THE REPUBLIC OF SOUTH AFRICA

IN THE HIGH COURT OF SOUTH AFRICA
(WESTERN CAPE DIVISION, CAPE TOWN)

Case No: SS65/2014

In the matter between:

THE STATE

and

TAARIQ PHILLIPS ***Accused***

JUDGMENT – 10 & 11 SEPTEMBER 2018

BOZALEK J

[1] The accused was arraigned before Court on 9 October 2015 on three charges all arising out of an incident on 1 January 2014 at or near Le Bac Estate, Paarl. On count 1 of the amended indictment it was alleged that the accused had sexually penetrated one, S C (who was also referred to as […]) by penetrating her vaginally with his penis or an object unknown to the State without her consent or under circumstances when the complainant was unable to give such consent. A further allegation was that the provisions

of Act 105 of 1997 were applicable and the minimum sentence of life imprisonment must be imposed in that the crime is mentioned in part I of Schedule 2 and further in that the victim was raped more than once and secondly, it involved the infliction of grievous bodily harm.

[2] On count 2 the accused was charged with committing a further act of sexual penetration of S C by similarly penetrating her anally without her consent or under circumstances when she was unable to give such consent. On the same grounds it was alleged that the provisions of Act 105 of 1997 were applicable and a minimum sentence of life imprisonment.

[3] On count 3 it was alleged that the accused had unlawfully and intentionally killed S C by strangling her or inflicting upon her violence unknown to the State. It was similarly alleged that the provisions of Act 105 of 1997 were applicable and a minimum sentence of life imprisonment in that the deceased's death was caused by the accused in committing the crime of rape.

[4] The accused, who was legally represented throughout his trial, pleaded not guilty to all three charges. He proffered a written plea but in it simply denied having raped or assaulted the deceased at the time and place in question without offering any further explanation as to what transpired between himself and the deceased. Later during the trial the accused made certain admissions in terms of sec 220 of Act 51 of 1977 admitting only the identity of the deceased, that Dr DK Abrahams performed a medico-legal post-mortem examination on the body of the deceased on 3 January 2014 and that on 13 January 2014 a Dr AA Pather performed a medical examination on the accused and collected from him a sample for DNA comparison. Despite having been arraigned for

trial in late 2015 the matter only commenced on 19 March 2018. There were numerous intervening postponements at the instance of the accused including postponements for several months whilst the accused unsuccessfully sought to hold the State to an alleged plea bargain from which it had allegedly reneged. Those civil proceedings were heard by another Judge and beyond the above description the details remain unknown to this Court.

[5] The trial ran for a total of 29 days including argument.

Background and evidence led

[6] The background to this matter is accurately reflected in the State's summary of substantial facts which states that during the evening of 31 December 2013 the deceased, S C, the accused and several friends attended a so-called rave party at Le Bac Estate, Paarl. They all stayed in tents located close to one another. At that time the deceased and the accused were in a romantic relationship.

[7] During the course of the evening the accused and some of his friends took drugs which the accused had bought earlier at the venue and then proceeded to the dance floor. Shortly thereafter the deceased started feeling unwell and was taken to the tent she shared with the accused. The friends returned to the dance floor and the accused and deceased remained alone in the tent.

[8] Approximately an hour or more later the accused called for assistance and the deceased was observed in the tent, naked and apparently experiencing a fit. The accused was with the deceased at all times. Medical attendants treated the deceased on the scene whereafter she was taken to Paarl hospital. After intensive treatment she passed away some 18 hours later. The deceased never regained consciousness.

[9] The State's case, based largely on medical and circumstantial evidence, is that the accused manually strangled the deceased in the course of raping her in the tent, both vaginally and anally. A further important element of the State's case, based on toxicology reports, was that the deceased did not ingest any drugs and therefore this played no role in her death.

[10] The case for the accused, apart from a general denial of the charges, and although admitting that he was with the deceased at all material times is that the deceased ingested LSD and MDMA *('ecstasy'*), that the combined effect of these drugs was the cause of the deceased's death, that he had no sexual relations with the deceased at the material time and that any injuries to her sexual organs were self-inflicted.

[11] In seeking to prove its case against the accused the State led evidence in five main areas; firstly, the evidence of the friends of the accused and the deceased who attended the rave party with them; secondly, the evidence of various paramedics who treated the deceased on the scene as well as the evidence of medical personnel who treated the deceased at Paarl Hospital, and; thirdly, the evidence of two forensic pathologists, namely, Dr Abrahams who conducted the post-mortem examination on the deceased and Professor L Martin who offered a second opinion on Dr Abrahams' findings. Fourthly, the State led the evidence of specialist pharmacologists and a technician regarding the toxicology reports relating to the deceased and, finally, the evidence of a number of police officers involved in the investigation into the deceased's death.

[12] On behalf of the accused the evidence of a forensic pathologist, Dr S Naidoo, was led challenging the finding of Dr Abrahams and Professor Martin as well as the evidence

of a further two persons who attended the rave party in the company of the accused and the deceased. The accused did not testify.

[13] Further evidence heard related to a trial-within-a-trial held regarding the admissibility of an exculpatory witness statement made by the accused to a police officer shortly after the incident which led to a ruling declaring the statement admissible.

[14] Amongst the principal issues which fall to be determined in this matter are whether the deceased ingested drugs that night and what effect they may have had on her death and whether the accused had sexual relations with the deceased that night.

[15] I propose to summarise the evidence given by all the witnesses, bearing in mind particularly the abovementioned issues.

Mrs M D

[16] Mrs D, the mother of the deceased, testified that her daughter, then a 21 year old law student, had lived with her. She had been dating the accused for some three years and they appeared to have a good relationship. Judging from the things that her daughter told her the accused seemed to care about the deceased. The accused came across as responsible, decent and polite and therefore Mrs D trusted him. In late December 2014 S told her that she was going to the rave party at Le Bac Estate in Paarl with the accused and would stay there for two nights, camping out. S took a two person tent from the house as well as sleeping bags, towels and rugs. She left after midday on 31 December 2013 and was due to return on 2 January 2014. Mrs D next heard from her daughter when the latter messaged her after reaching Paarl telling her it was very hot there. She sent S a message around 11pm but there was no response and she does not know if S received the message. At about 3am on 1 January she received a call from the accused who told her

that *'we have a bit of a situation here'* and that he was at Paarl Medi-Clinic. When she asked the accused what was wrong a nursing sister took the phone from him and told her that her daughter was in ICU on a ventilator and suggested that she get to Paarl as soon as possible. Mrs D asked what was wrong and was told that there had been an *'overdose'* arising from drugs. She was shocked to be told that drugs were involved. After making arrangements she arrived at the hospital after 4am. Whilst sitting waiting she heard conversations in the background about a naked girl being admitted and the police being called because she appeared to have been sexually assaulted. She thought this could not possibly be her daughter. Eventually Dr Franklin, the specialist who was treating S, took her to her daughter who was on a ventilator. He explained to her the medical problems and left her to spend some time with her daughter which she did but could get no response from her. She met some police officials who told her they were concerned about the situation since things did not look *'right'*. When she saw the accused in the hospital passage she remonstrated with him for them having taken drugs and he agreed that this had been stupid. The police official had then approached the accused for a statement who then requested that Mrs D stay with him with the result that she heard the first part of his statement. It was to the effect that he and S had taken drugs, she had not been feeling well and they had gone back to the tent. She did not recall anything in his statement beyond that point. At a later stage Mrs D was told that her daughter's condition was worsening and that she stood more chance of dying than living. She was also told that tears had been found in S's vagina. At some point the accused told her that he was going back to the camp site to pack all their luggage and thereafter he transported it back to Cape Town. Asked what the accused's demeanour was Mrs D stated that there was a coldness and a hardness in him that she had never seen before. At about 6pm that day she

had a further discussion with the accused who told her that he had told her the truth and added that when he and S were in the tent she began behaving strangely. She said that she was feeling hot, wanted to take her clothes off and was feeling sexually excited. Further that she had rolled around *'touching herself'*. According to the accused this was when S started feeling sick and when he decided to call the paramedics. Mrs D asked the accused whether he had ever left S alone and he said no he was with her all the time including when the paramedics were treating her. Mrs D asked the accused if they had sex and he said no. The accused told her that her daughter's strange behaviour was so strong that she had even scratched him and he lifted his t-shirt to show her a scratch on the left of his stomach. Mrs D testified that her daughter was not physically strong and that she often spoke about how strong the accused was, at least compared to her. When Mrs D told the accused that something was not right and that her daughter was fighting for her life his response was a very nonchalant *'Okay'* as if it was no surprise to him. Her daughter's condition worsened through the day and her heart rate started dropping after she underwent dialysis. Eventually the nurses told her that her daughter was going.

[17] When she unpacked her daughter's luggage and clothing after her death she saw brown stains on some items of clothing which she thought were blood and handed these to the investigating officer. Mrs D also looked at photos on her daughter's phone apparently taken on the day of her death and in one identified her daughter and the accused apparently taken at Le Bac Estate that day. She stated that several of the items of clothing the deceased was wearing in the picture that day did not come back including a bikini bottom. Sharisha had been a healthy person apart from the occasional infection or allergy and her eczema which would flare up in spring.

[18] Regarding the photo she stated that since it was dark she inferred that it was taken after 8:30pm on 31 December 2013 and therefore that her daughter was still well at that stage.

[19] Mrs D was cross-examined about the photos of her daughter before Court and others. In response to a query from the Court the accused's counsel advised that it was admitted that the photo in question was one of the deceased and the accused but that he was unable to state whether it was taken at Le Bac Estate that night or at some other rave event. Mrs D was also questioned about the relationship between the couple and said that she believed it was an intimate relationship and that her daughter was in love with the accused. She had not thought that it was an abusive relationship and certainly her daughter had said nothing of the sort. She was also asked questions about the various medications that her daughter used to control her eczema and antibiotics she had used for a possible bladder infection and confirmed that her daughter had been taking the pill as a contraceptive. Regarding the accused's demeanour Mrs D conceded it was possible that he was exhausted as a result of not having slept the previous night. She explained that she was shocked when she heard that drugs had been involved in her daughter's death because as far as she was concerned her daughter did not take drugs. Finally, it was put to Mrs D that the accused denied that he had assaulted or murdered the deceased or that he raped her.

Evaluation

[20] Mrs D was a very good witness, never stating more than she knew or believed and choosing her words with care. I accept her evidence without reservation.

Mr Pallo Manuel

[21] Mr Manuel attended the rave party at Le Bac Estate and knew both the accused and the deceased as acquaintances. At the time he was a sports science student at UWC and had taken level 1 and level 2 first aid classes. He arrived at Le Bac Estate between 4 and 5 that afternoon and met the accused and the deceased there. He set up his tent and identified it in photo G1 as being just next to the tent occupied by the accused and the deceased. He, his brother and Kyle Inglis went to the dance floor and stayed there until the midnight countdown. He does not recall spending any time with the accused or the deceased. The witness drank 4 to 5 double brandy's and coke that night and as a result was a bit tipsy but not drunk. He is a regular drinker. No one in his group took drugs that night. Sometime after midnight he went to his tent to change because he was feeling hot and sweaty. At the tent he heard what sounded like people having sex in the tent next to his. He testified that he knew it was the accused and the deceased's tent as it was next to his. There was no lighting so it was dark. In the tent he used his cellphone for light. He described the noises he heard as moaning and groaning from a male and a female and he assumed that these people were having sex. He was in his tent for a relatively short period of time just to change, approximately 10 minutes. The moaning and the groaning continued throughout that period. He went back to the dance floor and after a while he received a phone call to go back to his tent which he did with Kyle. Upon reaching the tents he heard someone shouting *'get the paramedics, get the paramedics'*. He ran to the paramedics' tent and told them five or six times that an ambulance and paramedics were needed. He was told that someone had already been sent and he returned to the site to where the tents were. When he got there he saw that the accused and the deceased's tent was now open and paramedics were inside over the deceased's body. She was lying on

her back and it looked as if she was convulsing. Her body was moving up and down as she gasped for air. The witness also described the deceased's movements as arching. She was naked on top but had something over her lower body. He was asked to assist in placing the deceased on a stretcher and he stepped into the tent and assisted in getting a stretcher board underneath her. He, one other person and the paramedics then proceeded to take her to the paramedics' tent. He observed the paramedics proceeding to hold the deceased down to see if they could find a vein to hook her up to a drip. It was necessary to restrain the deceased because she was convulsing at the time. They placed flat hands on her shoulders. The paramedics tried numerous times unsuccessfully to find a vein until eventually they found one in her foot. The witness remained there until external paramedics arrived and put the deceased into an ambulance. He did see the accused at the paramedics' tent and then saw him walk away. However, he was not focussed on the accused. By this time the witness had sobered up. From the time that he first saw the deceased in the tent till she was loaded into the ambulance she sustained no injuries that he was aware of. He had never seen the accused again.

[22] In cross-examination the witness stated that the paramedics' tent was about 150m away from the tent that the deceased occupied. Earlier when he had heard the noises which sounded like people having sex he heard no cry or shout for help nor any sound of assault so he told no one about the incident. The witness estimated that the paramedics were with the deceased in her tent for about 15 to 20 minutes and that in between her arrival at the paramedics' tent and the arrival of the ambulance some 45 minutes to an hour passed during which time the paramedics were busy with her. He estimated that approximately an hour passed between him leaving his tent after changing and getting a

phone call to go back to the tent. However, he was not looking closely at the time on his watch at that stage.

Evaluation

[23] Mr Manuel came across as a witness who had a reasonable recall of events. His evidence was not challenged in any material respects and there is no reason not to accept it.

Kyle Inglis

[24] The witness was also a student at UWC in December 2013 studying sports and exercise and was friendly with Mr Pallo Manuel. He too had attended two first aid courses. He knew the accused since they had been childhood friends, lived in houses close to each other and had gone to the same primary school and high school. They rekindled their friendship at university. The witness also knew the deceased i.e. the accused's girlfriend and he socialised with them on a regular basis. Mr Inglis also attended the rave party at Le Bac Estate arriving there just before 9pm on 31 December 2013 together with the deceased's cousin, Vanika Lalloo. When they arrived everything had been set up for them i.e. the tent. He was greeted with a drink and began socialising and relaxing with other members of their party. The witness recalled there being two dance floors which were 300m to 400m apart. The deceased and the accused were not at his dance floor. During the night he had drunk more beers and more vodka. The witness described himself as having had *'enough to drink'* but stated that he felt responsible at the time and *'of good mind'*. He took no other drugs that night. After the countdown to midnight he got a message to state that there was something happening at the camp site and himself and Pallo Manuel went back to the tented area. There they saw that the

accused's tent was open and inside a paramedic was kneeling next to the deceased who was on her side in the recovery position. The deceased was convulsing, having a fit. She was shaking quite vigorously and foaming at the mouth at the same time. The idea was to get the paramedics to attend to the deceased but they seemed to be waiting forever for the paramedics. The witness left the tent to see where the paramedics were and as he did so he came upon Pallo Manuel coming back with two or more paramedics and a stretcher. He assisted the paramedics in getting the deceased onto the stretcher and shortly thereafter she was taken to the paramedics' tent. In that tent she was put down onto a trolley or table and then he and Pallo Manuel moved away to allow the paramedics to do what they could. From about 10 meters away they could see that the deceased was still convulsing and was on her back. Sometime thereafter the paramedics moved her into an ambulance on site which then left for hospital. The deceased did not sustain any injury that he was aware of in the time that he was with her or in her presence. The accused then sought him out and said that they needed to also go to the hospital. He and the accused followed the ambulance to Paarl Medi-Clinic in the deceased's vehicle. The accused was frantic and worried and was *'quite shaky'*. The witness tried to speak to the accused but got nothing out of him. The witness spent some three to four hours at the hospital in the chapel area near the ICU and outside. He recalled that sometime after 6am that morning he and the accused drove back to Le Bac Estate but he had no further conversation with the accused and they did not discuss any details of the incident. At the site the police arrived with a sniffer dog and commenced their investigation. Mr Inglis was asked if the accused ever told him what had happened and his answer was no. They never had that conversation not at that time nor any time thereafter. Asked if he had remained friends

with the accused he says he never went back to the accused's parents place and he and the accused no longer have a *'practising friendship'*.

[25] Under cross-examination he confirmed that the paramedics had initially tried to find a vein without success to hook the deceased up to a drip. The paramedics' tent was an open gazebo.

Evaluation

[26] Mr Inglis appeared to be a credible and honest witness. He was not challenged in cross-examination and I accept his account of what happened without qualification.

[27] On 25 April 2018, during the trial, it was put on record by the State that the accused had, at his insistence, been given all medical aid statements relating to the deceased and her medical file which had been obtained by way of a sec 205 subpoena. Further admissions were made by the defence in terms of sec 220 of Act 51 of 1977 allowing for the admission of certain photographs taken of the deceased at Paarl Medi-Clinic on 2 January 2014 and photographs of the tent at Le Bac Estate on 1 January 2014. It was also admitted that a biological sample was taken from the accused in June 2014 for DNA comparison and properly treated.

Mr Riaan Martin

[28] Mr Martin testified that he knew the accused through his aunt, Lameez Martin, whose boyfriend, Rafiq Wagiet was the accused's cousin. In December 2013 he, Riaan Martin was 20 years of age and his aunt, Lameez Martin, was 23 years of age. He had attended the rave event at Le Bac Estate together with his girlfriend, Jade Grey. They arrived there at 1 or 2 pm on 31 December 2013, set up the tent and met the accused and the deceased an hour or two later. They all then went for a swim in the nearby dam. He

and Jade went back to their tent, got alcohol and then went to the dance floor. He drank quite a lot that evening and would describe his condition as drunk but he could still remember what had happened. Shortly before 12pm that night he and Lameez had seen the deceased and the accused sitting on the edge of the dance floor near the toilets. They went up to them and S said that she was getting cold and wanted to go back to the tent. S needed assistance so Jade Grey and another person helped her get up and walk by having the deceased place her arms around their shoulders. To the witness the deceased appeared drunk and she was barely able to walk. He was asked if an explanation was given for the deceased's condition and his answer was that the accused told them that they had taken drugs. They all proceeded to the accused's tent. At that stage the deceased had no visible injuries and he does not think that she sustained any injuries up to the time that she got to the tent.

[29] The accused and the deceased went into their tent and zipped it up. The witness and Jade Grey then went to their tent to get some further refreshments and went back to the dance floor. The witness testified that this was just after 12pm because when they were at the tent with the accused and the deceased they heard the whole New Year's Eve *'commotion'* i.e. the countdown. The deceased had no visible injuries when she went in to the tent with the accused.

[30] A few hours later he and Jade came back to the tent and saw a commotion outside. According to the witness this was probably some two hours later. They stood there and could see into the tent where the deceased was lying naked. The accused was in and out trying to help. The witness saw the accused a few hours later when the accused returned

from the hospital and all that the witness can remember is that the accused said he was not able to see the deceased at the hospital.

[31] Under cross-examination the witness stated that when he and Jade first saw the deceased at or near the toilets at the side of the dance floor she clearly did not look well. Her head was resting on her arms and her knees. When he asked the accused what was wrong the latter said that they had taken *'acid'*. He repeated that the deceased had looked *'drunk'* to him and was not her normal self that night.

Evaluation

[32] Mr Martin appeared to be an honest witness but he was clearly quite strongly under the influence of alcohol on the night in question and could not remember a great deal of what took place. I have no reason, however, to doubt the general thrust of his evidence.

Ms Vanika Lalloo

[33] Ms Lalloo testified that she and the deceased were cousins and that they had regularly socialised during 2013. She also knew the accused who was the deceased's boyfriend at the time. According to the witness the deceased and the accused appeared to have a very good relationship and it did not seem to her as if there was any problem between them. She had also attended the rave party at Le Bac Estate arriving there at 7:30pm on 31 December 2013 together with Kyle Inglis. When they arrived all the tents had been pitched and they met up with the other members of the party who included the deceased and the accused. Everyone was chatting and the deceased was applying a bindi (a black dot on her forehead between her eyes) as part of her Hindu culture. They all wore luminous head bands so as to be able to see each other. She identified the

photograph Exhibit J1 as showing the deceased, the accused and Lameez Martin and as having been taken that night. This was the photograph which the defence would not admit as having been taken that night. After a while the witness, the deceased and the accused went off to buy LSD and MDMA (ecstasy). They had agreed to do so in a discussion held beforehand. Prior to that evening the witness had heard of LSD and MDMA but had not taken such drugs. The three of them walked through the camp site to the dance floor where the accused went up to a man with a moon bag and purchased the drugs. At the time the witness was 19 years of age and she and S stood at a distance of about 15m from the accused while he made the purchase so she could not hear the conversation. The witness was not sure how much money she paid towards the transaction but it was about R150 to R170 for her portion of the drugs. It was the accused who told her how much money she had to contribute towards the drugs. The LSD purchase turned out to be small square pieces of papers about 5mm across in a larger sheet which was perforated and from which you tore off individual squares. The accused bought one sheet which was white and on which each square was a different pattern or picture. The MDMA was a transparent capsule with creamy powder inside. The witness stated that she could not state for certain that these drugs were LSD and MDMA but that she believed they were.

[34] After the accused had purchased the drugs the three of them returned to the tents whereafter the deceased and herself walked to the food stalls. The deceased was in a very good mood, very happy and excited to be at the rave event. They returned to the tent where the same group of friends were and the witness took her LSD sitting in front of the tent. She obtained her square of LSD from the deceased who was holding the sheet and from which she, the witness, tore a square off. By this time some pieces had already been

torn off the sheet. The witness put the piece of cardboard in her mouth and soon afterwards her tongue began to feel numb but apart from this she felt no other effects. She handed the sheet of LSD back to the deceased but did not see what she did with it. She did not physically see the deceased herself ingesting the LSD. After sometime they all left to go to the dance floor by which time it was around 10:30pm. Prior to this at the tent she had only specifically seen the accused taking LSD but she was not focussing on anyone in particular and was just enjoying the environment. When they left for the dance floor the deceased seemed okay but when they stopped at the bathroom/toilet the deceased said that she was feeling sick and her tummy was sore. The toilets were just before one reached the dance floor. Five of them stopped at the toilets where *'they'* took the MDMA or at least she did. She got the MDMA from the accused. The plan had been that they were going to take it there at that time. The accused handed her a capsule but she did not see him handing a capsule to anyone else. She did not actually see anyone else swallow a capsule. At the dance floor the accused and the deceased went to sit at the side of the dance floor because the deceased was not feeling well. The witness, however, began dancing and continued doing so until 12am. The effect of the MDMA was to make her feel more energetic and want to dance. After she went off to the dance floor she did not see what happened to the deceased and the accused. At some point during the night she sustained an injury to her foot when a barricade near the front of the stage shifted onto her foot. She went to the paramedic tent to get assistance and whilst she was sitting on a bench there icing her foot she saw someone carried in on a stretcher but did not know at that stage that it was the deceased. She saw Kyle Inglis and other people around the stretcher and he then told her that it was the deceased. The accused was also present. At some point she saw froth coming from the deceased's mouth and her eyes rolling

around, opening and shutting. The deceased was treated by paramedics at the tent and eventually taken away in an ambulance.

[35] The following morning she saw the accused at the camp site near the tents. He and Kyle stated that they had to pack up and that they were leaving after the police had checked out the accused's tent. The witness had a conversation with the accused. He showed her a scratch on his stomach and told her that the deceased wanted to have sex with him but that he did not want to because she was acting strangely. It was in the process of her wanting to have sex with the accused that she scratched him. The witness asked the accused how the deceased was and he told her that it appeared that she had been raped. She then asked him if they had had sex and he replied that they had not and that the last time they had done so was before Christmas.

[36] The witness was intensely cross-examined particularly in relation to two statements which she made to the police. The chief purpose of the cross-examination appeared to be to portray the witness as having changed her evidence from having told the police that the deceased had taken drugs to now denying this in her viva voce evidence. This cross-examination was misguided. The witness readily admitted that she told the police that the deceased had taken drugs. She explained her evidence in the witness box as being as a result of the prosecutor having pointed out to her in consultation that if she had not specifically witnessed the deceased taking either what they believed was LSD and MDMA she could not testify that the deceased had taken these drugs.

[37] The witness was asked whether she had heard of *'candy flipping'* and *'hippy flipping'* and replied that all she knew was that this referred to taking these drugs together

in a certain sequence and timing. Referring to her statement to the police that the deceased had taken drugs she explained that she realised that this was based upon a *'false assumption'*. On response to a question from the Court she clarified that the taking of the LSD and MDMA was done openly. She testified that neither she nor S had actually used the toilet when they stopped to take the MDMA and when the deceased had said she was not feeling well. She had assumed that the accused and the deceased had taken MDMA there but she did not herself witness this. The plan had been that they would take the MDMA when they approached the dance floor. About half an hour after taking that MDMA the witness had felt the effects, namely, that she had more energy. She recalled that it had been the accused, the deceased, Jade Grey and Riaan Martin who sat at the side of the dance floor when she went off to dance. When she saw the deceased on a stretcher much later she had gone into a complete state of shock. The witness had also been at the hospital and seen the deceased's mother but had not spoken to her until some four days after the funeral. She was referred to her first statement to the police, Exhibit AA and confirmed that she had stated therein that they had all taken drugs. At the time she had believed this to be the case until her *'false assumption'* had been pointed out to her.

[38] The witness was also cross-examined at length about why many of the details in her evidence did not appear in either of her statements to the police and she was taxed with discrepancies between her evidence and the statements. Eventually it was put to her that the reason for these discrepancies was that her evidence was, in respects, a recent fabrication, most notably that she was now lying when she testified that she did not see the deceased take LSD and MDMA. It was put to her that the accused would testify that although the three of them were together each one of them had separately bought their

own drugs. The witness denied this proposition stating that what took place was as she described it.

[39] In re-examination the witness stated that she had no reason to give false testimony. In response to a question from the Court the witness stated that the deceased never gave her any reason to believe that she was not going to take LSD and MDMA. When she was asked whether she would be surprised if she learnt that the deceased had not taken these drugs she stated that she would agree with this proposition as far as the LSD is concerned but would be hesitant about the MDMA because she said that at the point that that drug was taken the deceased was not feeling well.

Evaluation

[40] Ms Lalloo presented as an intelligent witness and was more than a match for the intense cross-examination to which she was subjected. Her explanation for *'changing'* her evidence from stating that the accused took drugs to stating that she could not vouch for this was entirely credible, namely, that she had not personally seen the deceased doing so and in that sense her prior evidence was based upon a false assumption. This does not detract, however, from the main thrust of her evidence which is that all the people in her group, including the deceased, planned to take the two drugs in sequence. Any criticism of her evidence on the basis that she was being untruthful regarding this aspect is without foundation. Ms Lalloo was a good witness whose evidence stood up to intense cross-examination and I have no qualms in accepting her testimony.

[41] The State's evidence established that two paramedics employed by the event organiser first attended upon the deceased in her tent. They were Mr Eugene Le Roux and a Ms Laurika Grunder. However, neither of these witnesses could be traced and thus

their names did not appear on the witness list nor were they ever found and called. Counsel for the defence sought to make much of this implying, at the least, that the evidence of Eugene Le Roux would have a cast a different complexion on matters. In this regard counsel repeatedly asserted in argument that he had asked counsel for the State to admit, by agreement, the content of a statement made to the police by the said Eugene Le Roux but that she had refused. In argument counsel for the State advised that she was now willing to place the statement of Mr Le Roux before the Court by agreement on the basis that its contents were correct. However, when defence counsel was asked to agree to this on behalf of the accused, he took an instruction and declined the offer. It goes without saying that this refusal underlined that any argument to the effect that the State was seeking to withhold the evidence of Eugene Le Roux because it was unfavourable to the State's case was to put it at its lowest, disingenuous.

[42] The State was, however, able to locate and call as witness two paramedics who treated the deceased at Le Bac Estate, namely, Mr Barry Barling who treated the deceased in the paramedic tent and Ms Shawreza Gail Mackier who treated the deceased in the ambulance and accompanied her to Paarl Medi-Clinic.

