

SERIOUS INJURY CLAIMS REJECTED BY THE ROAD ACCIDENT FUND: THE APPEAL PROCESS¹

M Slabbert

*BA BA(Hons) HED BProc LLB LLD
Professor, Department of Jurisprudence,
University of South Africa, Pretoria (UNISA)*

HJ Edeling

*MBBBCh FCS (SA) (Neuro)
Certified Independent Medical Examiner*

SUMMARY

The Road Accident Amendment Act came into effect in 2008. This Act limits the Road Accident Fund's liability for compensation in respect of claims where serious injuries have been sustained. In the event of the Road Accident Fund rejecting a serious injury claim the appeal process is prescribed by the regulations to the Act. The disputed case has to be referred to an Appeal Tribunal under the auspices of the Health Professions Council of South Africa. The Tribunal faces many challenges despite the fact that the use of the AMA Guides is intended to yield objective and consistent findings.

1 INTRODUCTION

The Road Accident Fund (RAF) was established in terms of the Road Accident Fund Act 56 of 1996. The Road Accident Fund Amendment Act 19 of 2005 (hereinafter "the Amendment Act") came into effect on 1 August 2008.² The Amendment Act limits the Road Accident Fund's liability for compensation in respect of claims for non-pecuniary loss³ to instances where "serious injury" has been sustained. The Amendment Act also limits the amount of compensation that the RAF is obliged to pay to claims for loss

¹ This article is a follow-up to the article Slabbert and Edeling "The Road Accident Fund and Serious Injuries: The Narrative Test" 2012 15(2) *PER* 268–289. See also in this context Steynberg and Ahmed "The Interpretation of the Amended RAF Act 56 of 1996 and the Regulations Thereto by the Courts with Regard to "Serious Injury" Claims" 2012 15(2) *PER* 245–266.

² For a history of the Amendment Act see *Road Accident Fund v Duma* 202/2012 and three related cases (Health Professions Council of South Africa as *Amicus Curiae*) [2012] ZASCA 169 (27 November 2012) par 3–11.

³ See Slabbert and Edeling 2012 15(2) *PER* 269 fn 1.

of income or a dependant's loss of support arising from the bodily injury or death of a victim of a motor vehicle accident.

In cases claimed as serious, by virtue of either 30 per cent or greater whole person impairment (WPI) or the narrative test, but that have been rejected by the RAF, the claimant may appeal to a Health Professions Council of South Africa (HPCSA) Appeal Tribunal for determination of the seriousness of the injuries.⁴ This article investigates the rejection of serious injury claims by the RAF and the appeal process prescribed by the regulations in cases of disputed rejections. The article also highlights guidelines to the narrative test intended for use by medical practitioners who compile RAF 4 serious injury reports. If the guidelines are followed it will help appeal tribunals to evaluate rejected claims. In conclusion a few Appeal Tribunal cases are discussed to indicate the abuse of the appeal process and the recurring problems and deficiencies in serious injury assessment procedures.

2 SERIOUS INJURIES

According to section 17(1A) of the Amendment Act whether or not a particular injury meets the threshold to be classified as "serious", an assessment must be carried out by a medical practitioner registered under the Health Professions Act 56 of 1974. The medical practitioner must follow a prescribed method. The method is defined in section 1 of the Amendment Act to mean "prescribed under s 26". Section 26(1) stipulates that the Minister of Transport may make regulations regarding any matter that shall be prescribed in terms of the Act. Section 26(1A) determines that the Minister may make regulations regarding, *inter alia*, the method of assessment to determine whether, for the purpose of section 17, a serious injury has been incurred. Accordingly the Road Accident Fund Regulations of 2008 were promulgated by the Minister through publication in the *Government Gazette* of 21 July 2008. Section 3(1)(a) of the regulations provides that a third party who wishes to claim general damages "shall submit himself or herself to an assessment by a medical practitioner in accordance with these regulations". In terms of s 3(3)(a) a third party who has been so assessed, "shall obtain from the medical practitioner concerned a serious injury assessment report". This report is defined in the regulations as "a duly completed RAF 4 form".

The *American Medical Association's Guides to the Evaluation of Permanent Impairment*, Sixth Edition (hereinafter "the AMA Guides")⁵ should be used to determine the WPI percentage.⁶ Following this assessment, injuries that are found to have resulted in 30 per cent WPI or greater are regarded as serious injuries. In cases in which the WPI is found to be less

⁴ Road Accident Fund Act 56 of 1996: Road Accident Fund Regulations, 2008. GG 31249, Notice 770 of 2008-07-21, the Regulations became effective on 1 August 2008. See s 3(8) of the Regulations.

⁵ Rondinelli *Guides to the Evaluation of Permanent Impairment* (2008). For an explanation of the *AMA Guides* see *Law Society of South Africa v Minister of Transport* (10654/09) [2010] ZAGPPHC 26; 2010 (11) BCLR 1140 (GNP) (31 March 2010) par 59.

