REPUBLIC OF SOUTH AFRICA

IN THE HIGH COURT OF SOUTH AFRICA
GAUTENG LOCAL DIVISION, JOHANNESBURG

CASE NO: 4314/15

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

18/12/2019 Keightley
DATE SIGNATURE

In the matter between:

MSM obo KBM Plaintiff

And

THE MEMBER OF THE EXECUTIVE COUNCIL FOR HEALTH, GAUTENG PROVINCIAL GOVERNMENT Defendant

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Delict – medical negligence in public hospital causing cerebral palsy – damages for future medical expenses - whether common law to be developed to permit compensation in kind and periodic payments – judgment of Constitutional Court in MEC for Health and Social Development, Gauteng v DZ obo WZ 2018 (1) SA (335) (CC) analysed and applied – Held: wider interests of justice require development of common law to permit compensation in kind in appropriate similar cases – insufficient evidence to found case to develop common law to permit periodic payments – MEC ordered to render certain medical services to complainant at Charlotte Maxeke Johannesburg Academic Hospital

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J U D G M ENT

KEIGHTLEY, J:

INTRODUCTION

1. It is tragic that this matter involves yet another claim against the MEC for Health, Gauteng (the MEC) for damages arising out of negligent conduct by medical staff in a public hospital resulting in the birth of a child who is now severely disabled by cerebral palsy. Judges in this Division are now accustomed to presiding over these matters which are, unfortunately for all concerned, and particularly for the affected families, all too frequent. In this matter, the child concerned is K. She is represented by her mother as the plaintiff.

2. As this judgment demonstrates, there is a double tragedy inherent in matters of this nature. Not only are the disabled child and her family deeply and irreversibly affected, but so is the public healthcare system. This is because claims of this nature typically involve a substantial quantum of damages - often in excess of R20 million. These damages, if proven, are paid from the public healthcare purse, thus depleting badly needed resources that would otherwise be available for the healthcare needs of the residents of Gauteng, many of whom do not have the benefit of private healthcare.

3. This dual tragedy falls starkly in the spotlight in the case before me. In his defence to the quantum aspect of the claim, the MEC has raised what have become known among practitioners in this field as "the DZ defences". The defences flow from the

judgment of the Constitutional Court in *MEC for Health and Social Development, Gauteng v DZ obo WZ.*[1]

4. The MEC asks this court, based on the *DZ* judgment, to develop the common law as follows:

4.1. In the first instance, to permit the court to make an order of damages that does not sound wholly in money and to include an order of compensation in kind. In essence, the MEC's case is that some of the future medical requirements of the minor child, K, can be provided to her by the Charlotte Maxeke Johannesburg Academic Hospital (CMJAH or the Hospital), and that the level of service she will receive there will be equal to that she would otherwise receive in the private healthcare sector. The MEC contends that he should not be ordered to pay damages based on the costs of these services in the private healthcare sector. Instead of a damages award for these future medical expenses, the court should order that the Hospital provides the services to K.

4.2. In the second instance, to permit the court to order, insofar as any monetary award is made, that it be payable by way of periodic payments, rather than in one lump sum.

5. As far as the merits of the matter are concerned, these were settled in 2017. The MEC conceded liability for K's agreed or proven damages flowing from the neurological injury she sustained during her birth on 25 June 2012, and the resultant cerebral palsy she suffers. The MEC also obtained an order against K's mother, Ms M, for a contribution from her in her personal capacity, or an indemnification, as third party, of 40% of those damages. However, it is common cause between the parties

[1] 2018 (1) SA (335) (CC)

that this aspect of the matter has no relevance to the issues before me. Whether or not the MEC ever seeks to press its order against Ms M in her personal capacity has no bearing on the MEC's liability to her in her capacity as K's guardian, and her claim for damages in her representative capacity.

6. The plaintiff, on behalf of K, opposes the development of the common law in this case. She presses for an order in accordance with the existing common law, viz. an order for a lump sum payment of the full costs of her future medical expenses as calculated by the various experts.

7. K is now seven years old. It is common cause that she suffers from a severe form of cerebral palsy. Her agreed life expectancy is 24.6 years. Her mother has used the public health care system since K was born at the Leratong Hospital. K is already registered as a patient at the CMJAH, where she has attended the Nuerodevelopmental Clinic over the years. She has also received some therapy, such as physiotherapy, at her local clinic.

8. K's further treatment will depend on the outcome of this case. The MEC's proposal is that if the court makes an order in kind, K will receive all her treatments, including all therapies, at the CMJAH. She will be regarded as a special patient there and will receive all the therapies and other interventions the experts recommend from specialists at the Hospital. In addition, the Hospital will acquire for her the recommended equipment and other items, including medication and other disposables, through its procurement system. It is on this basis that the MEC moves for an order outside of the ordinary prescripts of the law of delict.

9. I should add, by way of introduction, that the plaintiff has agreed to a claw-back provision as regards any monies paid to K for her future medical expenses. I will have more to say about this later in the judgment.

PRELIMINARY ISSUE: RULE 16A

10. When the counsel for the plaintiff submitted argument to the court, she raised, for the first time, the fact that the defendant had not complied with the provisions of Rule 16A of the Uniform Rules of Court. In terms of this Rule, a person raising a constitutional issue in an action must give notice thereof to the Registrar at the time of filing the relevant pleading. The purpose of the prescribed notice is to give any interested parties an opportunity to become involved in the matter and to express their points of view. The involvement of other interested parties in cases that raise constitutional issues is generally regarded to be of assistance to the court, and Rule 16A facilitates this.

11. It is common cause that the defence raised by the MEC in this case involves the development of the common law, and that this is a constitutional issue. The MEC does not dispute that notice ought to have been given under Rule 16A. It seems, however, that both parties overlooked the requirements of Rule 16A before the trial commenced, and indeed until, as I say, argument was advanced.

12. The plaintiff submits that the MEC is to blame for this state of affairs. Not only because he failed to comply with Rule 16A, but also because the plea introducing the DZ defences (and hence the constitutional issue) was raised late in the day, being some 10 days before the trial commenced.

13. Rule 16A(9) permits a court to condone non-compliance with the Rule where this is in the interests of justice. In my view, a court should not lightly condone the failure to comply with it. However, in this case, it seems to me that such condonation is justified. The plaintiff did not object to the amendment of the MEC's plea to include the DZ defences, nor did the plaintiff raise non-compliance with Rule 16A at the start of, or even while the trial was running. By the time the issue was raised all the

evidence had been heard, and all that remained was for argument to be presented. It was impossible for the MEC to comply with Rule 16A at that stage. To try to turn back the clock would have caused a lengthy postponement of proceedings, with the possibility of needing to re-call witnesses who had already testified. The plaintiff did not seek such measures to be put in place but relied instead on a technical objection to the fact that there was not compliance with the Rule.

14. In my view, it would not be in the interests of justice to uphold this technical objection and non-suit the MEC when his defence, and the plaintiff's opposition thereto, have been fully ventilated by a large number of witnesses. It is in the interests of justice to condone the non-compliance with Rule 16A, and I hereby do so.

15. I turn now to consider the main issues in dispute. The obvious place to start is to understand what the legal position now is in light of the Constitutional Court's judgment in *DZ*.

THE LEGAL POSITION AS CLARIFIED IN *DZ*

The existing common law

16. In *DZ* the MEC had been ordered to pay a lump sum amount of R19 979 631 for the future medical expenses of a child who, like K, had suffered neurological injuries at birth, due to the medical negligence of public healthcare staff, resulting in cerebral palsy. Both the High Court and the Supreme Court of Appeal had rejected the MEC's defence that the law did not require payment in money for damages for future medical expenses. The MEC had argued that it was within the existing ambit of the common law for the MEC to compensate for the harm caused by giving an undertaking to pay service providers directly, within 30 days, for the child's medical expenses, as and when they arose. The SCA had held that this was contrary to the

"once and for all" common-law rule and that, if development of the law was necessary, this should be left to the legislature.

17. By the time the matter came before the Constitutional Court, two other MEC's had been joined as *amici* in the appeal against the SCA's decision. Both of these MEC's professed an interest in the appeal in that they sought to ensure that any decision of the Constitutional Court in *DZ* did not prevent them from raising certain defences they had raised in pending High Court trials.

18. The MEC for Health in the Eastern Cape sought to rely on two defences. The first being that claims for future medical expenses could be satisfied though the provision of medical services in the public healthcare sector as opposed to a once and for all lump sum award for damages for future medical expenses. The Court referred to this as the "public healthcare defence", and I will do the same. The second defence was an "undertaking to pay" defence on the basis that a claim for future medical expenses could be satisfied by an undertaking by the MEC to pay for medical expenses as and when they arose in the future.

19. It bears mentioning that the MEC in the matter before me raises the public healthcare defence, but not the undertaking to pay defence. Consequently, this judgment does not deal with the latter defence at all.

20. The Western Cape MEC in DZ addressed the court on a form of award that would involve the establishment of a ring-fenced trust in each case, which would be subject to a "top-up" and "claw-back" scheme. The effect would be that the damages awarded would be held in trust for the sole use of the affected child's future medical expenses. In the event that the child died earlier than the depletion of the funds, these would revert to the State. In the event that the funds became depleted during the child's life-time, they would be topped up by the State. As I have already

indicated, the parties in the present matter have agreed to a claw-back clause, without the inclusion of a top-up provision.

21. The Constitutional Court considered the implications for the existing law of delict of all of these defences. The judgment of the Court is comprehensive and I do not intend summarising it in full. Instead, I will attempt an analysis that addresses the issues that arise for determination in the case before me.

22. As a starting point, it is important to note that in its analysis of the common law of delict as it exists currently the Court reached two conclusions:

22.1. First, there is little reason to doubt the continued existence of the rule that insofar as the Aquilian action is concerned, damages are to be awarded in money "because money is the measure of all things."[2]

22.2. Second, the "once and for all" rule still forms part of our law of delict. This means that a plaintiff must claim, in one action, all past and prospective damages arising from one cause of action. This means, too, that courts are obliged to award these damages in one lump sum. This is to prevent the repetition of law suites, the harassment of a defendant by a multiplicity of actions, and the possibility of conflicting decisions.[3]

The Court consequently rejected the Gauteng MEC's foundational proposition in *DZ*, which was that in terms of our existing common law compensation need not sound in money.[4]

23. However, this was not the end of the matter. The Court recognised that the generally accepted method of calculating the damages payable in respect of future

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[2] At para 14, citing *Wynberg Valley Railway Company v Eksteen* 1 Roscoe 70 at 74, as cited in *Standard Chartered Bank of Canada v Nedperm Bank Ltd* [1994] ZASCA 747 at 782D-F
[3] At para 16
[4] At para 17

medical expenses is to base these on the costs of the relevant services in the private healthcare sector. However, the Court accepted the proposition that a plaintiff bears the onus of proving that her damages claimed are reasonable. Thus, a defendant could counter the method and measure of a damages claimed on the basis that the amount (based on the costs of private healthcare) was not reasonable because the plaintiff was more likely to use public healthcare, which was as good as, and cheaper than, private healthcare.[5]

24. The Court found support for this proposition in the case of *Ngubane v South African Transport Services*[6]. In that case it was held that evidence by the plaintiff of the cost of the use of private medical services and hospital facilities would discharge the *onus* of proving the cost of those expenses:

"unless, having regard to all the evidence, including that adduced in support of an alternative and cheaper source of medical services, it can be said that the plaintiff has failed to prove on a preponderance of probabilities that the medical services envisaged are reasonable, and hence that the amounts claimed are not excessive."[7] (my underlining)

25. The Constitutional Court in *DZ* concluded that:

"*Ngubane* is authority for allowing a defendant to produce evidence that medical services of the same or higher standard, at no or lesser cost than private medical care will be available to a plaintiff in future. If that evidence is of a sufficiently cogent nature to disturb the presumption that private future healthcare is reasonable, the plaintiff will not succeed in the

[5] At para 18
[6] 1991 (1) SA 756 (A)
[7] At paras 20-1

claim for the higher future medical expenses. This approach is in accordance with general principles in relation to the providing of damages."[8]

The Court also held that this approach did not offend the once and for all rule in that it involves a once and for all assessment on the evidence. Further, that in a case where the defendant has produced cogent evidence of the type referred to in *Ngubane*:

"although the claimant will (be proven to) need medical care in the future, it has not been proved on a balance of probabilities that this entails a loss in the sense that the claimant's patrimony after the delict is less than it would have been had the delict never occurred. It is not the mere injury and its further consequences that justify an award of damages, but the actual diminution of the claimant's patrimony."[9] (my underlining)

26. The Court rejected the SCA's finding in *Premier, Western Cape N.O v Kiewit*[10] in which the court dismissed a mitigation defence of this nature on the basis that it offended the once and for all rule, and the rule that delictual compensation must sound in money. The Constitutional Court found that this conclusion was reached without reference having been made by the court to *Ngubane*.[11]

27. On my understanding of this aspect of the *DZ* judgment, then, it is within the bounds of the existing common law for a defendant in a medical negligence case to mount a defence based on evidence that the future medical services the plaintiff needs are available at the same or higher standard from a public sector source at no, or less cost to the plaintiff. For simplicity's sake, I will call this the mitigation of healthcare costs defence. In that case, the plaintiff's claim for the cost of future medical expenses may be rejected on the basis that the claim for a lump sum payment based

[8] At para 21
[9] At para 22
[10] 2017 (4) SA 202 (SCA) at para 13
[11] At para 23

on the cost of private health care is unreasonable. This is because the services are available at no, or lesser cost to the plaintiff from the public healthcare sector. That being so, the plaintiff will not have suffered the patrimonial loss claimed. Her claim for monetary compensation for the costs of future medical expenses may be either rejected on this basis (if there is no cost to the plaintiff in accessing the services from the public healthcare sector), or a claim for a lesser amount will be ordered (in the event that there is still a cost to plaintiff in sourcing public healthcare services, but that this is less than it would be in the private sector).[12]

28. Importantly, the Court found that the mitigation of healthcare costs defence is consistent with existing common law principles. Thus, no development of the common law is necessary in making a determination on this defence.

