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

CASE NO: A2023-134184

(1) REPORTABLE: NO
(2) OF INTEREST TO OTHER JUDGES: NO
(3) REVISED: NO
26/08/2025

In the matter between :–

MEC FOR HEALTH GAUTENG PROVINCE

Appellant

and

M[...] C[...] C[...]

Respondent

Delivered: By transmission to the parties via email and uploading onto Case Lines the Judgment is deemed to be delivered.

JUDGMENT

SENYATSI J, MAHOMED J, SNYCKERS AJ

INTRODUCTION

[1] This is an appeal from a judgment delivered in this court on 25 April 2025 (Mia J), leave having been granted by the court *a quo*.

[2] The judgment was given in a trial action instituted by the respondent (Ms M[...]) as plaintiff against the appellant (the MEC) as defendant, for damages said to have arisen from the negligent rendition of medical care to the plaintiff (Ms M[...]) by servants of the MEC's department acting in the course and scope of their duties.

[3] The trial that yielded the judgment was on the separated issue of 'merits' (encompassing the issues of negligence and causation), with quantum standing over for later determination.¹

[4] The court *a quo* found for Ms M[...]. The MEC appeals against the whole judgment.

BACKGROUND

[5] Ms M[...] attended the Chris Hani Baragwanath Hospital (Bara) on 28 March 2013, for the delivery of her child. This was her third delivery at Bara, the first having resulted in a stillbirth. One of her earlier deliveries had been by caesarean section. She was HIV positive and on retro-viral treatment. The delivery entailed an episiotomy. The baby was healthy and of normal size and the birth itself appeared to entail no complications, save with respect to the episiotomy, as considered below. The delivery was attended to by two nurses/midwives, who performed the episiotomy and attended to the stitching (suturing) of the episiotomy with vicryl soluble or absorbable stitching or suturing).

[6] Three days after her episiotomy, Ms M[...] visited Itereleng Clinic in Dobsonville for pain. A nurse noted her stitches were unusual and healing would be slow, but reassured her. At her six-week check-up, she reported severe pain and difficulty sitting, especially during bowel movements. She was referred to a clinic

¹ Order of Ismail J granted on 29 June 2020.

doctor who prescribed antibiotics and advised follow-up if symptoms persisted for possible referral to Bara.

[7] Ms M[...] was hesitant to be treated at Bara due to negative prior experiences and requested treatment elsewhere in September 2013, citing trauma associated with the hospital. The Department of Health instructed her to attend Bara, and a matron called her in November 2023 advising her accordingly, which she heeded.

[8] On 26 November 2013, Ms M[...] saw Dr Schackis at Bara, who diagnosed an infected episiotomy with an abscess and sinus. She reported pain and coloured discharge, especially during defecation. Surgery was recommended but not considered urgent and could be scheduled during her employment leave in the new year.

[9] Ms M[...]’s condition worsened, prompting her to return on 23 December 2013 before her scheduled leave. Initially told surgery would be in late February 2014, she insisted she could not wait, so she was scheduled for 6 January 2014. After being sent home due to a doctor’s absence, she returned on 14 January and was then referred to the colo-rectal unit at Bara under Dr Kiss upon discovering her issue was anal, not vaginal.

[10] Dr Kiss formed the view that Ms M[...]’s CD4 count was too low for a safe operation and it was rescheduled. There were some delays, inter alia caused by loadshedding. Be that as it may, on 7 February 2014, Dr Francis, then a registrar in the colo-rectal unit at Bara, performed a fistulectomy on Ms M[...]. This essentially entailed repair of a fistula (tract) into which the sinus had developed,² in the perineum, from the vagina towards the anal aperture.

[11] An initial post-operative visit in March 2014 after the fistulectomy appeared to reveal nothing untoward, and the fistula appeared to have been repaired satisfactorily.

² A fistula is a tract connecting two surfaces or cavities.

[12] But on 1 April 2014 Ms M[...] experienced a radical episode of faecal incontinence while in public. This condition started afflicting her severely since then.

[13] She obtained two reports, one from Prof Oettle and a second opinion from Prof Lindeque. Neither gave expert reports for either party and neither testified at the trial. Some of the experts who did testify had recourse to those reports in their own assessments. Both Prof Oettle and Prof Lindeque advised her that her sphincter muscle had been cut during the fistulectomy, and that this was the cause of her incontinence. Correction was tendered – for now, this is not relevant.

