

[5] The following emerged from the said records :

5.1 Plaintiff was admitted to Umphumulo Hospital on 1 September 1995.

5.2 That on the same day :

5.2.1 Her skull was first x-rayed and "NAD" noted (no abnormalities detected).

(a) Her very swollen left leg was x-rayed showing a fracture to the tibia and the fibula.

5.2.2 She was hospitalised for 48 days.

5.2.3 On 27 September 2001 (six years after the accident) plaintiff was taken to the **Phelophepa Health Care Train** whereupon she was referred for an educational assessment by a psychologist for an appropriate school placement. Her referral letter states that she presented with the following symptoms.

"Slow cognitively, personality problems after an MVA that occurred in 1995. Traumatised by the death of her brother in the same accident."

[6] In the second part of the form a different social worker states the following :

(6.1**) "Query whether the problem is genetic or caused by the incident….refer to a clinical psychologist."**

Exhibit C 26

(6.2) On 9 October 2001 it was noted that she was suffering from **PTSD** (post traumatic stress disorder) and was aggressive, with nightmares and flashbacks. It was also noted that she had a problem with transport.

(6.3) On 6 November 2001 **fluoxetine** (an antidepressant) was prescribed.

(6.4) On 14 January 2002 it was noted that she is on **prozac** (an antidepressant) for her PTSD.

(6.5) On 26 November 2002 it was noted that she is "apsychotic".

(6.6) On 28 May 2003 it was noted that she is in remission.

(6.7) On 19 January 2004 it was noted that she was improving slowly and that she was back at school.

(6.8) On January 2004 it was noted that plaintiff refuses to bath (this is at the age of 18).

(6.9) On 4 November 2005 it was noted that the patient is refusing **haloperidol** (a major tranquiliser which is considered an antidepressant drug).

(6.10) On 1 October 2005 it was noted that she has behaviour problems and haloperidol is added to her prozac medication.

(6.11) On 31 October 2006 it was noted that she suffers from depression.

(6.12) On 9 February 2006 she was referred to as "a case of mental retardation".

(6.13) On 18 May 2006 she was noted as suffering from mild mental retardation and dysthymia.

(6.14) This was repeated on 3 November 2006 where it was also noted that he mother reports behaviour problems and problems at school.

(6.15) On 1 December 2006 it was again noted that she suffers from mild mental retardation and dysthymia and that her mother was complaining that she was not compliant, often suffered from a low mood and that she laughed to herself.

(6.16) On 29 December 2006 it was noted that she completed Grade 11 with poor results.

(6.17) On 24 January 2007 it was again noted that she suffers from mild mental retardation and depression and that she was refusing to attend at the hospital (this had been noted often previously).

(6.18) A referral letter dated 24 January 2007 from the psychiatric clinic at Stanger Hospital stated that she suffers from depression and is taking prozac.

SCHOOL RECORDS (EXHIBIT B)

[7] Her school reports (**exhibit B**) indicate that :

7.1 She repeated grade one at a different school after the accident and did very well.

7.2 That when she was in grade four (standard two) in 1999 she was "doing very badly".

7.3 That in grade five her conduct, self confidence, self organisation and response to health education was weak, and that she was doing badly.

7.4 In grade nine she obtained a 30.8% average, indicating that she had not achieved. The remark was that her work was not satisfactory and not good.

7.5 In November 2007 she obtained a matric certificate at the age of 20 (with an average of 36.1%)

[8] The issues for determination in this trial are essentially:

8.1. Whether the Plaintiff suffered a head injury at the time of the collision and if so whether that head injury caused cognitive deficits justifying any general damages and/or special damages. What quantum should be awarded for the head injury if such is proved.

8.2 What should be the quantum of the damages occasioned by the orthopaedic injuries.

[9] The following evidence was adduced in support of Plaintiff's case.

[10] The Plaintiff's mother, Jabulisiwe Ngema testified that after the accident in September 1995, she visited Plaintiff in hospital and found her crying. Plaintiff reported to her what had happened and enquired about her cousin who was 10 years old and who had died in the accident.

[11] She observed injuries on Plaintiff's face, more particularly on the right temporal region and on the leg. Plaintiff was hospitalised for about a month. After her return from hospital she did not return to school for that year as she was on crutches.