29. However, it is important to draw a distinction between the mitigation of healthcare costs defence, on the one hand, and the public healthcare defence, on the other. What they have in common is that the defendant must adduce evidence to show that the plaintiff may access the future medical services to the same or higher standard in the public healthcare sector. But they differ in an important respect: while the mitigation of healthcare costs defence falls within the existing principles of the law of delict, the public healthcare defence may not.

30. This is particularly so if, in a case like the present, the MEC has raised the prospect of an order in kind, i.e. an order that obliges the MEC to render specific medical services to K at the Charlotte Maxeke Johannesburg Academic Hospital. An order of this nature goes beyond the existing common law rule that delictual compensation

[12] See the discussion in para 23 of the *DZ* judgment

must sound in money.[13] Accordingly, it would be necessary for a court to develop the common law to permit an order of this kind.

31. As far as the payment of damages for future medical expenses by way of periodic payments is concerned, the majority judgment in *DZ* adopted what it called a cautious approach. It found that it had not yet been definitively decided at common law that it was permissible for a court to order the payment of an assessed delictual loss in instalments, rather than in one lump sum. On this basis, an order of this nature would also require a development of the common law.[14]

32. In summary, then, in terms of our existing common law, a plaintiff who claims damages for the cost of future medical expenses bears the onus of establishing that the damages claimed (and hence the cost of the medical expenses) is reasonable. Generally, it will be accepted that the costs of the services offered in the private healthcare sector will be reasonable. However, in order to counter the plaintiff's case in this regard, a defendant may adduce evidence to establish that the expenses claimed are not reasonable, based on the availability of the same medical services in the public sector at no or lesser cost to the plaintiff. On this basis, and in accordance with our existing common law, the defendant may either plead for the claim to be dismissed or reduced. No development of the common law is necessary in this scenario.

33. However, if the defendant wants to go further and to plead either for an order that it render services in kind (the public healthcare defence) or for payment of the

[13] *DZ* at para 24
[14] At para 25

damages to be made in instalments, some development of the common law will be necessary.[15]

Development of the common law

34. The *DZ* judgment includes an extensive discussion of the proper approach to the development of the common law. I highlight what I consider to be the most important aspects for purposes of the case before me:

34.1. To begin with, the Court stressed that the development of the common law does not necessarily entail the changing of a common law rule altogether, or the introduction of a new rule. It may also occur in the situation where a court must determine whether a new set of facts falls within or beyond the scope of an existing rule. What is important is that common law development cannot take place in a factual vacuum.[16]

34.2. There are two potential legal bases for the courts' development of the common law: s39(2) of the Constitution, or s173 of the Constitution. In terms of the former, the court must, among other things, enquire whether the existing common law rule offends s39(2). In other words, is it at odds with the normative framework of the Constitution and the Bill of Rights? In terms of s173, the enquiry is wider. The question there is whether, even if the common

[15] At para 24
[16] At para 28

law is constitutionally compliant, there are wider interests of justice that necessitate its development.[17]

34.3. In both instances, the court must also: (1) determine what the existing common law position is; (2) consider its underlying rationale; (3) if it offends s39(2), or if the wider interests of justice necessitate development, the court must consider how the development ought to take place; and (4) consider the wider consequences of the proposed change on the relevant area of law.[18]

34.4. The Court cautioned courts to be mindful that, in accordance with the principle of the separation of powers, the major engine for law reform should be the legislature. However, courts should take into account factors such as whether the common law rule is a judge-made rule; the extent of the development required; and the legislature's ability to amend or abolish the law.[19]

34.5. In determining whether a common law rule offends s39(2) or whether the wider interests of justice necessitate development, the context of the inquiry is important. In particular, in the case of *DZ* (as in the case before me), the court is dealing with a child suffering cerebral palsy occasioned by the medical negligence in a public healthcare institution:

"It is within that context that it is argued that the law should allow either an order to ensure the actual rendering of the necessary medical care or periodic payments of the assessed loss."[20]

35. Ultimately, in *DZ* the Court found that:

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[17] At para 32
[18] At para 31
[19] At para 34
[20] At para 36

"... any development of the common law requires factual material upon which the assessment whether to develop the common law must be made. Here that factual material is absent. The only possible factual foundation for an argument that the common law must be developed is the mere fact that WZ was born in a public healthcare institution and that is where the medical negligence occurred. This is woefully inadequate to ground development of the common law in the manner sought by the Gauteng MEC. The appeal must fail, for that reason."[21] (my underlinging)

36. Consequently, although the court considered the issue of whether the development of the common law was necessitated, either on the grounds of s39(2) or s173, it made no finding in this regard. Despite this, there are, in my view, two important aspects of the Court's decision that bear emphasis for present purposes:

36.1. First, the Court expressly left the door open to the future development of the common law in cases like the one before me. It held in this regard that:

"But the failure of the appeal does not mean that the door to further development of the common law is shut. We have seen that possibilities for further development are arguable. Factual evidence to substantiate a carefully pleaded argument for the development of the common law must be properly adduced for assessment. If it is sufficiently cogent, it might well carry the day."[22]

36.2. Second, although *obiter*, the Court discussed in some detail the ambit of the arguments that could be made to support the development of the common law. It did this in respect of both the public healthcare defence, and the development of the once and for all rule to permit payments by instalments. In so doing, the Court lays down important guidelines for courts to follow in

[21] At para 57
[22] At para 58

assessing whether a case has been made out for the development of the common law in cases involving claims for future medical expenses occasioned by the negligence of public healthcare officials in cerebral palsy cases.

37. As far as the public healthcare defence is concerned, the Court made the following salient points:

37.1. Despite its earlier caution that courts should be mindful that it is the legislature's primary duty to develop the law, it also cautioned against letting the past bind us.[23]

37.2. The Court considered that in principle the actual rendering of services (as opposed to the payment of monetary damages) would fulfil the two-fold purpose of the law of delict, viz. redressing damage and compensating the victim.[24]

37.3. Thus, our law has made an evaluative choice in requiring compensation in money, rather than in kind.[25]

37.4. While the Court considered it doubtful that this common law choice offends the normative underpinnings of our legal order, it went on to say:

"But it is arguable that the fundamental right of everyone to have access to healthcare services and the state's obligation to realise this right by undertaking reasonable measures

[23] At paras 37 and 39-41. The Court identified two reasons for this. First, it noted that the ancestry of the rule that damages must sound in money "has its own quirks". It had no specific precedent in Roman sources. Further, in *Wynberg Valley Railway Company* (the case often cited in support of the "money is the measure of all things" principle), the court appeared willing to accept that a partial award in kind would be fair, but for the specific wording of the section in question. Second, the Court pointed to the importance of giving serious attention to how African conceptions of constitutional values should be used in the development of the common law.

[24] At para 43

[25] At para 44

introduce factors for consideration that did not exist in the pre-constitutional era. Aligned to this is the 'ever-increasing shift from the classical model of individual loss-bearing towards a collectivisation of losses' that is reflected in the 'gradual absorption of [delict] law, or at least large parts of it, into the modern social-security system'".[26]

38. As far as the once and for all rule is concerned, the Court expressed the following views:

38.1. Both the rule and the periodic payment system are open to criticism. The former because it involves speculation and requires the court to make what is often a very rough estimate. The latter can be criticised because it involves, among other things, piecemeal consideration of the effect of injuries, administrative difficulties and problems with adjustment for inflation, taxation and the like.[27]

38.2. Although both are open to criticism, it could not be said that either was in conflict with the normative constitutional value system. The periodic payment system was not out of sync with the high value the Constitution places on socio-economic rights.[28]

38.3. What was required was an accommodation between the two. Although this might be difficult at an abstract level, it may not be necessary to leave development of the law up to the legislature:

"Resolution of the dilemma may lie in leaving the choice at the level of each individual case, depending on which form of payment will best meet its particular circumstances."[29]

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[26] At para 45
[27] At paras 51 and 52
[28] At para 54
[29] At para 55

38.4. Finally, and significantly, the Court noted that:

"We must remind ourselves again of the context in which the argument for development of the common law is made here. We are not called upon to decide the fate of the 'once and for all' rule in all personal injury cases arising from medical negligence. The most important future imponderable is the ultimate one: death. Periodic payments subject to a 'top-up/claw-back' will give less speculative expression to the general principle of compensation for loss. And the likelihood of a dependant's claim, which might present problems in other cases, is less, if not entirely absent, here."[30]

39. Thus, while the Court refrained from taking the step of finding that the relevant common law rules must be developed, its judgment provides a solid basis upon which such development can take place in an appropriate case, and where the court is favoured with the necessary evidence. In the case before me the MEC has led evidence in support of his defences. He has pleaded that certain (albeit not all) of the identified medical services that K will require in the future can be met at the Charlotte Maxeke Johannesburg Academic Hospital. I will refer to these as "the identified services". He has also pleaded that insofar as an order of monetary payment is made, this should not be by way of a lump sum payment, but by way of periodic payments.

40. Both of these aspects of the plea require me to develop the common law. The question I am faced with is whether, on the basis of the evidence adduced by the MEC, and the opposition mounted by the plaintiff, this is an appropriate case in which to develop it.

[30] At 56

PROCESS TO BE FOLLOWED

41. What process should be followed in making a determination in this regard? It is necessary as a preliminary step to determine what K's future medical and related needs are, what the claimed costs are of these services are, and which of these services are to be categorised as identified services for purposes of the public healthcare defence.

42. Thereafter, and based on my analysis of the *DZ* judgment, it seems to me that the proper approach to adopt is as follows.

42.1. The first question to consider is whether the MEC has placed sufficient cogent evidence before me to establish that, insofar as the identified services are concerned, they will be available in the future for K at the CMJAH, at the same or higher level and at no or less cost to her than those available in the private sector. If the MEC provides such cogent evidence, it will be important for two reasons:

42.1.1. It will rebut the plaintiff's case that her claim for the full cost of future medical expenses is reasonable.

42.1.2. In addition, it will establish an evidentiary basis upon which to consider whether this is an appropriate case in which to develop the common law insofar as the MEC's public healthcare defence is concerned.

42.2. The next question to consider is whether, based on that evidence, the MEC has established a need to develop the common law rule that currently requires that compensation for future medical expenses must sound in money. In other

words, has the MEC made out a case that the common law should be developed to permit an order that the identified services be rendered to K at CMJAH? In this regard, and guided by the views expressed by the Constitutional Court in *DZ*, I must:

42.2.1. consider the underlying rationale of the existing common law rule (which is already discussed fully in the *DZ* judgment);

42.2.2. enquire whether the common law rule offends s39(2), or whether there are wider interests of justice considerations that necessitate its development under s173;

42.2.3. in light of this, consider how the development ought to take place; and

42.2.4. consider the wider implications of the proposed development and

42.2.5. finally, consider whether this is an appropriate case in which to make an order for compensation in kind.

42.3. I must then consider whether the common law once and for all rule should be developed to permit periodic payments instead of a lump sum payment as regards those amounts to which the plaintiff is entitled in respect of K's future medical expenses. As the MEC concedes that only the identified services are available at CMJAH, the plaintiff is entitled to at least a portion of K's damages by way of a monetary payment. This means that this development of the common-law once and for all rule must be considered regardless of what I conclude in respect of the public healthcare defence. In this regard, I must:

42.3.1. as a preliminary issue, consider whether the MEC has placed sufficient evidence before the court to provide the necessary factual support for the

development of this rule in the present case. If not, the enquiry need go no further;

42.3.2. Only if I find that the MEC has provided the necessary factual support to develop the common law, will I have to apply my mind to the further considerations listed immediately above

K's FUTURE MEDICAL AND RELATED NEEDS

43. It is common cause between the parties that K suffers from a severe type of cerebral palsy, which is predominantly dystonic, with a GMFCS 5. According to the joint minutes of the paediatric neurologists, this means that she is capable of very limited independent mobility. Her co-morbidities include profound intellectual disability, lower limb contractures, strabismus, microcephaly and global developmental delay. There is evidence of cortical visual impairment.

44. As far as her future medical needs are concerned, in the main, there is agreement that she requires the following categories of services:

44.1. Speech therapy, including assisted communication devices and related therapy, feeding therapy and dysphagia therapy. In the event that the MEC's public healthcare defence is unsuccessful, it is agreed that the cost of these services is R623 420. 00 (having applied an agreed contingency deduction of 25%).

44.2. Ear, nose and throat services in the form of surgical management of K's hyper salivation. In the event that the MEC's public healthcare defence is unsuccessful, it is agreed that the cost of these services is R41 000. 00 (with an agreement that no contingency deduction should be applied).

44.3. Orthopaedic treatment, including possible hip reconstruction surgery; x-rays to monitor her scoliosis; possible surgical correction of her scoliosis; possible surgical treatment of fractures; monitoring of her osteoporosis; Botox therapy, and annual assessments by an orthopaedic surgeon. In the event that the MEC's public healthcare defence is unsuccessful, it is agreed that the cost of these services is R356 888. 00 (having applied the relevant agreed contingencies).

44.4. Physiotherapy treatment and equipment including:

44.4.1. An average of 60 sessions of physiotherapy per year until the age of 18, and thereafter 28 sessions.

44.4.2. One comprehensive physiotherapy assessment per year for the rest of her life.

44.4.3. Post-surgical physiotherapy.

44.4.4. Additional physiotherapy in the event of fractures.

44.4.5. Additional physiotherapy following Botox treatment.

44.4.6. Cardio pulmonary physiotherapy.

44.4.7. A portable aspirator, with replacement every 10 years.

44.4.8. A nebuliser, with replacement every 10 years.

44.4.9. Suction catheters.

44.4.10. A physiotherapy "plinth" to be used in the home.

In the event that the MEC's public healthcare defence is unsuccessful, it is agreed that the cost of these services and the equipment is R629 590. 00 (having applied an agreed contingency deduction of 10%)

44.5. Dental services, including examinations; theatre costs for dental procedures that will have to be performed under anaesthetic; anaesthetists fees; dental fees (including surgical fees); x-rays; and various dental consumables and accessories. In the event that the MEC's public healthcare defence is unsuccessful, it is agreed that the cost of these services is R589 458. 00 (having applied an agreed contingency deduction of 10%).