TRIAL

[14] Both parties submitted several expert reports for the trial. Ms M[...] testified, calling three experts: Dr Stevens (gynaecologist/obstetrician), Dr Rawlins (general surgeon), and Prof Nolte (midwife). The defendant presented both experts and factual witnesses. Initially, Dr Kiss was believed to have performed the fistulectomy and testified as a factual witness; however, it was later revealed he had not conducted the surgery, nor was his presence during the operation certain. Instead, Dr Francis, who actually performed the procedure, was called to testify. Dr Schackis, who saw Ms M[...] in November 2013, also gave factual testimony. The defendant's experts included Prof du Plessis (midwifery), Dr Fourie (colo-rectal surgery), and Dr Marishane (gynaecology/obstetrics).

[15] Only Dr Rawlins and Dr Fourie gave expert opinions on the fistulectomy itself; the other experts gave opinions on the episiotomy and treatment leading up to the fistulectomy.

BASIC FINDINGS IN THE JUDGMENT

[16] The court *a quo* found that Ms M[...]’s incontinence was caused by the negligence of the MEC's servants at Bara.

[17] Although the judgment is relatively terse on the details of the negligence found, it is clear enough to me that the judgment found as follows (allowing for liberal paraphrase):

1.1 The incontinence was due, directly, to the cutting of the sphincter muscle at the fistulectomy.

1.2 The cutting of the sphincter muscle occurred mainly because of two factors:

1.2.1 The risk to the anal area following the episiotomy was not properly assessed or documented—no evidence exists of a possible third-degree tear into the anus. Additionally, no digital ano-rectal examinations were performed before the fistulectomy or at any point after the episiotomy, despite subsequent sepsis and infection.

1.2.2 Due to pre-fistulectomy neglect, the area near the anus was so severely infected that Dr Francis could not properly identify the anal sphincter during surgery, making this the primary cause of negligence.

[18] The above findings were based on the court's assessment of the common cause facts between the experts, and the expert evidence itself, including the state of the records kept at various times.

[19] Whether the above findings are sufficiently supportable in the evidence presented, in an appeal on factual findings,³ is one of the issues in the appeal.

[20] The other issue, which was the main issue raised on appeal by the MEC, was whether the pleadings covered a case based on pre-fistulectomy negligence, or whether the case pleaded was confined to negligence in the performance of the fistulectomy. It is appropriate to consider this issue next.

ON APPEAL

³ The authorities cited for Ms Mtwazi stem from the criminal sphere and reiterate the inveterate test enunciated in *R v Dhlumayo* 1948 (2) SA 677 (A) when it comes to the proper approach to an appeal on findings of fact, namely the need to find a 'misdirection' or to find that the trial court was clearly wrong in its assessment, giving due deference to the trial court's superior position in having observed the demeanour of the witnesses and experienced the drama of the trial. Already in *Dhlumayo*, and in several subsequent cases, the test was held applicable equally to civil and criminal appeals. A recent example of the approach to factual appeals by a full bench in this division in a civil appeal was *BMK Kitchenbrand (Pty) Ltd v Sapor Rentals (Pty) Limited* 2021 JDR 2015 (GJ), applying *Dhlumayo*.

[21] The primary issue raised on appeal by the MEC, through *Ms Masevhe*, was that the court's findings assigning most of the responsibility for the main injury to pre-fistulectomy negligence differed from the scope of the case as pleaded, which focused on negligence occurring at and after the fistulectomy. It was argued that a negligence case would have been met with a prescription defence. The MEC also stated that if the midwives' and nurses' actions regarding the episiotomy had been clearly challenged, they would have been called as witnesses.

[22] Before considering the pleadings and the way the trial was conducted, some basic propositions are apposite. In *Mashele*,⁴ a medical negligence action also concerning procedures at a provincial hospital, Gilbert AJ was confronted at trial with a case that had developed before him beyond the confines of the pleadings. In *Mashele*, unlike here, the point was not taken or raised by the parties, even at the stage of seeking leave to appeal.⁵ Gilbert AJ *mero motu* expressed concern that the case as fought had strayed beyond the pleaded case. He therefore considered the degree to which the conduct of the case could legitimately broaden the issues beyond the confines of the pleadings in these kinds of cases. Gilbert AJ's analysis of the applicable principles and case law⁶ in *Mashele* is instructive and to the point and I endorse it, particularly as it concerned a case of medical negligence particularised at trial in a manner broader than and different from its particularisation in the pleadings, to be distinguished from a case where a new element, say wrongfulness, was brought to life despite not being an issue on the pleadings.⁷