⁶ See s 3(1)(b)(ii) of the Regulations.

than 30 per cent, but a medical practitioner nonetheless regards the injuries as serious, the narrative test should be applied.⁷

In terms of regulation 3(1)(b)(i) the Minister may publish a list of those injuries which do not qualify as serious *per se*. Accordingly the Road Accident Fund Amendment Regulations of 2013 was promulgated by the Minister through publication in the *Government Gazette* of 15 May 2013. The amended regulation 3(1)(b)(i) provides that injuries described in subsections (aa) to (pp) are not to be regarded as serious, provided that if any complication arises from any one, or any combination of such injuries, the third party shall be entitled to be assessed in terms of sub-regulations 3(1)(b)(ii), i.e. AMA Guides and s 3(1)(b)(ii), i.e. the narrative test.⁸

3 REJECTION OF RAF CLAIMS

In *Mngomezulu v RAF*⁹ the court provided guidelines with regard to the rejection of a serious injury claim. If the RAF is not satisfied that the injury has been correctly assessed there are two routes that may be taken. First, the RAF may reject the serious injury assessment report (RAF 4) and furnish the claimant with reasons for its decision.¹⁰ This only applies if the RAF 4 form has not been correctly completed. Examples of such incorrectly completed forms would include that the reports were completed by an unqualified person; the assessment was not conducted in terms of the prescribed method; the impairment evaluation reports for a specific body part were not attached as required; or the report was not completed in all particularity. It is important to emphasise that the RAF cannot just reject the claim without providing “sufficient reasons” which are substantial, relevant and rational to justify such rejection.¹¹ Second, before deciding whether to accept or reject a claim, the RAF may request the claimant to avail him- or herself for further assessment by an appointed medical practitioner at the RAF’s cost.¹² For the RAF to succeed in rejecting a claim on this basis, it must provide a dissenting medical opinion. Only when the measures above have been exhausted, can the matter be referred to the Appeal Tribunal at the HPCSA. The court also pointed out in the *Mngomezulu* case that road accident victims “are constantly faced with ill-founded, spurious and brazen attempts to delay finality of matters” whereas the aim of the amendments “was to shorten the time for settlement or finalisation of the claims rather than to further delay them”.¹³

If a claimant wishes to dispute the rejection of a serious injury assessment report, he or she must, within ninety days of being informed of the rejection,

⁷ S 3(1)(b)(iii) of the Regulations.

⁸ Road Accident Fund Amendment Regulations, 2013, published in R374 GG 36452 of 2013-05-15; and Regulation 3(a)(i) (aa)–(pp).

⁹ Unreported case no 4643/2010. Gauteng High Court.

¹⁰ S 3(3)(d)(i) of the Regulations.

¹¹ As was held in *Smit v RAF* unreported case no 47697/2009, Gauteng High Court.

¹² Regulations s 3(3)(d)(ii). See also *Road Accident Fund v Duma supra* par 8.

¹³ Ahmed “*Mngomezulu v RAF*, Gauteng High Court (unreported case no: 4643/2010)” <http://www.aif.co.za> (accessed 2011-12-19).

notify the Registrar¹⁴ that the rejection is disputed by lodging a dispute resolution form (RAF5) with the Registrar.¹⁵ The grounds upon which the rejection is disputed should be explained and medical reports and opinions relied upon should be added to the form.¹⁶

The Registrar should then, within fifteen days, inform in writing the other party (RAF) of the dispute and copies of all submissions, medical reports and opinions should be provided to the RAF.¹⁷ The RAF should then respond within sixty days to the Registrar and indicate which submissions, medical reports or opinions are in dispute and they should attach their information upon which they rely.¹⁸ After another sixty days, the Registrar shall refer the dispute for consideration by an Appeal Tribunal paid for by the RAF.¹⁹ According to the HPCSA's 2013 Annual Report a total of 22 Appeal Tribunals were held, 466 matters were dealt with and 377 cases were finalised.²⁰

The case of *RAF v Faria* (567/13) [2014] ZASCA 65 of 19 May 2014 dealt with the substantive and procedural legal requirements that follow the rejection by the RAF of a claim. The Supreme Court of Appeal stressed once again that the dispute resolution procedure if a RAF 4 claim has been rejected is provided for in the regulations specifically sub-regulation 3(4) read together with sub-regulations 3(5), 3(8), 3(10), 3(11), 3(12) and 3(13). "There is no other".²¹ The point was highlighted again that the dispute resolution procedure in the regulations culminates in a determination by an Appeal Tribunal and the determination of the Appeal Tribunal "shall be final and binding".²² Willis JA, by referring to the case of *RAF v Lebeko*,²³ stated that the court could not make an order for the payment of general damages as the court cannot assess whether damages are serious or not. This is an administrative process in terms of a prescribed manner.²⁴ He was referring to the dispute procedures through an Appeal Tribunal.