44.6. Urology services including urodynamic studies; treatment for urinary tract infections; consultations with urologists; and bowel management. In the event that the MEC's public healthcare defence is unsuccessful, it is agreed that the cost of these services is R82 929. 00 (having applied an agreed contingency deduction of 10%).

44.7. Dietary supplementation including various nutritional and vitamin supplements; dietician's consultations; a food blender; the possible placement of a percutaneous endoscopic gastronomy tube (PEG) and related equipment; and blood tests. In the event that the MEC's public healthcare defence is unsuccessful, it is agreed that the cost of these services is R421 350. 00 (having applied an agreed contingency deduction of 10%).

44.8. Psychiatric treatment. This is disputed by the MEC, although both psychiatrists agree on the need for psychiatric treatment. The plaintiff claims an amount of R116 411. 00 in this regard.

44.9. Paediatric neurology services including MRIs; EEGs; blood tests; medication; hospital admissions every second year; and consultations. In the event that the MEC's public healthcare defence is unsuccessful, it is agreed that the cost of these services is R229 253. 00 (having applied an agreed contingency deduction of 10%).

44.10. Orthotics and wheelchairs. In their joint minutes the experts agreed that K requires a Rifton activity indoor wheelchair, to be replaced every five to seven years, as well as the costs of upholstery; a compact stroller, to be replaced every five to seven years; a Pronestander, to be replaced every five to seven years; and consultations every six months for the rest of her life. In the event that the MEC's public healthcare defence is unsuccessful, it is agreed that the total cost of the wheelchairs is R388 281. 00; the re-uphostry costs are R60 422. 00; the total cost of the strollers is R62 279. 00; the total cost of the Pronestanders is R159 941. 00; and the total cost of the consultations is R21 420. 00 (after a contingency deduction at an agreed 10%).

The orthotic requirements are more contentious. Although the experts agreed in their joint minute on specific types of orthotic footwear equipment, the plaintiff's expert was subject to extensive cross-examination, partly on the basis that with K's particular mobility problems, it was questionable whether the foot orthotics would serve any real purpose. To the extent necessary, I will deal with this issue later. For present purposes, it is necessary to record that as per the joint minute, the foot orthotics that are recommended include bilateral Knee Ankle Foot Orthosis (KAFO) with multifunctional correction system joints, replaced every 1-2 years up to the age of 18 and thereafter every 2-3 years, as well as replacement straps every 6 months; bilateral solid Ankle Foot Orthosis Footwear Combination (AFOFC), with the same replacement schedule as the KAFO; and orthotic footwear modification and tuning. In the event that the MEC's public healthcare defence is unsuccessful, it is agreed that the

total cost of the KAFOs is R603 015. 00; the cost of the KAFO replacement straps is R26 775. 00; the total cost of the AFOFCs is R139 499. 00; the cost of the AFOFC replacement straps is R26 775. 00; and the cost of the modification and tuning is R23 660. 00 (after a contingency deduction at an agreed 10%).

In addition, the joint minutes record an agreement that K requires SPIO compression garments at a total cost of R89 397.00, and static Wrist Hand Orthosis at a cost of R49 891. 00 (after the agreed 10% contingency deduction).

44.11. Occupational therapy and equipment, including regular occupational therapy sessions; home programmes; full reassessments; travel costs to therapy sessions; a transportable ramp; a range of equipment and supplies to assist in K's care in the home (eg sleeping system, adjustable bed, hoist, bath chair etc); therapy or stimulation toys; and disposables (including gloves, nappies etc). The agreed total cost of these services and the equipment, should the MEC fail in his public healthcare defence, is R877 465. 00 (after the agreed 10% contingency deduction).

44.12. Care givers. In their joint minute the occupational therapists agreed that K requires 24-hour care to be provided by caregivers. The MEC does not dispute this. The amount claimed in this regard by the plaintiff is R24 000.00 per month up to the age of 18 years, and 31 400. 00 per month thereafter. Further he agreed that an amount of R15 000. 00 per annum be provided for specialised nursing care in times of unforeseen ill-health, at a total cost of R249 453. 00. A further amount of R101 139. 00 is claimed for a registered nursing sister to supervise the caregivers, and a further amount of R203 478. 00 for domestic assistance once a week. An agreed 10% contingency has been applied in respect of the latter three claims.

44.13. Specialised schooling. The occupational therapists agreed that K would be best placed in Pathways School which would cater for her special needs. It is common cause that K has already been placed at the school at a monthly cost of R4 004. 00, and a total cost of R449 520. 00. The MEC is in agreement with this amount, and that it should be paid to the plaintiff.

44.14. Vehicle claims and mobility claims. Joint minutes were filed by mobility specialists who agreed that K requires a sedan motor vehicle, and thereafter a MPV, for her transportation. The cost of the sedan is R131 850. 00 and the MPV R153 305. 00 (taking into account the trade-in value of the sedan). She will also require a hoist and restraints, at a cost of R518 204. 00 and a car seat (until her skeletal maturity of 25 kg), at a once-off cost of R32 390. 00. The MEC does not dispute these claims and amounts. He does dispute the claimed annual running costs of the vehicles, including licence, GPS tracking, AA running costs, totaling R234 764. 00.

44.15. Alterations to home. It is common cause that the plaintiff intends to procure a suitable RDP house for the family. The plaintiff does not claim any financial assistance from the MEC as regards the cost of the acquisition of the house. However, the parties are agreed that K is entitled to claim the costs of alterations to the home, which total R1 108 450. 00 (after the agreed 10% contingency deduction).

44.16. Insurance costs for wheelchairs and equipment. The parties are in agreement that a total amount of R196 781. 00 is reasonable in respect of the cost of insuring the wheelchairs and other equipment that will be kept in K's home.

44.17. Case manager. The occupational therapists agreed that it would be beneficial to appoint a case manager to, among other things, monitor K's progress, provide support to the family as to the implementation of K's treatment plan and therapies; assist in securing a house; liaising with the architects concerning the alterations and sourcing vehicles and other equipment; and liaising with the trustees who are appointed to the trust into which K's damages are to be paid. The MEC does not dispute that the appointment of a case manager is reasonable. However, what is not agreed is the reasonable cost of the case manager's services in the event that the MEC succeeds in his public healthcare defence. In that event, an internal case manager who is already in the employ of the CMJAH will be appointed to oversee and administer the implementation of the order within the Hospital. It is argued that the external case manager's fees should be reduced accordingly as she will play a lesser role than would otherwise be the case. In the event that the MEC does not succeed in that defence, the total cost of the case manager's fees claimed is R449 385. 00.

45. As far as the identified services are concerned, the MEC's case is that all of the therapies and equipment from the speech therapy and equipment, up to and including the occupational therapy and equipment can be provided by the CMJAH. These are the identified services. The MEC does not dispute the needs and costs of the specialised schooling; vehicle and mobility needs (save for the annual running costs); alterations to the home; insurance costs; and the need for a case manager (save for the disputed costs involved). These are the non-identified services, the costs for which the MEC accepts should be the subject of a monetary damages award.

46. Mr Soni, on behalf of the MEC, led some evidence in an attempt to lay a foundation for an argument that the CMJAH could also provide for the services of care givers, and that this cost should be excluded from the damages award. In my view, the provision of home care givers is something that falls well outside of the core function of a public hospital. The evidence led did not establish that at this stage the MEC, whether with the assistance of the hospital or otherwise, is in a position to make provision for services of this kind. In fact, Mr Soni did not press this point in argument before me. In my view, correctly so. In this case, at least, it is clear that this is a cost that must be borne by the MEC by way of a payment to the plaintiff. This cost is thus excluded from the list of identified services that fall for consideration in respect of the public healthcare defence, and forms part of the non-identified services.

47. As far as the non-identified services are concerned, the plaintiff is entitled to an order that the costs associated with these be paid by the MEC. Whether this is to be a lump sum payment, as provided currently by the common law, or a periodic payment, as contended for by the MEC, will be dealt with later.

EVIDENCE LED IN RESPECT OF THE IDENTIFIED SERVICES

48. As I indicated earlier, before considering the issue of the development of the common law in respect of the public healthcare defence I need to assess the evidence adduced by the MEC in support of his contention that the identified services are available to K at the CMJAH at no cost to her and at the same standard as she could expect in the private sector. In *DZ* the MEC fell short in adducing the requisite evidence to meet the public healthcare defence. The question is whether the evidence presented before me is sufficient to permit the MEC in this case to avoid the same outcome.

49. In support of his case the MEC led the evidence of two witnesses who are involved in the management of public health, one at CMJAH, and one at Provincial level. These were the Chief Executive Officer (CEO) of the CMJAH, Ms Bogoshi, and Dr Medupe Modisane, the Acting Deputy Director General: Hospital Services in the Department of Health, Gauteng (ADDG). I deal with their evidence first, as it provides the broad context within which to assess the MEC's public healthcare defence.

50. Thereafter I will consider the evidence given by a range of specialists who are employed at the CMJAH, and who have been tasked with ensuring that K's needs, as specified by the identified services, will be met, in the event that the court makes an order to that effect. These witnesses include:

50.1. Dr Heather Thomson, who is a paediatrician and the Head of the Neurodevelopmental Clinic at the CMJAH.

50.2. Prof Anthony Robertson who is an orthopaedic surgeon and the Head of Paediatric Surgery at the CMJAH.

50.3. Dr Faeeza Mohamed, who is a duly qualified psychiatrist attached to the Child, Adolescent and Family Unit at the CMJAH.

50.4. Dr Ahmad, who is a urologist and the Acting Head of the Department of Urology at the CMJAH.

50.5. Dr Ebrahim Patel, who is a qualified dental practitioner employed at the Wits Oral Health Centre, which is part of the CMJAH.

50.6. Dr PR Makaulele, who is an ear, nose and throat specialist, who is employed in the ENT, Head and Neck Surgical Department at CMJAH.

50.7. Ms Tshifihiwa Mukheli, a qualified physiotherapist with a Masters Degree in Early Childhood Intervention, and who is currently the head of physiotherapy at CMJAH.

50.8. Ms T Jogianna, a speech therapist who is the Director of Speech and Audiology and the Head of Department at the CMJAH.

50.9. Ms Veda Yip, a qualified occupational therapist and Head of Occupational Therapy at CMJAH.

50.10. Ms Karen Steynberg, who is a qualified dietician and head of Dietetics at CMJAH.

50.11. Mr M J Machaba, a qualified Medical Orthotist/Prosthetist. He is the Chief Orthotist employed in the Orhopaedic workshop at the Chris Hani Baragwanath Academic Hospital.

51. In addition to this evidence, the parties agreed to an on-site visit to the CMJAH for the purpose of inspecting the units where it is envisaged that K would receive the identified services.

The evidence of Hospital and Provincial management

52. Ms Bogoshi is the CEO of the CMJAH, and has been in this position since 2013. Previously she was the Acting CEO and then CEO of Helen Joseph Hospital from 2006 until her appointment at CMJAH. She was also previously in a management position at Chris Hani Baragwanath Academic Hospital. Ms Bogoshi trained as a physiotherapist and has an MSC in Neurology, as well as a further Masters in Public Health in Hospital Management from Wits.

53. As the CEO of the CMJAH, Ms Bogoshi is expected to have her finger on the pulse of how her hospital operates, what its challenges are, and what would be needed to be put in place to ensure that K received the services that the MEC asserts can be provided to her there. In this respect, she was a critical witness, and I deal with her evidence is some detail.

54. By way of background, Ms Bogoshi explained that public healthcare services in Gauteng work on a cluster system. Central hospitals, like CMJAH, offer specialised services, whereas smaller, local hospitals in the cluster serve the general healthcare needs of patients in their area. Usually, unless a patient has a special need, she will be treated in her local hospital or clinic. Leratong Hospital, where K was born, is a local hospital in the cluster.

55. CMJAH is one of four central hospitals in Gauteng. As such, it offers specialised treatment, acts as a referral hospital from other hospitals in the cluster, and is used as a training and teaching hospital. It is linked to the University of Witwatersrand and is held up as a centre of excellence. Ms Bogoshi explained that this is one of the reasons why the MEC has decided that K should be referred to the CMJAH for all of the further treatment she requires, if the court makes an order to this effect. The CMJAH offers the full range of all of the services that K requires. K will be treated as a special patient, meaning that any treatment or equipment that she requires over and above what is already available will be arranged for her by the Hospital at no expense to K.

56. According to Ms Bogoshi, this will ultimately represent a cost saving for the state, as CMJAH uses economies of scale and is able to negotiate better prices with suppliers than in the private sector. There is also no cost to the Hospital for the

individual therapies and treatments that K will receive, as staff are not paid per hour for the treatment they administer, as in the private sector.

57. She explained further that CMJAH does not only have one prospective supplier. They go out on tender for their goods and services at both National and Provincial level. However, off-tender goods and services can also be obtained either through the petty cash, or the buy-out/quotation system. Ms Bogoshi explained that for items of up to R500 000. 00 she has the discretion to authorise procurement on the recommendation of each head of department. For items that K will need, CMJAH would use a combination of tender lists and the buy-out/quotation option, or even petty cash to ensure their procurement. As Ms Bogoshi herself has the authority to put this into action, she assured the court that it would be done.

58. Ms Bogoshi explained the procurement process in detail, with specific reference to how the buy-out system works. Although there is a standard operating procedure regulating buy-outs, the CMJAH had adopted its own terms of reference to make the process more stream-lined. Heads of Department put forward their requests for buy-out/quotation items and the Hospital managers meet every week to go through the requests. If the process has been properly followed, the documents are taken directly to the CEO to authorise. Ms Bogoshi also explained that as CEO she has authority to make her own decisions about procurement in special cases. She had studied the lists of items of equipment that the experts had recommended. Some were already on contract, and for the rest the CMJAH would follow the buy-out/quotation route.

