THE HIGH COURT OF SOUTH AFRICA

(WESTERN CAPE DIVISION, CAPE TOWN)

In the matter between Case No: 22407/14

JONATHAN BRUCE HAY	**APPLICANT**
and	
HEALTH PROFESSIONS COUNCIL OF SOUTH AFRICA	**FIRST RESPONDENT**
Dr H EDELING N.O.	**SECOND RESPONDENT**
Dr APJ BOTHA N.O.	**THIRD RESPONDENT**
Dr A LOUW N.O.	**FOURTH RESPONDENT**
Dr E MUTASA N.O.	**FIFTH RESPONDENT**
THE ROAD ACCIDENT FUND	**SIXTH RESPONDENT**

Coram: ROGERS J

Heard: **18 NOVEMBER 2015**

Delivered: **25 NOVEMBER 2015**

JUDGMENT

ROGERS J:

[1] The applicant is the plaintiff in a pending action against the sixth respondent ('the RAF') in which he claims damages for injuries sustained in a motor car accident on 18 September 2010. He was then aged 22. His claim includes general damages, in support of which he alleges that he suffered a 'serious injury' as contemplated in the proviso to s 17(1) of the Road Accident Fund Act 56 of 1996 ('the Act'). The RAF rejected the serious injury assessment report submitted on his behalf. The applicant notified the first respondent's Registrar that he disputed the rejection. The second to fifth respondents, being the doctors appointed by the Registrar to serve on the appeal tribunal, considered and rejected the appeal on 21 May 2014. By way of the present application the applicant seeks to have the tribunal's decision set aside on review. The application is opposed by the first to fifth respondents (for convenience I refer to them collectively as the respondents).

[2] In the accident the plaintiff suffered a fracture of the cervical spine. Initially he was treated conservatively with a hard collar. On 4 October 2010 he underwent a discectomy and anterior fusion of the left C6/C7 vertebrae. Speaking very generally, his long-term problems are neck and shoulder pain and occipital headaches. There is also a psychiatric dimension. As a teenager the applicant had an episode of depression. The accident triggered a further bout of depression. Each bout of depression increases the risk of further breakdown, a risk which in his case is increased by the stress occasioned by his neck injury.

[3] The medical practitioners on whose reports the applicant relied in his appeal to the tribunal were: (i) Dr Burger, a general practitioner, who examined the applicant on 16 November 2011 and produced a report of the same date; (ii) Dr Domingo, a neurosurgeon, who examined the applicant on 16 November 2011 and produced a report dated 10 September 2012; (iii) Dr le Fèvre, a psychiatrist, who

examined the applicant on 16 July 2012 and produced a report dated 5 September 2012; (iv) Dr le Roux, an orthopaedic surgeon, who examined the applicant on 12 June 2013 and produced a report dated 15 October 2013.

[4] On 6 March 2013 the applicant was examined by Dr Steyn, an orthopaedic surgeon nominated by the RAF. His report was also before the tribunal.

[5] The second to fifth respondents are respectively a neurosurgeon, a physician, an occupational physician and an orthopaedic surgeon.

[6] The applicant's grounds of review are that (i) the tribunal acted arbitrarily and capriciously; (ii) it failed to consider relevant considerations; (iii) its decision was not rationally connected to the information before it; (iv) its decision was procedurally unfair. The last of these grounds was based on a criticism that the tribunal rejected Dr le Fèvre's assessment despite the fact that its members did not have psychiatric expertise.

Condonation in respect of s 7(1) of PAJA

[7] The applicant took the view that the 180-day period specified in s 7(1) of the Promotion of Administrative Justice Act 3 of 2000 ('PAJA') for the bringing of the review application expired on 21 November 2014, being 180 days after the applicant's attorneys were notified of the tribunal's decision on 27 May 2014. The review application was issued on 15 December 2014, ie about three weeks late. The applicant seeks condonation in terms of s 9(2) of PAJA.

[8] The 180 day-period starts to run from the date on which the aggrieved party becomes aware of the administrative action and the reasons for it or might reasonably have been expected to have become aware of the action and the reasons for it. As will appear from the next part of this judgment, the applicant requested reasons but these were not forthcoming and he launched the review application without them. Had reasons been furnished, the 180-day period would have been reckoned from the date they were furnished and this application would thus almost certainly not have been out of time.

