IN THE HIGH COURT OF SOUTH AFRICA
EASTERN CAPE LOCAL DIVISION – PORT ELIZABETH

Case No: 273/2013

In the matter between:

F M Plaintiff

and

MEMBER OF THE EXECUTIVE COUNCIL,
DEPARTMENT OF HEALTH, EASTERN CAPE Defendant

JUDGMENT

REVELAS J:

[1] On 2 March 2010 the plaintiff underwent surgery (a laparoscopic cholecystectomy, i.e. o the removal of her gallbladder) at the Livingstone Hospital in Port Elizabeth. During this surgery, she sustained injuries (two perforations, 2mm in diameter) to her common bile duct as a result of which bile leaked into her abdominal cavity, causing her to become very ill. She was readmitted to the Livingstone Hospital, on 9 March 2010, suffering from acute bile peritonitis. On

11 March a second operation was performed to repair her bile duct. The plaintiff was in the hospital's intensive care unit for 9 days and remained in hospital for two weeks. The plaintiff subsequently, during 2013, instituted an action against the defendant for damages.

[2] It was not in dispute that Dr Vogel, the surgeon who performed both procedures and the other hospital staff who assisted him, acted within the scope and course of their employment with the defendant. Therefore, if the plaintiff succeeds in establishing a delict, the defendant would be vicariously liable for the plaintiff's damages.

[3] The present proceedings were concerned only with the question of liability since a separation of the merits and quantum was ordered by agreement between the parties.

[4] The plaintiff's case was that, in causing the injury, the defendant's employees, who bore a duty to conduct a proper surgical procedure with reasonable professional care, failed in that duty and were therefore negligent. Had the cholecystectomy been performed correctly, and with the correct instruments, she maintained that her common bile duct would not have been injured.

[5] The defendant's defence to the plaintiff's allegations was firstly, the plaintiff had accepted the risks or possible complications inherent in a procedure of this nature, which were explained to her prior to surgery, and to which she consented in writing. Secondly, the defendant disputed that there was any negligence on the part of any of its employees, and in particular Dr Vogel who performed the procedure. The plaintiff disputed that she could have consented to an injury to her bile duct or to negligence.

[6] In 2009, the plaintiff had presented with symptomatic gallstones which necessitated the removal of her gallbladder, a common treatment for her ailment. An operation to remove the gallstones was scheduled for 25 January 2016, but had to be rescheduled to 2 March 2016, because she was suffering from a respiratory tract infection.

[7] It was not in dispute that the decision to remove the plaintiff's gallbladder by performing a cholecystectomy was correct. It must be noted there that it was common cause between the parties that the refusal of the surgery was not a reasonable option for the plaintiff as the operation was necessary.

[8] The plaintiff was forty-one years old when she underwent the surgery presently under discussion. She has two children, both born by caesarian section. She suffered from bronchial asthma and as a young woman, she suffered from tuberculosis that was cured with medical treatment. The plaintiff testified that prior to her operation no one explained the nature of the risks of the operation to her and only after the operation was performed, she learnt, to her surprise, that she had undergone a laparoscopic or *"laser operation"*. After her discharge from the hospital on 3 March 2010, she went home to recuperate but became very ill on 8 March 2008. Hence her readmission on 9 March 2010. Apart from being told that her bowels were obstructed, the plaintiff said she was never provided with any information regarding her problem. She was however told by one of the hospital personnel that Dr Vogel had committed an error during her operation. She testified that she took his hands in hers and told him that since he made a mistake he should perform the repair operation.

[9] A laparoscopic (keyhole or *"minimum access"*) cholecystectomy procedure involves the insertion of four small operating ports and a gastric tube through very small incisions in the abdominal wall. A telescopic video camera and surgical instruments (in tubes) are placed

through the operating ports. The camera is placed into the abdominal cavity from where it sends an enlarged image of the inside of the abdominal cavity to a screen, providing a close up, two-dimensional view of the tissues and organs inside the cavity. The surgical procedure is then performed by manipulating the surgical instruments through the operating port. The gallbladder is removed by dissecting the cystic duct, to which the gallbladder is attached. The gallbladder is placed into a plastic bag and pulled through one of the ports – usually the one below the patient's bellybutton.