Mr Barry Barling

[43] Mr Barling testified that he had qualified as an Advanced Life Support Paramedic by completing a Bachelor of Health Sciences Paramedic degree in 2010 at Victoria University in Australia. He also had various other short course qualifications in the field and was currently a medical student at Wits in his third year of study. He was at the rave event at Le Bac Estate in 2013/2014 as one of the event organisers with stipulated responsibilities. There had been paramedics in attendance but none with advanced life

support qualifications. He had been employed by the event organiser, Fourth Dimension, with a general portfolio but had kept in mind that he might be needed for his paramedical services although he was not employed for these as such. He had a recollection of what had taken place in relation to the incident involving the deceased although no witness statement had been taken from him. Sometime after 1am on 1 January 2014 he heard reports of someone having seizures in the camping area. He fetched his advanced life support paramedic equipment from his vehicle and went to wait for the patient at the paramedics' tent. When she arrived he observed that she was having continuous seizures. He started to treat her and attempted to establish an IV line (intravenous access) but was unable to do so. It was dark, the patient was having seizures and her veins appeared to be peripherally shut down. The only light available was from one or two torches. He administered an injection into the muscle of a 5mg dose of anti-convulsion medication named diazepam but it did not have the desired effect. He attempted to gain IV access through the external jugular i.e. at the side of the patient's neck and the femoral artery in the groin area. This was unsuccessful but eventually he was able to gain access through the patient's right arm. He then administered a further 5 mg dose of diazepam through the drip which he had set up. After sometime, approximately 20 to 30 minutes, the convulsions stopped. During treatment they had also put an oxygen mask on the patient's face, covered her with blankets, put her in the lateral position to keep her airway open and monitored her. He could not recall whether the patient had an airway inserted into her mouth when she arrived in the paramedic tent for treatment.

[44] He had been assisted by basic ambulance assistants and some first aiders. One assistant was Eugene Le Roux who had been part of his team but who he had not met then or since. He, the witness, was in essence a volunteer in treating the deceased.

[45] The witness had been preparing to intubate the deceased and he had administered some medication to facilitate this, namely, 5 mg of morphine. Morphine causes deep sedation and suppresses the gag reflex in a patient. When the Metro ambulance arrived the patient was moved into it where there was more light. He handed the patient over to the Metro paramedic (Ms Shawreza Gail Mackier) and she intubated the patient. Whilst under his care the patient suffered no injuries.

[46] Mr Barling testified that later that same morning he had completed a patient's report form the headings of which referred to incident details, a primary survey of the patient, a history, a secondary examination, crew details, vital signs, treatment, fluids and medications and details of the handover. That document is Exhibit O. Having regard to the patient report form and Mr Barling's evidence the following emerges. It was 1:25am when the witness heard the first report of the incident and 1:45am when the patient arrived at the paramedic tent. The ambulance left for Paarl Medi-Clinic with the patient at 3:20am. As far as the patient's history is concerned some of her friends reported that she had taken drugs. She had been administered oxygen and peripheral pulses were felt but a super ventricular tachycardia (racing heart rate) was detected. The patient's history on the form reads *'patient was carried to medical tent on spine board, patient is status epileptic, patient is covered by towels (was found naked); patient's friends said patient consumed acid, MDMA and alcohol'* and, further, that the *'patient was found lying naked in the camping area convulsing after consuming drugs and alcohol'*. He had recorded that the patient was warm to the touch, that she presented with secretions from the mouth and trismus (clenched jaw); her pupils were dilated and unresponsive to light and that her airway was clear bilaterally. He recorded that there were no other abnormalities detected on the body but that the examination was carried out in a poorly lit environment. He had

recorded as the patient's vital signs a high heart rate, low blood pressure and a Glascow coma score of 3 out of 15. He had also administered further midazolam for a suspected methamphetamine overdose.

[47] The witness testified further that he had previously treated approximately 20 drug overdose cases. Treatment depended on the drug taken. Convulsions and a super ventricular tachycardia can be signs of an amphetamine overdose under which umbrella MDMA falls. By the time he handed the patient over to the Metro ambulance services she was in a sedated state and convulsions had stopped. Mr Barling confirmed that Exhibits 1 and 2 before the Court were examples of the oropharyngeal airway (an 'OPA'), a curved tube of hard plastic about 5 inches long with a mouth piece which is inserted into the patient's mouth to facilitate breathing and an intubation device. It was his normal practice to insert an OPA but he cannot recall if he did in the instant case. He testified that if he had done so it would have been after the patient's seizures had ended. He had inserted such OPA's many times, never causing injury.

[48] Under cross-examination the witness stated that it was unlikely that the OPA had already been inserted in the patient when she was brought to him since she had trismus (clenched jaw) and it would have been impossible to insert the airway if this was the case. He testified that as a paramedic if you found the teeth clenched in an unconscious patient you would not go any further. The witness was not cross-examined at any length. In re-examination he stated that some of the paramedics present had assisted him to place the patient in a lateral position and that this was before her seizures had stopped. This would involve touching of the shoulders, hips and feet but would not amount to very much force and was unlikely to cause any bruising. The airway would have been inserted

once the seizures had stopped and would not have been inserted if trismus was present. In response to the Court's question Mr Barling advised that normal training was that if you cannot insert the airway easily you do not try and push it in.

Evaluation

[49] Mr Barling was a very good witness, clear thinking and obviously very well trained and professional. His evidence was not challenged in any material respect and I accept it without qualification.

Mr Sebastian Driessen

[50] Mr Driessen is an appointed safety officer working for a firm of health and safety consultants who were involved in the preparation for the rave party at Le Bac Estate in Paarl in December 2013/January 2014. He testified that only persons over the age of 18 years were permitted to attend the event and that all vehicles entering the premises were stopped and searched, with alcohol being removed and recorded in a register for later collection. Alcohol was sold at the event, however. He testified further that it was possible to smuggle in drugs and that this occurs at all such events. A private events company, Fourth Dimension, arranged the rave event. Mr Driessen testified that he was a trained paramedic although not presently registered as such. He had attended a school for paramedic training in Johannesburg and in Cape Town, six month courses and had been a registered paramedic for nine years.

[51] At about 1am on 1 January 2014 he received a radio message to attend at the paramedics' tent. When he arrived there he heard on the radio system that security were seeking medical assistance at the central camping area. At that point a man that he identified as the accused arrived at the paramedics' tent asking assistance at his tent

because his girlfriend was not feeling well. The witness ascertained from security that this ill person was one and the same person. Mr Driessen testified that this person's demeanour was one of concern and that he wanted people to hurry up and come to the tent. He also appeared to be under the influence of alcohol but not excessively so. The two paramedics on duty, Eugene Le Roux and Laurika Grunder, left with their equipment and a stretcher for the tent where the patient was. Mr Driessen remained at the paramedics' tent until he heard on the radio that Le Roux wanted a female security guard present because the patient was naked and was having convulsions. Mr Driessen then proceeded to the tent to assist which was about 120m away. There he saw the deceased lying on the tent floor having convulsions. She was put on the trauma board stretcher and secured thereto with six harness points so that she could not fall off. This was after she had been wrapped in a towel. She was then taken to the paramedics' tent where she was transferred to their bed and the two paramedics continued treating her. The patient had a further convulsion and was turned on her side whereafter her airway was cleared out by a hand sweep of her mouth. The witness saw liquid and blood in the patient's mouth. At some point the patient's female friends and one, Pallo or Pablo, came in and stood around while the patient was treated. At some point the accused's demeanour had changed radically. He suddenly said *'sorry baby, sorry baby'* and he became aggressive and emotional whereas previously he had been calm. The person whom the witness had referred to as Pallo stood up and took the accused outside. The accused came back into the tent and tried to light up a cigarette and was told that this was not a good idea because the paramedics were getting ready to administer oxygen to the patient. Two security guards tried to control the situation and removed him from the tent. Mr Driessen asked two female friends of the patient for the latter's personal and medical aid details so that

they could trace her parents and when they could get no information from them this was sought from the accused but he too could not help. The dilemma of the paramedics was that they had no idea whether the patient was being treated for any pre-existing condition or whether she was on any medication.

[52] At one stage while Mr Driessen and Eugene Le Roux were standing alongside the accused the latter said that he had been having sex with the patient and then she had *'conked out'* on him. Pallo's words upon hearing this were *'Ny bra, can't be'*. Prior to this the witness and a senior paramedic (presumably Mr Barling) had called for an ambulance. When the Metro ambulance arrived the deceased was transferred to it where she obtained further treatment and was put in a stable condition before she could be transported to hospital. This treatment involved inserting a drip and administering oxygen. The patient had sustained no injuries while she was in his presence. The following day he had seen the accused at the camp site and observed the police who had wanted to see the accused's tent and had walked through the whole area inspecting it.

[53] Under cross-examination Mr Driessen confirmed that he had made a statement to the police. This he had done by explaining orally what happened and then writing out his own statement which he had signed. He testified that he remembered the incident involving the patient well and that the patient's friends had suspected that it was a drug overdose and that there was talk that the patient had taken MDMA. In his statement he made reference to a *'large male'* whom he first encountered when that person presented at the medical tent asking for assistance. The witness insisted that this person was the accused notwithstanding that he had not identified him as such in his written statement and notwithstanding the further suggestion that this was, in all probability Mr Pallo

Manuel who stood 6 ft 8 inches tall as opposed to the accused who is of a normal height. It was put to the witness the accused would testify that it was not him who came to the paramedics tent to ask for assistance but that he had asked others to do so and that Mr Pallo Manuel had done so. The witness insisted that he could not have made a mistake in this regard. The witness resisted suggestions that the patient could have sustained bruises or abrasions on any parts of her body as a result of her convulsions which he saw her experience or as a result of being moved. He testified that when the accused spoke about the deceased *'conking out'*, the witness, Mr Eugene Le Roux and Mr Pallo Manuel were present. The witness was taxed at length with his statement not being the same as the evidence which he gave in the witness box insofar as the former lacked the detail given in his viva voce evidence.

[54] It was put to the witness on behalf of the accused that he denied saying anything such as *'sorry baby'* but the witness stuck to his evidence in this regard. It was also put on behalf of the accused that he denied saying that he had had sex with the deceased and that she *'conked out'*. Again the witness stuck to his evidence in this regard.

Evaluation

[55] Mr Driessen was a somewhat curtly spoken and dogmatic witness. He was clearly mistaken about the identity of the person who first arrived at the paramedics tent since that was obviously Mr Pallo Manuel and not the accused. Apart from this aspect and notwithstanding these traits the witness was credible with a good recollection of what had happened some four and a half years previously.

Ms Shawreza Gail Mackier

[56] Ms Mackier testified that in 2014 she had been employed by the Metro ambulance services as a paramedic. She had qualified as an advanced paramedic in 2009 and presently had 14 years experience in total as a paramedic. She recalled the incident involving the deceased at Le Bac Estate. One of Metro's ambulances had been called to the scene and she had been called out later following a report that the patient was suffering from convulsions. She drove to Le Bac Estate in a response vehicle and found that the patient was already in the ambulance on her arrival. She was told of the background and evaluated the patient for consciousness. She later filled in the form recording her treatment etc. which is Exhibit R. She first investigated the patient's airway to check that she was breathing and decided that she had to be administered oxygen. To do this the patient had to be intubated which involves inserting a plastic tube down the patient's throat. She took out the airway, (an example of which is Exhibit 1) which was already in the patient's mouth and then, using a laryngoscope, inserted the intubation tube. This is done by opening the patient's mouth and using the extended blade of the laryngoscope to move the tongue to one side so that the intubation tube can be inserted down the throat through the V of the vocal cords to just beyond them. The laryngoscope has a light at the end of the blade which turns on when the blade is extended. The patient was already sedated when Ms Mackier performed this procedure and there was therefore not resistance from her and no problem in opening her mouth. In order to perform this procedure the paramedic sits in the ambulance on a seat behind the patient's head and tilts it backwards so that the mouth is facing up. The witness stated she had an independent recollection of performing the procedure. Once the intubation tube was inserted it was secured to the patient by putting a stretch bandage around it and over the

patient's head. The patient was then intubated using an ambubag which pumped oxygen by hand into her lungs every five seconds or so. The patient was also breathing of her own accord. During this whole process the patient did not sustain any injuries. The witness testified that by that time she had been performing similar procedures for some five years approximately twice a week. During the time she treated the patient and took her to hospital the patient never regained consciousness. Nor did any accident take place and therefore the patient sustained no further injuries on the journey.

[57] At Paarl Medi-Clinic they were directed straight to the ICU and she handed the patient over to the doctor and the sisters present. Having regard to the form, Exhibit R, the witness testified that the patient had presented with status epilepticus after reportedly taking LSD and some other *'uppers'*. On examination, the patient had fixed dilated pupils and a heart rate of 160 beats per minute. Ms Mackier testified that she got the information about the drug ingestion from the accused. She recorded that the patient's skin had been hot to the touch although her temperature was not recorded. Her total score for alertness, verbal ability, pain and responsiveness put her as a *'red'* case i.e. a patient in the most serious condition. The patient had been covered by a towel but when the witness took this off she was naked save for pants around her thighs. She noted two bruises on the patient's pelvis and recorded these in her notes. The patient's heart rate had been very high throughout and she had a very low systolic blood pressure. She had scored only 3 or 2T on the Glascow coma scale and had been sedated with dormicum. Ms Mackier testified that convulsions and secretions from the mouth were consistent with a drug overdose. She stated that if the patient was experiencing trismus one would not force the mouth open. Further in this regard, the witness stated that paramedics are trained to do the patient no harm and that they would never force someone's mouth open. She resisted the

accused's counsel's attempt to concede that the patient's mouth might have been forced open to insert an airway. If trismus was present the first treatment would be to try and stop the convulsions by giving the appropriate medication to get the body relaxed.

Evaluation

[58] Ms Mackier was a good witness with a clear recollection of what had taken place and was clearly an experienced paramedic. I accept her evidence without qualification.

Nurse Mariette Troskie

[59] Nurse Troskie testified that she was a registered nurse employed by Paarl Medi-Clinic in the ICU. She had been on duty on 1 January 2014 when a Metro ambulance arrived at about 3:25am bringing the deceased with a recent history of a drug overdose. The patient was transferred to a bed and coupled to various life support machines although she had already been intubated. Work began in taking the patient's blood tests and assessing her. The specialist on duty was Dr Craig Franklin who was called in from home to deal with her. Dr Bartleman was the casualty officer on duty. Nurse Troskie was part of the team working with the patient until her shift ended at 7am that morning. She saw the accused present but he was mostly in conversation with Dr Franklin although she heard some of the explanations which he gave.

[60] Nurse Troskie testified that whilst they were initially assessing the patient and wanted to insert a catheter she observed that things were *'not right'* with the deceased's private parts. That area was very wet and it looked as if something had *'happened there'*. They also found two large bruises on the patient's hips and scrape marks on both of her knees. The patient had been wearing nothing but oversized short pants. After observing these disturbing signs she had contacted the sisters in casualty who told them to do

nothing further and notify the police. Dr Franklin had asked the accused if he had had sex with the deceased and his answer was no. A woman detective or detectives had arrived with a rape kit and Dr Franklin had asked Dr Bartleman to come and do the examination and take the swabs. The witness was present when Dr Bartleman did this which involved taking three vaginal swabs but nothing rectally. After this rape kit had been administered the nursing staff went on to clean the patient including the vaginal area and insert a catheter. The patient was not further injured by the nursing staff. Nurse Troskie observed later that the patient was bleeding from a needle prick mark at her neck, her left hip bone bruise became much more distinct and there appeared to be bruise marks on her breasts. These injuries were not caused by the hospital staff. As the patient's condition deteriorated she began to bleed. She herself heard no explanation from the accused for the injuries on the patient. Her colleague during treatment had been Sister Julene Bam.

[61] Under cross-examination the witness explained that samples for blood tests were taken by the insertion of a needle into a port which had already been established. The pathologist staff would come and collect these blood samples which are marked and put in a packet. Dr Bartleman's investigation had followed after Dr Franklin's initial investigation. The witness had been present throughout.

Evaluation

[62] Nurse Troskie was a good witness whose evidence was not challenged.

Sister Julene Bam

[63] Sister Bam testified that she was a registered nursing sister with 15 years' experience and on 1 January 2014 was on duty at Paarl Medi-Clinic with Nurse Troskie when the patient was brought in by a Metro ambulance at 3:25am. Her condition was

unstable and she was naked apart from a pair of oversized short pants. The patient was Nurse Troskie's and thus it was the witness' responsibility to obtain particulars from the patient's friend, namely, the accused. She asked him for medical aid details and contact numbers for the patient's parents and he gave her a telephone number for the patient's mother. The witness then asked the accused whether he knew what had happened to the patient. He told her that the patient had taken *'acid and LSD'* and that this was the first time she had done so. He said further that the patient had begun to feel hot and had taken off her clothes. The witness asked the accused about the scrapes on the patient's knees and he said that she had fallen over tent pegs or tent poles. The witness had noticed scratch marks on the patient's knees. She asked the accused where the patient's clothes were and he said he had them in the rucksack on his back. The patient had sustained no further injuries from the staff at Paarl Medi-Clinic.

[64] Under cross-examination it was put to the witness that in her statement she had said that she had been told that the patient was *'onvas op haar voete en geval het'*. It was further put that the accused would testify that he had said nothing about tent pegs or tent poles. The witness remained resolute that the accused had said what she had testified to.

Evaluation

[65] Sister Bam was a very good witness whose evidence was largely unchallenged and must be accepted.

Dr Emmerentia Bartleman

[66] Dr Bartleman testified that she qualified as a doctor in 1998 and began working in a practise at Paarl Medi-Clinic in approximately 2012. She had also been a district surgeon in Jamestown between 1996 and 1997. Her work at Paarl Medi-Clinic was done

on a roster basis and she had been on duty on 1 January 2014 when she was requested by an ICU sister to see a patient there. When she first saw the patient she was being transferred from the ambulance onto a bed in ICU. She noticed that there were marks on the patient's knees and also on her hips, anterior. She was unclothed but covered. Dr Bartleman did not do a full investigation since the physician in charge, Dr Franklin, had asked her to investigate only for possible sexual abuse. She had not been experienced in this field and did little of that whilst at Paarl Medi-Clinic. After examining the patient she filled in the J88 form, Exhibit S, where her main findings were that the patient had bruised area on both pelvic rami, anterior measuring approximately 2cm². She had bruised and scarred areas 1cm² on both knees. There were puncture wounds on her anterior neck and left lower abdomen. The patient was unconscious. Her clitoris and the frenulum of her clitoris were normal but blood stained. Her urethral orifice was blood stained. Her labia majora were normal with slight bloody discharge visible. She made the same finding in respect of the labia minora. There were tears inside the vagina and the fossa navicularus was normal but with a bloody discharge. The cervix was bruised with a bloody discharge and there was a bloody discharge at the perineum. She concluded that the injuries and tears may be an indication of sexual intercourse. On anal examination she found that there was blood on the skin but conducted no detailed examination.

[67] In a contemporaneous sketch she marked two tears within the patient's vagina. Dr Bartleman testified that she did not do a pregnancy test and also did not do a thorough test on the patient's anus because, for one thing she had used up all of the swabs in the test kit supplied by the police. There were no visible tears on the outside of the anus. Dr Franklin was anxious to resume his treatment of the patient so he chased Dr Bartleman a little to complete her examination. Of the three swabs she took one was a sample from

inside the vagina, one on the outside near the labia and one on the perineum. She did not go very deep with these swabs. The patient's body temperature had not seemed warm or feverish to her. She completed her examination by 5am. She wasted no time in doing so because the patient needed medical attention urgently. She had been hooked up to a ventilator. Dr Bartleman repeated that she had not done a full anal examination and her conclusion reflected that she had vaginal intercourse in mind. She conceded that her finding was consistent with consensual intercourse.

[68] On behalf of the accused it was put to her that the tears in the vagina could have been caused by masturbation to which the witness responded that she did not think any woman would injure herself in this manner if she was in her sound senses since the purpose of masturbation is pleasure. Pressed on this point the witness stated she had no training in masturbation.

[69] In response to the Court's question Dr Bartleman stated that before the incident in question she had never done a previous sexual examination as required by the J88 report form. She added that she did only the most limited anal examination because she did not want to injure the patient.

Evaluation

[70] Dr Bartleman was a very good witness whose evidence can be accepted without qualification.

Dr Craig Franklin

[71] Dr Franklin qualified as a medical doctor in 1998 and as a specialist physician in 2004. He testified that he spent eight years working at a hospital in Pretoria and the past five years working at Medi-Clinic in Paarl. He was the treating doctor to the deceased on

1 January 2014. He was called from home and arrived at the hospital at about 4:30am after the patient had been admitted by the casualty officer. Dr Franklin handed up a report, Exhibit G, which comprised notes which he kept contemporaneously on his cellphone or his computer and to which he added later. In his report he recorded that according to the accused the patient had taken one dose of LSD and at least one MDMA capsule. She said she felt hot then started '*rolling around on the ground'* and was taken to the tent. There she allegedly said she felt turned on and took all her clothes off. Previously she had fallen a few times on the way to the tent. She then started repeating things and the accused called the medics. According to the accused the patient and he did not have sexual intercourse and she was never left alone. Dr Franklin recorded that prior to her admission she had had a hypoglycaemic spell and was given glucose and Ringers. On examination her blood pressure was 117/67 and her pulse was 145 beats per minute. He observed two bruises on the patient's pelvis and knees, a small puncture mark in the neck and above the pubic rim. Neurologically the patient gave no response but was intubated. She showed decreased doll's eye movement and extension withdrawal more in keeping with the type of convulsions. Dr Franklin recorded his working diagnosis of the patient as having a possible LSD and ecstasy related overdose or intoxication along with alcohol. He recorded further, that there were signs of possible sexual intercourse with bruises and a tear in the vagina suggestive of this. He recorded that the vaginal examination had been performed by Dr Bartleman. He further recorded the present problems as being a decreased level of consciousness, acidosis, an episode of convulsions and features still suggestive of this, hyperkalaemia and possible rhabdomyolysis. He noted that the patient seemed to be develop a bleeding tendency inasmuch as she was bleeding from all puncture sites and also renal failure.

[72] In his evidence Dr Franklin explained that hypoglycaemic indicates low blood glucose, that Ringers is the fluid which is replaced into the body through a drip. He explained that a doll's eye movement is when you turn the head of the patient from side to side and the eyes follow the head rather than looking straight ahead and that is an indication of brain death. Testing her motor signs Dr Franklin had initially concluded that she did not show any brain stem damage. The initial main problem Dr Franklin faced was that the patient was very acidotic which, if is not reversed, can lead to death of the cells and the development of multi organ failure. Hyperkalaemia indicates very high potassium levels in the blood whilst rhabdomyolysis is muscle breakdown. Dr Franklin testified that he did not consider anything other than a drug overdose because that was the only history that he had received. As mentioned he noted a bleeding tendency developing and also signs of renal failure. One of the earliest tests done on the patient was a five test on her urine sample the result of which was that it showed positive for opioids, a sedative. His interpretation was that this result reflected the medication which she had received from paramedic's prior to her admission, namely, diazepam, morphine and midazolam/dormicum all of which are pain medications or sedatives. On the history he received he would have expected the LSD and/or MDMA to show on the tests but it did not. Dr Franklin was asked what the cause of the bleeding disorder was which the patient suffered and his answer was that many things can cause this disorder, referred to as DIC i.e. disseminated intravascular coagulation, including the ingestion of drugs and shock. He added that it was almost irrelevant as to what caused the disorder. In lay terms DIC is a clotting cascade that goes haywire so at one and the same time you can be using up all your clotting agents and therefore you are bleeding and clotting at the same time or over-bleeding and over-clotting. It is very difficult to correct this imbalance. The presence of

the DIC in the patient was evident by the facts of her physical bleeding, her abnormal level of fibrinogens and her blood platelet levels. By 12:30pm the patient's acidosis was worsening. Dr Franklin was consulting with a coagulation specialist through the day. By 6pm he was very happy to record that her bleeding had miraculously improved. The patient was also put on dialysis so that her kidneys' functions could be taken over but this was a difficult exercise since her blood pressure was low. By 22h00 the patient was in dire straits. Her abdomen was distended which suggested that there was excess fluid or bowel necrosis through lack of oxygen. However, the patient was never a candidate for surgery because she was too weak. At around 24h00 the patient's heart just stopped beating and she died. The overall damage to her organs was just too great. Amongst some of the contemporaneous or semi-contemporaneous observations that Dr Franklin made were:

08:35 patient *'still fitting'* and '*bleeding from everywhere'*

12:30 patient now developing full blown DIC.
The acidosis is also worsening.
Unable to get arterial line inserted.

18:00 the bleeding has miraculously improved.
Stopped bleeding and HB and platelets all normalised.
'the acidosis is still a problem and on relatively high dosages of imotropes'.

22:00 patient was started on dialysis because the DIC was cleared up but the acidosis was still present.
'neurologically' never woke up and still in coma.

24:00 patient developed bradycardia and passed away.

[73] At the bottom of his initial notes Dr Franklin recorded under the heading 'Final Diagnosis'

'Picture suggestive of LSD overdose with all the (associated) complications especially coma and the coagulation defects which is well described. Possible sexual intercourse/rape cannot be excluded.'

[74] Follow up notes that Dr Franklin recorded on 7 January 2014 included the comment that a CT of the brain had been taken which had proved to be *'normal' 'specifically no intracranial haemorrhage identified'*. He also recorded *'Need forensic assessment. The one thing I would like them to also look at is the small puncture wound on the anterior aspect of the neck that I could never explain and with which she came in'*.

[75] On 7 January 2014 Dr Franklin recorded in his report some of the scan reports and *'follow up notes from new information … and thinking back'*. Here he recorded:

'1. The patient did develop progressive organ failure with the bleeding tendency that worsened during the day as can be seen on the bloods and this is probably also the reason why the bruises became so prominent;

2. The boyfriend was orientated and calm while giving me the history and did not seem intoxicated or even perturbed by what happened;

3. I never introduced anything into the anus. I never examined the anus as part of sexual assault because in my mind this was done by the casualty officer and police before I could start treating patient

…

5. The bruising on the body became more pronounced during the day most likely related to the DIC and the area surrounding the neck area was more prominent;

6. I fixated the ET tube and did not insert it and never caused trauma to the facial area of the mouth. She did have an airway inserted in the mouth to prevent the tube from being bitten that was placed by the ambulance personnel and removed by me when we moved to the ventilator

...

8. The fact that she might have been sexually and physically assaulted etc. was not on the foreground of my mind during the day because in my mind there were more serious problems that were life threatening that is why I did not look for associated problems e.g. assault, bruising etc. Once again this was according to me part of her assessment done by the police and casualty officer initially and not part of my duty at that time.

...

10. The sisters only inserted the urinary catheter after the vaginal examination was done by the police and casualty officer.

11. Neurologically it is difficult to say how bad the extent of the problem was but she did have decerebrate picture and doll's eye movement was abnormal although she still had some pupillary movements present initially. The problem is that she was in a severe metabolic state and many other metabolic problems so needed to correct everything before saying she is brain dead but my impression was that there was some serious problems and that is why we also scanned her brain looking for haemorrhage etc. The fitting (convulsion) also complicated the neurological assessment.

...

13. She was never left alone during the time that she was alive in the ICU and constantly under one on one ICU care. We never caused any serious physical trauma that was not part of normal medical treatment. I never saw her alone and the nursing staff was always present.

[76] Dr Franklin initially stated that the CT scan of the patient's brain was taken at 19:41 but after reviewing his notes etc. he testified it made more sense that it would have been done much earlier at 9:00am and other records bore this out. The purpose of the CT scan was to exclude major pathology such as a large bleed or a tumour. Dr Franklin

emphasised that there was a limit to what can be observed with a CT scan as opposed to an MRI. He used the analogy that a CT scan is like looking at the moon through binoculars whereas an MRI is equivalent to using the Hubble telescope. Dr Franklin testified further that a CT scan won't necessarily show a pathology early on so that a negative CT scan does not necessarily mean the brain is normal. He testified that it was a waste of time to use a CT scan to try and pick up small bleeds.

[77] Dr Franklin went through the results of various tests conducted by Path Care which he used during his treatment of the patient. He was challenged by the defence counsel as to the accuracy of such tests inasmuch each test result contains a standard clause that the results may not be used for medico-legal purposes. Dr Franklin explained that doctors have to trust the results and that they could rely on them as being 99.9% accurate.

[78] Dr Franklin explained that as regards the further notes he added on 7 January 2014 that he had had some interaction with the state forensic pathologist and was asked to answer various questions regarding why certain bruises were not initially seen on the patient. He had realised that something more might come of the matter after this interaction. Dr Franklin emphasised that sexual assault is not one of his areas of expertise. He mentioned that he was also asked, presumably by the pathologist, if he had considered whether the patient's hypoxia could have come from another source such as strangulation. Dr Franklin stated that he had no history other than the one which he received but that without any additional information what he observed would have fitted in with hypoxic damage. Finally, Dr Franklin was asked in chief whether manual strangulation would fit in with the picture which he saw and treated and his answer was

that one can have full blown DIC and convulsions and develop multi-organ failure after such an insult to the body. In this context his answer was *'definitely'*.