[9] On the assumption that the 180 day-period must, because of the institution of proceedings in the absence of reasons, be calculated from 27 May 2014, it was nevertheless not unreasonable for the applicant and his advisers to hold matters in abeyance pending the anticipated receipt of reasons. Furthermore, the applicant has explained that there were certain difficulties in finalising the papers when the file was transferred from one attorney to another within the firm representing him. Counsel was unexpectedly overseas when the new attorney wished to discuss certain issues.

[10] The delay was not very great. The respondents have not shown any prejudice. Although they did not concede that condonation should be granted, Mr Maodi, who appeared for them at the hearing, did not address me on the issue. I am satisfied that condonation should be granted in the interests of justice.

The request for reasons

[11] On 2 July 2014 the applicant's attorneys requested reasons for the tribunal's decision in terms of s 5 of PAJA. The tribunal did not furnish reasons within the 90-day period specified in s 5(2) or at any time prior to the launching of these proceedings. In oral argument Mr Maodi sensibly abandoned the respondents' contention that the letter notifying the applicant's attorneys of the appeal outcome contained reasons.

[12] Section 5(3) provides that if an administrator fails to furnish adequate reasons for an administrative action

'… it must, subject to subsection (4) and in the absence of proof to the contrary, be presumed in any proceedings for judicial review that the administrative action was taken without good reason.'

[13] Mr Branford, who appeared for the applicant, submitted that unless the 90-day period for furnishing reasons has been extended in terms of s 9, an administrator is precluded, in review proceedings, from adducing evidence to show that the action was not taken without good reason. He argued that if it were otherwise an administrator could with impunity disregard the duty to furnish reasons.

[14] I disagree. If an extension is granted in terms of s 9 and reasons are furnished within the extended period, the administrator will not have failed to furnish reasons within the meaning of s 5(3) and the presumption created by that subsection would not be operative. Section 5(3) deals precisely with the position where review proceedings are instituted against the backdrop of an administrator's failure to furnish adequate reasons. The words 'in the absence of proof to the contrary' mean that the administrator may in the review proceedings put up evidence to justify his or her decision. This does not mean that the administrator's previous failure to furnish reasons is without consequence. Firstly, his failure will trigger the presumption in s 5(3) and thus shift the burden of proof to the administrator (see Hoexter *Administrative Law in South Africa* 2nd Ed at 482; *Bader v SA Council for Social Services Profession & Another* [2015] ZAGPPHC 318 para 17). Second, if the aggrieved party, on reading the reasons contained in the answering papers, is satisfied with them and abandons the review, he would ordinarily be entitled to costs.

[15] Mr Maodi conceded that the respondents bore the onus of displacing the presumption created by s 5(3). The presumption (that the action was taken 'without good reason') does not have its exact correlative in the grounds of review set out in s 6(2). Generally speaking, action taken 'without good reason' would infringe the constitutional requirement of rationality (cf s 6(2)(i)), would be arbitrary and capricious (s 6(2)(e)(vi) and would be so unreasonable that no reasonable administrator could have so acted (s 6(2)(h)). There may be overlap with other grounds of review as well but the onus does not automatically shift in respect of all grounds of review. For example, if an applicant complains of procedural unfairness or bias or bad faith, a failure to furnish reasons would not result in the administrator bearing the onus of disproving such complaints.

[16] In the present case it seems to me that, if the tribunal has discharged the burden of proving that its decision was taken not without good reason, it will for all practical purposes have refuted all the applicant's grounds of review. The tribunal does not, however, have to prove, as Mr Branford suggested in argument, that the applicant did not sustain a serious injury. In terms of reg 3(3)(d)(i) the RAF must reject a claimant's serious injury assessment report if the RAF 'is not satisfied that

the injury has been correctly assessed'. It is against this rejection that the claimant may appeal in terms of reg 3(4). The tribunal's powers are set out in reg 3(11), one of which is to confirm the RAF's rejection of the claimant's serious injury assessment report. The tribunal could rationally and properly have rejected the applicant's appeal if it was for good reason not satisfied by the evidence placed before it that the applicant had suffered a serious injury.