59. When I asked Ms Bogoshi about the budget availability for this, she said that she had already engaged with the Finance Manager of the CMJAH in this regard. They had considered the list of recommended equipment against the line items in the

general budget for items of this nature. All of the equipment could be covered under the existing budgeted line items. If an item had to be bought in on quotation it was unlikely to affect the budget. She explained that even if there is overspending on some line items, there is always room for flexibility to make the necessary adjustments in consultation with the Finance Manager.

60. As far as the actual medical and therapeutic services are concerned, Ms Bogoshi confirmed that the relevant staff at the CMJAH could provide all of the identified services listed by the various experts in their expert minutes within their available resource capabilities.

61. Ms Bogoshi was asked in her evidence in chief about the risks involved in the CMJAH having committed to comply with a court order in respect of K and then not being able to do so. Ms Bogoshi responded that she had thought deeply about the situation. She had decided that the best way to ensure that the identified services were provided to K as ordered was to use the existing case manager system that already operates in the Hospital. Case managers are staff members who are health professionals but who, in addition, have administrative functions. Ms Bogoshi said she would appoint one of the existing case managers, Sister Cindy Verne, who has a BSc degree from Wits, to be K's designated in-house case manager. Sister Verne would be tasked with the administrative oversight and management of the services and items to be provided to K.

62. Ms Bogoshi indicated that Sister Verne would liaise and co-operate with any private case manager that is appointed under the court order. She envisaged that Sister Verne would compile monthly reports and hold meetings with the family members at six-monthly intervals. Ms Bogoshi would receive the monthly reports and attend

at the family meetings. In this way, as CEO, she would be kept abreast of how K's treatment and other services were being managed.

63. Ms Bogoshi was asked for her comments on the impact that court orders requiring lump-sum payments for damages for future medical expenses have on public hospitals and the services that they are obliged to render to the public. She responded that they have a huge impact. One of the difficulties highlighted by Ms Bogoshi is that public hospitals cannot plan for a damages award being made against them. For one reason, these court processes take a long time and so these expenses can't be fitted into the annual budget.

64. In addition, the hospital that was responsible for the negligent conduct in issue is usually held responsible for financing the associated damages awards made against the MEC. Although the Provincial department has centralised the payment of these orders, a journal entry is made against the relevant hospital's provincially allocated budget. By way of example, CMJAH has a budget for goods and services of R1 billion, and an overall budget of R3,6 billion. Any damages awards made against the MEC for negligent acts arising out of CMJAH would ultimately have a negative impact on this. Ms Bogoshi said that this was even more problematic for smaller hospitals, like Leratong, which are allocated smaller budgets. As regards the impact on the provincial department, she estimated that in the 2017/18 financial year, approximately R500m was ordered against public hospitals in Gauteng for damages for medical negligence.[31]

[31] The South African Law Commission, in its Issue Paper 33, Project 141 "Medico-legal Claims" (SALC issue paper) reports that in Gauteng, the amounts paid out for medico-legal claims in public hospitals rose from R8,2 million in 2010/11 to R153, 6 million in 2013/14. The amount of the contingent liabilities in Gauteng as at March 2016 was over R13 billion. Of course, these are not all for cerebral palsy births, but the value of claims is shockingly high over all.

65. I asked Ms Bogoshi about the public perception that patient care was neglected in public hospitals. She was candid about difficulties with, for example, record keeping at the CMJAH, but indicated that they had already embarked on a programme to digitise all records so that the Hospital no longer needed to rely on paper records.

66. Ms Bogoshi accepted that there was a general problem with the standard of nursing care in all hospitals. She said that this was not a problem specific to public hospitals. At CMJAH they were aware of this although they were perhaps less affected. She explained that in a busy hospital like Chris Hani Baragwanath Academic hospital, up to 70 caesarian sections were carried out in one day, whereas at CMJAH they only did about 400 per month, because it was a specialised hospital. Their nursing department was currently undergoing a coaching and training process with a view to improving performance and skill.

67. Ms Bogoshi also pointed out that CMJAH has a resident engineer whose job it is to see that the wards are properly maintained and upgraded. The Hospital is currently in the process of revamping its wards. In fact, there was evidence of this when we conducted the site inspection of the Hospital.

68. The cross-examination of Ms Bogoshi focused on a number of key areas. One of these was what plaintiff's counsel described as the lack of proper planning for the public healthcare defence raised in this case. Ms Bogoshi was questioned about the meetings that had been held to discuss putting the plan for K's treatment at CMJAH in place. The point was made by counsel for the plaintiff that the public healthcare defence was introduced at a late stage in the case, and that after the plaintiff had closed its case in November 2018, no witnesses were available to give the necessary evidence in support of the defence. It was put to Ms Bogoshi that

this showed that no-one had really applied their minds as to how to implement the proposed scheme.

69. In this regard, Ms Bogoshi explained that it was not protocol for her to have discussed the issue directly with the MEC, and she had not done so. Thus, she could not speak to what may have been discussed or planned at the MEC or Head of Department level in respect of K's case. Ms Bogoshi said that she was approached by the MEC's legal team sometime after the joint minutes in the matter had been filed. She understood from the discussion with the legal team that CMJAH had been identified by the Department to render the required services to K because she was already a registered patient at the Hospital, and because CMJAH is a referral hospital. She confirmed that a cost analysis of the exercise had not been conducted for CMJAH.

70. The next focus of attention under cross-examination was on the treatment of K as a special patient, and the fact that she would be the first patient to be dealt with in this way. Ms Bogoshi explained that CMJAH already has the systems in place and the necessary experience to provide K with the services she requires. It therefore made sense for CMJAH to agree to commit to her treatment in the event that the court makes an order to this effect.

71. She also explained that it is not unusual for the Hospital to treat patients as "special" in the sense of arranging for out of the ordinary treatment for them. It is part of the general practice of the Hospital to outsource services for patients if the CMJAH's capacity to render those services at any given time is limited. Ms Bogoshi explained that they have arrangements with other hospitals, both public and private, that if, for example, their ICU unit is full, or a particular surgical procedure cannot be performed at CMJAH, a patient may receive the necessary treatment at another hospital, at the

expense of the CMJAH. In other words, special treatment for patients is not an unusual occurrence for the Hospital.

72. She testified further that even though CMJAH had not been responsible for causing K's injuries, it made sense for CMJAH to accept K as a special patient. The Hospital is a public hospital and, as such, it has an obligation to assist in providing care to patients regardless of where the original negligence occurred. As a referral and specialised hospital it was one of CMJAH's functions to use its resources to assist other hospitals. Ms Bogoshi stressed that she was mindful of the fact that a public hospital had been negligent and had caused harm to K, and that the public healthcare system must make reparation to put things right. In her view, this justified CMJAH committing to being placed under a court order to render all of the services that K would require in the future.

73. Ms Bogoshi said that she saw this type of order to be an opportunity for the public healthcare system to increase efficiencies and to reduce costs. She anticipated that there would be other cases that might need to be treated in the same way. She was aware that the Department had been concerned for many years about the overall impact that damages awards in these cases had on the ability of the public healthcare system to render healthcare services to the public, and of the need to consider alternative solutions. She conceded however that she was not aware if anyone in the Department had done a study as to the costs involved if the plan was extended to other claimants. Although, for her part, as CEO of the CMJAH, she anticipated that she may be asked to take on more special cases.

74. She was asked what she has done as CEO to try to prevent the negligence that gives rise to cases like this. She gave a detailed response, including, among other things: reporting negligent nurses to the Health Professions Council of South Africa;

requiring nurses to report to the CEO for the last 24 hours on shift; weekly mortality meetings with all affected staff; and causing staff who have been responsible for stealing records to be arrested. Ms Bogoshi again was candid about the fact that it could not be said that the CMJAH did not face problems.

75. Counsel for the plaintiff, Ms Munro, took Ms Bogoshi through a range of documents, including newspaper reports, that she (counsel) said demonstrated that the Hospital faced multi-factorial problems that undermined its ability to actually render the services to K that it says it can. I will not list these in any detail as, in my view, many were not relevant to the real issues at hand as regards K's particular needs and the services that can be rendered to her.[32]

76. Ms Bogoshi dealt directly and without hesitation with the issues that were put to her in this regard. She had full knowledge of all of the incidents and was able to provide additional information not contained in the reports.

77. Ms Bogoshi was shown a SA Medical Journal article about senior medical staff complaining about unsatisfactory budget controls. Ms Bogoshi explained that this pre-dated her tenure as CEO (the article was from 2011), and in any event, she said that the procurement process at CMJAH had been completely overhauled since then to obviate those problems. Counsel also raised with her reported problems with the Gauteng Shared Services Centre in the procurement process Ms Bogoshi responded that the GSSC had been dismantled some time ago and that the Hospital now did its own procurement. She reiterated that the current system allowed for the unproblematic procurement of all of K's equipment needs.

[32] For example, one report was about junior medical staff going on strike, vandalizing hospital property and blocking access to parts of the Hospital in a pay dispute. Another was about a miscarried foetus that had been found among medical waste in a sluice room.

78. She was asked about underspending by the Provincial Government, the implication being that if the Provincial health department was underspending, it could not claim a need to reduce the costs of delictual awards made against it by raising the public healthcare defence. Ms Bogoshi responded that there can be many reasons for underspending. For example, in the hospital environment it may be because a particularly expensive item of equipment is budgeted for in one period but delivery and installation is delayed and thus payment only occurs in the next budgetary period. She conceded, however, that irregular spending presented difficulties. However, she said that as CEO, she had taken steps to deal with this.

79. Ms Bogoshi was also questioned about vacant posts as reported by the Gauteng Provincial health department, the implication here being that the CMJAH is understaffed. She explained that at CMJAH there was only around an 8% vacancy rate for all staff. As far as medical staff were concerned, she explained that the Provincial vacancy figures (which were higher) included doctors who are appointed on contract while they were specialising. When their specialisation period is over, their contracts automatically come to an end and they are reflected as having become vacant. Because CMJAH is a teaching hospital it has many contract appointments on this basis. Thus, she explained, the actual vacancy rate of permanent medical staff is much lower than was reflected.

80. Ms Bogoshi was a most impressive witness. She did not shy away from answering the hard questions that were put to her. From her evidence it was clear to me that she is a hands-on manager who understands her hospital, its systems and processes, and its challenges very well. She presented as a dedicated professional who was committed to the public healthcare system. Her answers to the issues raised with her by counsel were reassuring and demonstrated that one must be careful to draw negative conclusions from what one sees on paper.

81. The second management witness for the defendant was the ADDG, Dr Modisane. He testified that his main duty is to ensure that hospital services in the Province function properly and that quality medical services are provided to health care users in the Province.

82. In his evidence in chief Dr Modisane was asked how public hospitals would cope if the services that the MEC was proposing for K were to be extended to other litigants in a similar position. He answered by saying that the Department had adopted a strategic view of, and plan for, the problem it faced in being held liable for delictual damages in numerous actions involving cerebral palsy births. According to Dr Modisane, the plan involves extending the services that are currently on offer in public hospitals to enable them to provide to other successful litigants the same type of service that they are able at present to provide to K. He said that the plan was to expand beyond the CMJAH and to involve all four of the central hospitals in the treatment of these patients. He acknowledged that it would require an increase in resources to ensure that successful litigants could be treated as priority patients within the public healthcare system.

83. Dr Modisane stated that the strategy was being co-ordinated by him and the four heads of departments of paediatrics at the central hospitals involved. The plan was to develop these hospitals as centres of excellence. This would be for the ultimate benefit of all cerebral palsy patients, including, but not limited to, those who are successful litigants, like K.

84. According to Dr Modisane, his job in the Department is to make sure that the four hospitals that it is envisaged will be involved in the extended scheme are properly funded for this purpose, in terms of the additional personnel and equipment they might need. He confirmed that the HOD and the Director General were supportive

of, and were involved in, the plan. Further, the MEC had been briefed and it had his support.

85. One of the possibilities that the Department was also giving consideration to was to involve the Nelson Mandela Children's Hospital (NMRH) in the provision of services to patients like K. He said that the NMCH was also a referral hospital but was under-utilised at present. This would not affect K, who would be a patient at CMJAH, but it might be that in future, NMCH could become the focal point of treatment for other litigants.

86. Dr Modisane confirmed that he had specifically undertaken an inspection visit of all the clinical units at the CMJAH who would be rendering services to K for purposes of the case. He said that he was satisfied that these units provide an excellent service and that they have the capacity to provide K with the services that she requires. He went on to confirm that the Provincial Department of Health was fully supportive of the CMJAH's approach in this case.

87. Under cross-examination he was asked if there was anything in writing from the DG or the MEC about the extended plan. Dr Modisane said that a policy framework had been drafted and had been sent to the HOD. It was based on the plan to develop centres of excellence for cerebral palsy that he and the heads of paediatrics from the central hospitals were working on. Once the HOD had ratified it, it would become official policy. He said that although it is a long-term plan, to the extent that the resources are already available in public hospitals, it can be implemented immediately.

88. He confirmed that as far as K is concerned, the only additional resources that will be necessary will be for additional items of equipment, but that these can be covered in the budget as it already stands. On the contrary, he said, monetary damages are

not budgeted for in the course of ordinary budget planning. He said that the idea behind the strategy was to adopt an alternative approach to paying out large sums of money to private healthcare providers when the equivalent level of service was available in the public sector, with the additional benefit of that service being multidisciplinary. The Department's view was that this approach best served the needs of the affected patients.

89. Counsel for the plaintiff took Dr Modisane through a press article involving an interview with the newly appointed MEC, Dr Masuku. Dr Modisane agreed with the sentiments expressed by Dr Masuku about staff not being happy because they are overworked; the need for quality healthcare and the priority being to ensure that all hospitals are functioning properly before new hospitals are built. Dr Masuku agreed that there were problems in the public healthcare system.