[79] Under cross-examination it was put to the witness that he had seemed hesitant when he gave the last abovementioned reply. His response was to state that he only hesitated because he realised that his answer could implicate someone. I pause to observe that this was the clear impression that I obtained of his answer and certainly not that he was uncertain in his reply. The accused's counsel put to him that the *'final diagnosis'* which he recorded in his report (*'picture suggestive of LSD overdose with all the associated complications …'*) was a final and conclusive statement of fact but Dr Franklin clarified that this was no more than a working diagnosis. He was also challenged about his expertise in the field of haematology. Dr Franklin conceded that he is not a haematologist but stated that as a physician he was not unqualified to speak about haematological aspects.

[80] It was further put to Dr Franklin that the forensic pathologist to be called by the defence, Dr Naidoo, would testify that there is no case in history of strangulation causing the medical picture with which the patient presented, namely, DIC and acidosis. Dr Franklin responded that in part that DIC can easily be caused by many things. It was also put to him that strangulation could never have caused the sustained global hypoxia seen in the patient. His answer was that he was not an expert in strangulation. Another area where Dr Franklin was cross-examined at length was in regard to the issue of whether the patient ever had hyperthermia. Dr Franklin was resistant to this notion since he did not observe any signs of hyperthermia and by definition did not treat the patient for such a condition. He eventually found, in the hospital notes, the recordals for the patient's

temperature through the day and they were consistently around the 36.6 degrees centigrade level, namely, a normal temperature. He did concede that the patient was in a state of peripheral shutdown and her blood pressure eventually developed into hypotension. Various symptoms experienced in patients who ingested *'ecstasy'* (MDMA) as recorded in scientific articles were put to him and he conceded that there were considerable similarities with the patient in several of these cases. It was put to him that Dr Naidoo would testify of a case in Durban where the deceased died of hyperthermia induced DIC after taking ecstasy. In short Dr Franklin firmly rejected the suggestion that the patient had hyperthermia upon or after her admission to hospital although he conceded that she did show two of the other signs of hyperthermia, namely, a high heart rate and low arterial pressure.

[81] Dealing again with the Path Care test results he emphasised that they were completely reliable and were analytically conducted. When asked about the accuracy of drugs tests following a time lapse between the intake of drugs and the testing he agreed that this could have an effect but deferred to chemical pathologists or a pharmacologist in this field. Dr Franklin conceded that the patient could have suffered from hyperthermia prior to her admission. He testified that he was familiar with the concept of taking LSD and MDMA at specified intervals so as to heighten their combined effect, apparently known as '*candy flipping'*.

[82] Dr Franklin was also cross-examined at length about the CT scan that was taken of the patient's brain and it was put to him that if there had been a head injury as contended for by the State's forensic pathologist, Dr Abrahams, then it should have been evident on the CT scan. Dr Franklin testified that the CT scan was an imperfect instrument for

picking up such injuries and that the findings of extensive brain swelling and traumatic subarachnoid haemorrhages bilaterally noted by Dr Abrahams could either have been missed by the CT scan because of its imprecision or perhaps could not have developed sufficiently by the time the scan was taken. When it was put to him that the absence of any injury on the CT scan is consistent with there being no such injury his response was to ask how then were the injuries caused. Dr Franklin did testify, however, that the DIC pathology can cause spontaneous bleeding i.e. without trauma. Reverting to the question of the visibility of bruises and injuries Dr Franklin stated that they initially only noted the bruises on the pelvis and the knees and it was only later, after the development of full bodied DIC, that other marks or bruises became visible. It was put to Dr Franklin that the CT scan was the *'modality of choice for head injuries and better even than an MRI'*. The witness disagreed firmly with this proposition stating that the CT scan was better for large bleeds than for micro bleeds. Questioned about the puncture mark in the patient's throat which he could not explain Dr Franklin stated that only a very brave paramedic would make an incision in the patient's throat. He confirmed the opinion he had expressed earlier, namely, that hypoxic brain damage can cause DIC. It was put to Dr Franklin that Dr Naidoo would testify that hypoxic brain damage can cause coagulopathy but usually only with a severe head injury combined with poly trauma to other parts of the body such as seen in motor vehicle accidents or severe falls. The witness stated that he agreed that there did not appear to be literature of a patient undergoing asphyxiation which causes full blown DIC but added that he was not a strangulation nor a DIC expert. *'DIC is difficult'* he testified.

[83] In re-examination Dr Franklin that if he had the toxicology reports from external labs available when he wrote his *'final diagnosis'* i.e. which reports indicated no presence

of LSD or MDMA, he would not subscribe to his diagnosis again. He was again referred to the medical journal articles discussing cases of hyperthermia after ingestion of MDMA and agreed that one common element therein was that all had showed positive MDMA toxicology reports or readings. Dr Franklin expressed scepticism of the notion that the patient could have suffered hyperthermia prior to her admission. He was unable to explain the absence of any trace of MDMA in the tests or LSD for that matter.

[84] In response to the Court's questions he stated that he generally regards the Path Care test results as 99.9% accurate. Significantly, he was sceptical of Dr Abrahams' evidence regarding injuries to the patient's mouth and spoke of the possibility of the DIC magnifying the results of trauma to the mouth possibly caused by the paramedics inserting the airway endotracheal tube. He found, however, it much more difficult to explain the neck injuries away.

Evaluation

[85] Dr Franklin was an excellent and completely objective witness who gave considered and careful evidence in answer to questions put to him. At no stage did he make exaggerated or unsubstantiated claims and was quick to point out when questions were putting him in an area in which he lacked expertise. As previously mentioned, the one instance of hesitation in his evidence was clearly attributable to his taking care and realising the implications of any answer he might give rather than to uncertainty in his mind.

Dr Deidre Abrahams

[86] Dr Abrahams is the head of the clinical unit in Forensic Pathology services in Paarl. She is registered with the Health Professions Council of South Africa as a medical doctor and a forensic pathologist. Dr Abrahams testified that she obtained her medical degree in the Netherlands in 1992, her diploma in Forensic Medicine and Pathology in 1997 and had been a specialist in that field since 2003. She began working in the field of Forensic Pathology in 1995 and in 2003 she became the clinical head at Paarl. Dr Abrahams conducted the post-mortem examination on the deceased on 3 January 2014. She prepared a very detailed report and amongst the chief findings she made were:

1. Evidence of manual strangulation with multi-focal haemorrhages in the muscles and soft tissues of the neck;
2. … petechial haemorrhages of the upper eyelids and sub-conjunctival haemorrhages bilaterally;
3. Sub-pleural petechial haemorrhages of the lungs with congestion of the lungs;
4. Brain swelling with contusions and traumatic subarachnoid haemorrhage;
5. Evidence of forceful and external airway occlusion with contusion and laceration of the upper and lower lips and contusion of the inner cheeks;
6. Evidence of forceful vaginal and anal penetration, ante-mortem;
7. Evidence of blunt trauma to the torso and extremities;
8. …
9. Evidence of oedema of the body and organs with early autolytic changes.

[87] In her report Dr Abrahams concluded as result of her observations that the cause or causes of death were *'consistent with manual strangulation. Drugs may have played a contributory role'*. The report goes on to set out in detail her post-mortem findings and observations of the body. Dr Abrahams noted that there was a post-mortem drugs screen positive for opioids and benzodiazepine, that extensive photographs of the patient pre and post dissection were taken and that ante-mortem bloods and urine had been submitted for drug testing at Path Care and at the forensic toxicological laboratory. Dr Abrahams also

prepared two detailed diagrams, one showing the various injuries and bruises and marks found on the body and another depicting the injuries to the patient's vagina and anus. On 15 May 2015 Dr Abrahams deposed to an affidavit entitled *'Response regarding the case of S D (the deceased)'*. The affidavit is a detailed document containing Dr Abrahams' comments on the cause of death and numerous observations on the treatment which the patient underwent at Paarl Medi-Clinic dealing also with the results of blood and urine tests by Path Care and other external laboratories. Amongst the findings recorded in the affidavit are the following:

> *'16. Based on the examination of my autopsy report, the Path Care Laboratory results and the medical records I conclude that the cause of death remains consistent with manual strangulation.*
>
> *The consequences were asphyxia with global hypoxia renal and liver failure.*
> *This leads to metabolic acidosis and coagulopathy*
> *…*
> *The injuries of the mouth and neck are consistent with external pressure to the peri oral area with injuries of the inside of the mouth and lips.*
> *These are not consistent with paramedics attempting to intubate the patient.*
>
> *The injuries to the neck are consistent with forceful pressure to the neck consistent with manual strangulation.*
>
> *They are not in keeping with attempted intubation or resuscitation. With forceful vaginal and anal penetration and pressure to the neck and peri oral area, consent cannot be assumed to have been given.*
>
> *There is evidence of brain swelling with contusion and traumatic subarachnoid haemorrhage.*
> *Brain swelling is in keeping with hypoxia due to the manual strangulation*
> *…*

There is no clear evidence of a toxic substance which may have caused the death on its own.

I concluded in my autopsy report: that a substance may have played a contributory role.
Cocaine taken several hours or days prior to death should be at a toxic level to cause the seizures and hyperthermia and other neurological changes noted on the scene by the ambulance or paramedic staff.

Based on the examination of my autopsy report, the Path Care laboratory results and the medical records (I) conclude that the cause of death remains: Consistent with manual strangulation and the consequences thereof.

There is no clear evidence that substances played a role.'

Dr Abrahams stated that she received the report of Dr C Franklin, medical records and the lab results prior to the autopsy. The report with retrospective notes of Dr Franklin was given after autopsy.

[88] Before dealing with Dr Abrahams' viva voce evidence I shall set out some of the more detailed findings made by her in her initial post-mortem report. There were numerous needle prick marks on the patient's elbow, left wrist, right wrist and neck, the groin, foot, left lower abdomen and left hand. Apart from the haemorrhages in the upper and lower eyelids there was a curved abrasion high on the right cheek bone and a linear abrasion, a laceration on the right and left lower lips at the inner aspect, contusion and swelling of the upper lip and on the inner aspect of the upper and lower lips. These injuries, Dr Abrahams noted, were consistent was forceful pressure to the mouth from externally. There were contusions on the right chest, left chest, arms, abrasions on the

right and left elbows and numerous other contusions on the arms, left lower abdomen and right and left hip.

[89] Dealing with the sexual organs and the anus Dr Abrahams noted the following:

1. Extensive swelling of the labia majora and clitoral hood and labia minora;
2. A tear at the inferior aspect of the clitoral hood at 12 o'clock of ±10mm, ante-mortem;
3. Circumferential rubbing friction abrasion of the labia minora and inner aspect of labia majora, inner aspect of labia minora in a round the clock from 0 to 24 hours with loss of skin, redness and blood tinged fluid on the surface;
4. Tear at 6 o'clock at the vagina of 5 to 6mm from posterior fourchette through fossa navicularis. There was blood tinged fluid oozing from the tear.
5. There was a loss of skin and redness and swelling from outside the labia minora and along the inner aspect of the vagina to depth of ±70mm. There was blood tinged fluid on the surface;
6. There was blood tinged fluid and creamy light coloured fluid in the vagina with a few sand grains high in the vagina at and around the cervix. This, Dr Abrahams noted, was consistent with seminal fluid mixed with blood.
7. The cervix was round and closed with a contusion on the 4 o'clock to 6 o'clock surface.
8. The perineum appeared intact but swollen.
9. All these injuries, Dr Abrahams noted, were consistent with forceful, non-consensual ante-mortal vaginal sexual penetration.

[90] On examination of the anus Dr Abrahams found wounds similarly consistent with forceful, non-consensual ante-mortal sexual penetration and in particular the following:

1. Surrounding the anus and from the external surface and along the inner surface over 35mm x 40mm there was contusion with rubbing friction peri-anal and anal abrasion with swelling and redness and loss of skin over a distance of ±70mm into the anal canal at, above and below the level of the dentate line.

Photographs taken on incision showed significantly large soft tissue haemorrhage;

2. At the 6 o'clock position of the anus there was a tear of ±5mm which extended slightly into the perineum and with blood tinged fluid present;
3. There was blood tinged fluid and minimal clear fluid in the anus;

[91] In respect of each of these findings in respect of the vagina and the anus not all of the photographs are as clear as others but, at least to the layman's eyes, many of the injuries which Dr Abrahams reported on appear to be borne out. The photographs are not only of the patient's vagina and anus in situ but Dr Abrahams also performed dissections in this area. Further observations made Dr Abrahams were as follows:

> Skull
>
> The scalp was swollen over the vertex and shows extensive subcutaneous haematoma from the frontal scalp over the vertex and smaller haematomas confluent at occipital scalp. This was consistent with blunt trauma. There were no skull or skull base fractures.
>
> Intracranial contents
>
> There was extensive brain swelling, right and left inferior temporal lobar contusions effaced lateral ventricles and traumatic subarachnoid haemorrhages were noted bilaterally.
>
> The Neck structures
>
> A bloodless field neck dissection was done and there was diffuse and extensive swelling with soft tissue haemorrhage and intra-muscular haemorrhage at the right and left sternomastoid muscles and other muscles up and around the thyroid gland. Other haemorrhages were present but there was no fracture of the hyoid or thyroid although there was haemorrhage around the horns of the thyroid and hyoid cartilage. These injuries were consistent with manual strangulation with pressure to the neck.

[92] Dr Abrahams testified that in her opinion the contusions inside the deceased's lips were a result of quite severe pressure from outside such as to force a person not to speak or cry out, using hands or a pillow. Its duration would be more than an instant and could be several minutes. There was also indications of a lot of pressure from fingers or hands thereby producing the contusions to the chest and arm areas. There was evidence of gripping and pulling marks on the patient's lower arm and abrasions marks on both arms not consistent with medical treatment. There were large contusions on the sides of the hips consistent with force on the hip area as if the patient was penetrated sexually lying on her sides. Tears in genitalia occur where there is forceful penetration, unlubricated and unwilling. In her view it looked like severe and forceful pressure which would be very painful. The mechanism in forceful penetration is that the skin is rubbed and abraded, it starts to swell and then starts to ooze blood and blood tinged fluid. In her opinion this would not be a onetime penetration but repetitive forceful penetration, most likely a penis.

[93] In Dr Abrahams' opinion the sand grains found in the vagina were likely to have come about through forceful penile penetration and contact with sandy areas. According to her this fitted in with non-cooperative penetration. Shown photos of the tent Dr Abrahams testified that if the incident took place there it would fit in with the scenario which she sketched. The witness testified that the swelling of the anus would be as a result of repeated forceful insertion and would be extremely painful. The depth of the abrasion found would be consistent with the length of an erect penis. The abrasions found on the patient's knees would be consistent with forceful sexual penetration both *'normal'* i.e. vaginal penetration and anal penetration. Dr Abrahams expressed the view that the head injuries could be the result of the head being banged on the ground or abraded when

the patient was in a position on her knees. The injuries to the skull and the haematoma would be a result of multiple blunt trauma and more than one blow.

Intracranial contents

[94] Dr Abrahams testified that herniation is swelling of the brain caused by hypoxic injury as a result of a lack of oxygenated blood supply to the brain. She testified that this could result as a result of pressure being applied to the neck area for a period as little as three minutes and up to five minutes. She stated that convulsions alone would not cause contusions in the brain. She stated further that the difficulties which the paramedics had finding her vein would be due to extreme hypoxic occlusion which leads to a lack of perfusion to the tissue and this leads to the shutting down of the vascular system in order to preserve a supply of oxygenated blood to the brain.

The alleged strangulation

[95] Dr Abrahams testified that the strangulation could have occurred from the front or behind the patient while she was on her knees that one hand would be sufficient to supply the pressure. She stated that a fracture of the hyoid or thyroid bone is not as prevalent in young persons where those structures are cartilaginous. So even if they were subjected to severe pressure they would not necessarily fracture but might just haemorrhage around those structures. The presence of the opioids and benzodiazepine in the blood and urine tests was consistent with the medication which would have been used by the paramedics and the doctors to sedate the patient and treat her seizures.

[96] Dr Abrahams testified that her initial report, Exhibit H, with the external laboratory toxicology results was placed in front of her and she was asked to comment finally on the cause of death.

[97] In cross-examination Dr Abrahams testified that, amongst other reasons, she prepared her second report because she then had access to all the reports from Path Care and those from the external forensic chemistry laboratories. Based on those reports she concluded that the cause of death remained consistent with manual strangulation and eliminated the possibility of drugs playing any role in the patient's death. The external testing involved having the initial samples taken by Path Care in the Paarl Medi-Clinic and the post-mortem blood sample taken by her tested by the State's forensic laboratory. It was put to Dr Abrahams that her initial report at least referred to a *'history of mixed drug intake'* but Dr Abrahams insisted that those findings had to be confirmed and were no more than allegations. She was taken through a range of documents emanating from the paramedics and the ambulance personnel and hospital personnel making references to diagnoses of drug overdose but Dr Abrahams' attitude remained the same, namely, that allegations of drug ingestion had to be objectively proven. Dr Abrahams testified that she took her own blood sample from the deceased during the autopsy and had this subjected to testing for drugs. It was put to her that Dr Naidoo had calculated that a total of more than six litres of fluid had been administered to the deceased post admission but Dr Abrahams was of the view that this was an overestimate of the fluids administered to the patient. Dr Abrahams testified that she never received the docket, only the photographs of the scene and was briefed at the autopsy of the circumstances surrounding the patient's death, namely, attendance at the rave party, that the patient had been alone in the tent with the accused and that he reported that he never had sex with the deceased nor left her alone and further that the patient allegedly masturbated herself. It was put to Dr Abrahams that the patient had passed dark coloured urine and that this was a result of rhabdomyolysis i.e. skeletal muscle breakdown due to hyperthermia. However Dr

Abrahams stated that dark urine might simply be hyper-concentrated urine mixed with blood from her vaginal injuries. The witness was also taxed with the proposition put to Dr Franklin regarding the CT scan. She too, however, adopted the point of view that a *'normal or negative CT scan'* did not necessarily reflect an absence of brain injuries. She testified that she had seen many such scans which did not show injury which nevertheless was evident on autopsy.

[98] In answer to a question from the Court it emerged that Dr Abrahams' conclusions as to the cause of death were based, in no small part, upon the assumption that the deceased took no drugs as there was no toxicological proof of this. She was further asked what her position would be should it be found that the deceased might well have taken such drugs and her answer was that this would depend on what drugs she took and the quantity. Dr Abrahams' conceded that the question of what drugs someone had taken and the possible effect thereof is a specialist subject within the province of a pharmacologist.

[99] Dr Abrahams' noted that there were some 24 needle prick marks on the deceased. Questioned about her theory that the marks on the inside of the deceased's mouth were caused by external force in an attempt at strangulation, Dr Abrahams stated that this was the only inference which could be drawn. It was put to her that the injuries on the inside of the mouth could have been caused when the intubation tube was inserted through the use of a laryngoscope or when the airway was inserted. Dr Abrahams replied that this was unlikely not least because at that stage the bleeding tendency (DIC) had not manifested. In advancing her view that the mouth injuries were a result of external

'forceful pressure' Dr Abrahams stated that during forceful vaginal or anal penetration the deceased would have cried out and would have tried to escape from those positions.

[100] It was also put to Dr Abrahams that the 32 or so hours which passed between the patient's death and her post-mortem autopsy could have affected her findings. Dr Abrahams confirmed that decomposition starts from the moment of death and that the patient's body was in an unrefrigerated state for some 12 hours. She confirmed her view namely that the deceased had been manually strangled which caused her to become hypoxic and led to the damage to the brain and the other organs of the body. The witness stated that in 99% of cases such as the present the victim would die immediately but the deceased may have survived for some time because of her youth. In her view the strangulation would have cut off oxygen to the brain causing global hypoxia thus effecting all the body's organs. It was further put to her that Dr Naidoo would testify that a strangulation would not cause a clotting disorder, brain disorder nor global hypoxia. It would further be advanced on behalf of the accused that the global hypoxia was a result of the DIC and not the brain injury. Dr Abrahams stated that she did not agree with the reversal of the theory namely that the DIC was the cause of global hypoxia rather than vice versa, the position for which she advocated.

[101] It was put to her that the injuries to the patient's mouth could have been caused by the paramedics but Dr Abrahams responded that none of the paramedics' notes speak of any difficulty in intubating the patient. It was also put that Dr Abrahams' theory of strangulation flew in the face of the clear CT scan and the absence of fractures to the hyoid and thyroid bones. Dr Abrahams conceded that there were no such fractures but stated that there was severe haemorrhages around the horns of those bones and that at the

age of 21 years the patient did not need to show fractures of those bones to have been strangled.

[102] In summary it was put to Dr Abrahams that the various injuries to the patient's body did not support her strangulation theory inasmuch as:

1. a diffuse swelling of the patient's neck was explained by resuscitation attempts by the paramedics;
2. her body was in an early stage of decomposition and bloating;
3. the patient was administered *'massive'* amounts of fluid;
4. the neck is a tough compartment which will manifest any swelling as a result of bleeding but which would have been caused by coagulation and not strangulation; and
5. there was no similar case to be found in the medical literature.

[103] Dr Abrahams' comments were, respectively, that the paramedics could not have caused the haemorrhages she recorded and no attempt to resuscitate would have caused such injuries. Secondly, decomposition would cause some bloating but not haemorrhaging; thirdly, the patient received limited fluids only some 200ml on the scene and less than 6 litres including the period of hospital treatment; fourthly, the neck can swell to accommodate haemorrhage and, fifthly, the coagulopathy disorder only came later in the patient's demise.

[104] It was also put to Dr Abrahams that many of the injuries she noted, except for the abrasions were consistent with the treatment that the paramedics gave the patient. Dr Abrahams disagreed stating this was most unlikely and making the point that the paramedics wold not fight with someone who was convulsing, rather try to calm her down or sedate her. It was also put to Dr Abrahams that the deceased fell to the ground and rolled around on the ground in the tent. As regards the bruising to the patient's sides

and on the hips, it was put to her that these were either medical restraint injuries or because the deceased fell to the ground. Dr Abrahams responded that the injuries were quite severe and did not fit in with a fall or paramedic inflicted injuries.

[105] As regards injuries to the genitalia it was put to Dr Abrahams that another likely explanation for them was generalised bloating of the genitalia following the heavy administration of fluids and the DIC bleeding into the area. Her response was to state that these injuries must be seen in the context of the other tears and abrasion injuries found. It was also put to her that another reasonable explanation for the injuries involving skin loss could be skin detachment as a result of early decomposition. Dr Abrahams denied that there were any *'decomposition injuries'*.

[106] It was put that Dr Naidoo would testify that female masturbation involves the insertion of fingers into the vagina which can produce tears at 6o'clock and 12o'clock. The accused, would if necessary, testify that the deceased was sexually aroused and in the tent she had vigorously fingered herself. Dr Abrahams again rejected the notion that the injuries to the genitalia could be attributed to decomposition explaining that a body does not tear in decomposition. She was also extremely sceptical regarding the masturbation explanation stating it would be extremely painful to self-inflict the friction abrasion injuries and tears. She added that the general picture did not fit with the extent or depth of the injuries and if masturbation had been taking place it would be lubricated. Instead there was a lack of lubrication which explains the injuries. Dr Abrahams added that some injuries went right up to the cervix. She disputed that skin slippage would account for any of the injuries and referred to para 3 of her initial report dealing with secondary post-mortem changes where she recorded as follows:

'There is evidence of secondary autolytic changes with bloating of the body and marbling with no skin slippage'.

[107] Dr Abrahams confirmed that she had done block dissections vaginally and peri-anally so as to get a much better picture.

[108] Dr Abrahams was also questioned at some length about the presence of sand grains high up in the patient's/deceased's vagina and it was put that a plausible explanation was that this could have been as a result of intercourse on the ground or that the deceased had transported these sand grains into her vagina when masturbating. Her comment on the latter was that this was highly improbable since the grains reached or were found around the cervix and sand grains cant *'jump up'*.

[109] The accused's counsel put to Dr Abrahams that the same theory of decomposition and skin slippage could explain the anal injuries and further that the vaginal and anal *'tears'* found could be caused by masturbation and constipation respectively. Dr Abrahams replied that these were very unlikely explanations and furthermore that she saw bloating but no skin slippage. As far as constipation was concerned she stated that such tears would be internal whereas the tears she found were on the outside. The notion that the anal injuries were caused by masturbation was very unlikely as this would be very painful. There was an area of friction abrasions surrounding the anus.

[110] It was further put to her that Dr Bartleman's J88 examination revealed nothing untoward in the anal area. Dr Abrahams stated she could understand this since Dr Bartleman's anal examination was superficial as the patient needed immediate and extensive care to try and save her life. She added that such injuries could also show up more clearly at a later stage. It was put to Dr Abrahams that the deceased might have

sustained the knee and elbow abrasions as a result of falling and inasmuch as there were injuries on all sides of the patient's body. It was further put that the accused would deny that any fluid found in the deceased was deposited by him. Dr Abrahams testified that on smell and examination it seemed like seminal fluid. Asked why she did not take a sample her response was that swabs had already been taken by Dr Bartleman in the J88 process. She conceded that the DNA testing had proved negative. The fullest account of the accused's version of events was put to Dr Abrahams and was as follows:

> He and the deceased had taken LSD and MDMA earlier that evening together with others. The drugs were bought from an unknown person and taken in combination: first the LSD and about half an hour later the MDMA. It became evident that they were adversely affecting the deceased. Later in the evening the deceased began to feel unwell on the dance floor. She sat down complained of not feeling well and stated that she wanted to go back to the tent. At this stage she could not stand on her own. She had to be assisted by the accused and by Jade Grey and Riaan Martin who helped her to stand after she tried to do so but fell onto her knees. They then supported her and walked to the tent but at times her knees buckled and she subsided to the ground. Riaan Martin and Jade left after they had assisted the deceased to the tent. The accused and the deceased went into the tent, with the accused thinking that the deceased would rest and let the effects of the drugs wear off. However, in the tent the deceased expressed that she was sexually aroused, removed her clothing and insisted that they have sex. The accused refused. The deceased was in a state he had never seen her in before in their relationship. She did strange things whilst on the ground she rubbed herself and inserted her fingers into her vagina. The accused tried to calm her down but she started to shake and

then began having fits. The accused panicked, became very worried and screamed for assistance from friends camping around them. Before he went for help he put short pants onto the deceased. Some of his friends arrived. He was in a frantic state and the deceased was on the ground convulsing. After the paramedics arrived they tried to calm the deceased and *'get things into her'* but they struggled to do so. After sometime they placed her on a stretcher and took her to the paramedics' tent. The deceased was still convulsing. There the paramedics struggled to get needles and *'things'* into her. At some point the paramedics asked for a wet towel. An ambulance arrived and the deceased was placed inside and taken to Paarl Medi-Clinic. He and Kyle Inglis followed. At Paarl Medi-Clinic ICU he spoke to medical personnel including Dr Franklin. He also spoke to certain police officials and gave a statement to one such official. The further events of the day were described.

[111] It was also put that the accused had never raped, assaulted or strangled the deceased on 31 December 2013 or 1 January 2014, that they were in a loving relationship and that he had no reason to do so or to cause her any harm. Dr Abrahams was then asked to comment on this lengthy account from a medical point of view. She stated that all the temperatures taken of the patient showed no hyperthermia and all the drug tests showed no presence of amphetamines. All the blood samples were analysed and reanalysed and nothing was found besides the substances that formed part of the medical treatment the deceased received. Consequently Dr Abrahams was of the view that drugs played no role in the deceased's death. There was also no evidence of any sexually stimulated or hyper-stimulated state in the patient. She maintained her opinion that the cause of death was strangulation and that drugs played no role.

[112] In re-examination Dr Abrahams was asked whether she was aware of the patient's DIC pathology when she drew up her first report and her response was that she had been aware since inter alia she had Dr Franklin's report. Asked why there was no specific reference in her first report to the DIC pathology Dr Abrahams' reply was lengthy but vague.

Professor Lorna Martin

[113] Professor Martin has an MBCHB acquired in 1989, a diploma in forensic medicine, a Masters in Forensic Pathology and a fellowship in Forensic Pathology from the Medical Colleges of South Africa in 2011. She has 19 years of experience as a forensic pathologist and before that also did clinical work as a district surgeon.

[114] Professor Martin was asked by the State to give a second opinion on the subject matter of Dr Abrahams' post-mortem report. To do so she read all the relevant reports and documentation. She explained that she is the clinical department head for Forensic Pathology services for the Metropolitan and Southern Cape Area and also head of the department of Forensic Pathology at UCT. Dr Abrahams is a regional pathologist in charge of the Paarl area and supervises other pathologists. Dr Abrahams does not report to her although she (Professor Martin) is her superior on the relevant organogram. Professor Martin prepared a report (Exhibit W) the contents whereof she confirmed. Amongst the documents she considered were Dr Abrahams' two reports, Dr Naidoo's medico-legal opinion, Dr Franklin's report, the Path Care results, the report of Professor Peter Smith and the report of the forensic chemistry laboratory.