[10] When a laparoscopic procedure is not possible to perform, the only alternative surgery is an open cholecystectomy, which is a more invasive procedure, where the gallbladder is removed through a much larger, Kocher's incision in the abdominal wall and tissues. The latter used to be the standard procedure, but has been largely replaced by the former. Sometimes, for various safety and technical reasons a laparoscopic cholecystectomy is converted into an open cholecystectomy.

[11] Each party relied on the testimony of one independent expert witness. Dr B H Pienaar was called to testify on the plaintiff's behalf and had also prepared a medico-legal report which prefaced his

evidence in court. The defendant's expert witness, Professor P C Bornman, similarly prepared a medico-legal report setting out the opinions he would be called upon to testify about. It was accepted that both Dr Pienaar and Professor Bornman were both highly qualified and respected surgeons who were very experienced as academics and surgeons and both had particular, specialized knowledge of *inter alia,* gallbladder removals and the repair of common bile ducts. The two experts met with the view to find areas they could agree upon to narrow the issues between them, but each adhered to his opinion regarding the question of alleged negligence on the part of Dr Vogel.

[12] Dr R J Vogel is also an expert witness, but since he has a vested interest in the outcome of this matter, he ought not to be categorized as an independent expert witness. However, his testimony about the procedure in question and his experience in laparoscopic surgery remains highly relevant.

[13] The experts agreed on most aspects regarding the procedure which ought to have been followed in an operation such as the one under discussion, but disagreed on those aspects, which , if an error occurred, would constitute negligence. They did however, find common

ground on some aspects which were recorded in the minute of their joint pre-trial meeting. These were:

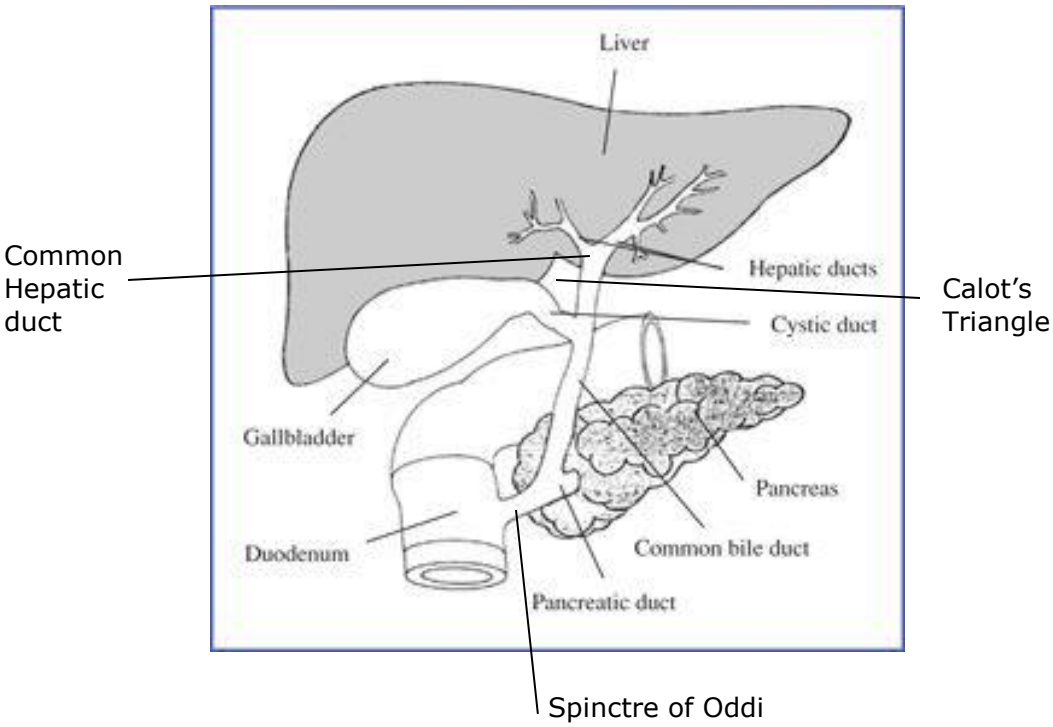
(a) The injury to the common bile duct occurred during the laparoscopic cholecystectomy performed by Dr Vogel and/or other employees during the aforesaid procedure.