The definition of 'serious injury'

[17] Certain injuries are, in terms of reg 3(1)(b)(i), expressly excluded as serious injuries. The applicant's case is not excluded by any of these. In terms of reg 3(1)(b)(ii) an injury is serious if it has resulted in a 30% or more 'Impairment of the Whole Person' ('WPI') as provided in the American Medical Association's Guides to the Evaluation of Permanent Impairment. The applicant's case does not rise to this threshold. This leaves the so-called narrative test in reg 3(1)(b)(iii), of which items (aa) and (cc) are of potential relevance, namely whether the injuries

'(aa) resulted in a serious long-term impairment or loss of a body function' or

'(cc) resulted in severe long-term mental or severe long-term behavioural disturbance or disorder'.

[18] The words 'serious' and 'severe' in these items are not defined. They connote a degree of impairment or disturbance or disorder which cannot be fixed by quantitative measure. The assessment requires a value judgment though one to be performed on the basis of a correct interpretation of the words used in the narrative test. Dictionary definitions of 'serious' in a context appropriate to the narrative test include 'having important or dangerous consequences; critical'; 'approaching the critical or dangerous' while definitions of 'severe' include 'inflicting great pain or distress; of a serious or considerable degree or extent; grave'; 'unsparing; pressing hard; hard to endure'.[1] In ordinary parlance the word 'severe' connotes to my mind a greater intensity than 'serious'. This contrast is reflected in the definitions in the *Shorter English Oxford Dictionary*: 'serious' – 'important; grave, having (potentially) important, esp. undesired, consequences; giving cause for concern; of significant

[1] These are taken respectively from the *Longman Dictionary of the English Language* and the *Chambers 20th Century Dictionary.*

degree or amount'; 'severe'– 'disagreeably intense, unpleasantly extreme; causing hardship, pain or suffering by its degree of extremity'. Since the lawmaker chose to use 'serious' in items (aa) and (bb) and 'severe' in item (cc), it is reasonable to infer that some difference of degree was intended. The distinction may have been drawn because impairment or loss of body functions was regarded as more tangible than mental or behavioural disturbances and disorders.

[19] The purpose of limiting non-pecuniary damages to cases of 'serious injury' must have been to introduce a significant limitation on the RAF's liability for general damages. In context, 'serious' and 'severe' should not be regarded merely as 'not trivial', since trivial cases are unlikely in the past to have placed a significant burden on the public purse. On a continuum from trivial at one extreme to catastrophic at the other, descriptors which come to mind are mild, moderate, serious and severe. That which is 'serious' must be more intense than 'moderate'. And that which is 'severe' must be more intense than 'serious'.

[20] Seriousness and severity must take into account the victim's particular circumstances. While some impairments, disturbances or disorders might be serious or severe for whomsoever suffers them, others might only attain these thresholds because of the victim's chosen profession or pursuits (the ballerina's toe or violinist's finger).

[21] In the case of items (aa) and (cc) the impairment, disturbance or disorder must be 'long-term'. This does not present a difficulty in this case. The applicant's current symptoms are likely to be permanent.

[22] The manner in which pain is accommodated in the narrative test is not clear. Item (aa) requires an impairment or loss of a body function. Pain is not per se the impairment or loss of a body function. Depending on its intensity, pain may give rise to an impairment of a body function. The ability to concentrate, for example, could aptly be described as a body function (a function of the brain) and might be impaired by pain. I rather doubt whether pain per se could be described as a mental disturbance or mental disorder though again it might, depending on its intensity, cause a mental or behavioural disturbance or disorder (for example, depression).

Review, not appeal

[23] Where the RAF's rejection of a claimant's serious injury assessment report is disputed, the lawmaker has entrusted to the tribunal the function of determining whether or not to uphold that rejection. There is no appeal from the tribunal to this court. The distinction between appeal and review must not be blurred (*Bato Star Fishing Pty Ltd v Minister of Environmental Affairs & Others* 2004 (4) SA 490 (CC) para 45). Bearing in mind the incidence of onus in this case, I cannot set aside the tribunal's decision if the tribunal has shown that it did not act arbitrarily, capriciously or irrationally. The mere fact that I might on the merits have reached a different conclusion would not justify a finding that the tribunal acted arbitrarily, capriciously or irrationally (*Road Accident Fund v Duma and Three Similar Cases* 2013 (6) SA 9 (SCA) para 19; *Brown v Health Professions Council of South Africa & Others* Case 6449/2015 WCHC paras 13-18 and 40 (as yet unreported judgment of Bozalek J dated 23 November 2015); cf *MEC For Environmental Affairs & Development Planning v Clairison's CC* 2013 (6) SA 235 (SCA) para 18). Appropriate respect for the administrative agency in the present case is particularly apposite, bearing in mind that one is concerned with a question of medical judgment in regard to which the members of the tribunal, unlike the court, have qualifications and expertise.