[12] When she returned to school, in Grade one, she performed very well, until informed about her cousin's death, where after her condition altered. She would not bath or speak to other children and would cry and laugh, contrary to the way she behaved pre-accident.

[13] In 2001 she took her to a Health Care Train. Plaintiff was 14 years old at the time.

[14] She testified that the Plaintiff displays aggression. She had flashbacks and nightmares. This action was only instituted after her visit to the Health Care Train. The Plaintiff attempts to kill herself if she did not take her medication. Plaintiff did however secure a condoned pass in matric.

[15] She confirmed that her one son was abnormal from birth and that her sister's son was mentally ill.

[16] The Plaintiff also suffered burns as a result of water being thrown at her. She was hospitalised a few days following the incident.

[17] It became apparent from this witness's testimony that Plaintiff's abnormal behaviour manifested more significantly when Plaintiff was in Grade 4, about 4 years after the accident.

[18] **Jane Bainbridge**, an occupational therapist assessed the Plaintiff on 19th August 2008. According to her summary:

18.1 She concluded that the Plaintiff sustained a possible head injury and has developed psychiatric sequelae as a result thereof.

18.2 Plaintiff demonstrates aberrant behaviour, poor cognitive abilities and emotional immaturity.

18.3 If the aetiology thereof is deemed to be related primarily to the Motor Vehicle Accident, this will have significant implications on her future care requirements and her loss of earning capacity.

18.4 She is ineligible for any realistic gainful employment in the open labour market for which higher than normal contingencies for periods of unemployment must be considered. Her report also confirmed that the Plaintiff's mother stated that plaintiff sustained a "scratch" on her forehead during the accident.

18.5 Plaintiff appears according to her to have no insight into her own condition. She does not bath, wears dirty clothes and leaves sanitary towels lying around. She is impulsive, lacks discernment,

and is apathetic, resistant and defiant. She throws things down and laughs to herself. She demands food and eats a lot and cannot reach satiety.

18.6 She is easily irritated and angered by petty issues and is teased by her peers.

18.7 She is naïve and vulnerable to sexual abuse.

18.8 She perseverates on scenes of her cousin having died and having been told by the police that her cousin would be coming home. She continues to dream of her cousin.

18.9 She has a history of running away from home.

18.10 According to **Bainbridge** the Plaintiff answers were initially monosyllabic and her behaviour was passively aggressive and reticent.

18.11 She demonstrated limited insight, and the assessment finding suggests the following :

- Weak planning on a 2D level.
- Impulsivity and difficulty following instructions.
- Weak visual moter integrative skills.
- Slow work speed.
- Weak upper limb speed and exterity.
- Weak visual moter control.

- Weak global visual perceptual processing ability.
- Weak mathematical reasoning.
- Error prone and unable to recognise errors
- Distract ability.
- Executive dysfunction.
- Retarded spontaneity.
- Flouted test rules.
- Poor self monitoring.
- Anergia.

[19] According to **Bainbridge** these are serious congenital problems. The deficits are consistent with those reported by **Professor Schlebusch** in his report of 18 October 2005 in which he concluded that plaintiff has a "clinical and psychometric picture consistent with a diagnosis of learning disorder, behaviour personality changes, insipient, oppositional defiant disorder, variable symptoms of cerebral pathology i.e. neuropsychological and intellectual fallout consistent with a possible cognitive (**concussive**) disorder…."

[20] Counsel for Plaintiff contends that the following comments of **Bainbridge** are of assistance:

20.1 That Plaintiff presented as someone who has suffered more than just a mild head injury

20.2 She was not malingering, and that "even on a good day she would be bad".

20.3 She mentioned that she spent approximately five hours with plaintiff, in relation to the 40 minutes which Dr Du Trevou spent with her. This would be an explanation for her noticing inappropriate conduct, which Du Trevou may not have noticed during the short time he spent with plaintiff. This is in any event according to plaintiff, admitted by Du Trevou.

[21] However, **Bainbridge** conceded that plaintiff may have had a psychiatric propensity which was triggered by the accident.