(b) The injuries were most likely inflicted or caused by Dr Vogel and/or other employees during the execution of the procedure.

(c) There were two defects in the common bile duct, i.e. the two minor perforations.

(d) The injury occurred due to a mechanical laceration with an instrument or it was an electrothermal injury caused by a failure to properly insulate the electrocautery device used during the operation.

[14] For purposes of convenience and proper understanding of the evidence, the relevant areas surrounding and including the gallbladder, liver and the bile duct are shown in the image below:



[15] Dr Pienaar is a principal specialist at the University of Pretoria and Steve Biko Academic Hospital where he is head of its colo-rectal and laparoscopic surgical unit. His department was instrumental in the establishing of the laparoscopic cholecystectomy procedures in South Africa and he was the first surgeon in the country to perform such an operation. He still performs the procedure regularly, and also with *"some regularity"* repairs bile duct injuries. He has been a practicing specialist for the last 27 years. He also has experience in litigation dealing with this type of *"Expert and Professional Witnessing"* which he

obtained in 2001 from the University of Pretoria. He has never caused any injury to a bile duct.

[16] Professor Bornman is formally retired but is an Emeritus Professor of Surgery at the University of Cape Town. He has also performed hundreds of procedures of the type under consideration. Like Dr Pienaar, he has also published several papers, received many awards and worked in numerous other countries. He has extensive experience in several areas. Dr Vogel had also worked under him at Groote Schuur Hospital as a young man.

[17] Dr Vogel obtained his degree in medicine (MBChB) in 1989 from the University of Cape Town. Since December 2005 he has held the position of Principal Specialist-General Surgery at the Livingstone Hospital. Prior thereto he held positions at Groote Schuur and Victoria Hospitals in Cape Town, Charing Cross Hospital in London (as Specialist Registrar – Gastrointestinal Surgery), the Prince Phillip Hospital, Wales (Specialist Registrar – General and Colo-rectal Surgery). Dr Vogel has also performed hundreds of laparoscopic cholecystectomies. He testified that the bile duct injury in question, was the first he had come across in his career.

The Plaintiff's Expert Witness

[18] Dr Pienaar was of the opinion that the iatrogenic bile duct injury in question, was caused negligently, because with the application of care, diligence and skill of a reasonable surgeon, if applied by Dr Vogel and the other employees of the defendant during the operation, would have averted the injury of the common bile duct. He also was of the opinion that an open cholecystectomy should have been performed from the onset, instead of opting for a laparoscopic cholecystectomy, alternatively the procedure initially adopted by Dr Vogel (the laparoscopic cholecystectomy), ought to have been converted to an open cholecystectomy. His criticism were premised on the following:

[18.1] Dr Pienaar emphasized that the injury to the common bile duct was not noticed by Dr Vogel or any member of his team while the operation was in progress, nor when it was being finalized. He noted in his report that *"an injury caused and not recognized by the surgeon is regarded as negligence, and major pay-out medical negligence claims*

are usually settled out of court for substantial amounts of money due to the devastating long term effects of iatrogenic bile duct injuries".

[18.2] The procedure lasted for 80 minutes, which he viewed as far too long and a clear indication that difficulties, such as poor visibility, were experienced by the surgeon (Dr Vogel) who ought to have converted to an open cholecystectomy once he encountered these difficulties. According to Dr Pienaar this type of operation should only last 30 – 35 minutes.