The evidence before the tribunal

WPI scores

[24] The WPI scores given by the various doctors for the applicant's injuries were as follows:

- Dr Burger – 6%;
- Dr Domingo – 11%;
- Dr le Fèvre – 4% (spinal) and 0% (psychiatric);
- Dr le Roux – 9%;
- Dr Steyn - 11%.

[25] The applicant was thus not close to the WPI threshold of 30%.

Reduced mobility?

[26] Dr Burger, who examined the applicant in November 2011, noted 'some impediment' of cervical spine movement and range of motion. He furnished the degrees of various motions but did not indicate how far these deviated from the norm.

[27] Dr Domingo, who also examined the applicant in November 2011, noted 'a mild reduction in his range of neck movements in all planes'.

[28] Dr Steyn, who examined the applicant in March 2013, reported 'mild restriction' in neck flexion but full extension and full left and right rotation.

[29] Dr le Roux, who examined the applicant in June 2013, stated that despite the C6/C7 fusion neck movement was normal.

Current pain and neck stiffness

[30] Dr Burger reported that the applicant suffered neck pain and stiffness when required to sit in a static ergonomic position or to look up for long periods or to rotate the head repeatedly. The applicant thus no longer had the ability 'to comfortably move and maintain the neck in the normal positions of posture that he could before the accident'. This negatively affected his 'general ability to lead a normal life at a social, occupational and/or recreational level'. The applicant was not, at the time he saw Dr Burger, taking analgesics for pain.

[31] Upon examination by Dr Domingo the applicant experienced 'mild pain at the extremes of movement' but there was no point of tenderness and axial loading did not induce any pain. Dr Domingo recorded that the injury had left the applicant with neck pain and stiffness due to the associated soft tissue injury of the neck and as a result of the increased stresses placed on the levels above and below the fusion. The applicant complained of experiencing neck pain and muscle spasm a few times

a week, the pain being mechanical in nature and worsening with heavy physical work. Dr Domingo classified the neck pain and spasm as ‘mild to moderate in severity’, opining that the applicant was ‘mildly disabled by his pain’. The applicant did not complain of headaches. Dr Domingo anticipated that the applicant would require intermittent treatment every year with analgesics and anti-inflammatory medication and would need ongoing physiotherapy. He reported that the applicant’s neck pain and discomfort did not interfere significantly with his studies (he was then a student) or with playing golf or with his social activities. The injuries had not had a significant impact on the applicant’s lifestyle though his lifestyle was likely to become ‘more compromised over the course of time’.

[32] Dr Steyn recorded that the applicant complained of ‘intermittent pain in the left shoulder, on a daily basis’, the pain being worse when he had been studying for long periods with the neck in a slightly flexed position. The applicant also reported that he suffered occipital headaches three to four times a week, each lasting about half a day. Lifting heavy weights did not aggravate his neck pain. The pain did not interfere with his golf or disable him from performing his work-related activities normally. Dr Steyn considered that the applicant would be able to continue working to his usual retirement age in his chosen profession.

[33] Dr le Roux, who saw the applicant a couple of months later, reported that the applicant complained of intermittent neck pain. It sometimes felt as if a knife was being pressed into his left shoulder. He struggled to sleep. When he lay for long periods his back became sore. Lengthy sitting, for example in front of a computer or when doing laboratory work, brought on neck and lower back pain. Driving for long periods caused neck pain but the injury not interfere with his golf. He also complained of intermittent occipital headaches. Dr le Roux considered that with appropriate adjustments the applicant should be able to work as a chemical researcher and lecturer until normal retirement age. The main adjustments would be that he should not sit with his neck in one position for lengthy periods or lift and handle heavy objects. His productivity, capacity for work and working hours might be negatively affected by future degeneration.