[115] She set out the background to the case and then expressed her overall opinion, namely, that the injuries as recorded as external findings at autopsy were due to blunt

force trauma consistent with manual strangulation, compression/closure of the mouth and forceful genital and anal penetration. She added that the injuries to the patient's anus, chest, abdomen, legs were also consistent with blunt force trauma/application of force and could have been caused by grabbing or holding down. The injuries to the elbows and knees could have been sustained if the deceased was on all fours. In further comments Professor Martin referred to the coagulopathy which developed in the deceased as a result of the *'global hypoxia injury'* sustained and the multi organ failure that developed. She noted that there was no pharmacological/toxicological evidence to suggest that a drug had initiated the confused, depressed neurological state, the convulsions nor the metabolic acidosis or DIC (renal and hepatic failure). She further noted that Dr Abrahams was aware of the medical history and specifically the treatment at Paarl Medi-Clinic before she performed the autopsy. Professor Martin added that she had never seen such injuries to the mouth, lips or cheeks being caused by health care personnel when inserting an oropharyngeal airway or suctioning secretions. Similarly she had never seen such injuries to the neck region - by insertion of an endotracheal tube – or to the genitalia – by insertion of a urinary catheter. She noted that all of the above medical interventions were administered to the deceased well before the onset of the DIC in the patient. She did not believe that the genital and anal injuries could have been self-inflicted by the deceased's fingers. She noted that a friction abrasion (rubbing abrasion) is a common term in forensic pathology nomenclature; further that there was no evidence of the deceased being hyperthermic. She noted that in Dr Abrahams' second report she had had access to all the medical records including the ICU chart and nursing notes whereas Dr Naidoo did not appear to have that information when he compiled his report dated 22 April 2015.

Further she noted that Dr Abrahams was a forensic pathologist whose focus was on the documentation of injuries whereas Drs Franklin and Bartleman were not such specialists.

[116] In conclusion Professor Martin's opinion was that the cause of the patient's death was due to strangulation and the consequences thereof and that the injuries to the genitalia and the anus were due to forceful penetration.

[117] In viva voce evidence she was asked to comment on the lengthy version which had been put to Dr Abrahams whilst Professor Martin was present in court. Amongst her comments was that she did not believe that constipation and masturbation could account for some of the injuries to the patient's private parts since the injuries to the anus were quite severe and would have caused *'exquisite pain'*. She noted that there was no evidence at all of any drug ingestion in all the samples tested. As far as she was concerned the rest of the evidence showing the clinical picture accords with strangulation rather than the ingestion of drugs. She did agree that the DIC could have played a role in accentuating the bleeding and therefore the injuries and that DIC can also lead to spontaneous haemorrhaging. Asked how severe the patient's injuries were Professor Martin stated one must look at the overall pattern and in doing so she saw the injuries as being severe i.e. the amount of force used. She sees the injuries as emanating from neck strangulation and also others as a result of a multiple interactions with someone being assaulted. She added that the deceased could also have been penetrated from behind.

[118] Professor Martin testified that she attended a roundtable meeting with several other experts involved in the case recording the various areas of agreement and disagreement. This signed minute was handed up as Exhibit F and records that there were four principal issues discussed, namely:

1. The evidential value of the results of toxicological testing;
2. The verification of lesions described as injuries;
3. The evidence of sexual injury and
4. The medical cause of death.

[119] As to the first topic i.e. the toxicological analyses, it was agreed that the results did not identify any toxic drug or compound the effects of which could have caused or contributed to the death. It was further agreed that a group of drugs, amphetamines, which could cause a clinical state of hyperthermia, rhabdomyolysis, bleeding disorder and acidosis were not found in the deceased after three different laboratory processes. The area of disagreement was whether drug intoxication was a cause or contribution to the patient's death. In this regard Dr Naidoo was of the view that a negative result on the drug test done did not entirely rule out causation by drug intoxication and that the laboratory analysis were not fully comprehensive in respect of the range of substances. The State's expert disagreed in this latter regard as MDMA and amphetamines were tested for and no test can ever be comprehensive in the sense that it tests for new (as yet unknown) agents.

[120] As regards the verification of injuries it was agreed that the injuries reported on the deceased looked much worse than they actually were due to the bleeding disorder that developed but that they had been present before the onset of the bleeding disorder. The areas of disagreement under this heading were the specific causation of the injuries. The State's pathologist (Professor Martin) believed that the injuries were inflicted on the deceased before her death and that the resuscitation procedures did not contribute to her

injuries described on her neck. The defence's pathologist was of the view that the injury appearances were created by the following combination:

1. injuries to the knees, the hips and genitals when the patient was in a disturbed and agitated state at the incident site and as a result of resuscitation procedures; and
2. the same intensified or magnified by the effects of the DIC.

[121] Regarding evidence of sexual penetration there was agreement that the finding of *'rape'* was not within the ambit of the medical examiner and the question was rather whether there was evidence of sexual penetration by the demonstration of genital lesions, whether consensual or not. The area of disagreement was that the State's pathologist believed that, based on the J88 and autopsy findings, there was evidence of vaginal injuries and the only explanation therefor was sexual penetration whereas the defence expert considered that the genital appearances could be explained by self-infliction, its appearances enhanced by the DIC.

[122] Finally, regarding the medical cause of death there was agreement that the terminal pathophysiological mechanisms of death were a generalised hypoxia, multiple organ failure, severe acidosis and severe bleeding disorder (although the latter was reversed by treatment). The area of disagreement was as to the underlying primary cause of death. The State's pathologist believed that this was manual strangulation which produced hypoxic damage to the brain and other organs leading to the coagulopathy and multiple organ failure and inasmuch as it could not be found that drug toxicity was a contributory cause. The defence pathologist considered that a *'systemic'* insult was suffered to cause multiple organ damage and it could not be conclusively shown that drug toxicity could be excluded from causation. He considered further that the neck findings

were more easily explained by resuscitation intensified in its appearance by the bleeding disorder; further that the state of multiple organ failure and coagulopathy was highly unlikely to be produced from strangulation alone.

[123] In her evidence Professor Martin testified that the bruising on the patient's hips were unlikely to have been caused by convulsions/rolling around but rather by blunt force trauma i.e. being hit or the body hitting something. Similarly she saw the internal mouth contusions and lacerations as being caused by pressure from outside and did not believe that paramedics would have caused them. As regards the neck injuries she considered that the absence of finger marks were not conclusive because a forearm could have been used in a choke hold. She stated that how long such pressure could have been applied would depend upon strength but could be up to eight minutes. She testified that it was a case of attempted strangulation and that she knew of only two such cases, one where the person eventually died and the other where the victim survived. In her view the cause of death is what starts the sequence or cascade of events leading to the eventual death. It could start with local hypoxia i.e. to the brain and then spread globally to when the brain shuts down and the other organs shut down as well. In her view the convulsions caused by damage to the brain following the attempted strangulation.

[124] In cross-examination the witness resisted the notion that the deceased may have been suffering from hyperthermia at any stage basing this on the observations made and notably the temperatures recorded. Asked if her opinion as to cause of death would change if the Court would find that the deceased took drugs her reply in essence was that it would take evidence of the deceased taking a lot of drugs for her to change her opinion. The issue of rhabdomyolysis was raised with her and she agreed that the patient was

treated for a breakdown of muscle tissue but stated that there were various causes for such a condition including systemic assault and hypoxic insult**.**

[125] Regarding injuries to the patient's lips and mouth Professor Martin considered that medical intervention was not a plausible explanation for these injuries even taking into account the role of the DIC. In this regard she noted that the patient was only intubated by the Metro ambulance paramedic when she was already in deep sedation. She conceded the small possibility of some trauma being caused when the patient was first treated but does not think it could have caused the lip damage. Professor Martin testified that she had seen more than 2000 cases of rape since she commenced practising as a doctor in 1999; she had conducted more than 12 000 autopsies and supervised more than 20 000. She had never previously seen such injuries caused by paramedics or medical staff.

[126] Dealing with the alleged strangulation, the witness accepted that there were no specific contusions to the neck such as finger marks but pointed to the contusion haematoma around the two bones as being indicative of blunt force trauma. She speculated that the forearm could have been used although she did not discount the use of hands. Professor Martin again expressed agreement with a finding that there was blunt force trauma to the patient's head and testified that a CT scan would not necessarily show such injuries at 9am on 1 January 2014. When it was put to Professor Martin that the genital and anal injuries were explained by heightened sexual arousal, masturbation, constipation and DIC the witness first set out her considerable experience dealing with rape cases, her academic writing on the subject and her supervision of studies in the area before expressing her opinion that these injuries were caused by blunt force trauma and could not have been caused by the factors advanced on behalf of the accused. Her reasons

were the severity of the injuries inter alia the abrasion to the anus being 7cm in depth and the lacerations to the genitalia. She herself had never seen injuries to that extent caused by masturbation or constipation. The witness noted that women deliver babies without incurring lacerations and similarly men have sex with men without anal lacerations. Her view was not affected by the fact that there was no positive DNA results. In re-examination the witness expanded upon this stating that if a DNA result is positive it is significant but that if it is negative it is not so significant since it is an eliminatory mechanism. The depositor may have been a non-secretor, there may have been a physical barrier or the sampling technique could be hit and miss. Regarding Dr Abrahams' evidence, strongly criticised on behalf of the accused, that the fluid she found in the patient's vagina had the appearance of seminal fluid, Professor Abrahams testified that such evidence was routinely given before sophisticated methods of testing fluids were widely available.

Ms Nokwanda Mbonambi

[127] Ms Mbonambi testified that she was employed as an analyst at the forensic chemistry laboratory run by the Department of Health in Woodstock. She had a national diploma in analytical chemistry and had worked at the lab since 2012 as a forensic analyst. She confirmed an affidavit she had made stating that she received certain blood samples from the forensic pathology service in Paarl on 10 January 2014 in a sealed polystyrene container which she analysed and found therein traces of acetaminophen, diazepam and midazolam. These samples had been kept in an access controlled area until their analysis on 20 March 2014. Access controlled refers inter alia to the fridges in the laboratory which are kept at between 4 and 8 degrees centigrade. The witness testified that the machines which she used to test the samples were very sensitive; further that she

used a sequence of two machines to test and picked up the results only in the second and more sensitive machine. Finally, she testified that if there had been any traces of MDMA and LSD at the very least the second machine would have picked this up.

[128] In cross-examination Ms Mbonambi stated that MDMA and LSD were part of the library of drugs for which she tested using a high performance liquid chromatograph. The witness gave clear evidence which was not materially challenged and which can be accepted.

Professor Marc Blockman

[129] Professor Blockman is a specialist pharmacologist and a professor at the department of internal medicine in the division of chemical pharmacology at Groote Schuur and UCT. He holds the degrees of MBCHB and Bachelor of Pharmacy and is a fellow of the College of Pharmacologists. He testified that Professor Peter Smith, a scientist in the division of chemical pathology had sought his opinion on drug levels in certain Path Care samples which had also been retested by his laboratory in relation to the demise of the deceased. Professor Blockman compiled a report in which he set out the documents to which he had regard including certain pharmacological results, a blood alcohol report, Dr Abrahams' report and Dr Franklin's report. He also attended the joint meeting of experts on 9 June 2017.

[130] Professor Blockman confirmed his report in which he set out the history of the matter and which noted inter alia that the laboratory samples did not reveal the presence of either LSD or MDMA. He noted that the referral confirmatory laboratory (Professor Smith's laboratory) itself could not establish LSD or MDMA presence. He expressed the opinion that if the deceased had taken LSD or MDMA at 22:30 the drugs or their

metabolites would have been expected to be found in blood or urine samples taken at around 4:30 the following day although the dose taken would obviously play a role. He stated further the fact that neither of these drugs were detected in either blood or urine means that *'there is no objective evidence that they were actually taken by the deceased'*. Professor Blockman stated that a moderate dose of LSD would significantly alter one's state of consciousness characterised by a stimulation of affect, altered psychological functioning and perceptual changes such as illusions and pseudo hallucinations. A moderate dose of LSD within a few hours after ingestion results in plasma and urine concentrations. The average time for determination of LSD in blood specimens is estimated to be 6 to 12 hours and 2 to 4 days in urine specimens.

[131] Regarding MDMA it is structurally related to amphetamines and causes an elevation of mood and increased energy. It also increased the desire to interact and bond with other people due to an outflow of oxytocin. Hyperpyrexia resulting in rhabdomyolysis or heat stroke has occurred due to serotonin syndrome or enhanced physical activity without recognising clinical clues such as overexertion, warm temperatures and dehydration. Professor Blockman testified that as an extension of the desired bonding and enhanced socialisation effects of MDMA, people may make choices about whether to engage in sex that they would not have otherwise. He testified that there is limited experience with treating MDMA induced adverse events and generally the therapies usually employed to treat the general disorder are used. He testified that the finding of trace cocaine metabolites i.e. the breakdown products of cocaine by the referral confirmatory laboratory may reflect that cocaine was taken days before. However, the result must be treated with extreme caution and the deceased may never have taken cocaine at any time. Professor Blockman stated that he was comfortable that his trace

metabolite finding played no role in the death of the deceased. He commented that the suggestion by the accused that the deceased may have taken LSD and MDMA does not explain the physical trauma found by the forensic pathologist i.e. manual strangulation. Professor Blockman concluded that in his opinion no medicines led to the deceased's death and he was unsure as to whether any of the drugs referred to were in fact ingested as laboratory assessment had proved negative.

[132] In viva voce evidence Professor Blockman was referred to the joint minute of experts and in particular Dr Naidoo's assertion that the laboratory analyses were not fully comprehensive in respect of the range of substances so that could be tested to account for the clinical picture. Professor Blockman disagreed strongly stating that it was not true since the test included MDMA and LSD and no test could be said to be non-comprehensive if you are testing for a new substance i.e. one which has not been detected before.

[133] Professor Blockman testified that MDMA is usually in tablet form with an E inscribed on it. He was referred to various academic articles produced by the defence in support of their theory that the patient suffered from hyperthermia. Professor Blockman observed that notable features in those cases were that each patient suffered from hyperpyrexia i.e. a temperature of more than 40 degrees and traces of MDMA were found in their blood samples, characteristics not present in the deceased's case.

[134] In cross-examination Professor Blockman stated that the ingestion of fluids can play a role in the detection of drugs, that the effect of drugs on individuals can vary and that in combination drugs can have an enhanced or different effect. It was put to him that the fact that the drug tests were negative for MDMA and LSD did not itself signify these

drugs were not ingested for the following reasons: the expert witnesses were not present, they played no role in the treatment of the deceased and there would be evidence that the deceased took these drugs. Professor Blockman stated that he cannot completely exclude the possibility that the deceased took these drugs. He stated that rhabdomyolysis is not inconsistent with a drug overdose. The accused's factual version was put to him and he was asked whether he still maintained his opinion and he confirmed that he did.

[135] In re-examination Professor Blockman made the point that for a drug to cause death it has to be in the blood stream. He confirmed that it would be very unusual to have a case of hyperpyrexia where the patient would have a temperature above 40 which then goes down to a normal temperature in hospital. The theory of the patient causing injuries to herself by masturbation, under the influence of the drug was put to Professor Blockman and he stated that he had never heard of any such case. He added that something which had worried was the suggestion that the patient was unable to walk to the tent but once in there was seemingly overwhelmed by strong sexual impulses and masturbated herself fiercely.

[136] Professor Blockman was a very good witness and clearly is a highly qualified pharmacologist. In his core area i.e. pharmacology, his evidence was not seriously challenged and must be accepted.

Professor Peter Smith

[137] Professor Smith has a PhD in Biochemistry and directed the therapeutic drugs monitoring lab at Groote Schuur from 1992 to 2017 when he retired. He also directed the mass spectrometry unit at UCT and was director of the clinical pharmacology unit from 2000 to 2017. LC mass spectrometry is a high performance liquid chromatograph and is

a very sensitive means of detecting drugs which looks at the time when an agent appears in the test, its mass and its fragmentation pattern. It is extremely rare for all three of these identifying features to be replicated i.e. producing an error. This process is different to toxicology analysis using immuno assay which is less sophisticated but widely used in commercial laboratories such as Path Care and at Groote Schuur. The liquid chromatography process is expensive but would also have been used at the Woodstock police forensic laboratory. Professor Smith's laboratory at Groote Schuur is a referral lab for Path Care and provides a more sophisticated testing service for certain samples which are delivered by Path Care using the mass spectrometry machine. Samples are delivered by Path Care by courier for testing about once weekly.

[138] In the present case they received a sample involving two blood samples and a small urine sample from Path Care on 6 January 2014 which the lab duly analysed using the LCMSMS method. The result showed clear traces of diazepam, midazolam and another agent also known as paracetamol. Also found was an antihistamine. The latter two agents were found in the urine. Also found therein was morphine, codeine and cocaine metabolites. Because of the low level of cocaine found either the deceased did not ingest the substance or took it some good few days before the incident. Professor Smith stated that if the deceased had taken LSD or MDMA the evening before her death it should have been picked up on testing. The qualification he added was that it was dependant on whether the amounts she took were very small. He handed the samples in question back to Sgt Sias on 9 May 2014. When it was put to him that these samples were kept at room temperature overnight in Paarl before being tested by the police laboratory Professor Smith observed that most drugs are quite tough and he would not expect to see any adverse effects or a big difference in the second testing results. Professor Smith also

confirmed a report by himself, Exhibit MM, in which he set out his evidence and his conclusion that there was no objective evidence that the deceased had taken LSD or MDMA at 22:30 since the drugs or their metabolites would be expected to be found in her blood or urine and in samples taken at 04:30 the following day.

[139] In cross-examination Professor Smith testified that the testing process in his laboratory would not pick up a very new *'designer'* drug for which the computer is not programmed. The result could be influenced by the amounts of fluids ingested by the person but this would have to be correlated with the creatinine levels in the blood and see whether it was influential.

[140] Professor Smith was a completely credible witness within his field of expertise.

Lieutenant Colonel Marissa Gordon

[141] Lt Colonel Gordon testified that in January 2014 she was stationed at the Paarl Family violence, child protection and sexual offences unit (*'the FCS unit'*). She commenced duty at 7am that day and a Sgt Morrison reported to her that she had received a charge of serious indecent assault and that the complainant was at Medi-Clinic in Paarl. The witness and two colleagues proceeded to the hospital at about 8:30am and were told by medical staff that the deceased had sustained serious injuries, in particular bleeding on the brain. She obtained the accused's telephone number and called him telling him that she was on her way to Le Bac Estate and that he must not break down his tent. She and her colleagues arrived at the estate at about 9:30am where she met the accused and they proceeded to his tent. Upon enquiry the accused told her that he had bought two pills, one LSD and one MDMA and had given the LSD pill to the deceased to take which was the first time she had done this. She then began to take off her clothes

because she wanted to have sex with him. With the help of two of his friends, Riaan Martin and Jade Grey he got her back to the tent. Outside the tent the deceased began to vomit and when he took her into the tent she began to roll on the ground, again wanting to have sex with him and taking off her clothes although he again refused. According to the accused the deceased then began to speak in a confused manner. She asked him whether he had stayed with her the whole time and he replied yes. The accused told the witness that the deceased could not breathe properly after a while. Her body became limp. He took her to the paramedics who made an incision in her throat so that she could breathe and from there the paramedics took her to hospital. Lt Colonel Gordon had asked the accused whether he had had sex with the deceased and his reply was no and that they could take a blood sample. The witness then went to the paramedic who treated the deceased but whose name she could not remember. He told her that when the deceased was brought to him she was already unconscious and that was why the incision had been made.

[142] Lt Colonel Gordon was cross examined at some length during which it emerged that her recall of detail and her knowledge of police procedure was quite poor. Nonetheless the material elements of her evidence were not challenged and can be accepted. These elements were confirmed in a semi-contemporaneous note which she kept and in which she recorded *'the victim took one LSD tablet and one MD tablet'* and the further phrase *'mentioned she threw up and rolled on the ground'*. Lt Colonel Gordon was subjected to a quite lengthy cross-examination during which it became clear that she did not have a very good recollection of the details of the events in question.

Sgt Ronel Morrison

[143] In 2013/2014 Sgt Morrison was employed by SAPS and had 17 years' service. She was stationed at the FCS unit in Paarl and Lt Colonel Gordon was her superior. She left the SAPS in 2016. On 1 January 2014 at about 3:45am she received a telephone call to the effect that she must proceed to the Paarl Medi-Clinic ICU which she did accompanied by two colleagues. The patient/complainant, (the deceased), was unknown to her and was unconscious and connected to various life support machines. The doctor told them that she had come in as an overdose patient and explained that it was a possible rape case. He asked for a crime rape kit and said that he was not comfortable doing the examination and asked a woman colleague, presumably Dr Bartleman, to undertake the examination. Dr Bartleman applied the kit and took the swabs but not in their presence although the samples were sealed before them. Sgt Morrison then went to the cafeteria to find the accused and she and a colleague began to take a statement from him.

[144] When the State sought to hand up the statement an objection was taken on behalf of the accused, namely that it was inadmissible because it was taken as a witness statement and then used against the accused. A trial within a trial commenced at that point. The issue in the trial within a trial was broadly the question of whether the accused was a suspect or a witness and, if the former, should he not have received warnings before a statement was taken from him. The accused's counsel advised that the contents of the statement were not in dispute, just its admissibility, and that it does not contain admissions, confessions or incriminating material. In fact, according to counsel, the contents were entirely consistent with the accused's defence. The State prosecutor advised that she wished to prove the statement merely for the purposes of a possible cross-examination of the accused.

[145] Sgt Morrison testified that she regarded the accused as a witness, that they had just begun their investigation and that she had to proceed some way before they could start thinking of a suspect. She was not even in a position at that stage to say whether an offence had been committed i.e. before the sexual kit and examination had been completed. She stated that she asked the accused to give his account as they sat together in the cafeteria after explaining to him that they needed his witness statement so that they could know in which direction to go. The accused agreed and whilst they were busy the patient's mother arrived. The accused told the deceased's mother that he was very sorry for what had happened and the mother asked whether she could sit with them while the statement was being taken. The accused agreed to this. The witness began to take down the accused's statement but he interrupted her and said could they go outside because he wanted to smoke. The witness acceded to this request and sat in her car taking the statement whilst the accused stood outside smoking. The witness testified that the offence they were investigating was the overdose and an alleged rape. She took the statement from the accused because he had been with the deceased throughout. Sgt Morrison stated that she was the investigating officer in the matter for no more than a day and a half before she handed it over to another police officer. The accused smoked incessantly, seemed nervous and was walking around all the time while she took his statement. She stated that if she had regarded the accused as a suspect she would have read him his rights beforehand. It was put to her that her telling him not to disappear before she had viewed the camp site indicated that she viewed him as a suspect. The witness denied this stating that in any rape case the scene has to be pointed out by someone so that photos can be taken and bodily fluids searched for. She testified that the accused had many opportunities to say if he was not comfortable making the statement. Later she had

attended at the camp site where a photographer had taken photographs and a police dog had been used to sniff for bodily fluids. Sgt Morrison testified that the accused read the statement which she took from him himself and pronounced himself satisfied. She was taken through the statement and corrected some of the more obvious errors.

[146] Sgt Morrison was a good and credible witness and there is no reason to disbelieve any of her evidence.

Sgt Terence Sias

[147] Sgt Sias was stationed at the SAPS detective branch at Paarl and was part of the investigating team. He testified that two dockets were opened, one a rape charge and the other an inquest case. After the autopsy the inquest was changed to a murder docket. It was sent to the DPP for guidance and instructions and in October 2014 they received instructions to arrest the accused. Sgt Sias testified that the accused only became such months into the investigation and after the DPP had become involved in the case. Sgt Sias also gave evidence that he collected the deceased's blood samples from the Groote Schuur laboratory, brought them back to the Paarl police station where they were stored overnight and thereafter delivered them to the Woodstock Forensic laboratory. Samples were marked Ms S D. Refreshing his memory from his statement he gave the sample number. Sgt Sias also testified that he made considerable efforts to find the paramedic, Mr Eugene Le Roux, but could not trace him even after using social media. He confirmed that the police dog brought onto the scene on 1 January 2014 found no positive signs i.e. bodily fluids.

Ruling pursuant to the trial within a trial

[148] At the conclusion of the trial within a trial I ruled that the witness statement made by the accused was admissible and it was entered into the record. I undertook to give reasons at a later stage and these are annexed to this judgment as Annexure A and form part of this judgment.

The accused's case

[149] The accused called an expert witness, Dr Segaran Naidoo, and two witnesses, Ms Lameez Martin and Ms Jade Grey in that sequence although I will set out the evidence of the factual witnesses first. The accused did not testify in his own defence.

Ms Lameez Martin

[150] Ms Martin testified that she knew the accused and the deceased and in December 2013 was dating the accused's cousin, Rafiq Wagiet and they would sometimes all four go out together. They were all members of a party which went to the trance party at Le Bac Estate on 31 December 2013. She arrived with four others that day at the venue when they set up the tent and scouted around. Thereafter they all went, including the deceased and the accused for a swim in a dam or a river. She, Rafiq and one, Yugan, shared a tent but she cannot say where it was situated in relation to the accused's tent. In the evening the witness got hold of some LSD and MDMA. She testified that drugs were freely available at this event. This was at or near someone's tent and present were the accused, the deceased, Vanika Lalloo, Yugan and Rafiq Wagiet. They then took the LSD. The witness testified that much of the day or the night was a blur to her and that she could not even remember the circumstances in which she procured the drugs. According to her the LSD is a small square which you put in your mouth like paper. Following

ingestion of the *'LSD'* the witness felt nauseous and was not feeling well at all. She was dizzy and struggling somewhat to see properly and to walk. What happened next was that someone needed the bathroom and they all went in that direction. The witness still did not feel well and she was throwing up. Asked about the deceased's condition she said she was also not feeling well, she looked weak and the accused was helping her to walk. After the bathroom stop she went to the dance floor with others because she thought dancing might help. She does not know when she used the MDMA but she must have done so because she felt energetic. At the bathroom someone had told her that the deceased was not feeling well and they were going back to the tent. It was the last she saw the accused and the deceased until she saw the latter at the emergency tent where she observed her having fits. She went back to the dance floor and can't remember for how long or much other detail of the rest of her stay at Le Bac Estate.

[151] In cross-examination the witness testified that she was 23 years old when the incident took place and that was her first drug experience. She identified Exhibit J as a picture of her that night with the accused and the deceased and the other photograph as pictures of Rafiq and Yugan together with the deceased and the accused. She also testified that she had bought the drugs she took herself. The witness' evidence was replete with *'I can't remembers'*. She recalls the MDMA as being in a capsule. Although she has no memory of taking the MDMA capsule she felt very happy and had high energy levels. She remembers the colours and the movements of the lights on a screen in a light show on the dance floor.

[152] In answer to the Court's questions she stated she last saw the accused and Rafiq Wagiet about four years ago. She was asked why she had not come voluntarily to court

but had to be subpoenaed and her reply was that she did not feel comfortable talking about something that she was embarrassed about.

[153] Ms Martin was a poor witness who could barely remember what happened on the day in question. Her evidence had an artificial ring to it almost as if she had been programmed to say that she took LSD and MDMA and conclude with the observation that no one should take drugs, the subliminal message being that the deceased died of a drug overdose. Limited reliance can be placed on her evidence.

Jade Grey

[154] Ms Grey is a final year Psychology student who in December 2013 had just finished Matric. She attended the event at Le Bac Estate with a party including the accused and the deceased and accompanied by Riaan Martin who is still her boyfriend. She had attended one such festival previously and in her experience there is usually a drug culture at such festivals although she does not use drugs herself.

[155] She first met the deceased when she was in Grade 8 at school but only met up with her again a few weeks before the festival. The witness and her party arrived at midday, pitched their tents and went for a swim with the group. That evening she sat with the deceased who brushed her hair outside her tent and she seemed completely fine and normal. Later she and Riaan went to the dance floor leaving the deceased and the accused still at the tents. She next saw them when she was on the dance floor and noticed the deceased and the accused at the toilet some 120m – 150m away. When she made her way there she found that the deceased did not look herself and was completely different. The deceased said she did not feel well and told the witness she felt as if she was melting. The witness tried to get her to stand up but could not since her (the deceased's) legs were like

jelly and she could not stand on her own. The deceased said she wanted to go to the tent which the witness said was not a good idea. The deceased also said that she wanted to go to the tent and have sex with the accused. The witness helped her to get back to her tent with one of the deceased's arms draped over her shoulder and the other over the accused's shoulder. Riaan walked with them. When they got to the tent the deceased looked fine, she was calm and could walk. The witness asked the deceased if she was okay and she said she was and Riaan and the witness went back to the dance floor where they stayed for a couple of hours. They then went back to the tent and at that stage she saw that the deceased was having a seizure and was foaming at the mouth. She was in the tent, the entrance of which was open, with the accused standing outside. Everything that happened thereafter was a bit a blur. Paramedics came and put the deceased on a stretcher and took her to the paramedics' tent next to the dance floor. At that tent she can recall that the paramedics were trying to put a tube in the deceased's mouth. Then the deceased was put in an ambulance and driven away. The witness testified that she was quite traumatised by the event and that she never saw the accused or the deceased again thereafter.