4 THE APPEAL TRIBUNAL AS PRESCRIBED BY THE REGULATIONS

The Appeal Tribunal as prescribed by the regulations²⁵ consists of three independent medical practitioners with expertise in the appropriate areas of

¹⁴ "Registrar" according to section 1 "Definitions" in the regulations means the Registrar of the Health Professions Council of SA established in terms of S 2 of the Health Professions Act 56 of 1974.

¹⁵ Regulations s 3(4)(a).

¹⁶ Regulations s 3(4)(b).

¹⁷ Regulations s 3(6).

¹⁸ Regulations s 3(7)(a) and (7)(b).

¹⁹ Regulations s 3(8)(a).

²⁰ www.hpcsa.co.za/Uploads/.../hpcsa_annual_report_2012_2013.pdf (accessed 2013-12-19).

²¹ *Road Accident Fund v Faria* (567/13) [2014] ZASCA 65 (19 May 2014) par 32.

²² *Ibid.*

²³ *Road Accident Fund v Lebeko* (802/2011) [2012] ZASCA 159 (15 November 2012).

²⁴ *Road accident Fund v Faria supra*; *Road Accident Fund v Lebeko supra* par 5, as well as par 20 and 23; and see also *Akaai v RAF* 10/04245 South Gauteng High Court 13 October 2011 par 7.

²⁵ Regulations s 3(8)(b).

medicine. They are appointed by the Registrar and he or she shall designate one of the three as the presiding officer. If need be the Registrar may appoint an additional independent health practitioner with expertise in any appropriate health profession to assist the Appeal Tribunal in an advisory capacity.²⁶ The Registrar must inform all the relevant parties who the persons are that he or she has appointed.²⁷

If it appears to the majority of the members of the Appeal Tribunal that there are relevant legal disputes, the presiding officer will indicate this to the Registrar, who will ask the chairperson of the Bar Council or the chairperson of the Law Society, of the jurisdictional area concerned, to appoint an advocate of the High Court of South Africa, or an attorney with at least five years' experience in practice, to consider the issues submitted by the presiding officer of the Appeal Tribunal.²⁸ The lawyer must then make recommendations in writing whether the nature of the dispute warrants a hearing for the purpose of considering legal arguments. If the Appeal Tribunal is convinced that there is a case, the lawyer will preside at a hearing for this purpose.²⁹ The parties are allowed legal representation during such a hearing at their own cost. After the hearing has taken place, the lawyer shall make written recommendations to the Appeal Tribunal in relation to the legal issues arising from the hearing. The Appeal Tribunal shall consider the recommendations made by the lawyer and determine, in writing, the legal issues.

If there are no legal issues, or the legal issues have been dealt with, the tribunal may, for the purpose of the medical assessment, direct that the third party to submit himself or herself, at the cost of the Fund or agent, to a further assessment by a medical practitioner designated by the tribunal; that the third party present himself or herself in person to the Appeal Tribunal for assessment;³⁰ that further medical reports be obtained by one or more of the parties and placed before the tribunal,³¹ that relevant medical or other records be obtained and placed before the tribunal; and that further submissions by one or more of the parties be made to the tribunal. The tribunal will then determine whether in its majority view the injury concerned is serious or not, after which they will either confirm the rejection of the serious injury assessment report by the RAF, or accept the serious injury assessment report and confirm that the injuries are serious. The findings of the tribunal shall be final and binding.

5 PROBLEMS FACING THE APPEAL TRIBUNALS

Since their inception Appeal Tribunals have identified significant problems in practice. Despite the fact that the use of the AMA Guides is intended to yield objective and consistent findings, tribunals have been frustrated by the many cases in which different practitioners have reported widely divergent WPI

²⁶ Regulations s 3(8)(c).

²⁷ Regulations s 3(9).

²⁸ Regulations s 3(10).

²⁹ Regulations s 3(10)(e).

³⁰ Regulations s 3(11)(a).

³¹ Regulations s 3(11)(b).

percentages. The AMA Guides requires a single medical practitioner, irrespective of his or her discipline, to report on all permanent impairments in each case, but in many reports a WPI percentage was found that it is limited to the area of expertise of the reporting practitioner, while other impairments are either ignored or are mentioned in a cursory fashion, but not included in the WPI percentage.

For example, an orthopaedic surgeon will report in detail on the musculo-skeletal system, but will fail to report on the mental impairment, psychological impairment, disfigurement or impairments relating to other systems. This has led to many unnecessary rejections of valid claims by the RAF.