[23] The general principle is clear enough. The parties are bound by their pleaded case on negligence, but if the case is presented and defended in a manner that extends beyond the confines of the pleadings with respect to the particularisation of the negligence contended for, and both parties participate in this exercise without leaving plausible room for prejudice to the party against whom a finding occurs beyond the pleadings, then a court is entitled to make findings on the expanded case

⁴ *Mashele v MEC Health Gauteng* [2022] ZAGPJHC 444 (GJ) (27 June 2022).

⁵ It was also not one of the bases on which leave to appeal was sought in *Mashele: MEC Health Gauteng v Mashele* (2014/32526) 11 August 2022 – leave to appeal refused.

⁶ *Mashele* paragraphs 180 to 187, in particular with reference to *EC Chenia & Sons CC v Lamé & Van Blerk* 2006 (4) SA 574 (SCA).

⁷ *Mashele* para 186, discussing the Supreme Court of Appeal and Constitutional Court approaches in *TM obo MM v MEC Health Gauteng* [2022] ZACC 18 (30/5/2018); [2021] ZASCA 110 (10/8/2021).

beyond the confines of the pleadings. In such a case it is expected of the party against whom the case is being broadened to object at an early stage.

[24] In the instant case, the particulars of claim set out the history of Ms M[...]’s interactions with the various healthcare practitioners employed by the state that attended upon her, and then, when it came to particularising the breach of a legal duty towards her, particularised this first in terms that were confined to “the surgical procedure”, where the particulars had earlier defined the fistulectomy of 7 February 2014 as “surgery” (paragraphs 27.1, 27.2 and 27.3). The particulars then made general allegations of negligence, but certainly in a manner, coupled with the principal allegations in paragraphs 27.1, 27.2 and 27.3 of the particulars of claim, that would lead the reasonable reader to believe the asserted negligence was confined to the surgery on 7 February 2014. It is also pertinent to mention that the MEC was cited as responsible for activities conducted at Bara, not for all activities conducted at provincial clinics, like the clinic in Itereleng, notwithstanding that these activities fell under the MEC remit in exactly the same way as those at Bara.

[25] What is interesting, however, is that the plea, in all its formulations, specifically pleaded to the pertinent paragraphs of the particulars of claim that appeared to be confined to the fistulectomy, in terms that specifically denied negligence at the episiotomy and before the fistulectomy, and ‘put the plaintiff to the proof’ of such negligence:

“Defendant denies that the episiotomy, subsequent abscess drainage, fistulectomy performed and any other ancillary medical procedures performed on the Plaintiff were performed without due care and diligence. The Plaintiff is accordingly placed to the proof of such negligence.”⁸

[26] Even on the pleadings, it is inconsistent for the MEC, as defendant, to assert a failure to comprehend the negligence alleged in the pleadings extended to pre-fistulectomy conduct, including the episiotomy and subsequent treatment. The conduct of the case then placed the matter beyond doubt.

⁸ Plea paras 19 and 20.

[27] No further particulars were sought. Ms M[...] sought pre-trial admissions,⁹ including that Ms M[...] had suffered ‘*an absence of care in dealing with the plaintiff’s complaints over 8 months*’, that the episiotomy should have been performed by a trained obstetrician, that, given the angle of the episiotomy, risks should have been highlighted and followed up, and several similar admissions relating to a case concerned with negligence at and after the episiotomy but long before the fistulectomy. The contentious admissions were not given. Clearly Ms M[...] was preparing a case based on pre-fistulectomy negligence, at least as a significant contributing factor.

[28] At trial, counsel for Ms M[...] made it clear that her case included claims of pre-fistulectomy negligence as a major factor, not just negligence during or after the fistulectomy. To this end, notably the following was said on behalf of Ms M[...]:

“Attention should have been given by the midwife to the plaintiff post-partum to examine the episiotomy area for signs of infection and tissue break down, especially when the plaintiff complained about continuous pain in the episiotomy area....

....the plaintiff was not timeously referred to a doctor....

The clinic sisters who were in contact with the plaintiff during the post parting (sic) period did not examine the episiotomy area for signs of infection and tissue breakdown, especially when the mother complained about continuous pain in the episiotomy area [reading from the midwives’ joint expert minute]... there were no other follow-ups with respect to her episiotomy [despite complaints]...