90. It was put to him that the strategic plan to develop centres of excellence for cerebral palsy at the central hospitals might look good on paper but that there was no knowledge yet about how it would work in practice. It was put to him that K was being used as a guinea pig by the Department. Dr Modisane denied this. He said that the plan was aimed at reprioritising this area of work in the public healthcare system. He had made a request for budget of R700 billion for the plan, and R500 million for the next year. This accorded with the R500 million that the Department has paid out in medical damages claims each year for the last two years.

91. Like Ms Bogoshi, Dr Modisane did not shy away from hard questions. He was ready to accept that the public healthcare sector faces challenges. It was plain from his evidence that much planning still needs to be done to implement the longer term goal of developing centres of excellence for cerebral palsy patients. However, the important point he made is that where the facilities already exist, then there is no

reason to delay implementation while the longer-term plan takes shape. The question that arises is whether CMJAH is in a position to render the services that are required by K and, in effect, to operate as her own centre of excellence. The evidence given by the specialists in the field was directed at giving an answer to this question.

Evidence of the medical specialists at CMJAH who would be involved in K's care

92. It is useful to start with the evidence of Dr Thomson, as the case presented by the MEC is to the effect that Dr Thomson's unit, i.e. the Neurodevelopmental Clinic (ND Clinic) will provide the primary base for K at the CMJAH. As I indicated earlier, K has attended the ND Clinic over the years, as reflected in the medical reports I will refer to shortly.

93. Dr Thomson testified that the ND Clinic is a unit within the Paediatric and Child Heath Department at the Hospital. The department has a team of paediatricians with a number of sub-specialties. The ND Clinic functions by providing a home base for children within the CMJAH for children with cerebral palsy and other neurological diagnoses.

94. The Clinic is supported by, and has access to, a range of, specialist services at CMJAH, including paediatric orthopaedics, paediatric surgery, child psychiatry, ENT, ophthalmology, radiology and nuclear medicine services. It also has access to allied health services such as speech and audiology, physiotherapy, dietetics, occupational therapy and social workers. In addition, it has access to the National Health Laboratory Services, and the Pharmacy, which are operated from the CMJAH.

95. According to Dr Thomson, the model on which the ND Clinic operates is that it provides a multidisciplinary and holistic form of treatment for patients like K. In Dr Thomson's view, this model has the advantage that the sub-specialties and allied services work closely with the ND Clinic, and thus are readily available to meet the patient's needs. The ND Clinic develops a close co-working relationship with all specialties who are involved in a child's treatment. This allows for a directed plan to be put in place for the treatment of their patients and it means that they can keep track of her treatment as a whole. The ND Clinic acts as the patient's primary caregiver in terms of overseeing all of the treatments provided both inside and outside the Clinic within the broader CMJAH.

96. Dr Thomson provided the breakdown of the staff component of the ND Clinic itself, which includes 9 doctors, 5 nurses, 4 administrative personnel, 5 therapists (occupational therapist, physiotherapists and speech therapists) and a social worker.

97. The ND Clinic offers ongoing diagnostic services, multidisciplinary management and management of co-morbidity services to its patients. Dr Thomson considered all of the medications listed by the experts in their joint minutes and confirmed that these were available in the Pharmacy and that the ND Clinic could source these for K. If stocks ran low (as it sometimes does for the Melatonin medication) Dr Thomson had been advised by the CEO that she (the CEO) could be directly approached to ensure the medication was obtained for K without undue delay.

98. Dr Thomson also confirmed that MRI facilities are available at the CMJAH and that they could arrange for K to undergo MRIs when necessary, as assessed by the individual treating physician responsible for K. She further confirmed that K could receive the extended EEG telemetry scanning facilities that were available at

CMJAH. She would also be able to receive the recommended physiotherapy, speech and communication therapy, dietetic services, and occupational therapy either in the ND Clinic itself, or in the specialist units at the Hospital.

99. Under cross-examination, Dr Thomson was questioned on the number of patients registered at the ND Clinic and the capacity of the Clinic to see to their needs. She gave a detailed response. In brief, she confirmed that in general most children who are registered patients at the ND Clinic are seen once every four months, but this is variable. Some children need to be seen more regularly by doctors, and they have the capacity to do so. It depends on how stable the child is, and whether treatment is required more regularly. Although they hold regular clinics for non-registered patients, existing patients are primarily seen by the same doctor each time they come to the ND Clinic. K would be seen either by Dr Thomson herself, or by Dr Bezuidenhout.

100. Dr Thomson was questioned about the MEC's plan to treat K as a priority patient at the CMJAH. Dr Thomson explained that although K would be regarded as a priority patient, she would receive the same level of care and medical services as all other patients in the ND Clinic. Where K would be given priority is in her appointments, meaning that she would not have to wait in a queue, and in this sense she would have priority access to the services on offer. Also, if K came into casualty, Dr Thomson or Dr Bezuidenhout would be alerted so that they could be kept abreast of, and co-ordinate any further treatment that K might need.

101. It was also put to Dr Thomson that by giving K priority treatment this would necessarily mean that other patients would be short-changed in the services they received. Dr Thomson did not agree with this proposition. She said that the only difference between the way in which K would be dealt with in the ND Clinic is that

she would be able to access services at a pre-arranged and particular time. This would not have any negative impact on the services the ND Clinic was able to render to all its other patients.

102. Dr Thomson was asked about the facilities in the Clinic. She confirmed that all consultations in the ND Clinic were conducted in private consultation rooms, and that the Clinic had enough rooms to ensure that an individual patient was seen by a doctor in one room. The ND Clinic also had its own waiting room, with an associated ward available to its patients.

103. According to Dr Thomson, there would be no difficulty in terms of the capacity of the ND Clinic to provide the necessary services to K. When she was asked whether the Clinic would not be overburdened if the same priority service was rolled out to other litigants, like K, Dr Thomson responded that this was an important issue, and that the Department of Health, Gauteng, would have to make sure that sufficient facilities were provided in the event of such a "roll-out". Dr Thomson did not know whether any feasibility studies had been done by the Gauteng Department as to the costs of treating K and the costs of such a roll-out to other litigants.

104. Dr Thomson said that the ND Clinic and paediatric department did not suffer from a high turnover of staff. On the contrary, the department had many permanent staff that had been there for a number of years. In her view, it is a functional department with a very low rate of turnover among permanent staff.

105. Dr Thomson was asked in cross-examination whether it was her firm view that the treatment that K would receive at CMJAH was akin to the level of care and treatment that she would receive in the private sector. Without hesitation, Dr Thomson replied that this was indeed her view, and that, in fact, with the holistic care that was

provided through the ND Clinic, the CMJAH actually offered a better level of service than that available through the private healthcare sector.

106. Dr Thomson received some criticism under cross-examination as to the treatment that K had received prior to the litigation, when she was a patient at the ND Clinic. It was put to her that K's hips had not been properly monitored during this time. When it was put to Dr Thomson that something had been missed in this regard, she agreed that it might look like this was the case. However, she said that from the medical notes it was clear that K's hips had been x-rayed at the CMJAH when she had attended the ND Clinic. This is an issue that was taken up in more detail with Prof Robertson, to whose evidence I now turn.

107. Prof Robertson gave evidence as to the orthopaedic services that could be offered to K at the CMJAH. He confirmed that through his Unit they could provide K with ongoing and regular monitoring of her musculoskeletal condition, with a full diagnostic and management plan. The Unit was fully equipped and capable of performing all the possible orthopaedic surgeries K might need. It was equipped to deal with any fractures, and to treat her underlying osteoporosis. It could also provide K with her Botox treatment, as it frequently does with other cerebral palsy patients.

108. He confirmed that he and his staff work in close collaboration with the ND Clinic and allied disciplines. They hold a monthly Combined Clinic specifically to deal with cerebral palsy patients. They have two full-day elective theatre lists per week, and are staffed by two orthopaedic surgeons, junior doctors, a full complement of trained nursing staff and a physiotherapist. It also has its own ward, which is child-friendly and dedicated to children only.

109. He was asked in his evidence in chief to comment on the medical notes dealing with the history of K's right hip. Subluxation of the right hip was diagnosed by Dr Firth, the plaintiff's expert orthopaedic surgeon, in his medico-legal report in May 2016. Dr Firth noted that it presented a risk of surgery. It was diagnosed again in May 2018 by the defendant's expert orthopaedic surgeon, Dr Ramakgopa, in his medico-legal report. He noted that it may need surgical containment to prevent dislocation.

110. K's notes from the ND Clinic noted in May 2018 that there was subluxation of the right hip, and that there was a risk of the femur head dislocating. The notes record that K's mother was offered surgical intervention, and that she wanted to discuss this with her family first before deciding. The next ND Clinic notes, dated 9 November 2018, record that K's mother had decided against the surgical option. However, shortly before this latter note, Dr Firth had recorded in his second medico-legal report dated 16 October 2018 that the hip was now dislocated.

111. When asked to comment, Prof Robertson explained that a displacement prevention operation would not have been recommended before 2016, as K was too young. There is an ideal window period for the operation, i.e. between when the child is too young and when it is too late to prevent the dislocation. At the ND Clinic visit in May 2018, the attending orthopaedic surgeon and Prof Robertson saw an X-ray of the hip for the first time. Prof Robertson explained that prior to this time it had not been routine to use x-ray screening for monitoring hip subluxation in cerebral palsy cases. It was a relatively new screening practice that was only introduced at CMJAH towards the end of 2017.

112. When they saw the x-ray results, they presented K's mother with the option of a preventative operation, but she ultimately decided not to proceed with it. Prof Robertson that this is not a decision he would criticise as there are many risks

involved in this type of surgery for patients like K, who are very fragile. He understood and respected K's mother's decision.

113. Under cross-examination Prof Robertson was questioned about the resources available and the capacity of his Unit to treat patients like K. He explained that for the Botox treatment there is no waiting list, as it is a quick procedure. The treatment generally can be performed within a week or two of it being recommended. The paediatric orthopaedic theatre is very well equipped with what Prof Robertson referred to as state-of-the-art equipment.

114. He said that there is a waiting list for the theatre, but it is not usually long, with most delays usually coming from the patient's own availability. They make surgical bookings two months in advance, but always leave theatre slots open for urgent cases. He confirmed that his theatre lists are not overloaded. According to Prof Robertson paediatric orthopaedic surgery is a growing field with registrars who are keen to specialise. He has a full complement of surgical staff at the moment and does not require any new posts to be created. He conceded that if the "floodgates" were opened, and his Unit was inundated with litigants like K, who were required to be treated as a priority, a different approach would have to be adopted. He suggested that it might be possible to partner with the Nelson Mandela Children's Hospital (NMCH) to deal with an increased number of cerebral palsy patients. He noted that he has previously partnered with the NMCH when ICU services have been in short supply at CMJAH. He stressed that all ICUs, whether public or private, were under stress.

115. I deal next with Dr Mohamed, who was the MEC's witness to testify to the psychiatric services available at CMJAH.

116. She confirmed that K was not receiving psychiatric services at the moment. (I should add in this regard that it is common cause that at present K does not manifest a need for psychiatric care. The evidence led by the plaintiff indicated that there is a possibility that she will need this care in the future). Dr Mohamed testified that if K's carers raised any concerns in the future about her psychiatric state, for example, if she displayed aggression, head-banging or agitation, the Child and Adolescent Family Unit at CMJAH could do an assessment of her psychiatric needs.

117. This Unit works very closely with Dr Thomson's ND Clinic. Their practice is to communicate with the Clinic about any psychiatric concerns the Clinic has about any of their patients. The Child and Adolescent Family Unit then conducts the appropriate assessment and provides whatever treatment is required. In addition, there is an adult psychiatric unit at CMJAH to which Dr Mohamed could refer K when she is older, or K's mother, should she need assistance.

118. Under cross-examination she was asked how K would be prioritised if she needed the services of the Child and Adolescent Family Unit. Dr Mohamed explained that although they would bear in mind that she was to be regarded as a priority patient, the Unit only operates on an appointment system in any event. In terms of the Unit's capacity, Dr Mohamed testified that they have spare capacity to take on additional patients and that they are currently doing so. She confirmed also that all of the psychiatric medication listed by the experts in the joint minutes was available from the CMJAH.

119. I consider next the evidence of Dr Ahmed, who testified as to the urology services available at the CMJAH.

120. He confirmed that all of the services identified in the joint minute of the experts are readily available at the hospital and would be available to K. These included

urodynamic studies, catheters and related equipment, medication (which he confirmed they use all the time), blood and urine tests, treatment for urinary tract infections, and renal ultrasounds. He stated under cross-examination that blood test results are usually available within hours and Registrars receive the results on their mobile phones.

121. As to K's prioritised status, Dr Ahmed said that although patients in general can wait to secure urology services at the hospital, they do not have a waiting time for urgent cases, and they would treat K as if she was an urgent patient so that she would not have to wait. In addition, his department would put a protocol in place to short-circuit the normal route if required.

122. Dr Ahmed said under cross-examination that his unit sees about 1-2 cerebral palsy patients per month. He also agreed that if the load of special patients was to be increased so that their ability to conduct routine procedures was affected, the CEO would have to provide additional resources.

123. The capacity of CMJH to provide dental services was dealt with by Dr Patel.

124. He testified that the Wits Oral Health Clinic is a joint initiative between Wits and the Gauteng Health Department. It is situated at the CMJAH. It offers specialised treatment and is a teaching unit for dental students. It is a referral clinic for a range of public and private dental clinics in the area.

125. He testified that the clinic offers a very high standard of care for cerebral palsy patients. While there is a waiting list for patients who require general anaesthetic for the treatments, cerebral palsy patients (who are usually treated under general anaesthetic) are usually given priority time in theatre. For general dental care there

is usually a waiting time of four to five months for non-urgent patients, but urgent cases get prioritised.

126. He confirmed that they would be able to attend to K on a regular basis within their current workload, and that her recommended treatment of a once per year examination under general anaesthetic could also be accommodated for the remainder of her life. When asked how many more patients like K they could accommodate, he replied that they had a lot of capacity, as the clinic was well staffed. They have 90 dental chairs, and three to four sessions per day. He also confirmed that the recommended dental consumables and equipment was readily available in the clinic, or could be accommodated in their budget and provided to K.