Degeneration and further surgery

[34] Dr Burger did not express an opinion on degeneration in adjacent vertebrae or the need for further surgery. This is understandable, given that he is a general practitioner.

[35] Dr Domingo stated that the applicant would 'almost certainly' develop 'accelerated degenerative changes at the C5/C6 level' (the vertebrae immediately above the fused C6/C7 vertebrae) and this would result in his developing 'increasing symptoms'. He referred to a medical article establishing that 'symptomatic adjacent segment disease occurs at a relatively constant incidence of 2,9% per year during the ten years following an anterior cervical fusion' and that two-thirds of all patients in whom new disease developed would require further surgery. He concluded that the applicant would over the next 40 years (his working life) 'develop accelerated degenerative changes' and had 'a 50% risk of requiring additional surgical intervention', namely 'extending the anterior fusion to the adjacent level'.

[36] Dr Domingo did not record any pre-existing problems in the vertebrae and discs immediately above and below the C6/C7 fusion. (Among the medical records to which he had access were MRI and CT scans of the cervical spine performed in September 2010.)

[37] I pause here to observe that the logic of Dr Domingo's conclusion is not self-evident from the premises. If the risk of adjacent degeneration is a risk which, if it eventuates, will manifest itself in the first ten years and at a constant rate of 2,9% per annum, I would have thought that the likelihood of the risk eventuating over ten years would be 29%. If two-thirds of the persons in whom the risk eventuates require future surgery, about 19% of persons similarly placed to the applicant would eventually need an anterior fusion of the adjacent level. Furthermore, one would have thought that, if adjacent degeneration had not in the applicant's case manifested itself within the first two years, the period of future risk would only be eight years, reducing the aggregate risk to about 23%.

[38] With reference to adjacent neck structures, Dr Steyn noted a large osteophyte (bony excrescence) extending from the antero-inferior margin of the C5 vertebra. The C5/C6 intervertebral discs and the C7/T1 intervertebral discs appeared to be normal radiologically. Dr Steyn observed that the medical research referenced by Dr Domingo found that adjacent segment disease occurred at a constant incidence of 2,9% per annum during the first ten years after surgery. The authors of the paper suggested that 25% of patients who undergo a cervical fusion develop adjacent disc disease. (This appears more consistent with the stated incidence of 2,9% over ten years.) Dr Steyn added that the authors qualified this finding by stating their belief that the adjacent disease 'was the result of progressive cervical spondylosis at adjacent levels' and was not caused by the arthrodesis (the fusion) itself. The article contained a further finding that, in a group of patients under the age of 50 who had few or no degenerative changes at the adjacent levels before the new disc herniation developed (in the present case, the 'new disc herniation' was caused by the fracture sustained in the accident), only 9% developed adjacent disc disease. The higher incidence of disc degeneration was thus only applicable to patients who already had degenerative disc disease prior to the fusion.

[39] Dr Steyn concluded that while it was possible that the applicant would require extension of the fusion in later years this was not a probability.

[40] Dr le Roux recorded that there was spondylosis (degeneration) and a benign osteophyte at the C5/C6 level. (Dr Domingo did not note these features. Dr Steyn mentioned the osteophyte but not the spondylosis.) Dr le Roux stated that according to statistics there was a 25% chance that following a fusion a patient would develop adjacent spondylosis. (He did not mention the source of this information but it was presumably the same research as Dr Domingo and Dr Steyn cited.) He considered that in the applicant's case it was the C5/C6 level which had the greatest chance of suffering degeneration, noting that there was already spondylosis at that level.

[41] He concluded later in his report that, if symptomatic spondylosis occurred at an adjacent level, an extension of the fusion to the C5/C6 level might be needed. The likelihood that a fusion would have to be performed was 75% and would take place at some stage after the applicant turned 45.

[42] The precise import of this conclusion is not clear. If Dr le Roux is saying that the applicant stands a 75% chance of having to undergo a C5/C6 fusion at some stage in the future, this does not appear consistent with the research cited by Dr Domingo and Dr Steyn. The more plausible construction of Dr Le Roux's report is an opinion that, if the applicant develops degeneration at the C5/C6 level (of which, according to the earlier part of his report, there is a risk of 25%), it is then very likely (75% probability) that the degeneration will eventually have to be treated with an extension of the existing fusion. The 75% probability is not explained though is not very different from the two-thirds likelihood mentioned in Dr Domingo's report.