Despite the arguments advanced in the case of *Law Society South Africa v The Minister of Transport*³² to the effect that the use of the AMA Guides should take the circumstances of the third party into account, tribunals have found that in the vast majority of cases any such consideration has no effect on whether the WPI percentage is greater than or less than 30%, in other words, no effect on whether the injuries are found to be serious or not.

In a small minority of cases it has been evident that the use of the AMA Guides, as a stand-alone test, provides a sufficient basis for determining that injuries are serious or not. In all the rest, tribunals have found the need for a narrative test. The most common reason for this need has been the failure of the AMA Guides to take the circumstances of the third party into account effectively. The AMA Guides fails specifically in the estimation of the effects of abstract and subjective impairments, particularly mental impairment, psychological impairment and chronic pain.

Unfortunately most narrative test reports, based as they have been on the wording in the regulations, have been lacking in relevant content or substantive meaning. Although this has led to frustration and added to the workload of the Appeal Tribunal members, criticism of the reporting medical practitioner has been tempered by the realisation that the regulations do not provide any indication of the required structure or content of a narrative test report.

Appeal Tribunals have been inundated with appeals in matters that should clearly not have been claimed and others that should clearly not have been rejected. These problems led to backlogs and delays in finalising claims. The HPCSA has therefore appointed a task team consisting of tribunal members to draw up guidelines to the narrative test.³³

6 THE GUIDELINES TO THE NARRATIVE TEST³⁴

The guidelines to the narrative test, as drawn up by the task team addresses the situation by defining what the narrative test is; reasons for applying it and

³² *Supra.*

³³ Drs HJ Edeling; NB Mabuya; P Engelbrecht; KD Rosman and D A Birrell.

³⁴ Edeling, Mabuya, Engelbrecht, Rosman and Birrell "HPCSA Serious Injury Narrative Test Guidelines" 2013 103(10) *SAMJ* 763–766.

who should compile it, as well as the required structure, contents and criteria in South Africa.

These guidelines are intended for the use of medical practitioners who perform RAF 4 serious injury reports; Appeal Tribunals who evaluate appeals against matters that have been rejected by the RAF; claimants and their representatives in deciding whether or not to institute claims for serious injury; and the RAF in deciding whether to accept or reject claims.

For convenience essential elements of the guidelines are summarised herein.

6 1 Who should compile a narrative test report?

The narrative test report should be compiled by a “medical practitioner”, defined in the regulations as “medical practitioner registered in terms of the Health Professions Act 56 of 1974”. The guidelines recommend that the narrative test report provided by a medical practitioner should generally be supplemented by the report or reports of other relevant experts, mainly in order to properly describe the relevant altered circumstances of the claimant. Relevant other experts refer to occupational therapists, neuropsychologists, educational psychologists, speech therapists, and industrial psychologists. Such supplementary reports of the relevant experts should refer to the diagnoses of the medical practitioner. Requisite comments on the supplementary reports, as specified in the guidelines, should be provided by the medical practitioner.³⁵

6 1 1 Structure and content of a narrative test report

A Narrative Test Report should include relevant and meaningful comments in relation to each of the following sections:

The injury diagnosis (acute)

The diagnosis of injuries sustained in the accident should be recorded by using a specific name to describe each injury during the acute post-traumatic period. The medical doctor should also provide an opinion in relation to the *nexus* between the accident and the diagnosed injuries. The following are examples of injury diagnoses: compound fracture of the left femur, head injury with severe brain injury, soft tissue injury of the lumbar spine, psychological trauma, *etcetera*.³⁶

The outcome diagnosis (permanent)

The diagnosis of the chronic condition that has arisen from the injuries should be recorded, in other words a meaningful name should be used describing each chronic post-traumatic condition following maximal medical improvement (MMI). The medical practitioner should provide an opinion in

³⁵ Edeling *et al* 2013 103(10) *SAMJ* 764.

³⁶ *Ibid.*

relation to MMI and in relation to the *nexus* between the injury diagnosis and the outcome diagnosis. The following are examples of outcome diagnoses: post fracture syndrome with malunion and deformity, post-traumatic organic brain syndrome, intermittent mechanical back pain or post-traumatic stress disorder. The outcome diagnosis also serves as a description of permanent impairment following the accident.³⁷

The external circumstances of the person's life

A factual description should be recorded of the external circumstances of the person's life, for example the environmental or contextual circumstances. These circumstances generally remain unaltered following the accident, but in case of any change, such changes should be recorded. External circumstances include: geographical location, type of accommodation, family support, financial status, cultural affiliation, religious affiliation, access to transport and access to health care. In this section it is acceptable and generally advisable for the medical practitioner to refer to the supplementary report/s of the other experts, so as not to duplicate facts. In order to do this it is essential for the medical practitioner to read such supplementary reports and to express an opinion in relation to the *nexus* between the injuries sustained in the accident and any reported changes in external circumstances.³⁸