[22] **Sonia Hill** is an Industrial and Counselling Psychologist who was requested to perform a vocational assessment and to comment on loss of earnings. She confirmed what is said by Bainbridge and Schlebusch in their reports as to the Plaintiff's present symptoms.

[23] During her assessment she used one of Plaintiff's peers as an interpreter namely **Pretty Mkhize** who provided some information relating to the Plaintiff's scholastic history. According to Pretty Mkhize the Plaintiff would walk aimlessly during class periods. If anyone laughed at Plaintiff she would hit them and they regarded

the Plaintiff as "very strange". It was also noted that during the entire assessment the Plaintiff did not face the interviewer. She had her fingers in her mouth most of the time and could not cope with complex instructions and gave up easily. Her level of intellectual functioning was within the borderline subnormal range and there was a 14 point differentiation.

[24] Clinical Psychologist, **Professor Schlebush** conducted an assessment of the Plaintiff on 18 October 2005.

[25] He spent two lengthy periods of time (three hours each) with Plaintiff and with her mother and did various psychometric and clinical assessments.

[26] In summary he states that:

26.1 Plaintiff's cousin died in the accident which traumatised Plaintiff significantly and that she is still emotional when this is discussed.

26.2 Various reports are in agreement that she has suffered several disabilities.

26.3 She has allegedly been left with various residual problems including headaches, pain in her left leg, the need for analgesics to cope with her pain, behavioural changes (lethargy, forgetfulness, poor concentration, being easily upset, fatigue, disciplinary problems, aggressiveness) etcetera), post traumatic decline in self esteem and scholastic functioning, learning difficulties and related problems and various other difficulties. He thereafter discusses the clinical, psychological / neuropsychological and related sequelae associated with his own findings which includes variable symptoms of cerebral pathology (i.e. neuropsychological and intellectual fall-out-deficits consistent with a possible **cognitive (concussive)** disorder.(emphasis provided)

[27] When he first saw Plaintiff he states that she presented as cognitively slow, sullen and often engaged in "give up" responses. She was apathetic, easily fatigued and had difficulty to persistently maintain a sustained attention span. She also had difficulty confirming some of the events surrounding the MVA because of her age at the time and reported loss of consciousness. At times she gave answers which were characteristic of impaired higher cognitive function.

[28] He states that the mother reported that Plaintiff was psychologically stable before the accident. **Schlebush** himself confirmed this independently through Plaintiff's developmental history checklist responses (which are based on a structured developmental history) and by her clinical history.

[29] The mother's concerns were the following:

- She will not progress as expected at school (which was subsequently confirmed by her grade 10, 11 and 12 reports submitted after she was first seen by **Schlebush**).

- That she will be unable to socialise properly.

- She will have difficulty to locate her anticipated employment.

[30] Her IQ is consistent with a borderline, below average, intellectual functioning.

[31] **Schlebush** accordingly in his first report, and in his evidence paints a clinical picture of a person with the following problems:

- Learning disorder.
- Aggressive.
- Moodley

- Fatigued.
- Forgetful.
- “Gives up”
- Undisciplined.
- Interpersonal problems.
- Defiant.
- Cerebral pathology (neuropsychological and intellectual fallout).
- Possible concussive disorder.
- Psychological distress.

[32] His second report delivered on 3 September 2008, by and large confirms what he states in his first report. He had by then also been furnished with the following reports:

(a) Neurosurgeon **De Trevou**;

(b) Industrial psychologist **Hill**;

(c) Clinical psychologist **Plunkett;**

(d) Occupational therapist **Bainbridge**.

[33] He states in his second report (submitted three years after the first report) that she is still quite emotional when she discusses the death of her cousin in the accident, and that she still suffers from the same disabilities which he had mentioned previously.

[34] He particularly stresses her oppositional defiant disorder.

[35] He repeats that her neuropsychological deficits at the time of his first assessment are variable and associated with her functional, psychopathology which could have overlapped with a possible concussive head injury.

[36] He comments that her current adjustment, intellectual level, neuropsychological deficits and other psychopathology are likely to continue to impact adversely on her potential occupational and psychosocial adjustment. He states that there is nothing to suggest that the adverse psychological profile she continues to present with existed pre-MVA. Therefore, a nexus between the sequelae of the accident and his current findings cannot be axiomatically excluded.