[43] Included in the papers is a radiological report by Drs Schnetler Corbett & Partners dated 6 March 2013. This appears to be the report with reference to which Drs Steyn and le Roux made their observations regarding the C5/C6 level. The report, apart from noting the fusion, stated that there was earlier spondylosis with a prominent anterior osteophyte at the C5/C6 level. Disc space above and below the fusion was, however, well maintained with no signs of degenerative disc pathology currently visible.

[44] Although the reports are not specific about the symptoms which are likely to be caused if there is adjacent disease and an extended fusion, it may be accepted that the applicant's pain and stiffness would be somewhat greater.

Psychiatric effects and risks

[45] Dr le Fèvre reported that as a teenager the applicant had a major depressive episode precipitated by the termination of a romantic relationship. Anti-depressant medication was prescribed and he recovered. His mental health was good for about eight years. Soon after the accident the applicant noticed a return of his depressive symptoms. He consulted a psychiatrist and was put back on anti-depressants. These helped, and he was symptom-free when he saw Dr le Fèvre. (The report does not indicate whether the applicant has remained on prophylactic anti-depressant medication.)

[46] Dr le Fèvre described the applicant's depression as being 'in remission' with no particular stress at present. Because the applicant had no psychiatric symptoms of note, he scored 0% WPI as measured by the AMA Guides relating to mental and behavioural disorders.

[47] Dr le Fèvre stated that the accident had precipitated a Major Depressive Disorder (MMD). As a rule, each MDD episode 'worsens the prognosis'. The applicant is thus 'at greater risk of another breakdown than he would have been if he had not had the accident'. Having a damaged neck 'could well be an added stress in precipitating another relapse'.

The doctors' 'serious injury' conclusions

[48] I have attempted fairly to state the main factual findings of the various doctors. For convenience I shall refer to the non-psychiatric findings as orthopaedic findings (ie the findings relating to neck pain, stiffness, headaches and the risk of adjacent disease and future surgery). In the case of Dr Burger and Dr le Roux, their opinion that the applicant had suffered a 'serious injury' in terms of item (aa) of the narrative test was essentially a conclusion or value judgment on their orthopaedic findings. In the case of Dr Steyn, his contrary opinion was similarly a conclusion or value judgment on his orthopaedic findings.

[49] Dr Domingo, apart from recording his orthopaedic findings, noted the psychiatric findings of Dr le Fèvre. He concluded that the applicant would have ongoing neck pain and discomfort and would probably require further surgical intervention. In addition, his risk of depression had increased. This would impact on all aspects of his life. He was thus of the opinion that the applicant's injury was severe and that he would 'continue to suffer permanent and serious long-term impairment in respect of his work and personal life'. This seems to be a conclusion based on a mixture of orthopaedic and psychiatric findings. However, his formal conclusion in the accompanying RAF4 form was limited to item (aa) of the narrative test.

[50] Dr le Fèvre, apart from recording his own psychiatric findings, noted the orthopaedic findings. He concluded that the applicant met both items (aa) and (cc) of the narrative test.

The tribunal's modus operandi and reasons

[51] Prior to meeting on 21 May 2014 the members of the tribunal individually studied and analysed the documentation relating to the applicant's case and to the other cases they considered on that day.

[52] Dr Edeling, the neurosurgeon who made the main answering affidavit for the respondents, set out the matters which the members of the tribunal noted and their views on those matters. Mr Branford submitted that Dr Edeling could not testify about the independent preparations undertaken by the other members of the tribunal. Because only Dr Mutasa made a confirmatory affidavit, Dr Edeling's evidence was hearsay insofar as Drs Botha and Louw were concerned. I reject that argument. The tribunal's members are persons of professional standing. Unless the reasons given in the opposing papers justify a finding that they could not have read all of the material before them, I have no reason to doubt that they prepared for the applicant's appeal in accordance with the general modus operandi described by Dr Edeling. Furthermore Dr Edeling's personal participation in the deliberations would have enabled him to conclude that his co-panellists were familiar with the various reports.