[18.3] Dr Pienaar also doubted that the injury to the bile duct could have consisted merely of the two perforations in question, based on the fact that the plaintiff spent nine days in intensive care, her poor condition and the large volumes of bile that had to be aspirated from her suggested that the injuries were of a more severe nature and extent than two *"punctures",* as he put it. He also stated that if the injuries were indeed only two perforations as suggested by Dr Vogel's notes made when conducting the second repair operation, one would have expected less bile. The plaintiff drained in excess of 200ml daily. He also opined that aspiration or drainage could have been effected laparoscopically by inserting a stent at the Spinctre of Oddi, if the injuries were minor. The whole repair procedure, he believed lasted far

too long (60 minutes) in his view, and would have been performed laparoscopically, and not by way of open surgery if the injuries were indeed of a minor nature.

[19] It is common cause that the second repair operation, had commenced as a laparoscopic procedure but was converted to open surgery.

[20] In his report Dr Pienaar opined that *"in all likelihood"* the injuries were caused by a defective electrocautery device used during the procedure, which caused *"back burn"* injuries. This ought to have been noticed by the team. According to Dr Vogel, who said he did not know how the injury occurred, the theatre staff checked the instruments. It was not ruled out that the injury was caused by Dr Vogel dissecting in the region of the common bile duct, as suggested by the joint minute of the expert witnesses' meeting. One of the alleged failures on the part of Dr Vogel, which constituted negligence, according to the plaintiff, was that he failed to ensure that the electrocautery device used during the procedure was properly insulated.

[21] The use of sharp instruments during the operation is essential for obvious reasons. Blades, needles and other sharp instruments are inserted through the operation ports, in tubes from which they can be retracted. These sharp instruments are potentially hazardous and may cause mechanical laceration of the wrong structure organ. No sharp instrument should therefore be in the vicinity of the common bile duct or any of the other vital ducts. As can be seen from the image reproduced above, there is an area called Calot's Triangle (the triangle is the triangular space formed by the surrounding common bile duct, cystic duct, and hepatic ducts). According to all the experts who testified, Calot's Triangle is a dangerous area. Dr Pienaar termed it a *"no-go area"* and stated that if the common bile duct was cut with a sharp instrument, it can only mean that a sharp instrument was unnecessarily introduced into Calot's Triangle near and too near the common bile duct, which means negligence on the part of the surgeon.

[22] Dr Pienaar explained that it was possible for a surgeon, to sometimes open the common bile duct, but that would be deliberate act in a planned procedure, for a specific reason. During a cholecystectomy the surgeon's instruments must be as far away from the common bile duct as possible. Good visibility was a primary concern in any laparoscopic procedure. The cardinal rule (one of "*The*

Ten Commandments" of gallbladder removals) is to properly identify the organs and anatomical structures. For instance, poor visibility caused by adhesions could result in the wrong structure being identified. A bile duct may be mistaken for a cystic duct (the cystic duct is divided when the gallbladder is removed). Poor visibility would be a good reason to convert to open surgery. All three experts were in agreement that the aforesaid rules applicable to the procedure in question. As I understood it, these rules were common practice followed by all surgeons. The experts agreed on virtually everything pertaining to the procedure in general, except on the aspect of when negligence could be inferred.

[23] Dr Pienaar concluded that any injury to the bile duct not intended during a laparoscopic cholecystectomy, whether caused by the surgeon or by his defective instrument, is due to negligence. Dr Pienaar was also of the view that informed consent by the plaintiff did not constitute a proper defence as the risks of the procedure ought to have been conveyed to the plaintiff in writing.

<u>The Defendant's Case</u>

[24] Professor Bornman could not agree with the conclusions reached by his colleague. He believes that one should distinguish between major injuries and minor injuries. As a starting point, he testified that a surgeon embarking on the procedure in question must ensure, before dividing any structure, that the relevant anatomy has been identified properly. He stated that it was generally accepted that a surgeon who divides the bile duct during the procedure in question has done so negligently because he identified the wrong structure. To put it plainly, if the surgeon confuses the cystic duct with the bile duct, the only possible explanation is that he failed to properly identify the correct duct. He emphasized that Dr Vogel had identified the correct structure (the cystic duct) he intended to dissect. Therefore there was no confusion caused by a failure to identify the structure correctly from the beginning of the operation. Accordingly, there could be no negligence, since the rest of the operation was properly performed.