So it will be submitted ... it is clear that negligence on the part [of] the defendant and its employees led to the injuries suffered by the plaintiff....”

[29] This was hardly surprising. Two of the three experts called by Ms M[...] had nothing to say about the fistulectomy. This was clear from their reports, and confirmed in their evidence at the trial. Dr Stevens specifically disavowed expertise in fistulectomies and Prof Nolte spoke purely to the episiotomy and post-partum

⁹ 2 June 2020.

care. There was never any suggestion from the MEC that the case was being expanded beyond the pleadings.

[30] Indeed, when counsel for the MEC cross-examined Ms M[...], she asked her specifically to confirm what her complaint was, and put it in these terms to her:

“Yes, now Mrs M[...] I hear when I sit here I hear the basis of your complainant (sic) to be starting at the cutting that happens during the birth of the minor child, would I be correct to say that?”

- Yes.”

[31] It is noted that the closing argument was not included in the record.

[32] I have no doubt that, even if it could be said (which is doubtful, given the way the MEC pleaded) that the negligence case pleaded was one confined to the fistulectomy, with the rest as “background”, the case the MEC came to meet, and fought, during the trial was one primarily concerned with pre-fistulectomy negligence, from episiotomy up to fistulectomy, and secondarily with fistulectomy negligence. Whichever case predominated, the case for pre-fistulectomy negligence was included, and the MEC could never have been in any reasonable doubt about this, but there was never any objection raised.

[33] The main issue on appeal must therefore be decided against the MEC.

WHETHER THERE WAS MISDIRECTION IN THE FINDINGS ON FACT

[34] I have alluded to the applicable test on appeal where the matter concerns findings of fact, derived from *Dhlumayo*, above.¹⁰ *Mr Morland*, who appeared for Ms M[...], heavily pressed on us the need to find a misdirection before we could interfere with the factual findings *a quo*. Courts, including in *Dhlumayo* itself, often hasten to add that appeal courts should not shrink from themselves assessing the evidence and inferences to be drawn from the evidence, and should bear in mind that the trial court does not possess any particular advantage when it comes to drawing

¹⁰ See footnote 3.

inferences or weighing probabilities, but that it should be afforded due deference with respect to its assessment of credibility and the general quality of evidence that is more difficult to assess on paper. Even then, undue deference need not be afforded to findings based on demeanour not supported by the appeal court's assessment of the evidence.¹¹

[35] The proper approach lies somewhere between purporting to retry the action fully on paper, at the one extreme, and deferring to the trial court's assessment as if it were the exercise of a discretion in the true sense, at the other extreme. Fact findings *a quo* should not attract the same degree of appellate diffidence as does the exercise of a true *Trencon* discretion.¹² A finding of fact is not the result of the exercise of a discretion.

[36] In the instant case, the problem of the precise degree of deference to be afforded to the factual findings *a quo* does not arise. This is so for the simple reason that there is more than enough in the evidence in the record, in my view, to support the factual findings of the court *a quo*, and to support additional bases upon which the court could have found for Ms M[...].

[37] Even the common cause propositions put forward by the respective experts in their joint minutes already come close to making out a sufficient case for Ms M[...].

[38] The following common cause propositions from the joint minutes ought to be highlighted in this regard (with some observations relating to how the evidence affected them in some cases):

38.1. The joint minute of Dr Stevens and Dr Marishane:

"10. There was no other follow up wrt her episiotomy even though Ms M[...] was HIV and high risk for infection and the symptom of pain persisted."

38.2. The joint minute of Profs Nolte and Du Plessis:

¹¹ See for example the observations by the Constitutional Court in *President of the Republic of South Africa and Others v South African Rugby Football Union and Others* 2000 (1) SA 1 (CC) paras 77 to 80.

¹² See the seminal decision of *Trencon Construction (Pty) Ltd v Industrial Development Corporation of South Africa Ltd and Another* 2015 (5) SA 245 (CC).

“3. The clinic sisters who were in contact with Ms M[...] during the postpartum period did not examine the episiotomy area for signs of infection and tissue breakdown, especially when the mother complained about continuous pain in the episiotomy area”.

3.1. The patient was not timeously referred to a doctor.”

[Here it is important to note that it was conceded in evidence that, given that she was indeed seen by a doctor at six weeks, this observation was unfair]

38.3. The joint minute of Dr Rawlins and Dr Fourie:

“No clinical notes could be found on the clinical examination that was performed on Mrs M[...] on 26 November 2013 or during the operation on 7 February 2014.