[53] According to Dr Edeling, the members of the tribunal noted the key features of each doctor's findings. Except in regard to the likelihood of adjacent disease and future surgery, the tribunal in essence accepted the orthopaedic findings of the various doctors which, despite some minor differences, were – unsurprisingly – broadly similar. The tribunal was of the view, however, that the conclusions reached by Drs Burger, Domingo and Le Roux, to the effect that the applicant's injuries were 'serious' within the meaning of item (aa), were not supported by the findings or by further explanation.

[54] In regard to the likelihood of adjacent disease and future surgery, two of the tribunal members, Dr Edeling and Dr Mutasa, had expertise in the field of spinal injuries and surgery. Dr Edeling said that both of them were aware of scientific knowledge that, following spinal fusion surgery, the risk of extension of fusion in later years was less than 50%. Various studies found the incidence of extension to range from 15% to 25%. The tribunal thus accepted Dr Steyn's opinion that the applicant's risk of future surgery amounted to a possibility but not a probability.

[55] Dr Edeling added that, even if the risk of further surgery amounted to a probability, this would not without more justify classifying an injury as 'serious' for purposes of the narrative test.

[56] In regard to Dr le Fèvre's psychiatric findings, the tribunal noted that the risk of a relapse into depression amount to 'an unquantified possibility'. They did not regard this as satisfying the requirements of the narrative test.

[57] Overall, the tribunal's finding was that the applicant's injuries could not be regarded as 'serious'.

[58] I do not regard the tribunal's views on the various reports or its ultimate conclusion as irrational. The fact that four of the five doctors whose reports served before the tribunal concluded that the applicant's injuries were 'serious' does not in itself justify a finding of irrationality. The tribunal, in this instance made up of four doctors, was not only entitled but obliged to bring its own expertise and professional judgment to bear on the case.

[59] The complaint that they did not have the benefit of examining the applicant is misconceived because they accepted the general tenor of the orthopaedic and psychiatric findings. What was important in this case was the value judgment to be passed on the orthopaedic and psychiatric findings which were broadly uncontentious. The same applies to the complaint that the tribunal should not have rejected the appeal without directing that further medical reports be obtained (something which it was entitled but not obliged to do – the *Duma* case supra para 26). The material before the tribunal did not indicate that the objectively verifiable

facts regarding the applicant's condition were materially in dispute. Merely increasing the headcount of value judgments on one side or the other could not have assisted the tribunal.

[60] I think the tribunal was justified in saying that the doctors who assessed the applicant's injuries as 'serious' under the narrative test did so without providing adequate reasons or explanation. To be fair, it may sometimes be difficult to explain or provide reasons for why one considers a stated set of symptoms and sequelae to be serious or severe for purposes of the narrative test but this simply highlights the point that, once the factual findings are established, the ultimate conclusion is a value judgment. The tribunal's value judgment that the applicant's injuries are not serious for purposes of the narrative test is no more an unreasoned conclusion than that of the four doctors who expressed the opposite view.

[61] However, I would in the present case have expected the doctors who concluded that the applicant's injuries were serious to have gone further than they did in explaining their opinions. In regard to item (aa) of the narrative test, the doctors needed to explain what long-term impairment or loss of body function the applicant had suffered as a result of his injuries. As I have already observed, pain in itself does not constitute the impairment of a body function. The various doctors considered that the applicant would be able to work to normal retirement age in his chosen career. The applicant's only leisure activity mentioned in the reports is golf which he apparently continues to enjoy without pain. The applicant's pain, which can be treated to some extent with analgesia and physiotherapy and the occasions for which can be reduced by manageable lifestyle adjustments (such as not holding particular postures for lengthy periods), does not, as I read the reports, rise to the level of seriously impairing any of the applicant's body functions (such as concentration or physical activity of a kind in which he would normally engage). Dr Domingo, it will be recalled, described the applicant's neck pain and spasm as 'mild to moderate' and said that the applicant was 'mildly disabled by his pain'. While neck mobility (which is a body function) has been adversely affected, the negative effect appears to be relatively modest.