127. Dr Makualele testified as to the relevant ear, nose and throat services available at CMJAH.

128. The joint minute of the experts referred to the need to make provision for a submandibular duct relocation surgery. Dr Makualele testified that there are different types of gland and duct surgeries available to treat the hyper salivation affecting K. At the CMJAH they do a range of these surgeries at least once a week. He also testified that another treatment option was Botox.

129. However, he stated that the particular surgery recommended in the joint minute is not done routinely at the hospital. He has never performed that particular surgery, but he testified that this would not present any problem as external surgeons are brought in to the hospital on occasion to conduct operations. If necessary, this could be done in K's case. In any event, the department would make its own assessment of which of the available treatment options (including surgical options) would be most appropriate for K. It may be that an alternative to the recommended treatment would be more suitable. The ND Clinic notes recorded that while K had

had Botox treatment previously for her hyper salivation, K's mother did not want the treatment repeated.

130. Under cross-examination, Dr Makualele said that there is one theatre set aside for ENT surgeries on three days per week. For non-urgent patients there is a waiting list, but for a procedure such as K might need, the wait would be between 2 weeks and a month. He explained that if K was admitted for gland surgery she would be in hospital for 2-3 days, with one night in ICU so that she could be monitored. He confirmed that the staff at CMJAH could deal with complications arising from the surgery. He said that the most serious complication is bleeding in the area, but this is rare.

Evidence of the auxiliary therapists and orthotist

131. As to the auxiliary therapies, Ms Mukheli testified about physiotherapy services available at the CMJAH, and what could be provided to K.

132. She clarified that because the Hospital is a specialised and academic facility, patients are referred for physiotherapy from other hospitals. The CMJAH focuses on acute and specialised patients. For other patients, it is the general practice within the cluster system for patient to receive their physiotherapy at a clinic closer to them. These services are available at many of the clinics.

133. Ms Mukheli said that K was registered as a patient at the CMJAH and had attended the Friday clinics at the ND Clinic over a number of years. She had been assessed on these occasions by an occupational therapist, for her visual issues, and a physiotherapist. The ND Clinic notes referred to earlier in relation to K's hip were notes from these Friday clinics. It seems from Ms Mukheli's evidence, and that of K's mother, that K had been referred to a local facility for her physiotherapy sessions

when she turned six. This was in line with the general policy applying to paediatric patients who are older than six.

134. As to the proposed treatment of K if a court order of the kind the MEC proposed was made, Ms Mukheli confirmed that in that case K would be treated as a specialised patient and would receive all of her treatment in the specialised unit at the CMJAH. She would no longer go to her local clinic for this treatment.

135. Ms Mukheli further confirmed that the unit would be able to provide all of the physiotherapy treatments recorded in the joint minute of the experts. They would be able to accommodate K for two sessions per week, once in the physiotherapy unit itself, and the second when K attended the ND Clinic on a Friday. In this way, K would receive the 60 sessions of physiotherapy recommended by the experts. When questioned whether the specialised physiotherapy unit had the capacity to deal with K on the more regular basis required, Ms Mukheli assured the court that because they deal only with specialised patients, their patient load is not heavy and they would be able to accommodate K.

136. Ms Mukheli also confirmed that post-operative physiotherapy, pulmonary physiotherapy and post-Botox physiotherapy is already undertaken at the CMJAH and would be available for K in the event that she needed it. Ms Mukheli was taken through the list of items that were recommended by the experts in their joint minute. She confirmed that:

136.1. A Pronestander was already on tender and could be acquired for K.

136.2. She had also previously obtained the plinth that was recommended, and this could be acquired for K.

136.3. They would be able to obtain a hoist on quotation.

136.4. Cerebral Palsy car seats were already on tender at the Hospital, and one could be acquired for K.

136.5. If the speech therapist and ENT surgeon recommended a nebuliser and suction for K, this could be obtained on quotation.

136.6. The sidepositioner was already on tender at the Hospital and one could be obtained for K.

137. Under cross-examination, Ms Mukheli confirmed Ms Bogoshi's explanation of how the procurement system works. She said that for items on tender, they can usually be obtained within a month, and on quotation it takes a little longer, perhaps up to 3 months. However, the Hospital can lend items, such as a nebuliser and suction, to patients like K, if necessary, in the interim.

138. Ms Mukheli was asked if they could accommodate another 10 patients like K, as specialised patients. She responded that with their present resources they could probably accommodate 2, but not 10 special patients. It was put to Ms Mukheli that the plaintiff would argue that the physiotherapy unit at the CMJAH does not have sufficient resources to provide the services K requires at the same level as in the private healthcare sector. Ms Mukheli did not agree with this proposition. She pointed out that two of her staff in the unit were specifically trained as neurodevelopmental specialists, and Ms Mukheli herself has a Masters in paediatric physiotherapy. This presented a far richer source of cross-experience than is generally available in the private sector.

139. It also put to Ms Mukheli that the plaintiff would argue that the treatment that had been given to K thus far had been sub-par, as her hip displacement had been missed. The plaintiff would argue that this could have been avoided by one or two

dedicated specialists working with K, and it was this level of care that K required in the future. Ms Mukheli responded that she agreed that K should receive dedicated care, but that this was precisely the plan that would be put in place for her in the physiotherapy unit at CMJAH. Their unit works on the basis that a patient who is referred there sees the same therapist all the time. K would be assigned either to Ms Mukheli herself, or to Ms De Kock who was completing her Masters in neurodevelopment. Further, the turnover rate in the unit was very low. Ms Mukheli said that since she had been there in 2016 there had been no resignations.

140. Ms Jogianna gave evidence as to the speech therapy/audiology services available at the CMJAH.

141. She explained that her unit works in a multidisciplinary manner with the physiotherapists, occupational therapists, dietician and the ear nose and throat specialist dealing with a patient. They also work in close collaboration with the ND Clinic, and form part of the multidisciplinary team managing the Clinic's patients. Their approach is to involve not only the patient but also the family in their intervention programmes. They provide the families with skills that they can use at home to carry through with the interventions they are putting in place during therapy sessions. This is a normal part of the therapy on offer. Ms Jogianna said that in the case of K, who may be assisted not only by family members but also caregivers, they would put the same system in place for the caregivers.

142. Ms Jogianna confirmed that according to K's assessments, the cerebral palsy had left her with very limited ability to communicate. She was not able to speak. In a case like this, they would look at alternative and augmented communication (AAC) devices to promote her communication skills. K had potential to use eye-gaze communication. The unit has a number of AAC devices in their trial stock. They

use these with patients in therapy to see which works best for them. Once a device is identified, they place one on order for the patient. These items are all on tender and so there is no difficulty in acquiring them. They have also previously ordered devices that are not on tender to suit a particular patient's needs.

143. Ms Jogianna went through the full list of therapies and items that the joint experts had recommended for K and confirmed that this could all be made available to her in the unit. In respect of any items that are not already on tender, as K was to be treated as a special patient, the CEO would be able to use her discretion to authorise any devices or items outside the tender list. As to the hours of therapy recommended, Ms Jogianna said that they could meet them and would even go beyond what had been recommended if they assessed that this is what K needed.

144. Under cross-examination Ms Jogianna was questioned on the possibility that K might be denied an AAC device because of strained resources. She was asked what would happen if despite Dr Levin (the plaintiff's speech therapy expert) having recommended particular devices, the unit disagreed. Ms Jogianna responded that it was always a question of assessing, through therapy sessions, what the patient's potential for using AAC devices was, and what devices would be most suited to that potential. Until a patient, like K, was assessed as having the skills to manipulate a device, one wouldn't be acquired. She stressed that this was not an individual decision, but involves a process, and monitoring over a period before a decision to acquire a device is made.

145. As to the occupational therapy services at CMJAH, Ms Yip gave evidence for the MEC.

146. She confirmed that they would be able to provide all of the occupational therapy recommended by the experts in their joint minute. Depending on a patient's

diagnosis, they see patients weekly or even twice weekly if required. They would be able to accommodate K in this regard. They could also arrange home or school visits if this was required, although they do not usually do so.

147. As to the items recommended by the experts in their joint minute, Ms Yip indicated that the wheelchair recommended, the Netti, was not the wheelchair that was on tender at the CMJAH. However, in the case of K, the CEO would be able to secure the wheelchair on the buy-out or quotation system. The same pertained to the other items listed in the report: if not on tender they would be acquired. She said that the lightweight buggy recommended is already on tender. The disposable/consumable items listed by the experts could be secured through the Pharmacy at the Hospital. As to re-uphostering and seating, this was part of what the occupational therapy unit at the CMJAH does in the normal course for all of their patients. They also make their own static wrist hand orthosis as a standard practice and would be able to do so for K. The unit makes its own pressure garments, but they are not the same as the garments that are recommended by the experts to avoid scoliosis.

148. Under cross-examination, Ms Yip was asked how the plaintiff and case manager would be able to keep track of what was being done for K in the occupational therapy department if the court made an order that she should be treated there. She responded that she monitors the notes of all the therapists in the unit and when they are involved in their sessions. In addition, the paediatric chief is the head of the entire paediatric department and also has access to all the notes of the therapists. Ms Yip would ensure that K would be assigned to a specific therapist for her care. She would receive both individual and group therapy. In terms of staff turn-over, she indicated that the senior staff had been there for between 6 and 10 years. Through their clinical training programme, in which Ms Yip is involved, they are training newer members of staff for succession planning.

149. Ms Steynberg gave evidence about the dietetic services available at the CMJAH which could be made available to K.

150. She confirmed that they would be able to assess K in her unit and provide monthly (as opposed to the two-monthly recommended) follow-up sessions, as they generally see patients every month. Ms Steynberg confirmed that the paediatric feeds recommended by the experts are available at the CMJAH. A new tender was in the process of being implemented, as the existing tender was due to expire. Ms Steynberg saw no reason why the feeds would not continue to be available. She confirmed that they are more cheaply available to the Hospital than in the private sector, and illustrated this by way of a schedule of prices.

151. In addition, they would be able to increase K's protein supplement, which appeared to be low, and provide all the immune boosters and other supplements recommended. A blender and steamer could be obtained on the buy-out/quotation system. They could also provide all the equipment necessary if a PEG was installed for K. She said that the installation of a PEG is a procedure that is commonly performed at the CMJAH, and if K needed to be fitted with one, it would be installed by a gastroenterologist at the Hospital.

152. They would monitor her growth once a month. K would be given a monthly appointment and would not have to wait in a queue. Her blood tests could be done at the same time and analysed at the Hospital.

153. Under cross-examination, Ms Steynberg was asked about the numbers of patients they see and their staff capacity. She gave the relevant details and said that they had the capacity to take on "another 20 K's", although this might mean shifting more dieticians to the paediatric section. The hospital policy is always to put disabled patients first, and they do not have a waiting list for dietetic services. She agreed

with counsel's point that thus far K's ND Clinic records showed that she had not been monitored on a cerebral palsy weight chart.

154. The final auxiliary services witness was Mr Machaba, who testified as to the orthotic services that would be available to K via the orthopaedic workshop situated at the Chris Hani Baragwanath Academic Hospital.

155. He explained that the workshop is a central one that services a number of hospitals, including the CMJAH. Patients are referred to them from the various hospitals. For orthotics, they make a mold from the patient's leg, which is then used to manufacture a surgical boot. The prosthetic shoe is made of leather and fastened either with Velcro or laces. He testified that they could make a shoe like the one reflected in the plaintiff's orthotists report, but that it would be at considerably cheaper cost. This is because the public is usually charged 10% of the manufacturing cost for orthotic shoes in public hospitals. Mr Machaba confirmed that in the workshop they regularly see cerebral palsy patients and fit them with orthotics. They also do repairs, and have repair days every week when items can be brought in for repair. He said that the KAFO is usually made of plastic so that it does not break.

156. Mr Machaba confirmed that the workshop would be able to supply K with the items that were recommended by the experts in their joint minute including the KAFO, AFOFC, orthotic footwear modification, and replacements. They would also be able to conduct the necessary consultations with her, including individualised appointments when necessary.

157. Mr Machaba refuted the suggestion that the workshop offers an inferior service to that offered in the private sector. He pointed out that all orthotists go through the same training, they generally use the same range of material to manufacture the

orthotics, and that in the workshop they had all the machinery, expertise and the time to provide K with what she needs.

COGENCY OF THE EVIDENCE

158. The question that must now be considered is whether the above evidence is sufficiently cogent to establish that insofar as the identified services are concerned these are available to K at the CMJAH at a level that is comparable with those in the private sector. If I conclude that this has been established, I must consider the implications for the public healthcare defence raised by the MEC, and the plaintiff's opposition to it.

159. The first salient point I draw from the evidence adduced on behalf of the MEC is that all of the medical procedures and therapies that K will need in the future are available and can be provided by the specialists who are employed at the CMJAH. Each of the specialist doctors and therapists gave detailed and undoubtedly credible evidence in this regard. All of them impressed me with their professionalism and their clear and genuine commitment to their obligations, as employees in the public healthcare sector, to render the best service possible to their patients.

160. Each of these witnesses confirmed that they could treat K and provide her with all of the procedures, care and therapies agreed to by the experts in the joint minutes. They were asked about the capacity in their units to do so, the numbers of patients that they see in general, and the turnover rate of staff. Each of them was able to explain how K could be accommodated within their existing resource capabilities. It is clear from their evidence that they service very many patients, but there was no indication that they do not have the capacity to accommodate K in terms of the services she requires.

161. Allied to this point is that of the level of service offered at the CMJAH. Counsel for the plaintiff put to a number of the witnesses that the level of service offered at the Hospital is inferior to that offered in the private sector. There is perhaps a common public perception that public hospitals provide bad service. This is no doubt fostered by the unfortunate number of medical negligence incidents that occur in the public healthcare sector. However, it is important to keep in mind that I must deal with the evidence before me.

162. The evidence shows that CMJAH is a teaching and learning centre that is used to train all doctors and allied disciplines studying at the University of the Witwatersrand. It is staffed by highly qualified specialists, as evidenced by each and every witness who appeared before me. In addition, if one considers the staff component of the various units, which formed part of most of the witness statements, the other members of the units in general are equally well-qualified.