[156] In cross-examination the witness stated that she seemed to recall drinking vodka and that she had had quite a bit to drink having started at about noon. It was put to her that Riaan Martin had said that he was quite tipsy and that she was probably in the same condition. Asked for more details about the deceased's condition near the bathroom the witness stated that she had tried to comfort the deceased and lift her up but she kept subsiding down (as opposed to her falling) and that she was weak in her knees. She would fall back into the sitting position. She can't say if the deceased sustained any injuries. She also said that the deceased was cold and that she saw goosebumps on her

arms. The witness estimated that she was 15 to 20 minutes with the deceased. She would not describe her as confused but she did not seem herself then. In her view she was under the influence of *'something'*. Asked whether she was in a state to have sex with the accused her answer was she did not think so. She does not recall the deceased falling on her way back to the tent and could not recall if she sustained any injuries. She confirmed that she made a statement to the police on 18 February 2014 after satisfying herself it was correct. That statement was proved. In it she makes no reference to the deceased appearing to be better by the time she was taken back to the tent. Nor is there any reference to the deceased telling her that she wanted to have sex with the accused. It also states that when the witness came back to the tent after some time to find the deceased convulsing she had asked the accused what had happened and he told her that the deceased had begun to have seizures. She told him to roll the deceased onto her side and put something in her mouth. The deceased was completely naked.

[157] In cross-examination the witness also stated that when she first came across the deceased ill at the tent her head was on her knees. Asked why she did not mention the sex aspect in her statement she says she was scared at the time but could not give an explanation as to why she was scared about giving this information to the police. She also said that she did not think it was a good idea that the deceased be in a small confined space i.e. the tent, in the condition in which she was. She would agree with Riaan's evidence that the deceased did not sustain any injury on the way back to the tent.

[158] In answer to the Court's question she said that from the deceased's condition she had assumed that she had taken drugs. She and Riaan left the deceased at her tent shortly after midnight and spent about two hours on the dance floor before coming back.

[159] Ms Grey was a reasonably credible witness although it appeared that she may have been strongly under the influence of alcohol that night. It is notable furthermore that the witness was unable to explain why she did not mention the aspect of the deceased allegedly saying she wanted to have sex with the accused when she had made no mention of that to the police.

Dr Segaran Naidoo

[160] Dr Naidoo has a MBCHB, a diploma in Forensic Medicine and a Masters in Forensic Pathology. He is an independently employed specialist forensic pathologist in private practice registered as such with the HPCSA. He has 32 years of experience of forensic pathology, 25 years of which were as a specialist and 18 years of which he was part of the academic staff of the University of Kwa-Zulu Natal and the last eight of those years he was an associate Professor and head of the department of Forensic Medicine.

[161] Dr Naidoo prepared a medico-legal opinion, Exhibit U, and confirmed its contents in his evidence. Dr Naidoo specialises in death investigation and injury analyses. For the last 16 years he has been involved in training in sexual offences medicine. He testified that he was in the final stages of compiling of a court handbook for lawyers regarding the anatomy of sexual offences medicine. Sexual offences/violence is one of his specialist focusses.

[162] In his report Dr Naidoo summarised the *'salient facts'* in the case, one of which was that the deceased took LSD and thereafter appeared to be ill and nauseous. It was not clear whether the deceased had taken ecstasy but she became acutely ill. Dr Naidoo listed observations he made from the autopsy photographs amongst them were that whilst in ICU the deceased showed early discolouration of bruising of the subcutaneous tissues of

the flank, thighs and ankles/feet, abrasions of the knee and needle puncture wounds of the anterior abdominal wall and one on the neck anteriorly. He observed noticeable gross oedema (swelling) of the genitals. According to him the autopsy images show engorgement of the genitalia with a dark discolouration of bruising accentuated by bloating and possible early post-mortem damage. In addition he observed an established *'marbling'* appearance of skin venous haemolytic changes at the shoulders, torso, upper arms and thighs with dark discolouration and early skin slippage. These, he stated, were post-mortem changes. He observed that the images of the dissected scalp and other portions of the body showed intense and large haemorrhages of the scalp, neck and supra-sternal tissues and of the para-trachael, glottic and para-oesophagal soft tissue, lips and cheeks. In overview an extensive haemorrhagic state was seen of the body.

[163] In his discussion Dr Naidoo noted that Dr Abrahams found multiple skin and mucosal haemorrhages of inter alia the neck tissues, eyelids and conjunctivae, oral cavity and lips and of the torso and limbs as well as of the ano-genital tissues in what she interpreted as blunt trauma. The injuries described in Dr Abrahams' report were of a much greater degree than those recorded by medical staff at Paarl Medi-clinic and herein lay the basis of the major discrepancy. Dr Naidoo observed that it was highly unlikely that Dr Abrahams was fully informed of the clinical details of the deceased's short hospitalisation prior to the autopsy and therefore he concluded that the pathologist was unaware of the DIC diagnosis which, in his opinion was largely the sole reason for the excessively gross appearance of bruising and bleeding. With such a major coagulopathy together with the needle puncture wounds and medical manipulation during examination and treatment minor abrasions lead to haematoma/bruise accumulation both internally as

well as on the skin apart from the possibility of spontaneous haemorrhages that may occur in such disorders.

[164] In that context, Dr Naidoo continued, the injuries seen by the pathologist at autopsy appear grossly accentuated and extreme causing (from the perspective of the uninformed pathologist) a concern regarding their causation when in ignorance of the full background medical history.

[165] Dr Naidoo also noted further additional concerns about Dr Abrahams' report including the lack of any signs of digital application of force to the neck as well as localised haemorrhages in the subcutaneous tissues, given the conclusion of manual strangulation. The autopsy description of the diffuse and extensive bruising was more in keeping with the emergency manipulation of medical care and in particular with emergency airway manipulation in the region of the neck. The haemorrhages in this region were all *'very possibly'* in keeping with spontaneous bruising in a coagulopathic state with or without medical manipulation. In his view the conclusion of strangulation was both incorrect and a misguided diagnosis. Further, Dr Naidoo reasoned, the above consideration should have been kept in mind when evaluating the appearances of the genital and anal lesions. He ascribed the 10mm tear of the inferior edge of the clitoral hood as being quite possibly the site of the *'vaginal biopsy'* referred to by Dr Franklin. I should observe that this consideration fell away since it became common cause that no vaginal biopsy was taken. He took issue with the use of the phrase *'rubbing friction'* by Dr Abrahams. Apparently relying on the witness statement made by the accused, he expressed the view that the deceased's masturbation in the *'last few minutes of her conscious state'* would cause the vaginal abrasion as well as the *'loss of skin and redness'*

of the labia minora and vagina and would show a gross and striking appearance when actively having bled from the effects of the bleeding disorder. This would also apply to the tear at 6o'clock of 5 - 6mm at the vagina.

[166] Dr Naidoo expressed the view that the blood tinged fluid seen in the vagina would be in keeping with coagulopathic bleeding from the mucosal lining and that the *'contusion'* of the cervix would be a manifestation of the same bleeding disorder. Dr Naidoo stated that the sand grains high up in the vagina were explained by her rolling on the ground naked before she received medical attention. He described Dr Abrahams' description of the light coloured fluid as *'consistent with seminal fluid mixed with blood'* as not objective and quite misleading. Dr Naidoo discounted the anal examination findings made by Dr Abrahams for reasons similar to those he used in discounting her findings in relation to the deceased's vaginal injuries. He regarded Dr Abrahams' conclusions of *'forceful non-consensual ...'* sexual penetration as subjective and in flagrant disregard or ignorance of the precept that consent (either its existence or the lack thereof) can never be diagnosed or concluded by a pathologist at autopsy. He expressed the further view that if Dr Abrahams had been aware of the clinical history of the bleeding disorder she would have arrived at a correct and precise diagnosis of the cause of the various apparent injuries. Dr Naidoo expressed the further view that the many areas of swelling found on the deceased could well be manifestations of *'increased capillary permeability'* as a result of the coagulopathy and early multiple organ failure combined with intravenous fluid administration.

[167] Dealing with the other brain findings that are *'consistent with blunt trauma'* he expressed the view that the *'traumatic'* subarachnoid haemorrhages on both sides of the

brain were typical and classic manifestations of the bleeding disorder, as were the scalp haemorrhages. He expressed regret that there had not been a *'meticulous fresh brain examination'* before a diagnosis based on the haemorrhages and contusions of the brain. Finally, regarding the autopsy conclusion of strangulation he noted that a patient who has experienced strangulation living for almost a day after such an incident is an extremely rare occurrence. He further noted in this regard that asphyxial deaths are usually sudden or abrupt deaths once the fatal limit of asphyxia or anoxia has been reached, with rarely a brief period of survival. Alternatively the patient survives completely with little sequelae.

[168] Reverting to the possibility of the deceased having been involved in sexual intercourse before she died he noted that firstly, that the *'injuries'* seen on the patient were well explained by him, that no male DNA was identified in the sexual assault samples taken from the deceased and that the '*evidence would suggest'* that sexual activity did not occur between the accused and the deceased at least for the period of few days before she died.

[169] Turning to the toxicology tests he observed that the *'general negativity of blood and urine results for illicit drugs in the clinical and autopsy samples cannot be easily explained'* but the excessive dilution of the specimen or '*other interfering substances'* may cause *'false negative results'*. He also raised a question mark about the specificity and sensitivity of testing.

[170] Turning to the cause of the deceased's death Dr Naidoo ascribed this to the severe coagulopathy and multiple organ failure following the consumption of LSD and MDMA. He noted that MDMA may also induce fatal hyperthermia and trigger a DIC leading to the body temperature reaching levels above 40 degrees centigrade and leading to severe

systemic effects and death. Dr Naidoo summarised his opinion as follows: firstly, the cause of death was most likely related to drug induced hyperthermia causing a severe coagulopathy and multi organ failure and systemic acidosis, leading directly to death. He noted that the drugs alleged to have been taken are well known causes of the above. Secondly, the multiple skin and mucosal haemorrhages as well as internal haemorrhages were not traumatic lesions and could be confidently explained by the bleeding disorder accentuated or facilitated by medical and other interventions or by spontaneous bleeding. Thirdly, the genital and anal lesions may be explained on the same basis, *'without difficulty'*. Fourthly, the factual evidence did not indicate recent sexual activity at least several days before death and that there was no physical evidence to suggest otherwise. Fifthly, the features of head, scalp, brain and haemorrhages may also be explained by the bleeding disorder and was not evidence of a head injury. Finally, the *'evidence'* of *'strangulation'* in the neck and associated structures was attributable to the bleeding disorder. According to Dr Naidoo the deceased was thus not strangled.

[171] Dr Naidoo confirmed that he was party to the joint minute drawn up pursuant to the meeting of medical experts on 9 June 2017. Commenting on the differences in the minute he expressed the view that the deceased's *'injuries'* could be explained on the basis of her rolling on the ground, being restrained and the '*frantic bid'* to insert an airway into her mouth. He was also of the view that the injuries around the deceased's mouth were magnified by the clotting disorder. He went so far as to state that it was impossible that the deceased's death could have occurred from strangulation and that it was *'only explainable'* through the mechanism of the illicit drugs. Dr Naidoo introduced some six academic articles (Exhibit T) regarding the fatal results of the ingestion of MDMA into the record. These cases generally involved the patient suffering from

hyperthermia and leading onto rhabdomyolysis (muscle breakdown). However, as was pointed out by the State counsel in cross-examination, most if not all of these cases had as an element the proven presence of MDMA upon testing and hyperthermia. Possibly anticipating that there was no acceptable evidence of hyperthermia, Dr Naidoo testified that one can develop coagulopathy without hyperthermia. In his evidence Dr Naidoo testified that at that time of autopsy skin slippage was present thus casting doubt on whether the findings of abrasions and cuts were not instances of skin slippage. He stated that he could see this in certain photographs. Even though he was not present at the autopsy nor ever viewed the body, Dr Naidoo took issue with Dr Abrahams' specific finding in paragraph 3 of her report under the heading '*Secondary post-mortem changes'* that there was evidence of secondary autolytic changes with bloating of the body and marbling but *'with no skin slippage'*. He noted that Dr Abrahams had testified that she was aware of the bleeding disorder but pointed out that she had not mentioned it in her first report. In this regard he stated that he would have expected of a pathologist first to have mentioned the history of the bleeding disorder and that even in the absence of that history the pathologist should have been alerted to the possible bleeding disorder because with so much bruising one would expect open wounds. Dr Naidoo testified at some length as to how the efforts of the paramedics to insert an airway could have caused injuries to the patient's mouth and neck. He extended this evidence to cover the insertion of the endotracheal tube by the paramedic in the ambulance using a laryngoscope. I must observe that the difficulty in this regard was that much of Dr Naidoo's evidence was not based on the evidence but on speculation as to how they might have conducted these exercises. He did, however, refer in this regard to an article from a medical journal cited by Professor Martin which referred to *'(t)raumatic intubations result in internal injuries*

of the deep musculature of the larynx, often completely mimicking the injuries of strangulation'. Dr Naidoo disagreed with Dr Franklin's evidence that the CT scan is an exclusionary mechanism and does not reveal as much as an MRI. However it would appear that Dr Naidoo's evidence was based on what he had learnt from radiologists and not his own personal experience. Dr Naidoo conceded that if a condom had been used in sexual intercourse there would be a minimal exchange of DNA. Dealing with the drug test Dr Naidoo repeated that the fact that no traces of MDMA and LSD were found on testing did not exclude the possibility that they were used. He conceded that there was no easy explanation for the absence of these drugs on testing. As far as he was concerned the deceased's death was only explicable by a drug overdose.

[172] Dr Naidoo also produced a supplementary report (Exhibit RR) in which he posed various questions and answered them. Amongst his answers were that there was no other plausible cause for the patient's death other than drug use and it was the most likely possibility for the cause of the illness and death. Reasons for the negative laboratory drug test were fluid administration and laboratory error. He considered that the clinical picture of the patient's symptoms were strikingly characteristic of an adverse reaction to ingesting MDMA. He expressed the view that it was highly likely that the patient had suffered hyperthermia and rhabdomyolysis. He further expanded on his theory that neck injuries to the deceased had been caused during attempts to resuscitate the patient and that the *'diffuse swelling of the neck'* described by Dr Abrahams were as a result of intravenous fluids administered and the DIC. He also repeated his evidence that the pattern of neck injury was not typical of strangulation. Relying on the negative CT scan he asserted that there was no evidence of a head injury. He devoted several pages of his supplementary report to the question of whether there was sexual penetration of a the

deceased the negative, was based on the assumption that the accused only spent 30 minutes with the deceased and that the deceased was sexually aroused and vigorously masturbated herself as well as the fact that no DNA evidence was found in the swabs administered by Dr Bartleman. He also relied on apparent discrepancies between the findings of Dr Abrahams and Dr Bartleman on examination. Again, without any apparent evidentiary foundation, he appeared to ascribe the tear in the patient's anus to constipation. In a section headed *'Final Notes'* Dr Naidoo conceded that the autopsy process in the case was a detailed and extensive examination and dissection of the entire body, however he took issue with the correct interpretation and evaluation of what was seen. He also expressed concern about the use of the words *'forceful', 'non-consensual'* and various other terms which Dr Abrahams used and which suggested non-consensual penetrative sex and a strangulation. This language he, suggested, indicated *'a lack of objectivity, neutrality and balance in expert testimony'*.

[173] In cross-examination Dr Naidoo conceded that his report was based on the accused's version but, he stated, this was only for *'guidance'*. He went so far as to state that even if the accused had said he did not know anything about the deceased taking drugs he, the witness, would still have maintained that the death was only explicable in terms of a drug overdose. In the absence of the drugs overdose explanation Dr Naidoo would regard the deceased's death as *'unexplained'*. He conceded that Professor Martin's experience in the field of rape victims was extensive but was of the opinion that he had as much if not more experience than her. It was also put to him that as far as could be determined the accused and the deceased were alone in the tent for at least one hour if not one and a half hours or one and three quarter hours. It was also put to the witness that there was evidence from state witnesses that there had been at least noises of sexual

activity between the accused and the deceased in the tent and evidence from another witness (Driessen) that the accused had said that night that he had been having sex with the deceased when she *'conked out'*. This evidence clearly took Dr Naidoo by surprise yet he stated that he would be surprised if there had been sexual intercourse because there was no DNA proof thereof. It was also put to him that Dr Bartleman had in effect conceded that she did not do a very good job of the taking the swabs and Dr Naidoo seemed to accept that it may have been inadequate.

[174] Under further questioning Dr Naidoo testified that he used the accused's statement to the police as *'guidance'* in his enquiry. Regarding his theory of hyperthermia it was put to him that there were no such indication in the case of the deceased. He nonetheless pointed out that there had been cases of MDMA without hyperthermia and testified that rhabdomyolysis and DIC can occur independently of hyperthermia. It was pointed out to him that in the medical journal articles that he himself had put up or had put before Court it seemed clear that in each case MDMA was found in the toxicology results. This he was not able to dispute. Dr Naidoo was also taxed with the evidence that the patient's temperature, at least in hospital, was always in the area of 36.6, i.e. normal. Dr Naidoo then testified that the patient's hyperthermia might have transformed into shock and her hyperthermia had passed by the time of her admission to hospital. He admits that this was largely a speculative view.

[175] In his supplementary report Dr Naidoo described the clinical picture of the deceased in the tent as being one of restlessness, agitation and bizarre behaviour *('rolling around'*) … visual disturbances (possible hallucinations), *'repeating things'* (confusions/delirium) and all this before the onset of convulsions and unconsciousness. It

was put to him by the Court that on this description it would appear to be a person who in colloquial terms was *'not in their right mind'*, a proposition with which he agreed. It was then put to him that such a picture would have implications if it was found that person had engaged in sexual intercourse. He took the point agreeing that in those circumstances one would have to *'question there had been consent or whether consent could be properly given in those circumstances'*.

[176] Dr Naidoo was questioned at length regarding the injuries to the deceased's neck and was eventually constrained to state that he could not exclude that there were no injuries on resuscitation. Nonetheless he testified he was unable to see any pattern in the injuries indicating manual strangulation. On the subject of skin slippage Dr Naidoo insisted that even though Dr Abrahams did not see it it was taking place. He clung to this evidence despite the prosecutor referring to articles which suggest that skin slippage happens after only three days. It was pointed out to him that the two state pathologists testified that there was no obvious skin slippage. His response was that there was *'subtle skin slippage'* which they missed. It was put to Dr Naidoo that Dr Abrahams was an experienced pathologist and was the only pathologist who saw and touched the patient and the skin. Dr Naidoo was referred to para 7 of Dr Abrahams' second report where she recorded that according to tests conducted at Paarl Medi-Clinic at 4:15am the patient was not suffering from any clotting disorder.

Vaginal and anal injuries

[177] Dr Naidoo expressed the opinion that what was referred to as the extensive swelling of the labia majora, labia minora and clitoral hood were the result of fluid infusion and decomposition of the body, using as an example that the loose skin in the

eyelid would become swollen. He had to concede however that the patient's eyelids do not look swollen in the photographs and nor did her feet. It was put to him that Dr Abrahams recorded only minor oedema of the eyes, face and extremities in her autopsy report. The witness was prepared to accept that there was a tear of the clitoral hood as noted by Dr Abrahams but stated that these were *'common'* in sexual intercourse. He conceded however that this could be a sign of a lack of lubrication and that he could not exclude penile penetration as causing this tear. The witness was also asked whether one would expect vigorous masturbation of someone who is apparently sick and nauseous. He conceded that this was difficult to envisage but according to him it was MDMA induced (notwithstanding the lack of any objective scientific evidence of MDMA ingested). The prosecutor pointed out to Dr Naidoo that his arguments regarding consensual sexual intercourse were misplaced since the accused denied any sexual intercourse on the night in question.

[178] Examining photographs of the vaginal and anal injuries identified by Dr Abrahams, Dr Naidoo ascribed most of them to decompositional change and other natural processes. It was pointed out that little of this had been challenged in Dr Abrahams' evidence. When it was put to him that Dr Abrahams was an experienced pathologist who would be making a fundamental error if she mistakenly identified something else as abrasions, Dr Naidoo had to concede that he would have to accept Dr Abrahams' observations of an abrasion. Dr Naidoo conceded that the injuries could have been caused by non-consensual penile sexual penetration but as far as he was concerned it was as likely that they were self-inflicted. He conceded that such self-inflicted masturbatory injuries would be highly unusual but in his view all the more possible if MDMA was used. He conceded that if someone was masturbating one would generally expect

lubrication to take place. Dr Naidoo also conceded that had the injuries been inflicted by masturbation it would be a painful process.

[179] As regards the sand grains found near the cervix Dr Naidoo suggested that they could work their way up the vagina independently but it was more likely that they were deposited through an object i.e. fingers or the penis. Regarding the anal injuries and in particular the *'contusion with rubbing friction peri-anal and anal abrasion with swelling and redness and loss of skin over a distance of ±70mm into the anal canal'* identified by Dr Abrahams in para 21.1 of her report (Exhibit C), Dr Naidoo stated that whilst it looked very convincing he had seem similar changes on decomposition. Again it was put to him that had Dr Abrahams incorrectly identified this as an abrasion as opposed to a consequence of decomposition she would be committing a basic error. Dr Naidoo conceded that if the injury was an abrasion injury it could have been caused by penile penetration. Regarding the tear at 6 o'clock position in the anus Dr Naidoo conceded it was a tear but described it as technically being at 12 o'clock in which case he regarded it as an atypical sexual injury. Dr Naidoo retreated from this positon a little later. It was put to him by state counsel that it would be argued that the deceased was incapacitated in the tent, possibly due to heat exhaustion and that the accused took advantage of her and raped her vaginally and anally and strangled her. The witness' response was that the deceased may have been incapacitated for various reasons but *'his impression'* was that there was no evidence to suggest that she was strangled and it did not look clear to him to be a question of rape. He summed up his opinion by stating that the only explanation he could see was a drug induced death despite the negative toxicology results.

[180] In re-examination the witness sought to explain the puncture wound in the patient's neck as being evidence of an attempt by a paramedic to establish an airway for the patient which, he speculated would be done if the patient was cyanotic (blue) and convulsing. The Court raised with the witness the abrasions to the patient's knees seen in the photograph and Dr Naidoo had to concede these but sought to explain them in terms of the deceased banging into objects.

Analysis and evaluation

The principal submissions on behalf of the State and the Accused

[181] At the conclusion of the evidence the State argued for convictions on all three counts. It contended that the Court should accept the evidence of Dr Abrahams, as supported by that of Professor Martin, that the cause of death was manual strangulation which led to hypoxia and which in turn led to the bleeding disorder (the DIC) and acidosis, the latter being the pathology which ultimately led to the deceased's multi organ failure and death. It contended further that the accused had manually strangled the deceased in the course of raping her both vaginally and anally. In regard to the role of drugs in the deceased's death, the State, relying on the evidence of Professors Blockman and Smith and other ancillary witnesses in this regard, argued that it had been clearly proven by means of toxicological testing that the deceased had ingested no drugs and specifically not LSD nor MDMA and therefore that they played no role in her death. It was further contended that there was clear evidence of genital and anal injuries which could not be explained away as the effects of the bleeding disorder.

[182] In regard to all three counts the State relied on the evidence of principally Dr Abrahams and Professor Martin of extensive bruising on the deceased's body inter alia

around the neck and on the hips, to mention but a few, in support of its argument that the deceased had been raped by the accused and strangled or asphyxiated by the accused during these acts. Reliance was also placed on the mouth injuries which the state pathologist found, as probably having been caused by the accused attempting to silence the deceased. As regards the evidence from both state and defence witnesses indicating that the deceased had voluntarily ingested either LSD, MDMA or both, the State argued that none of these witnesses could directly testify to the deceased having taken any drugs. A further cornerstone of the State's case was the accused's failure to testify notwithstanding what it contended was on a strong prima facie case against him. In this regard it was contended that the accused had put no version before the Court and that as a result much of his expert witness' evidence was built on sand and, furthermore, that the argument made on his behalf that his version was before the Court by virtue of the witness statement which had been proven through the trial within a trial was misconceived.

[183] The accused sought an acquittal on all three counts. On his behalf it was contended, notwithstanding the absence of scientific proof in the form of toxicological testing, that the deceased's convulsions and ensuing pathology was caused by drug ingestion. In this regard the accused relied on the evidence of various witnesses, and his *'version'* to the effect that LSD and MDMA had been purchased and ingested that night by members of the party which included the accused and the deceased. The defence relied also on the initial diagnosis by Dr Franklin and, to a much lesser extent, by Dr Abrahams, that drug ingestion played a role in the deceased's death. Ultimately, the defence sought to discredit the negative toxicological tests of the deceased's urine and blood samples on the basis that the State had failed to prove the necessary chain of

evidence proving that the samples emanated from the deceased and were uncontaminated. It also relied on the evidence of the various paramedics who treated the deceased as indicating that she had taken a drug *'overdose'*.

[184] As regards the extensive bruising found on the deceased post-mortem, notably around the neck, hips and mouth, it was contended that these injuries were probably caused by the paramedics and persons who attended on the deceased at Le Bac Estate and that in many instances they were exacerbated by the effects of the DIC which through internal bleeding and spontaneous haemorrhaging magnified the effects of any pressure placed on parts of the deceased's body. In regard to the injuries to the deceased's vagina and anus it was argued that these must have been caused when the deceased masturbated herself in a state of heightened sexual excitement in the tent, alone with the accused, and the anal injuries by constipation. It argued that these injuries were artificially magnified or exacerbated by the effects of the DIC and also by decomposition of the body prior to post-mortem. It was argued that no adverse inference could be drawn from the fact that the accused had failed to testify since his version was squarely before the Court in the form of the sworn statement which he made as a witness on the day of the deceased's death which had been proved by the State and ruled admissible by the Court.

The issues

[185] In the general determination of whether the State has proved the charges against the accused beyond reasonable doubt, two subsidiary issues loom large. The first was whether the deceased ingested drugs in the hours before she fell into a state of unconsciousness and, if so, what role, if any, they played in her death. The second issue was whether sexual intercourse took place between the accused and the deceased in the

tent between midnight and sometime after 1am that night. The difficulty in determining these issues and, in general the circumstances surrounding and leading up to the deceased's death, is the lack of direct evidence pertaining to the ingestion of drugs by the deceased and particularly what transpired in the tent between approximately midnight and 1:30am when the accused called for medical assistance for the deceased who was in a state of unconsciousness and convulsing. Only the accused could give a first-hand account in regard to these issues and he chose not to testify.

Did the deceased ingest drugs?

[186] The State led two types of evidence regarding the question of whether the deceased ingested drugs on the day preceding her death. There was the evidence of various members of her party who attended the event at Le Bac Estate notably Vanika Lalloo and, secondly, the evidence of various medical and technical personnel who arranged for or conducted tests of samples of urine and blood from the deceased. This chain of witnesses began with Dr Franklin and Nurse Troskie, the forensic analyst, Ms Mbonambi and extended to Professors Smith and Blockman who respectively supervised a retesting of the deceased's blood sample and offered an overall opinion on the process and on the question of whether the deceased ingested drugs.

[187] As I have indicated Professor Smith was a highly qualified medical biological scientist and an excellent witness. He described the highly sophisticated and sensitive LCS mass spectrometry test performed on the deceased's blood samples in the UCT Pharmacology laboratory by way of referral from Path Care. These tests proved negative for LSD and MDMA but positive for diazepam, midazolam and various other agents which are not of a contentious nature save for cocaine metabolites detected in the

deceased's urine sample. Professor Smith testified that the fact that neither of these drugs was detected in either blood or urine meant that there was *'no objective evidence that they were actually taken by the deceased'*. He noted that the original samples were taken at approximately 4:30am on 1 January 2014.

[188] Ms Mbonambi's evidence established that the self-same blood sample, also subjected to the LSMSMS testing method, revealed traces of diazepam, midazolam and acetaminophen (paracetamol) but no trace of LSD or MDMA. These results tallied completely with those of Professor Smith's laboratory. Proceeding one further link down the chain both these results tallied with the original test on the deceased's urine done at Paarl Medi-Clinic through Path Care at the instance of Dr Franklin. This was a five part test, the only result of which was to show positive for opioids i.e. sedatives which correlated with the history of the patient being administered diazepam, morphine and midazolam by the paramedics. However, the tests did not show MDMA or LSD. It appeared to be common cause that no blood test was ever positive for traces of alcohol.