A digital anorectal examination should have been done to assess for possible sphincter injury.”

[I deal below with the findings and evidence in regard to such an examination]

“By performing a proper clinical evaluation and examination on Mrs M[...], the delay in diagnosis and treatment could have been prevented”.

[39] What was of concern in this matter and has been reported as of concern in several such cases, was the absence of medical records indicating precisely what was done and not done when. In *Mashele*,¹³ Gilbert AJ referred to two important judgments in this regard, both called *Khoza*,¹⁴ but entailing different patients, in which the court examined the extent to which the absence of records tended to redound to the detriment of the defendant health practitioners and institutions, in the drawing of inferences, rather than to their benefit, despite the incidence of the onus of proof.

[40] In the present case, there were records relating to the episiotomy. But the nurses neglected to record whether there was a first, second or third degree tear. The expert evidence explained that an episiotomy itself would entail a second degree tear (as it entailed an incision of the vagina), whereas a third degree tear endangered the anus and required a doctor to attend to the suturing (stitching).

¹³ See footnote 5 above, at paras 157 to 162.

¹⁴ *Khoza v MEC Health* 2017 JDR 1912 (GJ) Van der Linde J paras 25 to 34; *Khoza v MEC Health* 2015 (3) SA 266 (GJ) paras 30 to 47.

[41] There was no record of any digital anorectal examination having been performed on Ms M[...] *at any stage*. The experts all agreed this should be done after the episiotomy, to test whether the stitching might have compromised the anus. This ought also to have been done before the fistulectomy. And the evidence is powerful that it ought to have been done somewhere between the episiotomy and the fistulectomy given the abnormal pain that was being reported as experienced at three days and six weeks and especially during defecation. Ms M[...]’s evidence was that it was not done. It seems that the conclusion that it was not done at the episiotomy or anywhere between the episiotomy and fistulectomy is not only warranted, but more consistent with the probabilities and the evidence as a whole than the contrary.

[42] Regarding the anorectal digital examination around the time of the fistulectomy, an unusual aspect became apparent. The MEC initially cross-examined based on Dr Kiss performing the surgery and examination. However, it was later revealed through handwritten notes that Dr Francis actually performed the operation, and Dr Kiss was unsure if he was present. When questioned about performing a digital anorectal examination in January 2014, Dr Kiss stated such an exam would not necessarily be recorded, but agreed that standard practice was "if it's not recorded, it's not done." He vacillated between asserting he had performed the exam and admitting it was possible he had not, ultimately conceding that his initial statement may have been incorrect and acknowledging he had no specific recollection nearly ten years after the event. None of this was helpful to the MEC’s case on the issue of an anorectal examination.

[43] During the fistulectomy, Ms M[...] was awake under spinal block and testified that only visual examination was performed. Dr Francis stated that a digital anorectal exam is standard practice but admitted in cross-examination he remembered only the notes, which did not mention such an exam.

[44] There was a more disconcerting feature in the evidence relating to the condition of Ms M[...] when she was referred to the colo-rectal unit for the fistulectomy. Dr Kiss was adamant that, had there been any suspicion of an anal

sphincter laceration, someone in the colorectal unit would have recorded it prior to the fistulectomy. He said that because there was no such recording nobody suspected anything like that. Late in the testimony of Dr Francis, under cross-examination, Dr Francis appears to have become agitated and emphatic. He then volunteered as a “fact” that Dr Kiss had made him understand that a consultant at the gynaecological unit had advised him (Dr Kiss) that Ms M[...] had been referred to the colorectal unit because of a “*missed third degree tear*”. It was entirely unclear when Dr Kiss conveyed this to Dr Francis. It understandably caused some consternation in Ms M[...]’s ranks. Dr Francis could not explain why Dr Kiss had said nothing about this when cross-examined about suspicions relating to anal involvement before the operation, and instead insisted had there been any such suspicions, they would have been recorded. If Dr Kiss had meant to draw a distinction between a sphincter laceration and a third degree tear into the anus, he certainly did not do so expressly, or at least not in any sense forthrightly. Dr Francis sought to find references to the third degree tear in the records, and opined that a record that “*the sinus was getting bigger*” had to be understood as reference to a third degree tear – something with which Dr Fourie, the colorectal surgeon called by the defendant, emphatically disagreed.