163. As a central, referral hospital CMJAH is in the fortunate position that it receives, and is thus geared to treating, patients who require specialised care. As a teaching and learning institution, and a specialised hospital, it is regarded in the public healthcare sector as a centre of excellence. If K receives her treatment at CMJAH she will be part of the specialised care to which the Hospital is geared to provide, and she will be treated by highly qualified members of staff.

164. In addition to the evidence of the witnesses, the site visit allowed the court to see for itself what facilities were on offer and to interact with ordinary members of staff who had not been called as witnesses. Although Ms Bogoshi conceded in her evidence that in terms of its infrastructure CMJAH is old, and needs a high level of maintenance, it seemed to me that there was nothing shoddy about the units we visited. While some corridors might need a lick of paint, the sections of the building

catering to paediatrics stood out with their colourful wall murals and child-friendly decorations. The wards we visited looked clean, comfortable and well equipped. The operating theatres were a model of modernity, and the dental section was very impressive.

165. The ND Clinic was well set up, with sufficient space, both general and private, to accommodate the needs of its patients. We were invited to observe a visual stimulation therapy session with a young cerebral palsy patient conducted by an occupational therapist and a physiotherapist. The patient's mother was in attendance. It was clear from the interaction between Dr Thomson, the therapists and the mom that there was a well-established bond between the patient, his mother and the ND Clinic.

166. We were also shown around the physiotherapy, occupational therapy, speech therapy units and the Child and Adolescent Family Unit. They look well-equipped, and the staff we spoke to were knowledgeble, helpful and informative. There was an utter absence of the chaos the public assumes goes on in public hospitals.

167. As I have already noted, a lot was made in Ms Bogoshi's cross-examination about various issues that it was contended impacted negatively on the quality of service that K could expect at CMJAH. Most of these were directed at a very general level, and did not deal with the actual quality of care that K could expect from the ND Clinic, or from any of the other specialised units that would be treating her. In my view, they do not disturb the evidence adduced by the MEC on this score.

168. Something was also made by the plaintiff about the fact that K's hip had deteriorated from subluxation to actual dislocation without the staff who had seen her at the CMJAH properly monitoring the situation. I gather from all the evidence at hand that this particular injury is not uncommon with cerebral palsy patients: subluxation can

develop into dislocation. It is so that preventative surgery can be performed. However, Prof Robertson was clear in his evidence that this is always a risky procedure for cerebral palsy patients because of their fragility. The medical notes from the ND Clinic show that the staff who saw K at the CMJAH noted the problematic condition of the right hip. According to Prof Robertson, it was only from the end of 2017 that x-rays were conducted as a routine measure to monitor this particular condition in cerebral palsy patients. This was not because the Hospital was remiss in this regard: it was a newer monitoring technique that was adopted in South Africa at that time from studies done in Australia.

169. At this first x-ray scan, the plaintiff was offered hip surgery for K, but refused the treatment. Her refusal was understandable, and it was not up to the Hospital to press her in this regard. While in theory it may have been possible to offer this treatment to the plaintiff earlier, I do not consider that any blame can be laid at the door of the Hospital in this regard. Monitoring was done and when the severity of the problem became apparent, the plaintiff was offered surgery. On the facts, there is nothing to indicate that K's situation would have been any different had the Hospital done so sooner.

170. I have no doubt whatsoever that the medical and therapeutic care that K would receive at CMJAH is at least as good as that which she could receive in the private sector. In addition, I am persuaded by the evidence given by Dr Thomson and some of the other witnesses about the advantages of having all K's needs met in one multi-disciplinary setting. The CMJAH provides for this. It has the advantage of cutting down on unnecessary traveling time for K, as she would receive all her therapies in one place and, insofar as is practical, they would be arranged concurrently, for her convenience. She will be serviced by a multi-disciplinary team of experts who are in constant and regular communication with each other. This

can only be seen as an advantage that K would not receive if she secured therapies and medical care from independent private practitioners.

171. What of the equipment and other items recommended by the experts in the joint minute? I need not repeat any of the evidence given in this regard. What it demonstrates is that almost all of this equipment and the items identified can be procured through the CMJAH. The court heard evidence about how the procurement system works. Some of the items are already on tender and can simply be ordered. Even for those items that are not on the tender list, none of them exceed Ms Bogoshi's discretionary limit of R500 000. 00. The evidence shows that they can be ordered and paid for within the Hospital's existing budget. Furthermore, the evidence indicates that there should be no undue delays in procuring these items, whether they are already on the tender list or not. All of the medicines and disposable items can be procured through the Pharmacy without difficulty.

172. For all of these reasons, I conclude that the MEC has adduced sufficient cogent evidence to establish that insofar as the identified services are concerned, the same, or better medical and related services could be provided to K at CMJAH than in the private sector.

173. The MEC pleaded, in his amended plea, that it would be unreasonable for the court to order that he be directed to pay to K the costs of her future medical expenses sourced from the private sector. In light of my finding on the factual evidence adduced, there is merit in this aspect of the plea. However, it is not the end of the matter, as the MEC has gone further in his defence: he asks the court instead to make an order in kind, and to direct the MEC to make provision for her to access these services in the public healthcare sector. As I have already discussed, this aspect of the MEC's case requires a development of the common law. My finding

on the evidence lays a basis for the next stage of the inquiry, viz. whether the MEC has made out a case for the development of the common law to permit an order in kind.

DEVELOPMENT OF THE COMMON LAW: PUBLIC HEALTHCARE DEFENCE

174. I have already outlined fully the approach that courts must adopt in determining whether to develop the common law. The existing common law rule that delictual damages awards must sound in money and its underlying rationale were discussed and confirmed in *DZ*. The Court also noted that in principle the actual rendering in kind of the services that are required as a result of the delictual wrong committed would serve the underlying rationale of the common law rule.

175. However, this in itself is not a sufficient basis upon which to simply order a development of the common law. The question that needs to be asked is whether there is anything unconstitutionally incompatible with the common law choice in its preference for money judgments as opposed to judgments in kind. If not, are there any wider interests of justice that necessitate extending the common law to permit orders in kind? In this regard, I must be guided by the context of this case, viz. the harm caused to K, who now suffers from severe cerebral palsy because of negligent acts committed by staff at Leratong hospital during her birth.

176. The MEC in this case pleaded his case for an extension of the common law on the basis of s173 of the Constitution, rather than s39(2) of the Constitution. In other words, the case he makes out is that there are wide interests of justice considerations that require a development of the common law to permit an order of compensation in kind in respect of K. Therefore, I will assume, for purposes of this case, that the common law rule that damages must sound in money, is not in conflict with our normative constitutional framework.

177. What are the wider interests of justice at play here? The MEC positions his case in this regard within the context of the constitutional duty imposed on the state under s27(2) to "take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of ... (health care services)". As I have already noted, the Court in *DZ* identified the state's socio-economic constitutional obligations as arguably introducing a new perspective on how the state ought to be required to make reparations for its unlawful conduct in medical negligence cases.[33] In my view, this is indeed a relevant consideration.

178. It is difficult to ignore the link between the state's liability to pay out increasingly large damages awards in medical negligence cases, and the inevitable reduction in resources available to meet its constitutional obligation progressively to realise the right to health care services for the populace. The South African Law Commission notes the following in this regard:

"For a developing country such as South Africa, where the right of access to health care services is constitutionally guaranteed and must be progressively realised, higher spending on health care is a positive sign. However, the same budget which provides for actual health care services is also used to pay out medico-legal claims. The increase in payments for medico-legal claims means that money has to be diverted away from the delivery of health care services, which further reduces the funding of an already severely burdened system. From the case law and the example of the Road Accident Fund (RAF) leglislation, it is clear that an urgent need exists to deal with this problem."[34]

179. While the existing common law rule that damages must sound in money may not be in direct conflict with this obligation (and I leave this question open), it seems to me

[33] At para 45 of *DZ*
[34] SALC issue paper, para 2.20, pg 16

that there is a clear constitutional imperative for the state to consider, and to pursue alternative means of making reparations in cases like the present. This is evident from the injunction placed on the state in s27(2) that it must take reasonable measures to achieve this right, and that it must do so progressively within its available resources: if reparation in kind achieves the purpose of making good the harm that has been inflicted, while at the same time acting as a measure to guard against a reduction in the state's resources, and hence its ability to meet its obligations under s27(2), this would seem to me to be a reasonable and compelling basis on which to consider developing the common law.

180. Such development requires a balancing of rights and interests: on the one hand the established individual right of K to some form of compensation for the harm she has suffered and the infringement of her constitutional rights, and on the other hand, the collective interests of the broader public to access to health care services, which the state is obliged to provide. This balancing between individual and collective interests is a direct and unavoidable product of our constitutional framework and its deliberate advancement of socio-economic rights.

181. In considering whether the common law should be developed, what other factors come into play?

182. In the first instance, the context within which I am requested to develop the common law is critical. The request is not that I must develop the common law to permit alternatives to monetary compensation in all delictual matters, or indeed in all medical negligence cases, or even in all medical negligence cases involving the state. The development of the common law here is limited to the same context that applied in *DZ*, viz. the case of a child who is suffering cerebral palsy occasioned by medical negligence at a public hospital. It is important to keep this context in central

focus, and to appreciate the limited ambit of the proposed development of the common law.

183. Following from this, I need go no further than to determine whether it is necessary to develop the common law to permit a court to consider an order of compensation in kind in an appropriate case where the plaintiff suffers from cerebral palsy as a result of negligence committed in a public hospital. In other words, I need only consider whether the interests of justice require that courts should no longer be bound to making orders of monetary compensation in cases like this, as is currently the case under the common law.

184. A further factor to consider is that public healthcare institutions are required under the Constitution to render services to all. They cannot lawfully turn away pregnant women who seek assistance in the delivery of their babies. The strain on state resources in this regard was alluded to by Ms Bogoshi, who testified that when she was at Chris Hani Baragwanath Hospital, they performed up to 70 caesarian sections per day. This does not take into account the number of vaginal births that occurred at the same time.

185. Thus, the inevitable consequence of the state's constitutional duty to render health care services to all who need it is that the state is at greater risk of being held liable for medical negligence leading to cerebral palsy births than is the private sector. Of course, this is no excuse. If the state is negligent it must make reparation, and it must make every effort to put procedures in place to ensure that medical negligence in childbirth is avoided. It bears a constitutional duty to do so. However, the heightened risk run by the state for claims of this nature is a reality that cannot be ignored.

186. This is relevant to the present discussion because it underscores the double-edged sword hanging over the state: while it faces expensive damages claims for cerebral palsy births, it remains constitutionally obliged to continue to render health services to everyone. Axiomatically, the more the state must pay out in monetary compensation, the less resources are available to it to comply with its constitutional obligation. In my view, this is an important factor for courts to consider when deciding whether in cases like this they should remain bound by the common law rule that reparation should be limited to monetary compensation only.

187. The plaintiff submitted that the MEC's defence could not succeed in the absence of evidence of a detailed feasibility study and costing to prove that the state would actually save money if orders of compensation in kind, rather than monetary compensation, were permitted to be made. I do not agree with this submission. In my view, what I need to consider is whether there are wider interests of justice that require a development of the common law. Interests of justice do not require rands and cents calculations. It is sufficient, in my view, for me to be satisfied that within our broad constitutional and social context there is a case to be made out for the need to develop the common law to permit flexibility in cases like this one. One of those considerations is the obvious conundrum presented by the double-edged sword situation the state faces. In any event, it is obvious, and the point was well made by Ms Bogoshi, that there is less cost to the state in using its budgeted, existing resources to render services to a litigant like K than to pay for the cost to K of sourcing those services in the private sector.

188. The plaintiff also reminded the court, correctly so, of the fact that the primary branch of government responsible for law-making is the legislature. As indicated earlier, this was a point stressed by the Court in *DZ*. Equally, however, the Court stressed that courts should not too readily accept that they should remain subject to the

binding force of the common law if this is out of step with more recent requirements of justice and the Constitution. It is so, as the plaintiff pointed out, that there is a draft bill before Parliament to amend the State Liability Act to permit both periodic payments and orders for the state to provide treatment to an injured party at a public health establishment. The proposed amendment was Gazetted in May 2018. It is now the end of 2019, and I must decide what the interests of justice require in the case before me. It is simply no answer to the defence raised by the MEC to say that he should wait until Parliament decides to adopt the amendment, if indeed this comes to pass. The principal that delictual damages should sound in money is a judge-made rule. In my view, it is not contrary to the principle of the separation of powers for a court to decide, in an appropriate case, to develop that rule.

189. The plaintiff submitted that the core of the MEC's case, viz. that K will be treated as a special patient at CMJAH, runs fundamentally counter to the constitutional imperative that there should be equal access to public health services. I do not agree with this contention either. It ignores the fact that the case for the development of the common law is made in the context of pre-existing negligent conduct on the part of the state. In these circumstances, it is correct that the state must make reparation to the individual harmed. In doing so, the state is not breaching its duty to ensure equal access to health care services. K is, by virtue of being a successful litigant, a special case by operation of law. Whether the state makes reparation by way of paying money to her, or making special provision to ensure that she receives her required treatment at CMJAH, makes no difference. The state must make good, one way or another, the harm it has caused her. Either way, the resources of the state are affected.

190. In any event, on the evidence before me there was no indication at all that by treating K as a special patient, other patients requiring the same services at CMJAH would

be negatively affected. The consensus of all of the witnesses was that they could accommodate her needs within their available resources.

191. As to the "floodgates" line of questioning that was put to the witnesses, it is clear that if CMJAH were to be flooded with more patients like K, this would put a strain on its resources. All of the role-players are aware of this, and Dr Modisane confirmed that there is a broader planning exercise under way to ensure that if the plan made for K is rolled out to cover more litigants, the resources will be there to make sure it can be done.