[25] When preparing his medico-legal report, Professor Bornman had due regard to Dr Pienaar's opinions and carefully, in a very structured manner, dealt with each of Dr Pienaar's assertions.

[26] The fact that the bile duct injury was not detected at the time of the operation was, according to Professor Bornman, not an indication

of negligence. He stated that it is well recorded that such injuries are missed in the majority of cases. An injury of this nature would have been even more difficult to identify unless there was a bile leak at the time, and none was noted by Dr Vogel.

[27] In response to the inferences drawn by Dr Pienaar in respect of the duration of the procedure (80 minutes), Professor Bornman pointed out that the time it takes to complete a laparoscopic cholecystectomy may vary greatly from case to case. He added that 80 minutes is an acceptable time to perform the operation in the presence of adhesions. Professor Bornman also, with reference to recent studies where more than half of the bile duct injuries occurred during a conversion to open surgery, added that a conversion to open surgery is not always the answer to dealing with adhesions. Dr Vogel was of the opinion that Dr Pienaar's estimate of a minimum period of 30 minutes for the execution of the procedure was unrealistic.

[28] Plaintiff was clearly in poor health after the operation. Bile peritonitis is a most unfortunate and very serious condition to be suffering from. Professor Bornman, who works in a department at Groote Schuur, which is mostly concerned with bile duct repairs, did not consider the plaintiff's condition inconsistent with a minor injury. A

major injury to the bile duct would have caused the plaintiff to present with drastic symptoms and much sooner than six days after the procedure.

[29] With regard to Dr Pienaar's conclusions about the possible causes for the injuries (too close dissection with an electrocautery device or a fault in the hook diathermy instrument) Professor Bornman opined that the injury could have been caused by a *"teasing method"* when inflamed tissue around the cystic duct and Calot's Triangle is *"stripped downwards"* with blunt dissection to obtain a critical view of safety before clipping and dividing the cystic duct. Dr Vogel believes this is how the procedure was indeed performed. Professor Bornman conceded that in the present case, dissection must have occurred too close to the bile duct causing the injury, (by whatever method). He added that it may sometimes be difficult *"to avoid this level of dissection to achieve safe removal of the gallbladder without causing a major injury to the bile duct".*

[30] Professor Bornman regarded Dr Pienaar's theory that the injury to the bile duct must have been far more serious than the two punctures, as *"conjecture"*. Firstly, he explained, the fact that no stenting was done (which would have been the procedure with a minor

injury) could be challenged because *"[t]he open repair had to be done because of the inability to place a stent at the time of the ERCP"* (the second procedure). Secondly, the large volumes of bile drained from the plaintiff did not necessarily indicate more extensive injuries. He pointed out that bile is very thin, not unlike water, and large quantities can leak through to small perforations. It would depend on many factors.

[31] As to the plaintiff's long stay of 14 days in hospital, Professor Bornman pointed out that there was nothing *"inordinate"* about the delay of 36 hours before the repair was done. The right diagnosis first had to be found. Professor Bornman concluded that all the correct steps were taken by Dr Vogel and his team. He also pointed out that in some instances, a surgeon has to dissect out of Calot's Triangle in order to identify and find the cystic duct and artery, in which case the dissection would be close to the bile duct. In such circumstances he believed it would be harsh to criticize the surgeon for being in that area. Professor Bornman testified that he himself has never caused a bile duct injury because he followed the rules. Counsel for the plaintiff also pointed out that according to Dr Vogel's operation report, he incorrectly used the hook diathermy after the cystic duct was divided when he removed the gallbladder. Professor Bornman

conceded that this was not what he taught, but he did not regard it as negligence.

[32] Professor Bornman agreed with Dr Pienaar that in principle that in many cases an injury of this kind can be regarded as neglectful, but qualified this statement by adding that negligence is usually associated with major bile duct injuries where there was complete bile duct transection. In other words the wrong duct was identified (i.e. the cystic duct was missed). Professor Bornman believed that the injury in question was minor, if one looks at the whole case in its totality. Since nothing can be perfect in surgery, he concluded that Dr Vogel was not negligent.