[37] In response to a question by Court he confirmed that a skull x-ray would not be done if there was not some cause for concern in that region.

[38] He conceded that if there was some genetic predisposition the trauma of the accident might well have "brought it out" (or precipitated / exacerbated it) as suggested by Plunkett (exhibit D 110).

[39] In cross-examination **Schlebush** stressed that Plaintiff's picture has become chronic (i.e. permanent).

[40] He performed tests for malingering, and there was no indication whatsoever that Plaintiff was malingering (in fact Plaintiff herself insisted that there was nothing wrong with her). When it was suggested to him that her mental state may be linked to the fact that she was burnt with water about six months after the accident, his spontaneous reply was that this accident was not an issue with the mother at all. He in any event did not find that this was a particularly stressful incident and Plaintiff was not at all disfigured by it (as confirmed by **Bainbridge**).

[41] He stated that her psychiatric disorder, as described by **Plunkett** is not a mental disorder but a behavioural difficulty.

[42] According to her functionality tests she falls within the category of 30% or less of the public.

[43] During cross-examination **Schlebush** stated that:

43.1 Given the deficits presented by Plaintiff, they would suggest a head injury rather than a mild one.

43.2 The fact that she only really began to present with problems in grade 4 is not unusual and is in fact supported in the literature.

43.3 There is nothing in Plaintiff's behaviour which suggests or illustrates or is evidence of a genetic disorder.

43.4 The mere fact that the x-ray showed that no abnormalities were detected, does not mean that there were none. This also applies to magnetic resonance imaging (an MRI scan).

[44] Plaintiff requires the court to infer that there was brain damage caused by head injury at the time of the collision by virtue of the following:

44.1 That the Plaintiff presents certain cognitive deficits which may be consistent with the head injury.

44.2 According to the Plaintiff's mother Plaintiff was fine before the collision and only started demonstrating the "deficits after the collision"

44.3 In hospital after the collision an x-ray of the child's skull was done and in this regard **Dr Du Trevou** the defendant's witness remarked that it was reported to be normal.

[45] It is well-established that the onus, or burden of proving all the facts relevant to the establishment of the quantum of her claim, either in an action for damages for bodily injury or in an action for damages for loss of support or services, rests upon the Plaintiff, which onus is discharged by proof establishing a balance of probabilities.

[46] Accordingly the Plaintiff must prove that the collision caused the head injuries complained off and that those injuries will cause a future loss of earnings. It is only thereafter that the issue of quantum arises.

[47] It is so that the Plaintiff relies on the following to establish that there was a head injury at the time of the collision:

47.1 The child presents with certain cognitive deficits which <u>may</u> be consistent with a head injury.

47.2 According to the child's mother the child was fine before the collision and only started demonstrating the *"deficits"* after the collision.

47.3 In hospital after the collision an x-ray of the child's skull was done, even though it was reported to be normal according to **Du Trevor**.

[48] Defendant submits that in assessing whether the onus is discharged the following evidence of the experts are instructive.

[49] **Schlebush**, in his reports and evidence, testified that the Plaintiff showed *"variable symptoms of cerebral pathology ... consistent with a <u>possible</u> cognitive (concussive) disorder (my underlining)"* Later in his reports he said *"her neuropsychological deficits were variable and associated with her functional psychopathology that <u>could overlap</u> with a possible concussive head injury (had this occurred)"*. **(Emphasis *provided)***.

[50] At no stage does **Schlebush** conclude in his reports that it is <u>probable</u> that these deficits were caused by a head injury. In fact he said in his second report that the fact that the child *"passed grade 12 ... is difficult to understand given that the patient was not*

copying well at school when I originally assessed her and in view of my earlier and current findings". He said further that *"there appears to be uncertainty about the possibility or nature / severity of a head injury sustained by her in the MVA when I originally assessed her. This still seems to be the case. Nevertheless she did present with certain neurocognitive and behavioural problems. Her neuropsychological deficits at the time of my first assessment were variable and associated with her functional psychopathology that <u>could</u> have overlapped with a <u>possible</u> concussive head injury."* **(my underlining)**

[51] In his second report **Schlebush** said the following *"there is nothing to suggest that the adverse psychological profile she continues to present with existed pre-MVA. Therefore, a nexus between the sequelae of the accident and my current findings cannot be axiomatically excluded".* Counsel for Defendant accordingly submitted that the effect of such a statement is that it cannot be *"axiomatically"* included either.