[189] The absence of any trace of LSD or MDMA in the deceased's urine and blood test was completely at odds with one of the main planks of the defence case, namely that the patient's condition and death was ultimately attributable to the ingestion of these drugs. Dr Naidoo testified on more than one occasion that it was *'not easy'* to explain these negative tests. In fact no plausible explanation for this apparently anomalous result was ever proffered. This did not mean no such possible explanations were not put up. In the first place, and at a comparatively late stage of the trial, it was suggested that the blood samples which were retested by the state laboratory and by the UCT laboratory were not those of the deceased. The grounds for this contention were that the State had failed to

provide adequate proof that the blood samples taken from the deceased were in fact those tested by Path Care and, in turn, that those samples were adequately maintained and tested thereafter by the UCT laboratory and the State laboratory. In this regard it was also suggested that the samples had not been properly maintained so that they did not degrade.

[190] Little was intimated of this challenge until a remark from the Court that perhaps the only thing that might explain the negative toxicology results was that the wrong blood samples were retested. This was developed into an argument that the State had failed to lead evidence, presumably from Path Care employees that they collected the relevant samples from Nurse Troskie, that these were the samples that were tested, that these very samples were transmitted to the Groote Schuur Laboratory i.e. every step of the chain. In this regard some reliance was placed on the procedures applicable to blood samples taken from persons suspected of driving under the influence of alcohol in terms of the Road Traffic Act. That, however, is a procedure specified by the relevant legislation, including time limits within which the blood sample may be taken.

[191] In the present case there was considerable evidence relating to how the samples were kept, gathered and transmitted but certainly not of every step along the way. Nurse Troskie testified that when a patient was admitted to Paarl Medi-Clinic, his/her personal details are captured on a computer and various stickers are printed out containing this information. When blood and urine samples are taken and sent to Path Care, those stickers are then placed on the samples. Professor Smith testified that he received a blood and urine sample from Path Care on 1 January 2014 with the name and date of birth of the deceased. The confirmatory analysis was performed in his laboratory. He was later contacted by Dr Abrahams and requested to hand the samples to Sgt Sias. In due course

he handed the blood sample of the deceased to Sgt Sias. Sgt Sias, the investigating officer testified that he received the sample from Professor Smith, booked it into the Paarl SAP13 overnight in accordance with procedure and the following day booked out the same sample and hand delivered it to the Department of Health laboratory in Woodstock. The sample was labelled with the name and date of birth of the deceased. Ms Mbonambi, the analyst at the Department of Health in Woodstock testified that she received the blood sample on 10 January 2014 and conducted the analysis on 23 March 2014. The seal numbers referred to in the evidence of Sgt Sias and Ms Mbonambi and confirmed in their respective affidavits, matched. The accused's contention that the chain evidence was lacking involved no dissection of this evidence, merely generalised statements. As I have mentioned the challenge to the integrity of the blood testing process was opportunistic and was seized upon only well into the trial. There is no suggestion in the joint minute of the meeting of medical experts that the integrity of the testing process was in doubt or was disputed. Implicit in the relevant portion of the minute is that the correct blood sample i.e. the deceased's, was tested. In other sections of the accused's argument, for example that relating to a trace of cocaine metabolite being found on testing, the blood sample is treated as unequivocally being one emanating from the deceased.

[192] There was evidence that Path Care seek to avoid becoming involved in litigation where their samples or testing process is in anyway relevant. This accounts in part for the State's failure to call Path Care employees as witnesses to the *'chain'* within Paarl Medi-Clinic. On the other hand Nurse Troskie's evidence covers this area to an extent as well as the inference that Path Care will only take clearly marked samples of blood for analysis since, if a strict protocol was not observed in this regard, the consequences for patients in the hospital are potentially catastrophic. The evidence also indicated that,

apart from the one night when the blood sample was stored in non-refrigerated conditions at Paarl police station it was stored in appropriate refrigerated conditions. Professor Blockman testified that blood samples are robust and that, in effect the period of non-refrigeration of one day would have no material effect on the quality of the sample. In the circumstances I am satisfied that the State proved the integrity of the chain involved in the taking and maintaining and testing of the deceased's blood sample. Further I am satisfied that it was the deceased's blood that was tested throughout the various stages of the process and that the blood sample was not degraded.

[193] Even if this evidence were not sufficient there is one final factor which puts the matter beyond doubt. The results of the blood tests conducted by the Woodstock laboratory and Groote Schuur laboratory both identified traces of the three substances, namely, the opioids/sedatives which in turn tallied with the substances which were administered by the paramedics to sedate the patient prior to her admission to Paarl Medi-Clinic. This is a virtual guarantee that it was the deceased's blood sample that was first tested by Path Care in Paarl and then transmitted from Paarl to Cape Town for two additional rounds of testing since the chances of a third party's blood sample getting mixed up in the process but yet exhibiting this test result must be minimal.

[194] The other challenges to the blood sample, albeit not vigorously pursued, were that the deceased's blood sample could have been affected by the over-administration of fluids to the patient or that she may have ingested drugs which were not part of the library for which the two laboratories tested. The first reason is no more than a theoretical possibility and there was no credible evidence that the deceased received such a large quantity of fluids that given the time when the blood sample was taken, this would have

affected the results. Secondly, as Professors Blockman and Smith pointed out, the patient's blood was tested for a full and up to date list of substances including LSD and MDMA and the test was not comprehensive only in the sense that no process can test for as yet unknown substances.

[195] However, the fact that the scientific testing process produced no positive results for LSD or MDMA is not the end of the matter since regard must also be had to other evidence that the deceased ingested recreational drugs, namely, what was believed, at least in lay terms, to be LSD and MDMA. The clearest evidence came from Vanika Lalloo who testified that, led by the accused, the three of them i.e. herself and the deceased as well planned that evening and specifically went off to purchase LSD and MDMA with a view to taking it in that sequence, with an interval in between for maximum effect. In her evidence Ms Lalloo testified that she took the LSD that evening in circumstances where she appeared to believe that the deceased and the accused were following or had followed suit. This belief was captured in her statement to the police a few days after the deceased's death when she stated *'at around about 22:30 we all took drugs LSD and MDM and went to the dance floor together'*. It is so that in her viva voce evidence the witness qualified her statement by stating that she never saw the deceased actually ingest the LSD nor the MDMA. She explained, however, that she was making this qualification only because in consultation the prosecutor had pointed out to her that if she could not testify to actually having seen the deceased physically ingest the LSD or the MDMA she could not testify that the deceased had done so. Upon questioning from the Court the witness stated that she would be surprised to learn that the deceased had not taken the LSD but perhaps less so regarding the MDMA because at the point when the MDMA was taken by the group the deceased was not feeling well. I previously stated

that Ms Lalloo was a most credible witness and her evidence is a strong indication that, at the least, the deceased took the substance which the members of the party believed was LSD and quite probably a little later what they believed was MDMA.

[196] This is not the only evidence of drug ingestion on the part of the deceased since a number of witnesses testified that sometime after drugs were taken by members of the party the deceased began to fell unwell, complained of feeling cold and had to be supported by two persons and taken back to the tent. Riaan Martin testified that, although under the influence of alcohol at the time, he came across the accused and the deceased shortly before midnight at the edge of the dance floor when the deceased complained of being cold, looked drunk and was barely able to walk. She was helped by two others to make her way back to the tent. Lameez Martin, although in certain key respects a vague and unsatisfactory witness, confirmed that members of the party, including the accused, the deceased and herself took LSD that night which had a deleterious physical effect upon her. Although she could not recall taking MDMA she believed she had because she had felt so energetic. She too testified of the deceased not feeling well by the time they reached the dance floor, looking weak and being helped to walk inter alia by the accused. Finally, Jade Grey testified to encountering the deceased near the dance floor late that night and being told by her she did not feel well and that she felt as if she was melting. The deceased could not stand on her own, wanted to go back to her tent had to be assisted to walk there.

[197] All this evidence, albeit of different quality, suggests that the deceased took recreational drugs and suffered an adverse reaction thereto. No other plausible explanation was advanced during the trial either by the State or the defence for the

deceased's condition before she entered the tent at midnight. There was no suggestion that the deceased consumed a significant amount of alcohol and the blood test for alcohol proved negative. At one stage counsel for the State suggested that the deceased may have been suffering from heat stroke but this was not backed up by any evidence and was no more than a speculative suggestion. There is thus, even leaving out of account the statement made by the accused to the police to the effect that the deceased took LSD and MDMA and the assertions made on behalf of the accused to one or more witnesses to this effect, a considerable body of evidence to suggest that the deceased took one or more recreational drugs quite possibly LSD and MDMA on the night in question.

[198] The question which arises is how to marry that body of evidence with the scientific evidence that no traces of any such drugs were found on testing. In my view the argument made by the State, namely that the scientific evidence in effect trumps all other evidence, cannot be accepted. Even the experts who testified regarding drug testing appeared to recognise that the scientific evidence was not dispositive of the question whether the deceased had taken drugs or not. Professor Smith framed his conclusion as follows, *'the fact that neither of these drugs was detected in either blood or urine means that there is no objective evidence that they were actually taken by the deceased'* and added in his evidence that the word *'objective'* is important. He also added the caveat that if the amount of drugs taken was very small they would not necessarily be picked up on testing.

[199] Similarly Professor Blockman reported having no idea as to the size of the doses that may or may not have been taken makes any inferences *'very difficult'*. He too used the formulation that negative testing for these drugs meant that there was *'no objective*

evidence' that they were actually taken by the deceased and concluded that he was *'unsure'* whether any of the medicines/drugs were in fact ingested. Professor Blockman also stated that he could not completely exclude the possibility that the deceased had taken the drugs in question and added that the deceased's inability to walk unaided at one stage, if alcohol were excluded, could be evidence of drugs ingestion.

[200] It is also of some significance that Dr Franklin arrived at a working diagnosis of a patient with *'possible LSD and ecstasy related overdose'* albeit based inter alia on the history of drug ingestion which he was given by the accused. After the deceased's death but before he received the toxicology reports he also recorded a *'final diagnosis'* reading as follows *'picture suggestive of LSD overdose with all the ass (ociated) complications especially coma(?) and the coagulation defects which is well described'*. Similarly Dr Abrahams after the full post-mortem and a detailed report thereon concluded that 'd*rugs may have played a contributory role'* in the cause of death. This report was also written before Dr Abrahams had received the toxicology reports.

[201] Taking this evidence as a whole I consider that at the very least the reasonable possibility that the accused may have ingested drugs, either LSD or MDMA or both, and that these played some role in her death cannot be excluded.

[202] In the light of this conclusion it is now appropriate to consider a second subsidiary issue namely the scientific evidence regarding the cause of death. That evidence is marked by a sharp difference of opinion between, on the one hand Dr Abrahams and Professor Martin and, on the other, Dr Naidoo. The former witnesses exclude the role of drugs in the death of the deceased and ascribe it to manual strangulation whilst in essence Dr Naidoo expressed the opposite opinion. This issues also involves an evaluation of Dr

Franklin's evidence who gave important evidence in this regard in his role as the treating physician.

[203] Before doing so however it is appropriate to have regard to some of the guiding principles followed by the Courts in relation to the evidence of expert witnesses. Some of these guiding principles were well expressed in *Holtzhauzen v Roodt* 1997 (4) SA 766 (W) in the following terms:

> '*The relevant principles applicable to the admissibility of expert opinion evidence in this particular case appear to me to be as follows:*
>
> *Firstly, the witness must be called to give evidence on matters calling for specialised skill or knowledge. It is therefore necessary for this Court to determine whether the subject of the enquiry does raise issues calling for specialised skill or knowledge. Evidence of opinion on matters which do not call for expertise is excluded because it does not help the Court. At best, it is superfluous and, at worst, it could be a cause of confusion…*
>
> *Second, we are accustomed to receiving the evidence of psychologists and psychiatrists, particularly in our criminal courts. However, we should not elevate the expertise of the witness to such heights that we lose sight of the Court's own capabilities and responsibilities. …*
>
> *Third, is that the witness must be a qualified expert. …*
>
> *Fourth, the facts upon which the expert opinion is based must be proved by admissible evidence. These facts are either within the personal knowledge of the expert or on the basis of facts proved by others. If the expert has observed them, then the expert must testify as to their existence:*
>
> "The duty of the expert is to furnish the Judge with the necessary scientific criteria for testing the accuracy of the expert's conclusions so as to enable the Judge or jury to form their own independent judgment by the application of these criteria to the facts proved in evidence."

...

Fifth, the guidance offered by the expert must be sufficiently relevant to the matter in issue which is to be determined by the Court. ...

Finally, opinion evidence must not usurp the function of the Court. The witness is not permitted to give opinion on the legal or the general merits of the case. The evidence of the opinion of the expert should not be tendered on the ultimate issue. The expert must not be asked or answer questions which the Court has to decide.'

[204] To this can be added a further important guiding principle, one which is particularly appropriate to the present case, namely that the expert witness must be neutral i.e. unbiased. This requirement was expressed as follows in *Stock v Stock* 1981 (3) SA 1280 (A) at 129 6E:

'If he is to be helpful he must be neutral. The (opinion of an expert) is of little value where he ... is partisan and consistently asserts the cause of the party who calls him.'

[205] In *S v Kotze* 1994 (2) SACR 214 (O) 225I Lombard J relied heavily on the opinions of experts – not only because they had advanced reasons in support of their conclusions but also because their opinions had the *'stempel van objektiewe proffesionalisme'* cited in (*Principles of Evidence, Third Edition, Juta, Schwikkard* et al page 100).

[206] The cornerstone of the State's case regarding the deceased's cause of death was the evidence of Dr Abrahams as expressed inter alia in her post-mortem report and conclusions. I have referred to her conclusions in her initial report made prior to her receiving the toxicological analysis. After reviewing this toxicological analysis Dr Abrahams filed a further report on 15 May 2014 when she reviewed in great detail the medical treatment which the deceased received from the paramedics and in Paarl Medi-

Clinic and concluded that the cause of death remained consistent with manual strangulation. She stated that the consequences of the strangulation were asphyxia with global hypoxia with hypoxic renal and liver failure which led to metabolic acidosis and coagulopathy and her formal conclusion read that based on her examination of her autopsy report, the Path Care laboratory results and the medical records she concluded that the cause of death remained as above stated. She added that there was no clear evidence that toxic substances (recreational drugs) played a role in the death. In her initial report Dr Abrahams, under the heading of *'neck structures'* set out her detailed finding which led her to conclude that the death was consistent with manual strangulation as a result of pressure to the neck. Amongst these were *'diffuse and extensive swelling ... at the right and left sternomastoid muscle and other muscles up and around the thyroid gland ... haemorrhages along the right and left jaw angles and anterior neck below the chin, at the level of carotid sinus bodies ... and posterior to the thyroid gland and to the trachea'*. However, she noted no fractures of the hyoid or thyroid bone although there were haemorrhages around the horns of these structures.

[207] Dr Abrahams testified of manual strangulation in not just one position but in several possible positions including the holding of the neck in the crook of the arm from behind. Such pressure could also be applied to the deceased from in front. She testified that a fractured hyoid or thyroid bone was not a necessary sign of attempted strangulation and not always present in a young person whose structures are cartilaginous. Her evidence was that the attempted strangulation would likely have taken place when the deceased was sexually assaulted or raped.

[208] She found that the injuries to the mouth were also consistent with external pressure. These injuries she recorded as a laceration of the right and left lower lips at the inner aspect over a distance of ±20mm bilaterally up to the mouth corners with extensive contusion and secondary swelling. This, she noted in her report, was consistent with forceful pressure to the mouth with tooth pressure against lower lip and the lacerations and contusion to the lower and upper lips due to the teeth. She expressed the further view that there was severe pressure to the neck area following which the deceased would have become hypoxic i.e. a lack of oxygen to the brain and organs of the body which triggered the chain of events leading to her death. The brain was injured and it could not put the body's survival mechanisms back on track. Coming back to the bruises on the inner aspect of the lips, Dr Abrahams interpreted these as having been caused by *'severe pressure on the lips from outside, lips pressed against the teeth'*. She testified this could be hand or manual strangulation or with a pillow in an effort to silence the deceased. Not only did Dr Abrahams dispute that drugs could have played any role in the deceased's death she discounted any possibility that the injuries and bruising in the mouth and neck area could have been caused by attending paramedics. Specifically she testified that the mouth injuries indicated pressure to the mouth as in closing it and not opening the mouth.

[209] In her viva voce evidence and in her second report Dr Abrahams testified that when she drew up her first report she was aware of the fact that the deceased had developed a severe DIC after her admission to Paarl Medi-Clinic. She did not dispute that the DIC would cause any bruising on the patient to be greatly magnified and would also result in spontaneous internal haemorrhaging although this was definitely not a centrepiece of her evidence. Notwithstanding this evidence and the length and great detail of her first post-mortem report there is no indication at all in that report either that the

patient developed the DIC or that the implications of that bleeding disorder were taken into account by Dr Abrahams in reaching her conclusion that the cause of death was consistent with manual strangulation.

[210] Dr Naidoo was particularly critical of this aspect of Dr Abrahams' report finding it extraordinary that this fact would not at least have been mentioned by a forensic pathologist in a post-mortem report. In my view this criticism has considerable force. Given the extensive findings of bruising and bleeding, both internal and external, which Dr Abrahams observed on the patient, and her conclusion that the cause of death was consistent with manual strangulation it is very difficult to understand why she would make no reference to the DIC which the patient developed if she had indeed been aware of this fact. One notes that the autopsy was conducted on 3 January 2014 and Dr Abrahams' affidavit embodying her observations and conclusions was signed on 10 January 2014. Dr Franklin's final report or notes on his treatment of the patient were only concluded on 7 January 2014 leaving but a few days for Dr Abrahams to have received these notes. It is of course possible that his incomplete notes or report could have reached Dr Abrahams a little earlier. Unfortunately there was no detailed evidence on how and when Dr Franklin's reports reached Dr Abrahams. This leaves open the possibility that Dr Abrahams may not have been aware of the bleeding disorder when she drew up her initial report or may have received the notes at a late stage and left her already drafted report unaltered. I mention these possibilities conscious of the fact that Dr Abrahams testified that she was aware of the DIC and had received Dr Franklin's notes prior to completing her report but because her omission of any reference to the bleeding disorder is in my view inexplicable.

[211] At the conclusion of her evidence Dr Abrahams was asked by the Court to explain this omission but could give no meaningful or satisfactory explanation. Dr Abrahams' expertise and experience cannot be doubted nor the meticulousness of her reports but what was worrying was her tendency to be implacable in holding to the case theory or conclusions she arrived at, notwithstanding a reasonable need, on occasion, to make concessions. Dr Abrahams' expertise and extensive experience was reflected both in her detailed reports and in her evidence before the Court, however the above criticism raises the distinct possibility that Dr Abrahams may have become wedded to a view, and an interpretation of what she observed in this matter, quite early on before she had a full appreciation of the treatment which the deceased underwent in Paarl Medi-Clinic and the conditions which the deceased exhibited there; and furthermore that she was temperamentally disinclined to modify her initial interpretation of the observations or the findings which she made.

[212] This criticism is not based solely on Dr Abrahams' failure to mention the deceased's severe bleeding disorder in her initial post-mortem report. There were quite a number of other instances, either in Dr Abrahams' report or in her evidence, where her conclusions strayed beyond those normally proffered by a forensic pathologist and into the domain of the fact finder. So for example Professor Abrahams spoke of *'forceful sexual penetration'* rather than injuries '*consistent with forceful sexual penetration'*. Dr Abrahams was reluctant to make any concessions which might favour the accused even when this dealt with activities which she could not personally testify to such as whether the paramedics could have inadvertently been responsible for some of the injuries to the patient's mouth during resuscitation. I accept that Dr Abrahams herself recognised (and testified) that her function was to be impartial and to assist the Court in its

determinations. However, I am left with the impression that Dr Abrahams may have become too wedded to what was referred to by the accused's counsel as a *'theory'* of the case which may have unwittingly impeded her ability to testify with the full measure of objectivity necessary for someone in her position. My observations in this regard must not be taken as anything approaching a wholesale rejection of Dr Abrahams' detailed and extensive evidence.

[213] Dr Franklin was both an excellent witness and, it would appear, an experienced and competent physician. Both in his role as a private physician and through the manner in which he gave his evidence it was clear that Dr Franklin had no axe to grind in the matter and was particularly careful before giving answers which could have far reaching consequences for someone such as the accused.

[214] In these circumstances his evidence regarding the possible underlying cause of the deceased's death must be given particular weight. As indicated earlier Dr Franklin's *'final diagnosis'* was that the picture was suggestive of a LSD overdose with all the associated complications. In later remarks, in response to queries from Dr Abrahams he emphasised that the bleeding tendency would have been the reason why the bruises on the patient became so prominent as time passed. In this regard he wrote *'(t)he bruising on the body became more pronounced during the day most likely related to the DIC and the area surrounding the neck area was more prominent'*. By the time he testified Dr Franklin had become aware of the negative toxicology reports. He testified that if those toxicology reports had been available to him earlier his final diagnosis would not have been *'suggestive of LSD overdose with the all the associated complications'*. In response to being asked whether the pathology of the deceased would fit in with asphyxia, Dr

Franklin stated *'if you present a scenario in front of me where a patient had asphyxiation or a decreased oxygen perfusion to the body, you can have full blown DIC, epilepsy – or not epilepsy – convulsions, and develop multi organ failure. So, if the body is not getting enough oxygen, it can also cause the picture'*. He also quoted from a medical journal article as follows: *'Cerebral ischemia – hypoxia induced intravascular coagulation and autophagy. Together these results suggest that ischemia – hypoxia is a powerful stimulus for spontaneous coagulation, leading to reperfusion deficit and autophagy lyosomal cell death in the brain'*. Although Dr Franklin conceded the possibility that the deceased's pathologies could have been caused by manual strangulation or asphyxiation, he was clearly not prepared to make this his definitive diagnosis, not least because he regarded that function as falling within the province of a forensic pathologist or some other fact finding authority. This attitude was captured in his evidence when he stated *'if you tell me afterwards that it could have been hypoxic brain damage or hypoxia, yes it can fit in with that, but I don't have any other history'*.

[215] When Dr Franklin was asked again whether the deceased's pathologies were explicable on the basis of a hypoxic episode not involving drugs his reply was *'well, it is abnormal for the amount of drugs that was used, and no test positive for me to, in retrospect, afterwards, now try and say it is all drug related. But I don't know'*. Later it was put to him that Dr Abrahams' basic thesis was that what happened to the patient was not as a result of drug ingestion but as a result of manual strangulation. Dr Franklin's response was that this scenario was *'definitely'* possible. As I understood Dr Franklin's evidence he clearly conceded the possibility of a non-drug induced cause of death and being the result of hypoxia caused by manual strangulation but then he would only be making such a diagnosis if he had the appropriate prior history. In cross-examination he

stated: *'and I'm not saying it was strangulation, I'm just saying hypoxic damage is one of the stuff that can look like that'*. The issue in this case is of course whether there was such a prior history or such a history can be inferred solely from the medical evidence and then as the only reasonable inference.

[216] One element of Dr Franklin's evidence which cannot be overlooked concerned the effects of the DIC. His evidence in regard to the DIC was that its magnifying and misleading effects in regard to areas of bruising and bleeding on the patient could not be underestimated. He testified as follows:

> *'I was asked by the pathologist whether we considered whether this patient was strangulated or cause hypoxic damage, and whether all the bruises that she was shown to us post-mortem, where did it come from. So ... the only way that I can explain the bruising, how bad the bruising is looking like, is because the DIC, the coagulation defect' ... 'they showed me pictures of areas of bruising, and asked how did it get there. So I said I don't know, but its – and why didn't I see it initially? Because we couldn't see it initially; she didn't have – bruises doesn't develop immediately. And the extent of the bruises was dramatic, in my opinion, looking dramatic because she's got a DIC. If you just push somewhere then you will find that she developed the problem, but it won't cause tears or lacerations. DIC will just make everything look worse so it becomes more pronounced'.*

[217] Dr Franklin emphasised that he was not an expert on asphyxiation. Firstly, his evidence was that a DIC can cause spontaneous bleeding *'almost without minor trauma, with anything you can get spontaneous purpura bleeding'*. He testified that where there is an area where there is damage/bruising *'it will look worse' 'so then you must go and look*

at the pattern perhaps'. Asked how one distinguishes between bruising which was caused by trauma and is now coming into sharp relief and bruising which is just a spontaneous result of the DIC his response was that as a medical physician, one needs a history. At a later stage he testified regarding the bruising on the inside of the patient's mouth and his explanation was along the following lines

> *'I was shown the pictures and I personally think it is all – the stuff that I could see in the mouth, can be explained with the coagulation defect that the patient has got, with an intubation, and then an airway, that plastic thing that I explained.*
>
> *... and the patient fighting this thing, convulsing and biting'.*

[218] He was then referred to the teeth indentations and responded

> *'Yes, but this plastic thing is preventing your teeth from biting the tube, and your lips end up under this thing. You bite your lips, and its going to look very bad with the DIC later on*
>
> *... we must keep in mind the DIC that's making things look different than what it's supposed to be.*
>
> *... And I feel strongly about that.*
>
> *So you don't jump immediately to the explanation that there must have been external trauma. This could have been as a result of these – this treatment that you refer to, and the insertion of those implements into her mouth --- And the subsequent movement in the mouth, and the bite wound.*
>
> ...

... So I'm sitting here unbiased, and we must be very careful to interpret stuff like that before – I would like to make 100% sure how does this explain – this can look bad.'

[219] Dr Franklin also testified that if a patient is convulsing and having difficulty breathing he/she will be pushed down in an effort to control them and get the airway in. He did state however that it was unlikely that any medical personnel would compress a patient around his or her neck. Dr Franklin's evidence regarding the secondary effects of the DIC in relation to bruising and haemorrhaging clearly sound a cautionary warning not to over-interpret such bruising or bleeding, a factor apparently overlooked by Dr Abrahams at least in her first report and given limited weight thereafter by herself.

[220] Professor Martin agreed with Dr Abrahams' conclusions in all material respects. It must be borne in mind however that she did not observe the autopsy or the deceased's body and is in no better position than any other informed forensic pathologist to evaluate Dr Abrahams' reports and findings. Professor Martin is a highly experienced forensic pathologist with a particular expertise in the field of rape. She came across as a credible and experienced witness and one who was prepared where appropriate to make concessions. In her view the cause of the deceased's death was manual strangulation which would have caused global hypoxia and which, taken together with the brain injury can lead to a DIC. She stated that she had never seen such injuries to the mouth, lips or cheeks being caused by health care personnel nor such injuries to the neck. She noted that all these interventions were administered well before the onset of the DIC. However, in this regard I note that one is talking only of a matter of six hours or so since by 8:30 medical personnel recorded that the patient *'was bleeding from everywhere'*. Professor

Martin agreed that the DIC could have played a role in accentuating the bleeding and that it can involve spontaneous haemorrhaging. Regarding the neck injuries and the strangulation Professor Martin testified that the absence of finger marks around the deceased's neck was not conclusive because something else such as a forearm or a chokehold could effect strangulation. Asked how long this would have to be it, she stated that could be up to eight minutes. Other evidence heard was that one would need at least four minutes of constant pressure to produce a dire result. Professor Martin was asked if her opinion regarding the cause of death would change if the Court found that the deceased took drugs and her reply was similar to Dr Abrahams' reply to the same question, namely, that much would depend on what quantity of drugs was taken. It was put to Professor Martin that Dr Franklin had conceded the possibility of the patient having suffered hyperthermia prior to her admission to hospital but Professor Martin remained sceptical of this.

[221] The fourth and final major witness testifying regarding the cause of death was the expert witness called by the accused, Dr Naidoo. Dr Naidoo did not attend at the autopsy nor perform his own post-mortem examination. His opinions and conclusions were based on his evaluation of Dr Abrahams' reports and evidence and on his own experience. That comprised extensive experience as a forensic pathologist but did not prevent Dr Naidoo from assuming an expertise in matters going beyond that field. For example, he testified at length about the advantages and disadvantages of a CT scan, did not hesitate to express opinions in the field of pharmacology relating to the effects of drugs allegedly ingested by the deceased and in the field of haematology. He however could lay claim to no qualifications in these areas and in one instance explicitly stated that he had *'spoken to or consulted with radiologists about a CT scan'* making it quite clear that he was relying on

the expertise of others. Whilst accepting Dr Naidoo's expertise in the field of forensic pathology he was in my view far too prone to offer authorative opinions in fields in which he had no or limited expertise.