The individual circumstances of the person's life and functional impairment

A factual description of pre-accident individual circumstances should be recorded; meaning the personal circumstances that are more vulnerable to change flowing from any permanent impairment. This should be followed by factual descriptions of functional impairments after MMI, including altered and unaltered post-accident individual circumstances. It is changes in these individual circumstances that typically describe the nature and elements of permanent disability. Individual circumstances include: basic and advanced activities of daily living,³⁹ personal amenities, such as sporting and other recreational activities, life roles, such as parent, child, sibling, spouse, partner, friend, breadwinner, mentor, supervisor, caregiver, *etcetera*, independence or degree of dependency, educational status and capacity, and employment status and capacity. Once again for this part the medical practitioner may rely on the supplementary reports of the other experts, but he or she must express an opinion in relation to the *nexus* between the injuries sustained in the accident and the findings of the other experts regarding the functional impairment and altered post-accident individual circumstances.⁴⁰

³⁷ Edeling *et al* 2013 103(10) *SAMJ* 765.

³⁸ *Ibid.*

³⁹ As set out in the AMA Guides 323.

⁴⁰ Edeling *et al* 2013 103(10) *SAMJ* 765.

Chronic pain, subjective suffering and/or loss of enjoyment of life

The consequences of injuries and impairment that are referred to above are largely tangible and objectively determinable. Injuries and impairments may also result in variable degrees of subjective suffering that are more abstract and difficult to measure. Bearing in mind that compensation for pain, suffering and loss of enjoyment of life, all of which are both subjective and abstract, a proper assessment of subjective and abstract suffering is crucial. Because such subjective *sequelae* of injuries are not amenable to objective or concrete measurement, and because their assessment is more difficult than that of more tangible/concrete *sequelae*, the report should include opinions based on the mindful professional judgment by the medical practitioner and relevant other experts in relation to the plausibility and congruity or otherwise of the complaints. In addition the medical practitioner should provide an opinion in relation to the *nexus* between the injuries sustained in the accident and the reported pain, suffering and loss of enjoyment of life.⁴¹

The level or degree of the changes

The consequences of injuries, as referred to above, and as seen in relation to the circumstances of the claimant, essentially describe the nature or elements of permanent disability. In addition to the above, a determination of the seriousness of injuries requires an assessment of the level or degree of permanent disability, in other words, the level or degree of activity limitations, participation restrictions and subjective suffering. The report should therefore include comments by the medical practitioner and other experts based on reported facts as well as the application of mindful professional judgment, in relation to the level or degree of activity limitations, participation restrictions and subjective suffering, meaning the significance or otherwise of the changes to the life of the injured person. Whereas it is not feasible to express such opinions in a rigid quantitative manner (for example a percentage rating of permanent disability), it is feasible and necessary to express semi-quantitative opinions using terminology such as “insignificant”, “trivial”, “inconsequential”, “mild”, “moderate”, “intrusive”, “severe”, “overwhelming”, “devastating”, or “significant”.⁴²

6.2 Proposed criteria for the assessment of serious injuries

Injuries are classified as serious when, having regard to the nature and elements of permanent disability as well the level or degree of limitations, restrictions and subjective suffering, it is evident that the injuries have resulted in significant life changing *sequelae*.

⁴¹ *Ibid.*

⁴² *Ibid.*

Examples of serious and non-serious chronic pain as well as serious and non-serious mental impairment are provided in the guidelines.⁴³ By way of further example, the loss of amenities related to the injured knee of an auditor who is no longer able to mow his own lawn, would not be regarded as serious whereas the loss of amenities related to a stiff knee of a teacher who is no longer able to teach extra-mural activities,⁴⁴ or that of a Muslim who is no longer able to kneel,⁴⁵ would be regarded as serious. The loss of employment capacity related to subtle mental impairment of an assembly line worker who has become dependent on some degree of structure and supervision in the workplace, but for whom such structure and supervision have always formed an integral part of the job, and who has remained in the same employment and continued to satisfy the requirements of the employer, would not be regarded as serious. But, the loss of employment capacity related to subtle mental impairment of an advocate who has lost the ability to succeed in court as well as loss of enjoyment of life related to losses of professional standing, respect, and independence would be regarded as serious.

Whereas it is not possible to provide an objectively measurable definition of significant life changing *sequelae*, Appeal Tribunals have found that a panel of experienced medical practitioners who are provided with the sufficient relevant information (as set out above), are generally and readily able to reach agreement by consensus in relation to cases in which injuries have resulted in significant life changing *sequelae*, and cases in which injuries have not resulted in significant life changing *sequelae*. The task team therefore recommends that in the determination of whether injuries have resulted in significant life changing *sequelae* or not, should be the final criterion for evaluation of injuries as serious or not serious.⁴⁶

The guidelines to the narrative test give practical effect to the intention of the Act and the regulations. It has been designed to rely on the standard training, experience and diagnostic skills of medical practitioners and other health practitioners. While it is part of standard clinical, medical practice to investigate a patient's circumstances for purposes of diagnosis, management and prognosis, it is not the standard clinical practice of medical practitioners to report extensively on circumstances. For the purpose of complying with the Act and the regulations, however, a narrative test report does require sufficient reporting on circumstances for the seriousness or otherwise of the permanent impairment to be understood by all concerned. Although medical practitioners are qualified to investigate the circumstances of their patients to a certain extent, detailed investigations of circumstances

⁴³ Edeling *et al* 2013 103(10) SAMJ 763–766.