[33] Dr Vogel explained that when operating in Carlot's Triangle, as is done in some cases, the tissue is teased off with a blunt, slight curved forceps to expose the cystic duct and artery. This had to be the case in the procedure in question. Hook diathermy was used according to his notes, to remove the gallbladder off the liver bed or surface (the fossa). He emphasized that it is most important, when dissecting in Calot's Triangle, is to dissect the cystic duct on the gallbladder side of the cystic duct and keep away from the common hepatic duct and the common bile duct. He also explained that fatty tissue or fibrosis may

impair one's view, but the position of those ducts must always be ascertained. He testified that he always followed these rules, and that is consistent with his track record.

[34] It was common cause between the experts that after the cystic duct and gallbladder are separated by dissection, two clips are placed on the cystic duct and artery. Thereafter the gallbladder is extracted through the umbilical port (in a plastic bag). This was done in the present matter.

[35] In a nutshell, the disparate views held by the two experts can be summoned up as follows: Dr Pienaar believes that any injury to the bile duct, whether caused by the surgeon or by a defective instrument, is negligent *per se*. Professor Bornman believes that negligence on the part of the surgeon ought to be inferred with due regard to the severity and extent of the injury to the bile duct.

Legal Principles

Experts

[36] A court faced with conflicting opinions of experts in highly scientific or technical issues, must determine whether and to what

extent the opinions advanced by the experts are founded on logical reasoning or has a logical basis.[1] In *Medi-Clinic v Vermeulen*[2] the Supreme Court of Appeal held that what is required in the evaluation of the expert's evidence is to determine to what extent:

> "Provided a medical practitioner acts in accordance with a reasonable and respectable body of medical opinion, his conduct cannot be condemned as negligent merely because another equally reasonable and respectable body of medical opinion would have acted differently."

[37] Credibility hardly plays any role in this determination.[3] In this matter it is especially true since the experts were both very experienced specialists in their field and they agreed on everything except on the question of what type of surgical error error would constitute negligence.

Negligence

[38] In *Mitchell v Dixon*[4] the following was said with regard to medical negligence:

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[1] *Michael and Another v Linksfield Park Clinic (Pty) Ltd and Another* 2001 (3) SA 1188 (SCA) paras 36 and 37. *Louwrens v Oldwage* 2006 (2) 161 (SCA) para 27.
[2] 2015 (1) SA 241 (SCA) at 243 para 5.
[3] *Brink Diesel Cape v O J Fishing (Pty) Ltd* (unreported WCD appeal decision, Case No. A584/08) at para 20.
[4] 1914 AD 519 at 525

> "A medical practitioner is not expected to bring to bear upon the case entrusted to him the highest possible degree of professional skill, but he is bound to employ reasonable skill and care…."

[39] In my view, Dr Pienaar's approach leaves no room for human error, which logically, not all surgeons may manage to escape. It was not in dispute that Dr Vogel had performed approximately 500 operations of the type under discussion, and that the injury to the plaintiff's bile duct was his first error of this nature. In the absence of any proof to the contrary, I am bound to accept that Dr Vogel's observation (as noted down by him during the repair procedure) that the injury comprised of two small perforations.

[40] Based on all the evidence presented, the error in question seems to be one that any reasonably competent practitioner in Dr Vogel's field could also have made. Dr Pienaar's reasoning is simply put, that the injury to the bile duct would not have occurred if Dr Vogel was not negligent and since the injury did occur, Dr Vogel was negligent. He therefore, in my view, set an unreasonably high standard for surgeons. Errors do occur. That is human nature, and to hold that all such errors constitute negligence would be dogmatic and unrealistic. The following

dictum by Brand JA from *Buthelezi v Ndaba*[5] is most apt in the present circumstances:

> "After all, as Lord Denning MR observed in *Hucks v Cole* [1968] 118 New LJ 469 ([1993] 4 Med LR 393):
>
> > 'With the best will in the world things sometimes went amiss in surgical operations or medical treatment. A doctor was not to be held negligent simply because something went wrong.'
>
> Or as Scott J said in *Castell v De Greef* 1993 (3) SA 501 (C) at 512A – B:
>
> > 'The test remains always whether the practitioner exercised reasonable skill and care or, in other words, whether or not his conduct fell below the standard of a reasonably competent practitioner in his field. If the error is one which a reasonably competent practitioner might have made, it will not amount to negligence.'
>
> [16] Turning to the conflicting views of the respective experts, it appears that Prof Green-Thompson's underlying reasoning departs from the inference that the injury to the respondent's bladder would not have occurred if the appellant was not negligent. To me that seems reminiscent of an application of the *res ipsa loquitur* maxim, which the court a quo quite rightly found inappropriate in this case. I say quite rightly because, as was pointed out in the locus classicus on medical malpractice, *Van Wyk v Lewis* 1924 AD 438 at 462, that maxim could rarely, if ever, find application in cases based on alleged medical negligence. The human body and its reaction to surgical intervention are far too complex for it to be said that, because there was a complication, the surgeon must have been negligent in some respect. Logic dictates that there is even less room for application of the maxim in a case like this, where it has not even been established what went wrong; and where the views of experts are all based on

[5] 2013 (5) SA 437 SCA at para 15 – 17.

> speculation — giving rise to various but equally feasible possibilities — as to what might have occurred."

[41] Professor Bornman also held the view that a surgeon having taken all steps to avoid any injury to the bile duct, could inadvertently cause a minor hole or a minute hole in the bile duct. By labelling the aforesaid error as *"negligent"*, under *any* circumstances would be setting the bar too high, i.e. holding a surgeon to unattainable or unrealistically high standard. Having considered all the evidence I am unable to reject Professor Bornman's opinions. They appear to be more in keeping with the test for negligence in matters where medical negligence is considered. Professor Bornman also appeared to be a very objective expert. One only has to compare the experts' reports to reach this conclusion As was pointed out in *Medi-Clinic*[6]:

> "Experts may legitimately hold diametrically opposed views and be able to support them by logical reasoning. In that event it is not open to a court simply to express a preference for the one rather than the other and on that basis to hold the medical practitioner to have been negligent. Provided a medical practitioner acts in accordance with a reasonable and respectable body of medical opinion, his conduct cannot be condemned as negligent merely because another equally reasonable and respectable body of medical opinion would have acted differently."

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[6] At 243, para 5.

[42] Certainly Professor Bornman embodies and represents a responsible body of medical opinion as referred to in *Medi-Clinic* and I am satisfied that in forming his views, Professor Bornman adopted a logical and balanced approach to the matter and had directed his mind to the question of comparative *"risks and benefits and reached a defensible conclusion".* [7]

Informed Consent

[43] The plaintiff signed various forms consenting to medical procedures, wherein the nature, risks, and consequences of the procedures were referred to. Dr Vogel testified that he had no specific recall of what he told the plaintiff, but he stated that it is his practice to always explain the risks to the plaintiff and therefore he must have explained the risks to the plaintiff. Other practitioners at the hospital also noted that they had advised the plaintiff of the risks of the procedure.

[44] According to the plaintiff, no risks were explained to her. The plaintiff did not strike me as a very reliable witness, mostly because

[7] At 244, para 7.

she did not give her evidence in a cogent manner. She was prone to exaggeration and at times her evidence was plainly incomprehensible. In any event, the question of informed consent is attached to the requirement of wrongfulness in the Aquilian action. Negligence on the part of a surgeon will be wrongful if the patient did not give informed consent. As negligence is still a requirement, where no negligence has been proved, as in the present case, the question of wrongfulness does not arise.[8]

[45] Since no negligence on the part of the defendant's employees could be established, the plaintiff's claim cannot succeed. Consequently, the following order is made:

> The plaintiff's action against the defendant is dismissed with costs.

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E REVELAS
Judge of the High Court

[8] *Castell v De Greef* 1994 (4) SA 408 (C) at 426 D – H.

Appearances:

For the plaintiff:	Adv D Niekerk instructed by Swarts Attorneys, Port Elizabeth
For the defendant:	Adv B Pretorius instructed by State Attorney, Port Elizabeth

Date delivered: 13 December 2016