[222] Dr Naidoo's opinions were clear and unwavering; the deceased must have ingested LSD and MDMA, despite the absence of any toxicological proof thereof since nothing else could have caused the pathologies which she exhibited i.e. the DIC and acidosis which led eventually to multi organ failure and her death. The injuries on her body generally and in particular around her neck and mouth would have been caused by a combination of her convulsing and rolling around on the ground, being restrained, falling and medical resuscitation. The injuries to her vagina and anus would have been caused or were likely to have been caused by masturbation and constipation and were either misdiagnosed or over described by Dr Abrahams apart from being magnified by the DIC and through the process of the body's decomposition.

[223] Dr Naidoo presented as an articulate and plausible witness at first blush with an engaging manner. However during the course of his lengthy evidence and cross-examination it became clear that Dr Naidoo was unwilling or unable to bring an impartial mind to bear on the evidence and on the issues which he addressed. He would only make concessions if these were extracted from him and on occasion having made such concessions would later retract them. An example in point was his initial concession that the deceased's clinical picture was compatible with strangulation. Later during cross-examination Dr Naidoo was asked the same question but on this occasion stated that he excluded compatibility with strangulation absolutely. When he was referred to his earlier

evidence he simply denied ever having made the concession, stating *'Oh I would never have agreed to that'* which was simply not borne out by the record and untrue.

[224] Another major difficulty with Dr Naidoo's evidence was that it was heavily reliant on a version of events either conveyed to him by the accused or the accused's legal representative or, at best, as set out in the accused's witness statement to the police. As will be discussed in greater length later, this was not evidence which could be accepted as factually based or even as evidence before the Court in the ordinary sense. Moreover, Dr Naidoo was reluctant to entertain or take into account evidence which differed from the version which he had been given. A case in point was his acceptance that no sexual intercourse had taken place but that the deceased had masturbated herself. When it was put to him that the witnesses Manuel and Driessen had given evidence indicating sexual intercourse between the deceased and the accused Dr Naidoo was, at least temporarily, visibly taken aback. I was left with the unfortunate but clear impression that Dr Naidoo regarded his brief as to refute or at the least cast doubt on any medical evidence which tended to implicate the accused. In doing so he obviously failed to meet one of the primary requirements for an expert witness i.e. that of impartiality and a desire to assist the Court in arriving at an informed evaluation of technical medical issues. Dr Naidoo's partiality was evident from the inception of his evidence when he handed up a list of medical definitions already tilted towards his interpretation of events and concluded with an analysis of his own evidence, apparently written by himself, which was handed up by accused's counsel in argument. This document is entitled *'Note on concessions (Dr SR Naidoo's testimony)*' and deals with the salient issues in this matter recorded under the headings *'Conceded'* and *'Retained'*, setting out of those parts of Dr Naidoo's initial evidence to which he adhered and those areas where he made concessions. Without going

into the proprietry of counsel handing up as part of his heads of argument a note which has been drawn up by one of his client's expert witnesses, the mere fact that Dr Naidoo was prepared to go to these lengths illustrates in my view his failure to maintain professional impartiality in giving expert evidence before the Court.

[225] That said, these criticisms of Dr Naidoo's evidence or his lack of impartiality do not mean that his evidence can be discounted wholesale. He raised legitimate criticisms regarding Dr Abrahams' findings and overall conclusions as endorsed by Professor Martin. The first such an area was the role of the DIC in magnifying the bruising caused by pressure to the deceased's body. One such area was bruising to the deceased's neck. Here Dr Naidoo's opinion was that the injuries were not only magnified but could well have been or were caused by resuscitation attempts on the part of paramedics or attempts at restraining the convulsing patient. This topic deserves closer attention. The deceased appeared to have been treated by three different sets of paramedics. In the first place when she was in the tent the paramedics, Eugene Le Roux and Laurika Grunder attended to her. Thereafter she was treated in the paramedics tent by Barry Barling who handed her over to Shawreza Mackier who treated the deceased in the ambulance and until she was handed over to the personnel at Paarl Medi-Clinic. Both Barling and Mackier testified and, as I have indicated, were very good witnesses. What is more they both appeared to have been very well trained and experienced paramedics who gave the deceased excellent care which they described in some detail. Without going into detail, I am quite satisfied that neither Barling nor Mackier treated the deceased in any way that could have inflicted significant injuries or bruising around her neck. Neither of them were responsible for the *'small puncture wound on the anterior aspect of the deceased's*

neck' which puzzled Dr Franklin and which he initially suggested should be forensically investigated.

[226] Unfortunately neither Le Roux nor Grunder could be traced by the State in order to give evidence. There is therefore a gap in the evidence regarding the paramedic treatment of the deceased with the result that the possibility cannot be excluded that when those paramedics treated the deceased they may have inadvertently caused bruising in and around the area of the deceased's neck. This is not a fanciful possibility since any paramedic would first be concerned to ensure that the patient was able to breathe. At that stage, by all accounts, the patient was convulsing and experiencing trismus, the condition in which the jaw is locked and quite possibly secreting from the mouth at the same time. In these circumstances it is possible that the paramedics who had initially attended may have applied some force to open the patient's mouth and insert an airway or may have applied pressure around the neck in the course making an incision there as an alternative airway. Support for this latter possibility is to be found in the evidence of Lt Colonel Gordon who was told by the accused that the deceased could not breathe properly after a while and that her body became limp. The paramedics then made an incision in her throat so that she could breathe and she was then taken to hospital. Gordon testified further that she went to the paramedic whose name she could not recall and he told her that when the deceased was brought to him she was already unconscious and that was why they made the incision. There was also evidence, of less weight, notably from Pallo Manuel that hands were placed on the deceased when she was being treated to restrain her.

[227] As regards the mechanism of death by strangulation or asphyxiation, none of the expert witnesses claimed any special expertise in this area. All appeared to concede that

death following some 24 hours after attempted strangulation would be an unusual if not a rare occurrence. Professor Martin was invited to place any medical journal articles before the Court which she felt could shed light on the phenomenon. This led to the introduction of Exhibit OO, a journal article entitled '*Unexpected delayed death after manual strangulation: need for careful examination in the emergency room'*. That article is not completely on point but states as follows in the introduction:

> *'Manual strangulation or throttling is a form of blunt neck trauma. The victim suffers fatal pressure on the airways, blood vessels and nervous structure of the neck, which leads to anoxia, irreversible brain damage and rapid death. Some victims of strangulation survive and several cases of delayed death after strangulation had been reported in literature. A neck injury may not be recognised in the emergency room due to lack of visible external signs or mucosal damage'*.

[228] And further *'... manual strangulation causes asphyxia through compression of the neck. Death may occur by combination of respiratory, circulatory and neurological factors. Survival after throttling is possible. Due to the static nature of the compressive forces involved in strangulation, victims may present at casualty with deceptively minor signs and symptoms. There may be few, if any clear external signs of injury to the neck skin'*. Another articled entitled *'Case Report. Delayed death after pressure on the neck: possible causal mechanisms and implications for mode of death in strangulation'* concerned the case of a deeply unconscious convulsing adult female admitted to hospital with signs of established hypoxic brain damage. Mechanical ventilation was instituted but her condition deteriorated steadily and she died seven days later. The cause of death was certified to the Coroner as *'hypoxic brain damage due to compression of the neck'*. In the discussion the following is stated:

'As was explained to the Court during the criminal proceedings, irreversible brain damage can occur after a period of at least four minutes unremitting deprivation of oxygenated blood supply. Such deprivation may occur because either: a) there is occlusion of the arteries in the neck supplying blood to the brain, to which may be added failure to oxygenate the blood due to occlusion of the airway, or b) the cerebral blood flow ceases because the heart stops'.

[229] Another article referred to by the legal representatives on several occasions was entitled *'Violence: Recognition, Management and Prevention. A Review of 300 Attempted Strangulation Cases by Dean A Hawley, MD, and others'*. The following passage appears in the article:

'Medical resuscitation, and organ procurement procedures, work against the pathologist's ability to detect fatal homicidal neck injury. An oxygen mask can leave abrasions on the mouth and nasal bridge. During resuscitation, an airway tube is placed into the mouth or nose, and inserted into the esophagus or trachea, to establish a path through which air can be forced under pressure to the lungs. The usual airway device is an oral endotracheal tube, but many varieties of hardware exist. The skill of the rescue staff, and the size and rigidity of the victim dictate how much injury occurs during this intubation procedure. Traumatic intubations result in internal injuries of the deep musculature of the larynx, often completely mimicking the injuries of strangulation.'

[230] Also relevant in regard to the cause of the deceased's death are the similarities in the mechanisms of death induced by a drugs overdose and strangulation. Medical journal articles were handed up through Dr Naidoo as Exhibit PP. The first is entitled *'Pathology of deaths associated with "ecstasy" and "eve" misuse'* by CM Milroy and others. In a table dealing with seven such cases and detailing the clinical data, toxicology and pathology of each case, common features were traces of MDMA or amphetamine on

testing of urine or blood, unconsciousness or convulsions and in one case cerebral hypoxia. Only two of the seven cases had documented hyperthermia. When 29 volunteers took MDMA more serious complications reported included hyperthermia, convulsions, other cardiac arrhythmias, rhabdomyolysis, disseminated intravascular coagulation (DIC), renal failure and cerebral haemorrhage. An extract reads:

> *'In five of the cases reported here complications followed shortly after ingestion. Four of these deaths seem to link directly to the toxic effects of MDMA and MDEA'.*

[231] A further extract reads:

> *'Hyperthermia may account for many of the changes seen in deaths from ring substituted amphetamine misuse, although it is interesting to note that raised temperatures were only documented in two of our cases.*
>
> *...*
>
> *The mechanism of damage in heatstroke is postulated to be caused by circulatory collapse and hypoxic damage, possibly combined with disseminated intravascular coagulopathy, which has been recorded in heatstroke, and as a complication of MDMA and amphetamine ingestion.*
>
> *...*
>
> *These changes provided further evidence that hyperthermia can cause death following misuse of ring substituted amphetamines. Evidence of disseminated intravascular coagulopathy was also present in the brain. These deaths may therefore be a complication of hyperthermia, DIC and shock'.*

[232] The article concludes: *'The short term risks of "ecstasy" use are becoming increasingly more apparent and questions must be asked about the long term effects on the brain, liver and heart considering the pathology found in those who die'*.

[233] As has already been discussed, toxicology testing for MDMA and LSD proved negative in the case of the deceased despite optimal conditions for testing. Nor did Dr

Franklin diagnose or treat the patient for hyperthermia. He did, however, albeit sceptically, concede the possibility of the patient having had hyperthermia prior to her admission. This possibility is also not so remote that it can be completely discounted. Although no paramedic took the patient's temperature, Barling recorded the patient's temperature as being *'warm'* whilst Mackier recorded the patient's skin as being '*hot to touch'*. When she testified Mackier stated that the patient was *'vuurwarm'* when she attended to her. She recorded her temperature as level 2 and if she had measured it as being over 40 degrees would have placed it at level 3 on a scale commencing at 0, presumably for normal.

[234] Stepping back from the medical evidence regard must be had to the overall picture which commences with a 21 year old woman in good health on the night of 31 December 2013. At a time which is not clear but which appears to have been sometime after 9pm she, the accused and Vanika Lalloo purchased what they believed to be LSD and MDMA in accordance with their plans to take these drugs in sequence and dance in the new year. Members of the party, possibly including the deceased, first took LSD and sometime later the MDMA before proceeding to the dance floor. After LSD was ingested the deceased begins to complain of feeling unwell and is seen sitting down with her head between her legs. She complains she is feeling cold and wants to go to the tent. She is reported as appearing to be *'drunk'* and unable to walk. She had to be assisted by two others to get to her tent. She goes into the tent with the accused. An hour or at the outer limit an hour and a half passes until the accused emerges calling for medical assistance. At this point the patient is unconscious and convulsing. She never regains consciousness and dies within 18 hours despite intensive medical treatment in ICU. The accused and the deceased are in what by all accounts an intimate relationship and there is no indication of it being an

abusive one. Whatever took place in the tent is now known only to the accused. The evidence shows that the accused was the leading figure in procuring and dispensing the drugs and there must be little doubt that he ingested what was said to be LSD and MDMA himself.

[235] Against this background one must consider whether the State succeeded in proving beyond reasonable doubt that the deceased died as a result of manual strangulation at the hands of the accused. There is no direct evidence of manual strangulation. The only evidence is circumstantial evidence of a medical nature. As was held in the oft quoted dictum from *Rex v Bl*om 1939 AD 188 at 202 – 203 there are two cardinal rules of logic which cannot be ignored. These are, firstly, that the inference sought to be drawn must be consistent with all the proved facts and, secondly, the proved facts should be such that *'they exclude every other reasonable inference from them save the one sought to be drawn'*. In these circumstances as was stated in the following[1] remarks of Davis AJA in *Rex v De Villiers*:

> *'The Court must not take each circumstance separately and give the accused the benefit of any reasonable doubt as to the inference to be drawn from each one so taken. It must carefully weigh the cumulative effect of all of them together, and it is only after it has done so that the accused is entitled to the benefit of any reasonable doubt which it may have as to the whether the inference of guilt is the only inference which can reasonably be drawn. To put the matter in another way; the Crown must satisfy the Court, not that each separate fact is inconsistent with the innocence of the accused, but that the evidence as a whole is beyond reasonable doubt inconsistent with such innocence'.*

[236] In *S v Reddy and Others* 1996 (2) SACR (1)(A), also dealing with circumstantial evidence the following was stated:

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[1] 1944 AD 493 at 508 – 509.

'In assessing circumstantial evidence one needs to be careful not to approach such evidence upon a piecemeal basis and to subject each individual piece of evidence to a consideration of whether it excludes the reasonable possibility that the explanation given by an accused is true. The evidence needs to be considered in its totality. It is only then that one can apply the oft quoted dictum in Rex v Blom.

It is equally trite that the State bears at all times the onus of proving the accused's guilt beyond reasonable doubt although, as it was put in S v Ntsele 1998 (2) SACR 178 (SCA) *'nie bo elke sweempie van twyfel nie'.*

[237] In performing the exercise of evaluating the evidence and determining whether the State has discharged its onus a Court must approach the evidence holistically. See *S v Van Aswegen* 2001 SACR 97 (SCA) and *S v Chabalala* 2003 (1) SACR 134 (SCA) at 139H:

'The correct approach is to weigh up all the elements which point towards the guilt of the accused against all those which are indicative of his innocence, taking proper account of inherent strengths and weaknesses, probabilities and improbabilities on both sides and, having done so, to decide whether the balance weighs so heavily in favour of the State so as to exclude any reasonable doubt about the accused's guilt. The result may prove that one scrap of evidence or one defect in the case for either party ... was decisive but that can only be an ex post facto *determination and a trial court (and counsel) should avoid the temptation to latch onto one (apparently) obvious aspect without assessing it in the context of the full picture presented in evidence'.*

[238] Finally, it must be borne in mind that an accused's failure to testify does not necessarily fill all gaps in the State's case. As was stated by Holmes AJA (as he then was) in *S v Khoza* 1982 (3) SA 1019 (A) at 1043 C – E:

'The fact that the appellant did not give evidence does not result in proof beyond reasonable doubt that he murdered or attempted to murder the deceased. I say this

because, before the absence of gainsaying testimony from an accused can be said to carry the day against him, there must first be a prima facie case against him'

[239] And further:

'The mere fact that the accused has been prosecuted, or shown to have behaved suspiciously, does not make it necessary for him to elect to deny the charge under oath and his failure to testify cannot be treated as an independent item of evidence capable of curing the deficiency in the prosecution's case. Furthermore, in considering what weight may be given to the accused's failure to explain, it is important to consider whether an explanation could reasonably have been expected. For example, if the accused is shown to have committed some act not ordinarily done except with a guilty state of mind, it will normally be reasonable to expect the accused to explain why he did it and, in the absence of explanation, to draw an inference of guilt – depending, of course, on the quality of evidence and the weight to be given to that evidence by a Court'.[2]

[240] Against the above background and having regard to count 3 the charge of murder the issue to be determined is whether the State has succeeded in proving beyond a reasonable doubt that the accused manually strangled the deceased and it was this conduct which caused her to fall unconscious and, some 18 hours later, pass away. In my view even taking into account the accused's failure to testify the State has failed to discharge the onus which rests upon it. There is no direct evidence that the accused manually strangled the deceased and the State must, perforce, rely on circumstantial evidence.

[241] The circumstantial evidence is largely of a medical nature. However that evidence too is not clear for a number of reasons. Firstly, there are strong indications, notwithstanding the negative toxicology tests, that the deceased ingested drugs and that

[2] See *S v Theunissen and Another* 2003 (6) SA 505 (C) at para [56] *citing Osman and Another v Attorney General, Transvaal* 1998 (4) SA 1224 (CC).

these had an adverse effect upon her. In this regard the evidence of drug use and drug testing cannot be looked at piecemeal but must be considered holistically. For that reason the negative drug testing cannot completely displace or trump the evidence from other sources that the accused, more probably than not, ingested illicit drugs. Further in this regard, the State has been unable to advance any explanation, other than the ingestion of drugs, for the condition in which the deceased fell sometime between 9 or 10pm and midnight.

[242] Notwithstanding the negative toxicology results I certainly consider it more likely than not that the deceased ingested LSD, MDMA or both substances. There was certainly a not inconsiderable body of evidence pointing in this direction. Firstly, it was clear from the evidence of Vanika Lalloo that the general plan, spearheaded by the accused, was to purchase MDMA and LSD and take it in sequence to enhance its effect. The evidence suggests furthermore that the deceased was a willing participant in this plan and that she took LSD as did Vanika Lalloo, the accused and others outside the tent earlier in the night and, very possibly, MDMA a little later. An adverse reaction to MDMA would be the most likely and plausible reason for the illness and confusion which beset the deceased not long afterwards and led to her being assisted back to the tent, unable to walk. In this regard there was no evidence that the deceased had ingested anything else such as alcohol in a quantity which would account for her suddenly being incapacitated. It was suggested on behalf of the State that what the accused, the deceased and others who ingested the drugs believed to have been MDMA may have been some other substance. Although this was a possibility it remains no more than that. Finally, both Jade Grey and, to a lesser extent, Vanika Lalloo testified as to symptoms which they

experienced which appeared to be generally consistent with those reported to be experienced after the ingestion of MDMA.

[243] A further factor which weakens the State's case is the nature of the medical evidence upon which it relied and in particular that of Dr Abrahams. I draw a distinction here between the factual post-mortem findings and observations made by Dr Abrahams and her interpretation thereof. In matters of interpretation Dr Abrahams' evidence was certainly not beyond criticism for the reasons I have set out above, most notably her failure to mention a factor of cardinal importance, the DIC and to record in her first report that this would present a distorted picture of the bruising and other injuries. Secondly, as I have indicated, Dr Abrahams appeared to wed herself too closely to her '*theory of the case'* namely that the deceased must have been manually strangled during an extended rape. Thirdly, there was a lack of evidence regarding the mechanisms of death by strangulation and the likelihood of this having been the cause of death.

[244] Fourthly, the evidence as to manual strangulation was in my view by no means conclusive and bedevilled by the possibility, referred to above, that some of the neck injuries, both internal and external, could have been caused during the attempted resuscitation or treatment of the deceased, particularly by the first paramedics attending on the scene who the State was unable to call to testify.

[245] For all these and other reasons which I have set out earlier I consider that the State has fallen short of proving beyond reasonable doubt that the deceased was manually strangled by the accused, thereby causing her death or that he caused her death by inflicting some other form of violence upon her.

[246] In reaching this conclusion although I have made limited reference to the medical evidence suggesting that the accused may have raped the deceased this does not mean that I have not taken it into account. It must be borne in mind, moreover, that if the accused sexually assaulted the deceased in one or other manner, it does not necessarily mean that he must therefore have caused her death by manual strangulation of by some or other means.

Counts 1 and 2

[247] Under counts 1 and 2 the accused was charged with sexually penetrating the deceased vaginally and anally without her consent or in circumstances where she was unable to give such consent in contravention of sec 3 of Act 32 of 2007 i.e. raping the deceased. The accused's defence was a denial of these charges and it was repeatedly asserted on his behalf during the trial that he denied having intercourse with the deceased on the night in question.

[248] Once again much of the evidence which the State brought to bear on these two counts was circumstantial and of a medical nature, although not exclusively so. The medical evidence consisted of the observations of nursing staff at Paarl Medi-Clinic indicating that the deceased may have been sexually assaulted, Dr Bartleman's examination of the deceased following which she completed a J88 form, Dr Abrahams' post-mortem findings in particular her findings of the injuries to the deceased's body, most notably to her vagina and anus. To Dr Abrahams' evidence must be added that of Professor Martin who endorsed Dr Abrahams' conclusion as to the likely cause of the genital and anal injuries. In addition there was circumstantial evidence from a number of non-medical witnesses, namely, Pallo Manuel, Sebastian Driessen, Vanika Lalloo and

Mrs D, the deceased's mother. What also has to be brought into account is the accused's statement to Sgt Morrison and what the accused told Lt Colonel Gordon and the evidence of other police officials regarding attempts made to ascertain whether sexual intercourse had taken place in the tent occupied by the accused and the deceased on the night in question. Also relevant is evidence from members of accused and the deceased's party as to the latter's condition in the hours leading up to midnight. Finally, regard has to be had to Dr Naidoo's evidence regarding the post-mortem's findings and conclusions in regard to the vaginal and anal injuries which, the State alleged, the deceased suffered and other medical evidence.

[249] Nurse Troskie testified that when they wanted to place a catheter in the patient they immediately saw that things were not *'right'* with the deceased's private parts. It was very wet and it looked as if something had '*happened there'*. She also found two large bruises on the patient's hips and scrape marks/abrasions on both of her knees. She and her colleague were advised by the sisters in casualty to do nothing further and notify the police. Dr Franklin then asked the accused if he had had sex with the deceased and his answer was no. Contact was made with the police in order to obtain a rape kit and Dr Bartleman was asked to do the necessary examination.

[250] Sister Bam testified that the patient was naked when she arrived save for a pair of large short pants. She asked the accused about the scratch marks on the patient's knees and he told her that the patient had fallen over tent pegs or poles. As I have indicated there is no reason to doubt the evidence given by either of these witnesses.

[251] Dr Bartleman testified that at the request of Dr Franklin she had performed the examination on the deceased at approximately 5am and completed the J88 form and

taken swabs from her. She did not do a full investigation. Dr Franklin had asked her just to investigate for possible sexual abuse. She was not experienced in this procedure since she had done little of this at Paarl Medi-Clinic and although she had been a district surgeon this was the first such examination she had conducted. Her main clinical findings were that there were bruised areas on both of the patient's rami, anterior, measuring approximately 2cm². There were bruised and scarred areas measuring 1cm² on both knees there were puncture wounds on her anterior neck and left lower abdomen. More importantly she found that the frenulum of her clitoris, her urethral orifice, her labia majora and minora were normal but with a bloody discharge visible. Significantly she found tears in the vagina and a bloody discharge and that the cervix was bruised. In this regard she found that the injuries and tears might be an indication of sexual intercourse. Her anal examination was superficial and she noted only blood on the skin. In her diagram she noted *'skuurtjies binne vagina'*.

[252] Dr Bartleman testified she did not do a thorough test on the anus as she used up all three swabs but there were visible tears on the outside of the anus. She added that Dr Franklin was anxious to carry on with his treatment of the patient so he *'chased her a little bit'* in her examination. The one swab she took was in the vagina, one on the outside near the labia and one on the perineum. When it was put to her that the tears to the vagina could have been caused by masturbation she was sceptical saying that she did not think that any woman would injure herself in this manner if she was in her sound senses. She testified that if the patient was menstruating the blood found in and around the vagina would be reconcilable therewith but she received no history of menstruation.

Dr Deidre Abrahams

[253] Amongst Dr Abrahams' chief post-mortem findings were *'evidence of forceful vaginal and anal penetration, ante mortem'* and *'evidence of blunt trauma to the torso and extremities'*.

[254] More particularly she found:

1. Extensive swelling of the labia majora and clitoral hood and labia minora;
2. A tear at the inferior aspect of the clitoral hood measuring ±10mm;
3. Circumferential rubbing friction abrasion of the labia minora and inner aspect of labia majora with loss of skin, redness and blood tinged fluid on the surface;
4. A tear at 6 o'clock at the vagina of 5 to 6mm from the posterior fourchette through the fossa navicularis and blood tinged fluid oozing from the tear.
5. There was a loss of skin and redness and swelling from outside the labia minora and along the inner aspect of the vagina to depth of ±70mm. There was blood tinged fluid on the surface;
6. There was blood tinged fluid and creamy light coloured fluid in the vagina with a few sand grains high in the vagina at and around the cervix which was contused. She found the perineum to be swollen.

[255] Regarding the anal areas she found:

1. Surrounding the anus and into it along the inner surface over 35mm x 40mm contusion with rubbing friction peri-anal and anal abrasion, over a distance of ±70mm into the anal canal with large soft tissue haemorrhage;
2. A tear of ±5mm at the 6 o'clock position of the anus, extending slightly into the perineum.

[256] Dr Abrahams also found minor abrasions of the knees.

[257] As indicated earlier Dr Abrahams ascribed the sand grains found high in the vagina to be consistent with forceful penile penetration and contact with sandy areas. She

testified that tears in the genitalia occur when there is forceful penetration, unlubricated and unwilling. To her it appeared to be severe and forceful pressure which would be very painful. With forceful penetration the skin is rubbed and abraded, it starts to swell and then to ooze blood and blood tinged fluid. She found that the penetrations could not be one time penetrations but repetitive penetration. Dr Abrahams expressed the view that the abrasions on the knees could be consistent with sexual penetration taking place with the deceased being on her knees. She also testified that many of the bruises on the patient's body, not least those on her pelvic rami would be consistent with the deceased being moved into different positions during the non-consensual intercourse. Regarding the effects of decomposition in her findings the witness confirmed that the deceased's body was kept 12 hours in an unrefrigerated state before it was delivered to the Paarl morgue.

[258] In cross-examination it was out to the witness that a likely explanation for the swelling of the genitalia was the heavy administration of fluids and the DIC. Dr Abrahams responded that all the injuries to the sexual organs must be seen in their full context i.e. the tears and the abrasion injuries found and she also disputed that the abrasion injuries could be explained by skin loss as a result of early decomposition. It was further put that the injuries to the vagina could be explained by the deceased having masturbated herself which could produce tears at 6 o'clock and 12 o'clock. Dr Abrahams was similarly most sceptical of this and said that the process of masturbation inflicting such injuries would be very painful. She added, furthermore, that the general picture of masturbation did not fit with the extent or depth of the injuries. Furthermore, if the patient was masturbating one would have expect her to have been lubricated thus reducing the risk of tears and injuries. Dr Abrahams pointed out that some of the injuries extended right up to the cervix. In response to a question from the Court she testified that

she observed no skin slippage on the deceased's body during the post-mortem and this is confirmed in para 2 of her report which describes the state of the body on post-mortem and one observation made is that there was *'no skin slippage'*. She explained that she had performed block dissections vaginally and peri-anally in order to obtain a better picture of possible injuries. Regarding the presence of the sand grains high in the vagina it was put to her that this could also be the result of intercourse on the floor of the tent or through the deceased's own hands when masturbating. Dr Abrahams' comment was that it was highly improbable as there was no evidence of masturbation and even if this were the case it was highly improbable that the sand grains would be transported so high to around the cervix.

[259] Regarding the tears to the anal area it was put to the witness that these injuries could be explained by decomposition, skin slippage and membrane detachment and furthermore that the *'tears could be caused by constipation and masturbation'*. Dr Abrahams' response was that these were very unlikely explanations and confirmed that she observed no skin slippage on post-mortem. Constipation might cause tears internally whereas the tears she found were external. Masturbation injuries were very unlikely as this would cause great pain. She testified that she first observed the injuries in the deceased's private parts before she performed the block dissections.

[260] Regarding Dr Bartleman's failure to find any injuries on anal examination Dr Abrahams stated that she understood that Dr Bartleman had only done a superficial examination in that area because of the circumstances then prevailing. An extended version was put to Dr Abrahams on behalf of the accused inter alia that the injuries to her body might have been caused when she fell on the way back to the tent. Dr Abrahams

was asked why she had not taken a sample of the whitish fluid in the vagina which appeared to her to be seminal fluid and her response was that she understood that swabs had been taken by Dr Bartleman in the J88 process.