⁴⁴ See, eg, *Bvuma v RAF* 2012 SA (GSJ) Case no: 2010/17220 delivered on 14 December 2012. In *Shongwe v Road Accident Fund* (27351/08) [2012] ZAGPPHC 214 (4 September 2012) the court found that an inability to “walk or stand for lengthy periods of time” or to “sit for long” or to “coach sport at school” did render the educator a “more vulnerable employee”.

⁴⁵ See, eg, *Abrahams v Road Accident Fund* (1531/2010) [2012] ZAECPEHC 37 (29 May 2012) par 11, “The plaintiff is a devoted adherent to the Islamic faith and was a regular attendee at the mosque prior to the accident ... In consequence of the injuries which he sustained to his right leg he is entirely unable to kneel during prayers and is required to sit in a chair in the mosque.”

⁴⁶ Edeling *et al* 2013 103(10) SAMJ 766.

are performed more satisfactorily by other health practitioners, such as occupational therapists, neuropsychologists, educational psychologists, speech therapists, and industrial psychologists. The recommendations in the guidelines leave it to the discretion of the medical practitioner, the claimant, the representatives of the claimant, the RAF and the agents of the RAF to determine whether the report of the medical practitioner should be supplemented by a report/s of one or more other health practitioners.

Although the process that underlies an RAF 4 serious injury assessment should be comprehensive, in many cases an adequate narrative test report may be quite short. Two examples are included:

Example A:

1. Injury diagnosis:
Head injury with mild brain injury. Soft tissue injury of the cervical spine.
2. Outcome diagnosis:
Recurrent headaches due to head and neck injuries. No mental *sequelae*.
3. External circumstances:
Unaltered: Lives in a house in Sandton.
4. Individual circumstances:
Unaltered: Married. Owns a car. Employed at same level as senior bank clerk. Enjoys playing golf and an active social life.
5. Chronic pain:
Diffuse mild to moderate headaches on 2 to 4 days per month. Relieved by OTC (over-the-counter) painkillers.
CONCLUSION – NOT SERIOUS. (Mild *sequelae*).

Example B:

1. Injury diagnosis:
Head injury with severe brain injury. Soft tissue injury of the cervical spine.
2. Outcome diagnosis:
Permanent neuropsychological disorder and personality change due to brain injury. Recurrent headaches due to head and neck injuries.
3. External circumstances:
Altered due to loss of earnings resulting from neuropsychological disorder. Moved from house in Sandton to a garden cottage in Hoedspruit, Mpumalanga. No direct access to hospital services.
4. Individual circumstances:

Altered due to neuropsychological disorder and personality change. Divorced. Lost friends. Unemployed. Dependent on public transport. No longer able to afford golf.

5. Chronic pain: Diffuse mild to moderate headaches on 2 to 3 days per week. Relieved by OTC painkillers.

CONCLUSION – SERIOUS. (Significant life changing *sequelae*).

7 DISCUSSION OF APPEAL TRIBUNAL CASES

The following Appeal Tribunal cases have been selected for inclusion in the article to indicate the abuse of the appeal process as well as recurring problems and deficiencies in assessment procedures that end up at the Appeal tribunals. If proper regard were had to the filling in of the reports or the guidelines to the narrative tests, these cases would not have ended up at the Appeal Tribunal.

7 1 RAFA/008178/2013

This matter represents an abuse of the appeal process by the RAF. No meaningful reasons for rejecting the claim were given in the notice of rejection. Had the officials or agents of the RAF applied their minds to the available joint minutes and uncontested reports, the seriousness of the head injury would have been apparent prior to the trial.

Two RAF4 reports, one by a general practitioner and the other by an orthopaedic surgeon were compiled. Medico-legal reports by the orthopaedic surgeon, a neurosurgeon, a neuropsychologist, a plastic surgeon and a psychiatrist were attached as well a joint minute between the neuropsychologists. In summary the expert reports found that the person had sustained a significant concussive head injury, fracture of the C6 vertebra, a fractured acetabulum and multiple lacerations. These were found to have resulted in a post-traumatic organic brain syndrome, chronic headaches and neck pain, scarring of the scalp and a depressive mood disorder. The degree of mental impairment was such that protection of funds was recommended.