[45] Suffice it to say that none of this assisted the MEC in mounting a challenge to the findings *a quo*.

[46] That leaves an aspect that formed an important part of the challenge to the findings *a quo* on the fistulectomy itself. The court *a quo* held that Dr Francis had conceded that the condition in the affected area was such that he could not properly make out the anatomy to avoid cutting the sphincter muscle. This condition was held to have been caused by the sepsis that had been allowed to develop due to insufficient testing and flagging of any potential anal involvement flowing from a medial episiotomy that had yielded intense pain on defecation at three days and six weeks. This was the reason the fistula was there in the first place.

[47] Ms *Masevhe* submitted this was a misinterpretation of the evidence of Dr Francis and pointed to a passage in his evidence where he said one could make out the red structure of the anal sphincter quite readily.

[48] It is true that Dr Francis said this. But it is also true that he volunteered, twice in the evidence, that his visual ability to identify the anatomy was compromised by the degree of sepsis present. When he got agitated on being pressed about this, he offered the following apparently significant and passionate testimony:

“... there is no way, imagine every time you make an incision or put your finger in there is nothing but thick pus that comes out. Would you be able to identify anything? How do you tell the difference using a digital exam, how do you tell the difference between a pus filled area and a muscle that is literally 4 to 5 millimetres thick? You have to be superhuman Advocate to be able to identify structures in the sight (sic) of sepsis in an area that is 2 centimetres and muscle structures that are literally 4 to 5 millimetres half a centimetre thick with your finger. It is, I am sure you appreciate how difficult the [indistinct] are of surgery in the perineum. You are trying to avoid blood vessels you are trying to drain the pus if she does not become more severely septic with necrotising pusiate (sic) this or worse with systemic sepsis that knocks out the kidneys. You try and get it in such a way that you do not destroy the structures that her vagina will still work, that the anus will still work after the fact that you are literally in an area that you could fit into a matchbox.”

[49] This was after the witness had earlier volunteered, when asked if there was any involvement of the sphincter,

“So we did not encounter at that stage any identifiable muscle but remember this area was distorted by the sepsis the longstanding sepsis. So anatomy was not the greatest in this area...”

[50] This was one aspect where the observation by the trial judge of the demeanour was indeed important. The impression formed by the trial judge of this evidence was that this witness indicated he could not see as well as he would have liked because of all the sepsis.

[51] Dr Fourie, the colorectal expert called by the MEC, herself testified that the sepsis would have made it difficult to identify the anatomy and this made for a

difficult operation. She testified she would in these circumstances have drained the pus with a seton instead of performing the fistulectomy then and there.

[52] There was, in my view, more than enough of a basis in the evidence for the relevant finding *a quo*, that the condition that had been allowed to develop was such at the time of the fistulectomy that it made the operation difficult and materially contributed to the cutting during the fistulectomy of the sphincter muscle.

[53] In summary, strong evidence suggests anal involvement during the episiotomy was overlooked and unrecorded, necessary examinations and follow-ups were not conducted, and complaints of severe pain were ignored, leading to a dangerous fistula. The lack of proper examination before the fistulectomy resulted in cutting the anal sphincter and subsequent faecal incontinence. This conclusion accurately reflects the findings of the court *a quo*, and I find no fault with it.

[54] I must note that the proposition put forward by Dr Marishane for the MEC, that it was highly unlikely that the sinus, abscess and fistula had anything to do with the episiotomy, was so out of kilter with the relevant expert evidence of all the other experts that it was rightly rejected *a quo*.¹⁵ At the appeal, *Ms Masevhe* correctly conceded as much.

ORDER

[55] In the circumstances the appeal is dismissed with costs on scale B.

SNYCKERS AJ
ACTING JUDGE OF THE HIGH COURT
JOHANNESBURG

I agree

SENYATSI J

¹⁵ “Dr Marishane’s evidence contradicted the experts and did not clarify the position or assist other than to deny any statements put to him” - para 27.

**JUDGE OF THE HIGH COURT
JOHANNESBURG**

I agree

**MAHOMED J
JUDGE OF THE HIGH COURT
JOHANNESBURG**

Heard: 13 August 2025

Judgment: 26 August 2025

For appellant: T Masevhe

Instructed by: State Attorney Johannesburg

For respondent: LCM Morland

Instructed by: Houghton Harper Johannesburg