[52] **Du Trevou,** an expert Neurosurgeon reported, and testified, that the hospital records *"did not record any other injuries and in particular there is no mention of the head injury, or of an altered state of consciences".* He found further that the child showed. *"no obvious abnormalities of personality, or affect. In particular the inappropriate behaviour of which her mother complained was not evident during my consultation with her".*

[53] **Du Trevou** also reported that the child *"has a good recollection of the accident with no obvious post-traumatic, or retrograde amnesiac period"* Further,*"she has no recollection of having suffered any pain on her head.* As set out above he was of the view that the fact that the GCS score was not recorded at the Mphumalanga Hospital, would suggest that there was no significant brain injury.

[54] **Hill** reported and testified that:

(a) The child had *"no recall of the events surrounding the accident"*

(b) The child's mother claimed that she had seen an injury of the child's head when she visited the child in hospital.

(c) At a cognitive level the child's intellectual functioning was well within *"the borderline sub-normal level range"*. And that her *"overall pattern of test performance <u>may</u> be consistent with the injury sustained as a result of the accident"*. She was of the opinion, deferring to Professor Schlebush in this regard, that the child's *"functional psychopathology…could overlap with a possible concussive*

head injury (had this occurred). In this view, given the uncertainty surrounding the matter of a head injury, further comment is required from a Neurosurgeon".

(d) Her recommendations were *"with regard to the uncertainty surrounding the matter of the head injury, assessment by a neurosurgeon is strongly recommended".* As set out above, that Neurosurgeon found no evidence of brain injury.

[55] **Brainbridge**, the occupational therapist, reported and testified that:

(a) The child *"appears to have sustained a possible head injury"*

(b) The child *"has patchy recall of lying in the road and being taken to hospital but does not recall police or an ambulance being summoned to the accident".*

(c) Conceded that the evidence of *"behavioural dysfunction and executive dysfunction"* are not specific to a brain injury

(d) Because the Plaintiff's deficits *"appear to be consistent with a <u>possible</u> brain injury…deference is made to a*

Neurosurgeon and Neuropsychologist with regard to the aetiology of the problems"

[56] **Plunkett**, a clinical psychologist, did not testify because his report was admitted by consent. It was accordingly submitted that whatever he said in his written report must be accepted as it was not challenged by the Plaintiff. In this regard he said that:

(a) "There is no objective evidence that Thandeka sustained a head injury in the accident…."

(b) "There is some concern that the severe burns she received subsequent to the accident could not have caused some psychological effect. Further information needs to be canvassed in this regard".

(c) "There is a history of psychiatric problems which is vague and seem to start at least in 2001"

(d) "She demonstrates certain cognitive difficulties but these are not specific to mild closed head injury". Schlebush agreed with this proposition in his testimony."

(e) *"Her psychiatric difficulties may have emerged anyway (despite the accident)*. Indeed, some evidence of family dysfunctionality is noted with various family members suffering from psychiatric disorders (such as substance abuse, behaviour problems in the home, antisocial behaviour etcetera)."

(f) *"The picture is uncertain due to a lack of information. Knowledge and investigation of pre-accident factors may provide answers"*.

[57] **Plunkett,** more appositely, reported the following:

"given the family background, it would appear that Thandeka has already achieved her likely potential and it is questionable whether she would have progressed much further but for the accident….however, in general, her class position and comparison with the grade median certainly indicates that she has the mental capacity to function in the average range of her grade and higher".

[58] The issue of when the cognitive deficits and behavioural changes started to manifest themselves is critically important. In this regard:

(a) **Schlebush** testified, initially, that the Plaitiff'ss mother had said they had started immediately after the collision. He was of the view that that would have been expected if there had been a brain injury. He was of the opinion that if there had been a brain injury the deficits would not only have manifested themselves years later.