192. However, I am not faced with the question of what will happen in the future and whether a roll-out will be feasible. As I have already indicated, my concern in this case is whether the common law should be developed to permit courts, in appropriate cases, to depart from the current position which restricts them to making orders of monetary compensation. A development of the common law by me will open the door to courts to consider making orders in kind in appropriate cases. However, if I find that K's case is an appropriate case in which to order compensation in kind, this will not bind a court in another matter to follow suit. This is something that each court faced with a similar defence will have to consider on the evidence before it. If the plan to roll out similar treatment for other litigants is not underpinned by proper resourcing, then it seems to me that a court would be justified in dismissing the defence when it is raised in those circumstances.

193. A further argument raised by the plaintiff was that s66 of the Public Finance Management Act[35] precludes the court from making an order for compensation in kind on the basis that this is a "guarantee" for purposes of this section. This argument was made, and rejected by my learned brother, Van der Linde J *in NP*

[35] Act 1 of 1999

obo NE v The Member of the Executive Council for Health of the Gauteng Provincial Government.[36] I am in agreement with his determination on this issue. In the circumstances, no more be said about this argument.

194. Having taken account of all of these factors, I conclude that it is indeed necessary, in the wider interests of justice, to develop the common law to permit courts, in cases like this, to make orders for compensation in kind as opposed to being restricted to making orders for monetary compensation for future medical expenses. If the door remains closed to the state to seek this alternative form of compensation, based on our current common law, the inevitable result will be a continued drain on its financial resources which are so critical to it in meeting its constitutional obligations under s27(2). Where the resources to render the medical services required already exist in the public healthcare system, and where there will be no detriment to the plaintiff in receiving those services in that system, it would be contrary to the broader interests of justice for courts to continue to be bound to ignore this as a factor, and to continue to be limited in having no choice other than to order the state to pay for the cost of those services in the private sector.

195. In my view, this will not undermine the underlying rationale of our common law which requires wrongdoers to make reparation to victims. All that this development of the common law will permit is for courts to consider ordering compensation in a form other than in money, where it is appropriate to do so. As the Constitutional Court pointed out in *DZ*, this concept is not alien to the Roman law foundations of our law of delict, nor necessarily to our jurisprudence.[37]

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[36][2019] ZAGPJHC 24 (7 February 2019)
[37] At paras 36 & 37

196. As I have already indicated, in view of the limited ambit of the development necessary in this case, the wider consequences for the law of delict are similarly limited. The development applies only in the context of cases like the one before me, viz. where the MEC is sued for the cost of future medical expenses by a plaintiff who suffers from cerebral palsy due to the negligent conduct of staff in a public hospital. It does not apply, as plaintiff suggested, to all medical negligence cases in the state sector, or in the private sector. Whether the common law should be developed more broadly in those instances too remains open to consideration in the appropriate case.

IS THIS AN APPROPRIATE CASE IN WHICH TO MAKE AN ORDER FOR COMPENSATION IN KIND?

197. This question will always depend on the evidence presented in each case. I have set out, in some detail, the evidence adduced by the MEC. I concluded earlier, on the basis of that evidence, that as far as the identified services are concerned, they are available for K at the CMJAH and that the standard of service that she will receive there will be the same, if not in some respects even better than, the service she would receive in the private sector if the MEC was ordered to pay monetary compensation.

198. As I have noted earlier, the evidence demonstrates that K can be accommodated within the Hospital's existing resources. This applies not only to the actual medical services that she will receive, but also to the equipment and other items that the experts have recommended she will require. The Hospital has the budget, and the procurement processes are in place for these items to be acquired for her.

199. As far as a plan for the management of K's care at the hospital is concerned, her home base will be in the ND Clinic. Dr Thomson and her staff work on an

interdisciplinary model and will be in constant communication with the other specialists who will treat K. Over and above this, Ms Bogoshi has appointed an in-house case manager who will ultimately be responsible for ensuring that K's treatment is implemented, and reporting to both the family and the CEO. She will work with the private case manager. In my view, and given that at least part of the order I make will be for monetary compensation for non-identified services, it is appropriate to include the cost of a private case manager as part of the monetary award. However, it is reasonable to make some deduction in this cost due to the fact that her duties will be narrower than originally envisaged. I will apply a deduction of one third of the case manager's costs in this regard.

200. One of the factors that is peculiar to the case before me is that the plaintiff has agreed that a "claw-back" provision be included in the order I make. In other words, in the unfortunate event that K passes away before her agreed life expectancy of 24.6 years, whatever funds remain in the Trust because they have not yet been used for her care will revert to the state. Excluded from the claw-back provision are the amounts awarded in respect of K's general damages, and her damages for loss of future income. The claw-back concession is a reasonable one for the plaintiff to have made, and I endorse this arrangement. However, in my view it is not a reason to refuse to make an order for compensation in kind. One cannot speculate how much, if any, of the damages that might otherwise be awarded for future medical expenses would revert to the state in the unfortunate event of K's early passing.

201. On the evidence before me I am persuaded that this is an appropriate case in which to make an order for compensation in kind in respect of the identified services. I see no detriment for K in making an order of this nature. She will receive the treatment she needs. I am satisfied that her needs will be adequately met and, as I have already stated, in some respects will be better met at CMJAH than they would

be if she used the services of multiple, independent service providers in the private sector. In these circumstances, I believe that this will serve K's best interests.

DEVELOPMENT OF THE COMMON LAW: ONCE AND FOR ALL RULE

202. There is some obvious overlap between the common law rule that delictual compensation should sound in money, and the rule that a plaintiff in a delictual case must claim in one action all of their damages, both accumulated and prospective. The ancillary rule is that the monetary compensation must be paid in one lump sum. To a great extent, therefore, the same considerations apply in determining whether the common law should be developed to permit that MEC to pay monetary compensation by way of periodic payments.

203. I see no reason in principle why the common law should not be developed in this respect as well. Indeed, by concluding that an award can be made for compensation in kind, the once and for all rule is also implicated. This is because the services will not be rendered at once, but will be rendered over time, as and when required. This is an inevitable consequence of the development of the common law to permit an order of compensation in kind. It is thus necessary to accept a development of the once and for all rule to this extent at least.

204. However, the MEC asked me to go further than this, and to order that the monetary compensation to which K is entitled be paid in periodic instalments. This involves a more extensive development of the once and for all rule. While the MEC pleaded for this development, the plea was not supported by sufficient evidence. No witnesses addressed the questions of in what amounts, and at what intervals, the

envisaged periodic payments would be made, and how this would affect the actuarial calculations.

205. In the circumstances, I do not consider it necessary to address the question of whether the once and for all rule should be developed to permit periodic payments in this case. That question must wait until a proper case is presented on the issue.

206. In the circumstances, insofar as the MEC is ordered to pay damages to K, the payment must be in a lump sum.

CONCLUSION AND ORDER

207. In summary, I conclude as follows:

207.1. The common law rule requiring that delictual damages must be compensated in money is developed so as to permit a court to order compensation in kind in appropriate cases in circumstances where:

207.1.1.the MEC is held liable for the negligent conduct of public healthcare staff causing injury during or at birth to a child in the form of cerebral palsy; and

207.1.2. the MEC establishes that medical services of the same or higher standard will be available to the child in future in the public healthcare system at no or lesser cost to the child than the cost of the private medical care claimed.

207.2. In respect of the services categorised in this judgment as the identified services, the MEC will be directed to ensure, as soon as is reasonably possible, that they are provided to K at the CMJAH in accordance with the

recommendations contained in the relevant expert reports, and as recorded in this judgment, as having been agreed by the parties.

207.3. The plaintiff, in her representative capacity on behalf of K will be entitled to a lump sum payment from the MEC for the following damages:

207.3.1. Her claimed damages for loss of earning; general damages for pain and suffering and the costs of the Trust to be established.

207.3.2. The cost of her future medical and related expenses, excluding the costs of the identified services, i.e. those services identified in this judgment as non-identified services.

208. Insofar as a backstop is necessary to protect K in the event of the MEC not being able to provide any of the identified services, I will include in my order provision for the plaintiff to approach me, or another designated Judge, to seek an order that the MEC pay into the Trust the costs of those services.

209. As I indicated earlier, in most respects, the natures of the identified services are common cause between the parties. However, on the evidence presented there was some lack of certainty on the orthotics, the compression garments, the AAC devices and the wheelchair.

210. For sake of clarity, I record that in my view the orthotics that can be manufactured at the Chris Hani Baragwanath Academic Hospital orthotic workshop, as testified to by Mr Machaba, will be suitable for K. It would not be reasonable to order the MEC to secure the orthotics recommended in the joint minute of the experts. The workshop must supply orthotics to K at no cost.

211. As far as the compression garments are concerned, if the private case manager appointed is not satisfied that the garments that are manufactured by the Hospital itself will serve the purpose of the garments recommended by the experts, the MEC is directed to ensure that the recommended garments are procured for K by the CMJAH.

212. There was also some debate about the AAC devices recommended by the plaintiff's expert, Dr Levin. In this regard, I am satisfied that it should fall within the professional discretion of her treating occupational therapists at CMJAH to determine which type of AAC device should be procured for K and the timing of that procurement. In my view, it would be unreasonable for this court to order the procurement of devices at this stage when it has not yet been properly assessed what K's potential is in this regard.

213. As far as the Netti wheelchair is concerned, it is common cause that this is not the wheelchair currently on tender and available at the CMJAH. Ms Bogoshi has confirmed that she can procure the Netti wheelchair for K. For sake of clarity, it is recorded that the wheelchair to be procured for K by the MEC through the CMJAH is the Netti wheelchair, or an alternative to the satisfaction of the plaintiff.

214. I make the following order:

1. The common law rule requiring that delictual damages must be compensated in money is developed so as to permit a court to order compensation in kind in appropriate cases, where:

1.1 the MEC is held liable for the negligent conduct of public healthcare staff causing injury during or at birth to a child in the form of cerebral palsy; and

1.2 the MEC establishes that medical services of the same or higher standard will be available to the child in future in the public healthcare system at no or lesser cost to the child than the cost of the private medical care claimed.

2. In respect of the identified services and items, i.e. those listed under the claims for speech therapy; ear, nose and throat services; orthopaedic services; physiotherapy; dental services; urology; dietary supplementation; psychiatric treatment; wheelchairs and orthotics; paediatric neurology services; and occupational therapy (excluding the costs of care givers), the MEC is directed to ensure that these services are rendered to, and procured for K by the Charlotte Maxeke Johannesburg Academic Hospital (CMJAH) at the same or better level of service than in the private healthcare sector.

3. The MEC is directed to make payment to the plaintiff of the total amounts claimed, after the deduction of the agreed contingencies, in respect of the non-identified services and items, i.e. those listed under the claims for vehicle transport (including annual running costs, but excluding the car seat, if this is available on tender at the CMJAH); alterations to the home; care givers; and a case manager (with costs reduced by one-third of the claimed amount).

4. Further to paragraph 3 above, the legal representatives of the parties are directed jointly to calculate the amount due under that paragraph, and to approach Keightley J in Chambers for an order specifying such amount.

5. Further to paragraph 2 above, in the event of the MEC, through the CMJAH, failing to provide any of the identified services or items, the plaintiff may approach Keightley J, or another Judge designated by the Deputy Judge President, for an order directing the MEC to pay to the plaintiff the amount claimed for the relevant service or item.

6. The MEC is further directed to pay to the plaintiff the following damages:

6.1 The amount of R1 383 984. 00 for loss of earnings/loss of earning capacity.

6.2 R2 000 000. 00 for general damages for pain and suffering;

6.3 R1 399 333. 00 for the costs of the Trust to be established in accordance with a Trust Deed to be confirmed by the court ("the Trust").

7. It is recorded that of the aforesaid amount, R3 million has been paid by way of an interim payment, and such amount is to be deducted from the amounts to be paid under this order.

8. The balance of the monetary compensation awards is payable by 15 February 2020, whereafter interest will accrue at the prevailing legal rate of interest, such payment to be made to the Trust, in the event that it has been established by such date, alternatively into the trust account of the plaintiff's attorneys, Wim Krynauw Attorneys, Johannesburg.

9. It is recorded that the parties have agreed that the damages awarded for future medical expenses will be ring-fenced such that any residue in the ring-fenced portion at the time of K's death shall be returned to the MEC for Finance/Health, Gauteng, after the deduction of the pro rata fees and disbursements. The balance of the funds in the Trust are to devolve on Karabo's heirs.

10. The defendant is directed to pay the plaintiff's costs, on a party and party basis, including the reasonable costs of all medico-legal reports and joint minutes obtained by the plaintiff including the following:

(a) Drs L Grinker and Longano, psychiatrists (together with Dr Longano's costs for testifying as a witness)

(b) Dr P J Lofstedt, dentist

(c) Dr P Viljoen, ENT surgeon

(d) Ms M du Plooy, audiologist

(e) Dr K Levin, speech therapist

(f) L Isserow / I Retief, dieticians

(g) Dr S Choonara, urologist

(h) Dr G B Firth, orthopaedic surgeon

(i) Ms M du Plessis, occupational therapist with Crosbie Inc (together with her costs for testifying as a witness)

(j) Ms K Churchill, physiotherapist

(k) Mr D Rademeyer, mobility expert

(l) Mr S Simon, quantity surveyor

(m) D D Strauss, statistician and Life Expectancy expert

(o) Mr D de Vlamingh, industrial psychologist

(p) Dr DF Pearce, paediatric neurologist (together with his costs for testifying as a witness)

(q) M G Hakopian, orthotist/prosthetist (together with his costs for testifying as a witness)

(r) Ms R Jessen, railing expert

(s) Mrs P u Plessis, on trusts.

R M KEIGHTLEY

JUDGE OF THE HIGH COURT OF SOUTH AFRICA

GAUTENG LOCAL DIVISION, JOHANNESBURG

Date Heard	: 21/23/26/27/28 November 2018// 18/10/2019
Date of Judgment	: 18 December 2019
Counsels for the Applicant	: W Munro
Instructed by	: WIN Krynauw Attorneys
For the Respondent	: V Soni (SC)
Instructed by	: The State Attorney