In the court *a quo* three experts for the plaintiff, a psychiatrist, a neuropsychologist and a neurosurgeon, all testified that the person had sustained a significant concussive brain injury. Primary post-traumatic amnesia was reported to have persisted for 3 days. There was no evidence of any other neurological injury. The psychiatrist testified that the brain injury had resulted in an organic brain syndrome, which, together with a significant post-traumatic depressive mood disorder, had resulted in neuro-psychological disturbances. He agreed with the neurosurgeon that the depression was a result of the organic brain syndrome. The neuropsychologist testified that the injury had resulted in permanent brain damage, as evidenced by findings on psychometric testing.

The defendant failed to lead any evidence to refute the findings of the expert witnesses that the plaintiff suffered a post-traumatic concussive brain injury as a result of the accident. In a joint minute the defendant's

neuropsychologist agreed that the neuropsychological disturbances were attributable to the concussive brain injury, aggravated by the effects of a significant post-traumatic depressive mood disorder. In their joint minute the industrial psychologists agreed that from a neurological perspective the plaintiff was a vulnerable employee, limiting his prospects of securing and retaining employment. They agreed that he would find it increasingly difficult to secure employment and would eventually find himself unemployable. The court found that the plaintiff had sustained a post-traumatic concussive brain injury as a result of the accident, that he had suffered future loss of income and that he had lost the ability to administer the proceeds of the matter. It was ordered that the claim for non-pecuniary losses be separated from all other issues and postponed *sine die* for purposes of the referral thereof to the Health Professions Council of South Africa. Having regard to the above, the Tribunal found that the plaintiff had sustained a serious head injury according to the narrative test.

7 2 RAFA/008739/2014

In this case there was a RAF4 report of a general practitioner together with the medico-legal reports of two orthopaedic surgeons, a neurologist, a neuropsychologist, a surgeon, two occupational therapists and two industrial psychologists, as well as a joint minute between the industrial psychologists.

In summary the expert reports found that the person had sustained a head injury with fractured nose, plus occipital impact and depressed skull fracture, compound fractures of the right tibia and fibula and soft tissue injury of the lumbar spine. The lower limb fractures had been treated by open reduction and internal fixation surgery. An orthopaedic surgeon found loss of consciousness with dense PTA for one hour until regaining awareness in hospital, while the neurologist found no loss of consciousness.

The injured person had matriculated, and prior to the accident had been employed as an assistant at a supermarket and as an assistant mechanic at a mine. He had reportedly stopped working after the accident because of constant, severe pain and swelling of the right leg, lower back pain and a disciplinary hearing for too much sick leave or absenteeism. He had stopped playing soccer completely and was restricted to light activities at home. Persistent post-traumatic problems reported by the injured person included swelling, pain and discomfort of the right leg; night pain; limping; chronic back pain; severe daily headaches and cognitive decline. Persistent impairments found by the experts on examination, testing and investigation included a healed right tibial fracture with 7 varus angulation; mild retro patellar crepitus and tenderness of the right knee; synovitis/tendinitis of the right ankle; multiple right pre-tibial scars; lumbar spinal muscle spasm, scoliosis and tenderness to palpation; stress; depression secondary to physical disability and cognitive impairment. The general practitioner found 26% WPI and serious injuries according to paragraph 5 1 of the narrative test. One orthopaedic surgeon found 4% WPI and serious injuries according to paragraph 5 1 of the narrative test. No explanation was provided for the conclusion that the injuries were serious.

The other orthopaedic surgeon found WPI less than 30% (but did not provide an actual figure) and that the injuries were not serious according to the narrative test (considering the lower limb injury in isolation). On the basis of clinical examination and radiological findings he concluded symptom magnification and considered that pain would improve following removal of internal fixation. The neurologist found minor head injury, WPI 7% (for depression and headaches in isolation) and serious injuries according to paragraph 5.3 of the narrative test. No abnormalities were found on a late MRI brain scan. The ENT surgeon found chronic nasal bleeding due to the MVA. The neuropsychologist found PTSD and a major depressive disorder, resulting in significant cognitive impairments on neuropsychological testing. The occupational therapist of the RAF observed diminished focus due to physical and mental fatigue during testing. She opined that following treatment and rehabilitation he would be able to perform sedentary, light, medium as well as intermittent heavy work, but that he would have discomfort with prolonged static postures and would need to change his positions intermittently. In their joint minute the industrial psychologists noted that according to his direct supervisor at work he had been a very good, hard worker prior to the accident, he had hardly ever been absent from work; that post-accident he had been left physically impaired and had been absent from work more often; that almost every time that he was absent it was as a result of his leg; that he now struggled to walk or stand for long periods of time and that he struggled to bend down in order to climb under the machines to work. The industrial psychologists agreed that as a result of the injuries sustained in the accident he had become a vulnerable employee in terms of his ability to sustain his current employment, and also to obtain other employment if he were to be retrenched or dismissed. They agreed that he should be compensated for past loss of earnings and future loss of earnings.