(b) The Plaintiff's mother testified that after the collision the Plaintiff returned to school and *"did very well"***.** It was only sometime later in grade 4 that she started to perform poorly and behaved badly.

(c) It is common cause that the Plaintiff's mother only sought medical assistance for the alleged behavioural problems when she attended the *"Health Care Train"* in 2001. This, it is submitted, is corroboration for the fact that the alleged *"symptoms"* did not manifest themselves immediately after the collision.

(d) Very significantly, when she visited the *"Train"* in 2001 the relevant medical personnel recorded on the *"referral letter" "quiry (sic) whether the problem is genetic or caused by the incident"*. (Emphasis provided).

[59] Du Trevou reported that the child's mother complained that *"her daughter since the time of the accident has been "not normal"*. This is in contradiction with the mother's testimony.

[60] It is unclear from the reports of the other experts as to when the deficits had allegedly first manifested themselves, but in the light of **Schlebush's** evidence, if they only manifested themselves as late as the mother testified, then it is unlikely that they were the result of a brain injury.

[61] Defendant submits that it is also significant that:

61.1 The Plaintiff was forced to change schools after the collision. As was conceded by **Schlebush** and the other witnesses, this could very well have affected her emotionally and behaviourally.

61.2 Her December 2000 school report reflected marks of varying quality, some, such as general science, geography and Afrikaans being very high.

61.3 Her grade 4 report (for 1999) shows that out of a pupil number of 65 in the class she was positioned 37th. In other words average.

61.4 Her marks in 2003 ranged from “excellent” to “poor”.

61.5 In 2005, all of her marks were well above the “grade median”.

61.6 She passed her matric in 2007 (having failed none of her earlier years). Her certificate was attached as.

[62] It would appear that her reports demonstrate an average pupil within the context of the class as a whole. In this regard **Schlebush** reported *“she passed grade 12 (std 10) at school at the end of 2007. This is difficult to understand given that the patient was not copying well at school when I originally assessed her and in view of my earlier current findings”.*

[63] Counsel for Defendant submits that a determination of whether the evidence proves on a balance of probabilities that her cognitive *“deficits”* were caused by the collision or not cannot lose sight of the following facts:

63.1 There is evidence of mental abnormalities and/or aberrations in the family of the Plaintiff. Accordingly, within the genetic pool, a gene for mental / behavioural abnormality existed.

63.2 The Plaintiff's fourteen year old sibling Sukhulu was reported to have been *"abnormal"* from birth and currently experiencing fits.

63.3 The Plaintiff's aunt's son (Snuthi) did not attend school, despite being twenty six years of age, because he was described as being *"mentally disturbed"*.

64. The following aunts and/or uncles of the child died because they were allegedly *"sick"*. Their precise sickness was not clarified by the Plaintiff.

(a) Ubantu;

(b) Mandlenkosi;

(c) Musa (the above three all siblings of the child's mother)

(d) Emerentia;

(e) Simon (the above two being siblings of the child's father,

[65] As set out above the Phelophepa Health Care Train, Psychology Clinic, had expressed a view in 2001 that it was necessary to consider the possible genetic factors due to this history.

[66] Very importantly, when the child was assessed in 2001, the hospital records, record the following *"2 siblings mentally ill"*. This information could only have been received from the Plaintiff or her mother.

[67] All the expert witnesses conceded that genetics can play a part in the acquisition of mental deficits and Schlebush conceded the proposition that *"many years of research have demonstrated that vulnerability to mental illness – such as schizophrenia, manic depressive illness, early onset depression, automatism and attention deficit hyperactivity disorder – has a genetic component"*. He conceded further that mental illness is known to run in families.

[68] In the context of everything that is set out immediately above, it is so that no enquiry and/or investigation was ever done into whether the *"deficits"* being allegedly displayed by the Plaintiff were brought about in consequence of a genetic component and not the collision.

[69] No witness was able to say that there were any facts which suggested it was not caused by genetics considering the family history as set out above.

[70] The Plaintiff's experts focused entirely upon the possibility that the cognitive deficits were the result of the collision. They did not consider the question of the genetic component <u>at all</u> despite having

access to the Clinic's letter of 2001, the hospital records relating to the *"two siblings being mentally ill"* and the information received that members of the family were mentally ill and/or had died from being *"sick"* in unexplained circumstances.

