REPUBLIC OF SOUTH AFRICA

IN THE HIGH COURT OF SOUTH AFRICA

LIMPOPO DIVISION, POLOKWANE

CASE NUMBER: 10146/2022

(1) REPORTABLE: ~~YES~~/NO

(2) OF INTEREST TO THE JUDGES: ~~YES~~/NO

(3) REVISED.

DATE 17 June 2025

SIGNATURE

In the matter between:

B[...], N[...] O[...] **1ST PLAINTIFF**

B[...], P[...] **2ND PLAINTIFF**

-and-

THE MEMBER OF THE EXECUTIVE COUNCIL FOR DEFENDANT

HEALTH OF THE LIMPOPO PROVINCIAL COUNCIL

Delivered	:	**17 June 2025** This judgment was handed down electronically by circulation to the parties' legal representatives by e-mail. The date and time for hand down of the judgment is deemed to be **17 June 2025** at **00:00 am**.
Date heard	:	**17 and 18 March 2025**
Coram	:	**Bresler AJ**

JUDGMENT

BRESLER AJ:

Introduction:

[1] The First Plaintiff is the mother and natural guardian of the minor child, T…N…B…B (the 'minor child'), born on the 19th of July 2019. She sues in her personal capacity and in her representative capacity aforesaid. Likewise, the 2nd Respondent sues in his capacity as father and natural guardian of the minor child. He abandoned the claim in his personal capacity and the objection against his *locus standi* as father and natural guardian was abandoned by the Defendant after receipt of a report from a pathologist confirming his paternity.

[2] The Defendant is cited in her capacity as MEC responsible for the administration of the Department of Health of the Limpopo Provincial Government.

[3] The First and Second Plaintiff (jointly referred to the 'Plaintiffs') claims damages from the Defendant predicated on the Defendant's breach of its legal duty to render proper and appropriate medical treatment and exercise the degree of skill and care which can reasonably be expected of a nurse or medical practitioner in the prevailing circumstances.

[4] It is the Plaintiffs' case that during the period after the First Plaintiff's admission to FH Odendaal Hospital, and before the minor child's birth on 19 July 2019, and thereafter until the time of his discharge, the minor child suffered a global hypoxic ischemic injury to his brain (the 'injury). As a result of the brain injury, the minor child suffers from the following conditions, and which conditions were not present in the minor child as an unborn foetus:

4.1 Pseudobulbar palsy;
4.2 Cognitive impairment with behavioural difficulties; and
4.3 Dyspraxic clumsiness.

[5] The *crux* of the Plaintiffs' case is premised on the failure by the nursing and medical staff to correctly diagnose the breech presentation of the minor child timeously and to immediately expedite delivery by caesarean section. The Plaintiffs furthermore plead that the nursing and medical personnel at FH Odendaal Hospital failed to keep proper and accurate records relating to the care and treatment of the minor child. The actions and / or failure to act by the nursing and medical personnel therefore caused the damages being suffered by both the minor child and the Plaintiffs.

[6] The Defendant essentially pleaded a denial of the breach of the legal duty. The Defendant furthermore pleads that the Defendant's medical staff acted with the utmost care and diligence towards the First Plaintiff and the minor child, and that access was provided to adequate healthcare and emergency medical treatment.

[7] Curiously, the Defendant appears to plead that the First Plaintiff had an obligation to inform the medical staff that the minor child was in a breech presentation upon arriving at FH Odendaal Hospital, which she failed to do. No legal basis is however pleaded for this alleged obligation. Be that as it may, the Defendant furthermore pleads that a breech presentation can still be delivered vaginally. When the First Plaintiff was about to be taken to the theatre for an emergency caesarean section, the doctors observed that it was no longer a viable option, and the First Plaintiff was then moved to the labour ward for a vaginal delivery.

[8] It is the Defendant's case that the First Plaintiff caused the caesarean to no longer be a viable option as she expedited the vaginal birth by bearing down after being told not to do so.

[9] At the commencement of the Trial, Adv Maritz SC on behalf of the Plaintiffs, recorded *inter alia*:

9.1 That the parties have reached agreement as to the separation of issues, provided the Court approved, as stated in paragraph 2 of the Pretrial minute pertaining to the Pretrial meeting held on the 3rd of February 2025;

9.2 The Plaintiffs and the Defendant have furthermore agreed that the joint minutes between the various experts be placed on record as formal admissions, as contemplated in the **Civil Proceedings Evidence Act,** Act 25 of 1965.

9.3 The parties furthermore agreed that, with reference to the discovered medical records kept by and obtained from the Defendant, including ultrasound scan printouts, pathology reports, hospital records and the

notes and observations of the nursing personnel and doctors who attended to the First Plaintiff and the minor child at the Town Clinic Modimolle and the FH Odendaal Hospital and contained in the trial bundle, that such documents may be produced by the Plaintiff as evidence in the trial and as constituting *prima facie* proof of the truth of their content, without being required to call the author of such document, but subject to the parties' right to lead oral evidence to rebut the correctness of any fact, observation or finding recorded in such document.