[62] The tribunal's conclusion that the applicant did not face adjacent disc disease and future surgery as a probability seems to me to have been one that was legitimately open to them. I have already noted that the quantification of this risk by Dr Domingo and Dr le Roux is not self-evidently justified by the research to which they refer.

[63] The tribunal did not advert to Dr le Roux's observation of existing spondylosis at the C5/C6 level, a circumstance which may place the applicant at greater risk of adjacent disc disease. The fact that Dr Domingo, who saw the MRI and CT scans performed in September 2010, did not observe the pre-existing spondylosis is puzzling. The radiological report of 6 March 2013, while recording earlier spondylosis at the C5/C6 level, stated that there were no signs of degenerative disc pathology currently visible. It is thus not clear that the radiological evidence clearly pre-disposed the applicant to adjacent disc disease. In any event, the medical research cited in the various papers does not appear to support Dr le Roux's prognosis of a 75% likelihood that the applicant will have to undergo a C5/C6 fusion, and the tribunal – whose members had read Dr le Roux's report – specifically rejected that assessment of the probability.

[64] In any event, and even if it were more probable than not that the applicant would face a C5/C6 fusion at some stage in his life, this would not in itself justify a conclusion that his injury was 'serious' for purposes of the narrative test. The reports do not indicate that an extension of the fusion would prevent the applicant from working or pursuing his usual social pleasures. The tribunal in terms rejected the proposition that a probability of future surgery justified classifying the injury as 'serious'.

[65] The tribunal was criticised for rejecting Dr le Fèvre's opinion despite its absence of psychiatric expertise. (The applicant's attorneys, I note in passing, did not object to the absence of a psychiatrist when notified of the composition of the tribunal.) I do not think the criticism has traction in this case, for the simple reason that the tribunal did not reject Dr le Fèvre's opinion that the applicant's second bout of depression (brought on by the accident) placed him at greater risk of depressive episodes in the future or that neck pain and stiffness might be among the stress

factors which could precipitate further depression. Accepting these general psychiatric findings, the tribunal did not regard the conclusion of serious injury within the meaning of para (cc) of the narrative test as justified.

[66] Mr Branford submitted that Dr Edeling, in summarising the tribunal's deliberations regarding Dr le Fèvre, spoke of the risk of relapse into depression on account of 'the normal stresses of work, relationships and getting on in life' (the words used in the penultimate paragraph of Dr le Fèvre's report). This indicated, so it was argued, that the tribunal had overlooked Dr le Fèvre's statement earlier in the report that having a damaged neck 'could well be an added stress in precipitating another relapse'. I think this is too pedantic a criticism of the tribunal's reasoning. Dr Edeling testified that the tribunal's members read and analysed all the reports. In regard to Dr le Fèvre's report, the tribunal accepted, he said, all the psychiatric findings. The report was only 3½ pages long. I do not find it at all plausible that the tribunal overlooked the additional stresses caused by the neck injury.

[67] It was not irrational for the tribunal to consider that the unquantified possibility of future depression did not rise to the level demanded by the narrative test. Para (cc) calls for a finding of 'severe' mental disturbance or disorder which, as I have explained, probably indicates greater intensity than 'serious'. Dr le Fèvre did not quantify the likelihood of future depressive episodes or say how long such episodes were likely to last or how well future bouts were likely to respond to anti-depressant medication. He did not say that the applicant's position was such that he needed to be on long-term prophylactic anti-depressants. It may also be observed that Dr le Fèvre did not say that he had received reports from the psychiatrists who treated the applicant as a teenager and following the accident.

[68] It needs to be emphasised that the applicant is not precluded from recovering pecuniary compensation for the sequelae and future risks which have been caused by the accident merely because his injuries are not classified as 'serious'. Subject to appropriate proof at trial, he will be entitled to recover damages in respect of future medical expenses such as analgesia, physiotherapy, future surgery, treatment of depression and so forth, either in full or rateably according to the risk. There may also be associated pecuniary damages in respect of future earnings. But in the

absence of a finding of 'serious injury', he cannot recover non-pecuniary compensation.

Conclusion

[69] In my view, therefore, the respondents have discharged the burden of showing that the tribunal's rejection of the appeal was not a decision made without good reason. The applicant has not made out any other grounds of review.

[70] The application is thus dismissed with costs.

ROGERS J

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