[71] It is also on record that the child was exposed to other trauma post-accident. For example:

71.1 In April 1996 she was burnt by water to the extent that she, according to her mother, had to be taken for medical treatment. This is an important incident and was never related to Schlebush and certain of the other witnesses by the child or her mother. It was obviously traumatic to the child and occurred post-accident.

71.2 She lost a brother to a shooting in 2001. Most significantly this was about the time when she was first taken to the Psychology Clinic. There is no doubt that this incident traumatised her also.

[72] Indeed there are other traumatic events in the child's life (post-accident) which may very well have been the *"trigger"* for cognitive *"deficits"* to emerge more particularly because she is likely to have possessed the genetic propensity for such deficits through the family history. The experts all talked of an *"overlay"* of possible psychiatric problems.

[73] If one considers the following:

73.1 There is uncertainty as to when the *"deficits"* first manifested themselves. Unfortunately the school reports for grades 1, 2 and 3 at Khomba Primary School are not available. There is the evidence of the fact, however, that in her first year at school after the collision she performed "excellently".

73.2 There is evidence of a genetic component in relation to mental illness within the family. This is confirmed by Hill, the hospital records and the Psychology Clinic Note. Despite that absolutely no investigation was done in that regard and no evidence placed before this court to suggest that that possibility / probability was any less than the one contended for.

73.3 There is no evidence or information as to why an x-ray of the head was done after the collision. In any event, the x-ray was reported to be "normal"

73.4 The hospital records do not record a head injury or evidence of brain injury. No GCS was recorded.

73.5 The Plaintiff, on her mother's evidence, was conscious after the accident.

[74] Whilst it may be so that an x-ray of the head may indicate that whoever authorised it believed it was necessary because of a suspicion of a head injury, and whilst it may be so that that type of x-ray may not have picked up a brain injury, such possibilities are, as correctly submitted, in the context of the matter as a whole and particularly in the context of the onus, mere speculation.

[75] The Plaintiff has adduced neither evidence indicating that the "genetic" component did not result in the "deficits" nor any evidence that it is less likely than the collision to have done so.

[76] In the circumstances, I am unable to find on a balance of probabilities that the cognitive deficits presently displayed by the Plaintiff were the result of the collision.

[77] I turn now to the **orthopaedic injuries.**

[78] These are fully set out in the report of **Jelbert**, the Orthopaedic Surgeon which was admitted by consent. In summary he found that:

The Plaintiff *"sustained a swelling of the right leg and a fracture of the left leg. The swelling of the right leg was presumably bleeding ...into the muscles or under the skin. This seems to have settled and Lydia does not experience any problems with the right leg. The left leg was found to be fractured and was treated in plaster of paris for nearly seven weeks. The fracture was then noted to be stable and at the examination on 19/10/2005, the left tibia seems to have united completely in excellent position. There is no shortening of malrotation or angulation of the facture site, and Lydia walks normally without a limp. The leg is strong and she is able to hop on the left leg without problems. The slight reduction in dorsi-flexion is due to slight tethering of the muscles at the fracture site. This slight reduction in movement will be a minimal inconvenience if she has to climb up ladders or stairs, or go up steep hills. There may be slight reduction in her sprinting as well. However her normal day to day activities will not be affected…the bone has joined completely, but the scar tissue will remain when the bone grows, there may be stress on the fracture or on the scar tissue giving rise to slight pain. The pain will be more prominent after a growth spurt and often worse as well in cold weather. Generally this settles down in time, but it may continue until she is skeletally mature. This may be at 18 – 21 years of age. Generally the pain is more of a dull ache with only occasional need for anti-inflamatories or analgesics."*

[79] As regards pain and suffering, and future impairment, **Jelbert** reports as follows:

"Lydia sustained a fractured leg which would have been very painful. She would have required narcotic analgesics to control the pain, and even in plaster of paris the pain would have persisted for at least 6-7 days. After that, as the swelling and bruising settled, the pain would have become manageable by oral analgesics and anti-inflammatories, although there may have been break through pain, even with the leg in plaster. Plaster can never hold the fracture totally immobile and therefore twisting in bed, moving the leg to a more comfortable position, can all give rise to stabs of pain which may require increased medication. Lydia was then mobilised with crutches and there would have been an increase in pain as the leg would have been hanging down and there would have been swelling. When the plaster was removed and she was walking without support, there may have been an increase in pain again for a while. The pain would have gradually have settled over six weeks after the plaster was removed to a dull ache which is much the same as she is experiencing now".