Considering the above, the Tribunal found serious injuries according to the narrative test on the basis of the combined effects of his post-traumatic physical impairment, pain, psychological impairment and mental impairment.

This case illustrates a variety of recurring problems and deficiencies in serious injury assessment procedures. The members of the Tribunal had to read numerous reports that took the matter no further than the RAF4 report of the general practitioner. Examples of counter-productive problems experienced by the Tribunal include: Agents or attorneys not applying their minds to available information; occupational therapists regurgitating patient reports; individual assessment findings and opinions of other people, but failing to make clear statements of their own conclusion in relation to current work capacity and current capacity to enjoy amenities of life; expression of opinions on putative future work capacity pending successful treatment and rehabilitation, without any knowledge that the treatment or rehabilitation will be provided; and specialists providing partial WPI percentages relating to their area of expertise or interest, but without any clear statement that percentages for other impairments should be calculated and added.

7 3 RAFA/009489/2014

Regard was had to medico-legal reports by two orthopaedic surgeons and a plastic surgeon, who all found that the injured person had sustained a fracture of the left humerus. The injured patient complained of pain at the fracture site when lifting heavy objects. An unsightly operation scar over his left upper arm was noted on examination, but was not complained of by the injured person. The plaintiff's orthopaedic surgeon did not complete an RAF 4 report and did not express any opinion in relation to the seriousness or otherwise of the injuries. The plaintiff's plastic surgeon described the scarring, but did not consider the injuries to be serious on WPI or the narrative test. The defendant's orthopaedic surgeon did not calculate WPI, but found that the patient did not qualify for the narrative test. In their joint minute the orthopaedic surgeons agreed that he has full ranges of pain free motion of the left shoulder, elbow, forearm and wrist; that the fracture has united fully; and that removal of the internal fixation may be beneficial.

On the basis of the above the Tribunal found that the injuries were not serious. Referral of this matter to the Appeal Tribunal amounted to an abuse of the process by the Plaintiff, considering that the injuries were not regarded as serious by any of the examining doctors.

7 4 RAFA/008811/2014

The Tribunal was provided with a single RAF 4 report by the plaintiff and no opposing reports. In the accident the injured person sustained a burst fracture T12; spinal cord injury resulting in paraplegia; transverse process fractures from T11 to L5; spinous process fractures C5 and C6; and chest injury with fracture of the 11th rib and lung contusion. The injuries were found to have resulted in T11 paraplegia with total paralysis of the lower limbs. On this basis the Tribunal found serious injuries according to WPI and the narrative test.

The Tribunal expressed dismay at the failure of the RAF to recognize and acknowledge the obvious seriousness of the injuries. The rejection of the RAF resulted in an unjustified delay in compensating the victim, as well as wasteful expenditure and unnecessary work by attorneys, the HPCSA and members of the Appeal Tribunal.

The selected cases discussed above highlight only some of the problems experienced by the Appeal Tribunal. They are indicative of the fact that the people involved in a serious injury claim either do not apply their minds or lack knowledge on how to correctly compile a serious injury report or follow the narrative test. The result of this incapacity is lengthy appeal processes that could have been avoided.

8 CONCLUSION AND RECOMMENDATION

According to current legislation a person who has been injured in a motor vehicle accident will only be compensated for general damages if he or she has sustained a serious injury. In order to prove that a serious injury has been sustained an RAF 4 report must be completed by a medical

practitioner. If the injured person's claim for compensation is rejected by the RAF, he or she can appeal to the HPCSA Appeal Tribunal to finally determine whether a serious injury has been sustained.

Unfortunately, for a variety of reasons there has been a huge backlog in appeal cases and therefore in finalising claims. This article highlights guidelines to assist medical practitioners and Appeal Tribunal members. Use of the guidelines is expected to reduce unnecessary claims in cases that are not serious; to reduce unnecessary rejections of claims in cases that are serious; to reduce the burden of costs and professional/administrative time of the HPCSA and Appeal Tribunal members; and ultimately to speed up the finalisation of claims.

The process of determining the seriousness of an injury could be easier if the Minister of Transport were to amend the regulations so as to define the narrative test in a manner that clearly communicates its purpose, as argued on his behalf in the case *Law Society of South Africa v The Minister of Transport*.⁴⁷ This may be achieved, for example, by a wording such as "A narrative test report, which is intended to act as a safety net by taking the circumstances of the third party properly into account, should be included as the final element of the three-part collective assessment process". The process would further be facilitated if the Minister were to prescribe adherence to the existing guidelines drawn up by the HPCSA Appeal Tribunals task team.

⁴⁷ *Supra*.