[261] As previously stated Professor Martin agreed with the conclusions expressed by Dr Abrahams in all material respects. In particular she agreed that the injuries as recorded by Dr Abrahams were due to blunt force trauma, consistent with forceful genital and anal penetration. She expressed the view that the application of force could have been caused by grabbing or holding down the deceased and the injuries to the elbows and knees could have been sustained when the deceased was on all fours. She testified that she did not believe that the genital and anal injuries could have been by self-inflicted the deceased's fingers. In viva voce evidence Professor Martin testified that she did not believe that either masturbation or constipation could account for the injuries to the deceased's private parts since those to the anus were quite severe and both would involve *'exquisite'* pain.

[262] Professor Martin testified during cross-examination that she had seen more than 2000 cases of rape in her experience as a doctor and conducted more than 12000 autopsies. Drawing on this experience Professor Martin gave as her opinion that the injuries to the deceased were caused by blunt force trauma and could not have been caused by masturbation and constipation. Her reasons for this conclusion included the severity of the injuries inter alia the abrasion to the anus being 7cm deep and the lacerations to the genitalia. She has never previously seen injuries to the extent of those to the deceased's genitalia caused by masturbation. She pointed out that women have babies without incurring lacerations. As I previously observed Professor Martin was a

very good witness, prepared to make concessions where necessary and, yet confident under cross-examination whilst adhering to the main elements of her evidence.

[263] I deal now with the evidence of the non-medical witnesses which could be relevant to the charges of rape. Firstly, there was the evidence of Pallo Manuel. He testified that upon returning to his tent at about midnight which was alongside that of the accused and the deceased he heard the sounds of what sounded like people having sex in the neighbouring tent. He described the noises as moaning and groaning from a male and female and assumed that they were having sex. This noise continued for the period that he was in the tent to change his clothing, approximately 10 minutes. This evidence was not challenged in any way on behalf of the accused during cross-examination notwithstanding the repeated assertions made on his behalf or by him after the incident denying that he had sexual intercourse with the deceased that night.

[264] Mr Sebastian Driessen testified that at some point whilst the deceased was being treated at the paramedics tent the accused stated that he had been having sex with the deceased when she *'conked out'* on him. This evidence was disputed in cross-examination but despite intense cross-examination the witness stuck to his evidence in this regard.

[265] Riaan Martin testified that when he saw the deceased on the edge of the dance floor near the toilets shortly before 12am she appeared drunk and was barely able to walk. He testified that at that stage the deceased had no visible injuries and he did not think she sustained any injury up to the time that the deceased got to the tent, a trip during which he accompanied her.

[266] Vanika Lalloo testified that the deceased complained of feeling sick after taking the LSD and by the time they reached the toilets on the way to the dance floor. The deceased had fallen unconscious and was having convulsions when the witness coincidentally went to the paramedics' tent much later that night. The next morning before the police arrived she had a conversation with the accused who showed her a scratch on his stomach and told her that the deceased had wanted to have sex with him but that he refused because she was acting *'weird'* and in the process she had scratched him. When the witness asked the accused how the deceased was he told her that it appeared that she had been raped. She asked the accused if they had had sex and his reply was that they had not and that the last time they had done so was before Christmas. This evidence does not appear to have been disputed by the accused in cross-examination.

[267] The deceased's mother, Mrs D, testified that at about 6pm on 1 January 2014 at Paarl Medi-Clinic the accused had told her that the deceased had not felt well, that in the tent she had started behaving strangely, was feeling hot, took off her clothes, appeared to be sexually excited and was rolling around touching herself and was on her knees. Mrs D asked the accused directly whether he and the deceased had had sex and his answer was no and he also told her that her daughter had even scratched him and lifted his T-shirt to show a scratch on his left hand side under his breastbone. Mrs D told the accused that there was something *'not right'* and that her daughter was fighting for her life. The accused's response was a very nonchalant *'okay'*, as if he was not surprised. In cross-examination Mrs D testified that she thought that the relationship between the deceased and the accused must have been an intimate one, that her daughter was in love with the accused and she did not think it was an abusive relationship – at least her daughter had said nothing of this sort. Her evidence regarding what the accused had said regarding

sexual intercourse and the deceased's sexual behaviour was not disputed. It was simply put to the witness that the accused denied that he assaulted the deceased or raped the deceased on the night in question.

[268] Lt Colonel Gordon testified that upon questioning the accused on 1 January 2014 he had told her that outside the tent the deceased had begun to vomit and then he took her into the tent where she began to roll on the ground. She apparently wanted to have sex with the accused and took off her clothes but he refused. The accused told her further that after a while the deceased could not breathe properly and her body became limp. In his notes Dr Franklin recorded that the accused told him that they had never had sexual intercourse and that the deceased had never been left alone.

[269] Sgt Morrison testified that she took a witness statement from the accused on the morning of 1 January 2014. That statement, held admissible after a trial within a trial, reads in part as follows:

> *'While we were on the dance floor (close to the dance floor) we took LSD drugs. S went to sit down for a while. I could see that while she was sitting she wanted to throw up, but nothing came out and it was only winds. After that we took MDMA, also a drug. Me and other two friends, Riaan and Jade, helped me to took her out to get some fresh air. Riaan and Jade left me and S at the camp side (sic). I never left her alone and was all the time with her. She was rolling in the gras (sic) and she started to took off her top. I told her no, not to take off her clothing. After that we went back to the tent. We get inside I zipped the tent and open the window for air. Then she got un dress and start rolling around and she said to me that she is so turn on and she wanted to have sex. I then told her no that we not going to have sex. But then she inserted her finger into her vagina. She was rubbing all over her body with pressure. She kept telling me that she wants sex. We didn't had sex (sic). At some stage took crab (sic) my arms also with force. She put her hands and kept*

it on her face bagging (sic) me to have sex. She kept and inserted her finger/fingers into her vagina.

Before I call someone for help I took my pants which was lying close and slip it on for her to cover her and then I called for help. The paramedics arrived and I followed them to the hospital. Everything happened so fast and it was so scary because it was the first time I saw her like that. During our time of dating each other it was our first time using drugs.'

[270] Further relevant evidence was that at some later stage the accused had agreed to give a DNA sample but DNA testing for a match with the deceased had proved inconclusive. There was also evidence that during the course of 1 January 2014 a Sgt Timmie had used a police sniffer dog to try and find any traces of bodily fluids, including semen, in and around the tent occupied by the deceased and the accused but without success.

[271] From the side of the accused there was expert medical evidence from Dr Naidoo regarding the post-mortem findings relating to genital and anal injuries as well as evidence from Lameez Martin and Jade Grey. Martin testified that after members of the party took drugs that night S complained that she was not feeling well. She looked weak and the accused had to help her to walk. She next saw the deceased at the paramedics' tent undergoing treatment.

[272] Jade Grey testified that after members of the party took drugs the deceased did not look herself. She was completely different. She said she did not feel well and told the witness she felt as if she was *'melting'*. The witness tried to get her to stand up but she could not, her legs being like jelly. The deceased said she wanted to go to the tent. She also told the witness that she wanted to have sex with her boyfriend. The witness helped

the deceased get back to the tent being one of two persons who supported her. At the tent she asked the deceased if she was OK and she answered in the positive. She next saw the deceased a few hours later at the tent when she was convulsing. Under cross-examination she stated that the deceased kept subsiding as opposed to falling and she was weak in her knees. She would fall back into the sitting position. She could not say if the deceased sustained any injuries. Asked whether the deceased was in a condition to have sex with the accused her answer was that she did not think so. She could not recall the deceased falling on the way to the tent or sustaining injuries. As mentioned previously the witness' explanation for not mentioning in her witness statement to the police that the deceased had said she wanted sex was that she was scared to do so. She could not however explain why she was scared to mention this to the police. In answer to a question from the Court the witness stated that she and Riaan Martin had spent about two hours on the dance floor before coming back and finding the deceased naked in the tent having convulsions.

[273] In his report Dr Naidoo first speculated that the 10mm tear of the inferior edge of the deceased's clitoral hood may well have been the site of the *'vaginal biopsy'* referred to by Dr Franklin. He also ascribed the tears in the vagina to *'the accused's candid statement'* that the deceased had masturbated herself and he also ascribed the other injuries in the vagina to masturbation together with the effects of the bleeding disorder. He ascribed the *'contusion'* of the cervix to the DIC. He sought to explain the sand grains in the vagina on the basis of *'contamination'* as the deceased lay and rolled on the ground naked. He ascribed the injuries to the anus as attributable to constipation, decomposition and the DIC. Regarding the possibility of sexual intercourse he pointed out that the *'injuries'* were well explained and that no male DNA was identified. In conclusion he

found that the genital and anal lesions found may *'without difficulty'* be explained by the DIC and by reason of the factual evidence not indicating recent sexual activity.

[274] As I have indicated in an earlier discussion Dr Naidoo was anything but an impartial witness as indicated by his great reluctance to accept, initially at least even the possibility of sexual intercourse. His evidence that the injuries to the genital and anal areas were exacerbated by the DIC cannot explain the tears in the vagina found by both Dr Bartleman and Dr Abrahams nor can it explain the tear found in the anus. Dr Naidoo gave scant weight to the evidence of the swelling in the genital area, the *'rubbing friction abrasion ... with lots of skin redness and blood tinged* fluid'. Similarly he gave scant weight to the rubbing friction peri-anal and anal abrasion with swelling and redness and loss of skin over a distance of ±70mm into the anal canal.

[275] All of the medical personnel called by the State to testify regarding the vaginal and anal injuries i.e. Drs Bartleman, Abrahams and Professor Martin, were most sceptical of the explanation that the vaginal injuries were caused by masturbation. One or more of them pointed out that it was most unlikely that the deceased would masturbate herself to the point of causing tears which would be most painful and therefore counter intuitive to say the least. Even Dr Naidoo had to concede that masturbation could hardly account for the deceased's anal injuries and certainly not the internal anal injuries. Although the DIC might well have accounted for the blood tinged fluid found in the area of the deceased's vagina and anus there first had to be injuries i.e. the tears and abrasions, before such bleeding could take place. For this reason these injuries stand on a different footing to the bruising found on various parts of the deceased's body or bleeding from needle marks. Similarly Dr Naidoo's explanation of sand grains found deep in the deceased's vagina

was equally strained, namely, that these would have reached there through masturbation and/or rolling around on the floor of the tent.

[276] Professor Martin and Dr Abrahams had extensive experience in the field of examinations and autopsies in alleged rape cases, Professor Martin particularly so. By the time that they testified, at least, they were well aware of the potentially misleading effects of the DIC. Dr Abrahams recorded her observations in meticulous detail, many of them substantiated with photographs. On the other hand I was left with the distinct impression that Dr Naidoo saw his role as to cast doubt on any observation or finding indicating that sexual intercourse had taken place between the deceased and the accused and to rather bolster the account that had been given to him as set out in the accused's statement.

[277] The evidence that sexual intercourse took place is not confined to inferences drawn from the medical evidence although that evidence has considerable weight notwithstanding the lack of any positive DNA testing.

[278] There is in addition the unchallenged evidence of Pallo Manuel that he heard the sound of what appeared to be sexual intercourse taking place in the deceased and the accused's tent shortly after midnight. That evidence was undisputed and I accept it. Then there is the evidence of Mr Driessen as to the accused's statement whilst the deceased was being treated. Driessen had no axe to grind in the matter and the evidence which he gave in itself was not indicative of rape since he was testifying merely that the accused said he was having sex with his girlfriend when she *'conked out'*. Driessen would have had no apparent reason to give such evidence if it were false. The idiosyncrasy of the phrase used – *'conking out'* – lent veracity to his account and his evidence in turn lent support for the evidence given by Pallo Manuel. There are objective indications of sexual

intercourse having taken place. The deceased was found naked save for a pair of shorts hurriedly put on her by the accused according to his witness statement. It is also significant that the medical nursing staff immediately observed *'something wrong'* in the area of the deceased's vagina.

[279] More significantly, there is no direct evidence that the accused and the deceased did not have sexual intercourse. Although the assertion that no sexual intercourse took place was repeatedly asserted on behalf of the accused in cross-examination and formed part of his witness statement, the accused did not give this evidence and there is therefore no direct evidence at all either that no intercourse took place or that the deceased masturbated herself.

[280] At this point I must deal with an argument raised by the defence that the accused put his version fully before the Court by virtue of his witness statement having been declared admissible. The argument proceeds that not only was the statement held to be admissible after a trial within a trial but that the State went on to prove the contents of the statement through the evidence of Sgt Morrison. Therefore the State had proven the contents of the statement with the result that the accused's version had been placed before Court and, by implication, had rendered it unnecessary for him to testify. In these circumstances, it was contended, relying on *S v Pamensky* 1978 (3) SA 933 (E) 937 A – B, that:

> *'... there was [is] therefore an explanation before the court which might reasonably possibly be true and there was no obligation on the appellant [accused], in these particular circumstances, to confirm that statement on oath.'*

[281] This argument is fundamentally misconceived. In the first place counsel for the State made it clear at all stages that the State sought to have the accused's witness

statement declared admissible solely for the purposes of cross-examination of the accused in the event he should testify. At no stage did the State indicate, either expressly or by implication, that by proving the statement it was accepting the truth of the contents thereof. Secondly, *S v Pamensky* is entirely distinguishable on the facts. In that matter the magistrate, in convicting the accused, had commented adversely on the fact that the appellant had not given evidence to establish his state of mind at the time of the transaction. On appeal the Court found that the magistrate's criticisms of the appellant's failure to give evidence would have been valid but for the fact that prior to the trial the appellant had handed the investigating officer a written statement in which he explained his alleged contravention of the Exchange Control Regulations and why he had done it. The investigating officer subsequently testified that, based on his investigations, the allegations made by the appellant in that statement were true. Furthermore, the prosecutor informed the Court that the State did not dispute the basic facts as given by the accused in the statement. The Appeal Court held that the fact that the State expressly and without qualification or reservation accepted the truth of the appellant's statement meant that there was no obligation on the appellant, in those particular circumstances, to confirm that statement on oath.

[282] In the present matter there has never been any suggestion that the State accepted the contents of the accused's witness statement as correct. If it had there would have been no point in continuing with the prosecution of the accused. Accordingly the argument that no inferences can be drawn from the accused's *'silence'* and that his circumstances are therefore distinguishable from those which applied in *S v Boesak,* is wholly misplaced. It goes without saying that propositions put to state witnesses under cross-examination cannot be treated as if they amount to evidence placed by the accused before

Court.[3] As was pointed out to the accused's counsel in cross-examination neither such propositions nor a witness statement can be subjected to cross-examination or tested unless the maker of that statement, be it a witness or the accused, testifies.

[283] As stated previously there is no direct evidence from the accused that no sexual intercourse took place. Nor is there any apparent reason why the accused did not give this evidence or, if this was not the case, and he did have consensual intercourse with the deceased, why he did not testify to this effect. He was in a long term relationship with the deceased and by all accounts it was an intimate relationship. If he had testified that he had had consensual sex with the deceased there could have been no one who could have testified directly to the contrary.

[284] When one has regard to the accused's statement, notwithstanding its limited evidentiary value, it raises more questions than answers. He makes no reference in his statement to the scratch which he told Mrs D and another witness had been inflicted on his chest by the deceased in her frantic efforts to have sex and his statement does not explain the noises of sexual intercourse heard by Pallo Manuel. Nor is there any explanation as to what went on in the tent for at least one hour and perhaps up to one and a half hours. On a reading of the statement it would appear that some five or ten minutes may have been taken up with the deceased begging him to have sex, masturbating herself before falling into unconsciousness and convulsing. It was common cause that the accused and the deceased arrived back at the tent at about midnight. Barling recorded the *'time of the incident'* as 01:25 and himself as arriving at the scene at 01:45. Driessen testified of arriving at the paramedics' tent and someone coming through and asking for

[3] *S v Katoo* 2005 (1) SACR 522 (SCA) at 529 E – F.

assistance in relation to the incident *'after 1am'*. It is clear therefore that the deceased and the accused spent at least one hour in the tent before the alarm was raised. What happened in this one hour plus? In addition there was the evidence of Vanika Lalloo that the following morning the accused told her it appeared that the deceased had been raped but that he had not had sex with her. This evidence was not disputed but even on its own terms it is strange. Why did the accused not add to Lalloo that of course any suggestion that she had been raped was nonsense since he had been with the deceased throughout the evening and alone with her in the tent, had not had intercourse with her and therefore there could be no question of rape?

[285] The position is then that the deceased, although feeling ill, entered the tent with the accused apparently uninjured. Certainly there is no suggestion at all that she had incurred any sexual injuries by this stage. When medical help was called approximately an hour and a half later the deceased had sustained the injuries to her vagina and anus which were meticulously described by Dr Abrahams and which immediately caused concern on the part of medical staff at Paarl Medi-Clinic. There has been no suggestion that any other person other than the accused had any physical encounter with the deceased that night which could have led to the injuries which she sustained. In these circumstances there are only two possibilities: either the injuries were self-inflicted or they were inflicted by the accused.

[286] As to the first possibility there is no direct evidence that the injuries were self-inflicted or pre-existing. On the other hand there is other telling evidence that these injuries must have been inflicted by the accused in the course of having sexual intercourse with the deceased. Firstly, there is the undisputed evidence of Mr Pallo

Manuel that he heard, shortly after midnight the sounds of sexual intercourse coming from the tent occupied by the accused and the deceased. Then there is Mr Driessen's evidence of the accused explaining the deceased had *'conked out'* while they were having sexual intercourse. That evidence is of course disputed but stands uncontradicted by the accused. The only evidence of the deceased's injuries being self-inflicted is second-hand evidence emanating from the accused, namely, statements he made the next day to the effect that the deceased masturbated herself. These *'explanations'* do not account for the injuries to the deceased's anus. It is also very difficult to reconcile the evidence of the deceased being in an ill and semi-incapacitated state upon entering the tent with a version of her suddenly recovering, aggressively demanding sex and when refused masturbating herself with such intensity that she inflicted vaginal tears. As indicated above had these injuries been self-inflicted, it is difficult to understand why the accused was not prepared to testify to this effect.

[287] In considering all the issues which arise in relation to counts 1 and 2 regard must be had to the significance of the failure of the accused to testify bearing in mind that he was the only person who could testify as to what took place in the tent between midnight on 31 December 2013 and the next hour or so afterwards.

[288] In *S v Boesak* 2001 (1) SACR (CC) it was stated:

> *'The right to remain silent has application at different stages of a criminal prosecution. An arrested person is entitled to remain silent and may not be compelled to make any confession or admission that could be used in evidence against that person. It arises again at the trial stage when an accused has the right to be presumed innocent, to remain silent, and not to testify during the proceedings. The fact that an accused person is under no obligation to testify does not mean that there are no consequences attaching to a decision to remain silent*

during the trial. If there is evidence calling for an answer, and an accused person chooses to remain silent in the face of such evidence, a court may well be entitled to conclude that the evidence is sufficient in the absence of an explanation to prove the guilt of the accused. Whether such a conclusion is justified will depend on the weight of the evidence. What is stated above is consistent with the remarks of Madala J, writing for the Court, in Osman and Another v Attorney-General, Transvaal*, when he said the following:*

"Our legal system is an adversarial one. Once the prosecution has produced evidence sufficient to establish a prima facie case, an accused who fails to produce evidence to rebut that case is at risk. The failure to testify does not relieve the prosecution of its duty to prove guilt beyond reasonable doubt. An accused, however, always runs the risk that, absent any rebuttal, the prosecution's case may be sufficient to prove the elements of the offence. The fact that an accused has to make such an election is not a breach of the right to silence. If the right to silence were to be so interpreted, it would destroy the fundamental nature of our adversarial system of criminal justice".'

[289] The question, in the present matter, thus is, firstly, whether the evidence led by the State in relation to counts 1 and 2 was such as to call for an answer from the accused, and secondly, whether in the absence of any such answer, the evidence led by the State is sufficient to prove the guilt of the accused beyond reasonable doubt. Put differently has the State produced evidence sufficient to establish a prima facie case and if so, absent any rebuttal from the accused, is it sufficient to prove the elements of the offences in counts 1 and 2?

[290] There is of course the question of consent, a further element of the State's case which it must prove beyond reasonable doubt. Firstly, in the nature of things there is no direct evidence from the State that the deceased did not consent to vaginal or anal penetration by the accused. This could only have taken place in the tent occupied by the

accused and the deceased and only those two persons were in the tent for the critical one hour or one hour plus period when penetration must have taken place and the injuries were sustained. Secondly, it is of course possible that the deceased could have consented to these forms of penetration and that the injuries she sustained were a result of rough but consensual intercourse or penetration. The issue is, however, whether viewing the evidence as whole this was reasonably possibly the case.

[291] The two counts of unlawful sexual penetration allege that the accused did so *'without the consent'* of the complainant or *'under circumstances when the complainant was unable to give such consent'*. The concept of *'consent'* in relation to the offence is defined in sec 1(2) of Act 32 of 2007 as *'voluntary or uncoerced agreement'*. Section 1(3) contains a lengthy provision dealing with the interpretation of the words *'voluntary or uncoerced'*. It reads in part as follows:

> *'(3) Circumstances ... in respect of which a person ('B') (the complainant) does not voluntarily or without coercion agree to an act of sexual penetration ... include, but are not limited to, the following:*
>
> *...*
>
> *(d) where B is incapable in law of appreciating the nature of the sexual act, including where B is, at the time of the commission of such sexual act -*
>
> *...*
>
> *(iii) in an altered state of consciousness, including under the influence of any medicine, drug, alcohol or other substance, to the extent that B's consciousness or judgement is adversely affected;'*

[292] Jade Grey testified that she did not think that the deceased was in a position to have consented to intercourse. Secondly, Dr Naidoo, the accused's own expert witness

conceded that if the deceased had been under the influence of LSD and MDMA – as is the accused's case – her confused and disoriented state rendered it highly questionable whether she could consent to intercourse. This appears from the following passage from Dr Naidoo's evidence upon being asked a question by the Court:

> *'If your theory that this is a drug induced death is accepted then it would follow I presume that before – would it follow before unconsciousness and convulsions this patient must have been – the deceased must have been in a very disoriented state?* --- *Yes, M'lord. Agitated, disorientated, confused, incoherent, restless. That is the typical picture of a person who is under the influence of such a drug and possibly … (intervention).*
>
> *You have already told the Court that in those situations a large question mark is raised about questions of consent, if there was sexual intercourse.* --- *Yes'.*

[293] It would appear to me, quite clearly, that the deceased's state of consciousness, as described by the accused (second-hand) and by those who were with her before she entered the tent and who assisted her from the dance floor to the tent, together with the evidence given by the various experts on the effects of a drug such as MDMA, would bring her squarely within the category set out in section 1(3)(d)(iii).

[294] To summarise, there is clear evidence that the deceased had no injuries of a sexual nature before entering the tent at approximately midnight and that these injuries must have been sustained whilst in the presence of the accused alone during the following one or one and a half hours. The nature of those injuries are such that they could only have been suffered as a result of penetration of the vagina and the anus. Save for one instance, in the hours and days after the incident the accused insisted that there had been no sexual intercourse between him and the deceased at the critical time. Throughout the trial itself it was repeatedly put on his behalf that no sexual intercourse had taken place between him

and the deceased. Notwithstanding these assertions there were at least two pieces of evidence pointing clearly towards sexual intercourse having taken place in the tent during the critical period, namely that of Mr Pallo Manuel and the remark made by the accused in the presence of Sebastian Driessen. To this must be added the fact that the accused is the only person who could testify first-hand as to what happened in the tent during the critical period and, more particularly, how the deceased sustained the injuries to her vagina and anus. Such an explanation would, in the ordinary course of the events be expected from the accused. Moreover, had the injuries been caused by the accused during consensual intercourse or sexual activity with the deceased no adverse consequences could follow nor any adverse inference be held against him: he was in an intimate relationship with the deceased and were he to testify that there was consensual sexual intercourse between them in the tent no witness would be able to directly contradict him.

[295] In these circumstances the question must be asked, why did the accused not testify? In my view the answer to this question can only be that the accused was not prepared to subject himself to cross-examination on the discrepancies between, on the one hand, his version that there was no sexual intercourse between him and the deceased in the tent and all the indications that there was intercourse. That comprised the objective evidence of the injuries which the deceased sustained to her vaginal area and her anus as well as the evidence of the extensive bruising (even taking into account the magnifying effect of the DIC) which the deceased sustained as well as non-medical evidence, namely that of Messrs Manuel and Driessen, indicating that sexual intercourse had taken place. The accused would also have been cross-examined on all the bruises which Dr Abrahams observed and which she and Professor Martin testified could be explained by the accused having had forcible intercourse with the deceased in a number of positions. He would

also have had to explain how the deceased came to sustain the abrasions on her knees and elbows which, the same witnesses testified, could well have been incurred by the deceased when she was subjected to intercourse whilst on all fours.

[296] The accused thus found himself in a dilemma: on the one hand he had consistently denied having sexual intercourse with the deceased in the tent before she fell into a state of unconsciousness yet there was strong evidence, direct and indirect, that sexual intercourse or penetration must have taken place both vaginally and anally. On the other hand were the accused to admit to sexual intercourse with the deceased he would have to explain firstly, why he had consistently denied this and, secondly, if such intercourse was consensual, how the deceased had sustained such serious injuries to her vagina and anus. Finally, if the deceased's death was ultimately attributable to an adverse reaction to LSD or MDMA or both, and if she had been in the disoriented, confused state of mind which the accused described in his statement to the police before she fell into a state of unconsciousness and convulsions, how she could have given consent to sexual intercourse?

[297] One final argument put up by the accused must be addressed, namely that the apparent lack of any motive on the part of the accused to unlawfully penetrate/rape the deceased must count heavily in his favour. In this regard it was pointed out that prior to the incident the accused had apparently been in a loving and intimate relationship with the deceased. Although motive or the lack of motive may in certain circumstances be relevant to determining whether the State has proved its case against an accused beyond reasonable doubt, motive is obviously not an independent element of any offence. Two factors are relevant in this regard: firstly, the accused was not prepared to testify and be

subjected to cross-examination where the issue of motive or the lack of motive could be properly explored. Secondly, much was made by the accused, both through cross-examination and in the evidence of his expert, that the ingestion of MDMA can reduce inhibitions and lead to intemperate choices regarding sexual behaviour or to hypersexuality. This was explicitly advanced as the reason why the deceased allegedly inappropriately and insistently demanded that the accused have sexual intercourse with her and, when he refused, masturbated herself to the point of inflicting vaginal tears and *'rolling around'* on the ground. However, assuming some credence in the evidence that the ingestion of MDMA can lead to such behaviour modification it must not be forgotten that all the evidence suggests that the accused himself ingested MDMA and would therefore be equally prone to inappropriate sexual conduct or hypersexuality. If this were the case it would go some way to explaining his sexual assault upon the deceased notwithstanding that she was no longer in no state to consent to intercourse.

[298] In my view, the accused did not testify since he was unwilling to subject himself to cross-examination on the only explanation which he gave (indirectly) for the injuries sustained by the deceased, namely, that they were self-inflicted. In my view the suggestion that the deceased inflicted the injuries to her genitalia and anus herself or that these were pre-existing injuries is not only unsubstantiated but, what is more, most improbable. Given the absence of any direct evidence from the accused that the injuries were self-inflicted and given the overall highly improbable nature of the explanation furnished by the accused in his statement to the police and having regard to the evidence as a whole I find that the injuries to the deceased's vagina and anus were caused by sexual intercourse/penetration and that this intercourse/penetration could only have been with or been effected by the accused.

[299] Further in my view, the only reasonable inference to be drawn from the evidence as a whole and taking into account the accused's failure to testify is that the accused's sexual penetration of the deceased, both vaginal and anal, was not with the consent of the deceased.

[300] Put differently, in my view the State established a strong prima facie case that the deceased had been unlawfully sexually penetrated both vaginally and anally. In the particular circumstances of this matter, for the reasons already given, I consider further that the Court is entitled to conclude, in the absence of an explanation from the accused as to how the deceased sustained the injuries which she did, that the State has discharged its onus of proving beyond reasonable doubt that these injuries were inflicted by the accused through penetration of the deceased both vaginally and anally and furthermore that this took place without the consent of the deceased.

Conclusion

[301] For all these reasons I consider that the State has succeeded in proving the accused's guilt on counts 1 and 2 beyond reasonable doubt. In the result the accused is acquitted on Count 3, the charge of killing the deceased by manual strangulation or by inflicting violence unknown to the State upon her, but is convicted on counts 1 and 2, namely, unlawful sexual penetration of the deceased both vaginally and anally on 1 January 2014 at Le Bac Estate Paarl.

BOZALEK J

For the State : *Adv E Erasmus*
As Instructed by : *DPP*

For the Accused	*:*	*Adv J Moses*
As Instructed		*Bagraim Attorneys*
		G Duncan