[80] The appreciation of the pain may have been affected by the psychological stress she was under and should be covered in the psychologists report as well

FUTURE IMPAIRMENT

[81] The fracture seems to have affected only the tibia and fibula without extension to the joins. The bone has now united completely and the knee and hip are normal with no evidence of arthritis. The examination of the ankle showed only slight restriction of dorsiflexion which may give slight impairment for sprinting, going up and down stairs, but this is probably due to scarring within the muscles and not direct damage to the ankle itself. It is unlikely tat she will develop therefore arthritis in the ankle or foot."

[82] In addition:

82.1 The Industrial psychologist, **Sonia Hill,** reported that *"the impact of the orthopaedic injury on her future earning potential requires comment from an Occupational Therapist"*.

82.2 The Occupational Therapist, Jane Bainbridge, noted as regards the orthopaedic injuries, that *"Thandeka presents as a girl of medium stature. Mobility for walking was normal. She did not limp. She was able to assume all postures on and off the floor. Balance on either leg was adequate and demonstrated no left-sided weakness. Joint range and muscle strength in either leg was adequate. Her left leg did not demonstrate any marked residual abnormality."*

[83] I have had regard to the following cases as far as the orthopaedic quantum is concerned as referred to by Defendant's Counsel.

Gqangeni v Ciskie Motor Vehicle Accident's Fund 1991(4) C & B E5-1(Ck)

Chikanda v Mukumba 1988 C & H (4) E4-1 (Z)

Fielies v Road Accident Fund 1999 C & B (5) E4-1 (AFC)

Rossenbrock v British Insurance 1965 (1) C & B 668 (N)

Charlie v President Insurance Company Limited 1993 (4) C & B E5-4(E)

Duduma v Road Accident Fund 1999 (4) C & B E4-5 (Bisho)

Yende v General Accident Verseekeringsmaatskappy SK BPK 1994 (4) C & B E5-21 (T)

[84] I was referred to the following cases by Plaintiff's Counsel:

Khomo v S A Mutual Fire and General Insurance 1971 2 C & B 171 D and CLD

Coetzer v AA Onderlinge Assuransie 1981 3 C & B 370 A

Jones v Santam 1964 1 C & B 626 C

Lawson v General Accident Insurance 1990 4 C & B J 2-1 (C)

Clinton-Parker and Dawkins v Administrator, Transvaal 1996 2 SA 37 (T)

Bester v Commercial Union Versekeringsmaatskappy 1973 1 SA 769 A

[85] I have taken cognisance of the awards made in the above cases. I am also mindful of the rapid deterioration in the value of the rand. It is so that the Plaintiff was severely traumatised by the disclosure that her cousin with whom she had been walking on the day of the collision had died, which resulted in nightmares and flashbacks, and which she still suffers to date.

[86] Taken together with the injury to her leg which caused her discomfort, pain and suffering and hospitalisation for a period of seven weeks after the accident, resulting in her having to repeat grade 1, my view is that an amount of R130 000.00 for general damages is an equitable award.

[87] It is so, that the medical evidence clearly demonstrates that the Plaintiff is incapable of managing her own affairs and that the appointment of a curator bonis is desirable.

I accordingly grant judgment in favour of the Plaintiff as follows:

(a) General Damages in the sum of R130 000.00. (One Hundred and Thirty Thousand Rand)

(b) Costs including the qualifying costs of experts, Schlebusch, Jelbert, Hill and Bainbridge.

(c) In respect of Future Medical Expenses, limited to the orthopaedic injuries, the Defendant is directed to furnish the Plaintiff with undertakings to compensate all third parties in respect of Plaintiff's costs after the costs had been incurred and on proof thereof, and to pay the amount payable by it in respect of the said losses.

(d) Costs of the curator to be appointed for the Plaintiff.

K PILLAY J

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