[10] Adv. Monthso-Moloisane SC confirmed the submissions. She furthermore confirmed that the *crux* of the dispute is enunciated in paragraphs 7.8 and 7.9 of the Plaintiffs' Particulars of Claim wherein it is pleaded by the Plaintiffs that the First Plaintiff was not referred to the hospital for medical assessment and management after being diagnosed with a breech presentation of the foetus during her antenatal visits at the clinic, and the nursing personnel at FH Hospital failed to palpate carefully for breech presentation and incorrectly diagnosed a cephalic presentation with an engaged foetal head.

[11] The determination of the issues was separated as agreed upon by the parties and evidence was lead on the merits only.

Issues that require determination:

[12] This Court is only called upon to determine if the Defendant breached its legal duty to render proper and appropriate medical treatment and exercise the degree of skill and care which can reasonably be expected of a nurse or medical practitioner in the prevailing circumstances, resulting in damages being suffered by the Plaintiffs as contemplated in the particulars of claim.

[13] As stated herein before, the determination of the *quantum* will be determined in due course.

The Plaintiff's witnesses:

[14] The First Plaintiff testified that she is the mother of the minor child. During her 34-week prenatal visit at the clinic, she was informed that the foetus (minor child) was in a breech presentation. She did not receive an explanation as to the meaning of 'breech presentation'. She conducted online research to find further information and learned that 'breech presentation' presupposes that the baby has 'turned around'.

[15] During her 38-week visit at the clinic, she was told that her blood pressure was high, and she recorded that her fingers are excessively swollen. There is no record of any observation of the breech presentation.

[16] On the 19th of July 2019, she was taken to hospital after evidencing a bloody excretion. She was advised by her aunt to go to hospital. Upon her arrival, she handed the nurse her clinic card. The nurse did a vaginal examination whereafter the First Defendant was informed that the 'baby is still far'. At that stage she was under the impression that the minor child has 'turned around' and that the birth would be uncomplicated.

[17] At approximately 8h45 am she was examined again. The nurse informed her that she could not feel the baby's head and the doctors had to be called. Shortly hereafter, the doctor arrived and conducted a sonar. The First Plaintiff was then informed that the minor child is in a breech presentation. She was asked to complete and sign forms to perform a caesarean section.

[18] Hereafter, the was again examined by the doctor. She was then informed that she will be moved to the labour ward so that she can be assisted with the labour

process. The First Plaintiff categorically denied that she was told not to bear down. She was informed that if she has the urge to bear down, she should do so.

[19] After some time, the doctor attended to her. She observed that she felt being 'cut' and the doctor's hands 'pulling the baby out'. The minor child was shown to her very briefly whereafter the nurse left with the minor child. No explanation was proffered at this stage as to the health of the minor child.

[20] At approximately 12:00, a nurse collected her and took her to the ward. She also informed the First Plaintiff that a doctor will take her to see her baby. At 21h00 pm, Dr. Malatji attended the First Plaintiff. This was the first time that First Plaintiff was informed that the minor child was stillborn and had to be resuscitated. Dr. Malatji also informed the First Plaintiff that the minor child was not doing well at all.

[21] During cross examination, the First Plaintiff did not waiver in her testimony regarding the incident in question. This Court found the First Plaintiff a reliable witness and accepted her testimony as truthful.

[22] The Plaintiffs hereafter called Dr. Dianne Philomina du Plessis to testify. Dr. Du Plessis testified as to her experience and knowledge in the field of midwifery. She also confirmed that a joint expert report was compiled with the Defendant's expert, Prof. Livhumane Muthelo. Of particular importance is her testimony that one must pay specific attention to the position of a baby during the 34 – 36-week prenatal visit. An experienced practitioner can easily ascertain the position of the baby from an external examination. Experts of this calibre is however seldom found at state hospitals. Midwifes are however obliged to call a doctor to assist if they are unsure.

[23] Dr. du Plessis also testified that, having regard to the clinic records of the First Defendant, it is clear that no proper examination was conducted as none was recorded during the 36- or 38-week prenatal visit. This information is critical to record as it serves as a pre-indication that the birth may be difficult or complicated and preventative measures can then be taken accordingly.

[24] Dr. Du Plessis further testified that it is extremely unlikely that a baby will turn or change position after 36 weeks. At 36 weeks gestation, the head of the baby is normally engaged in the pelvic area which makes it virtually impossible for the baby to withdraw his / her head from the pelvic area and turn around. A proper assessment must therefore be done to ensure that the baby is still in the ideal birth position (with his / her head facing downwards). It does not appear from the records that a proper assessment was done. In the absence of any recorded information, it must be assumed that this was not done.

[25] Dr. Du Plessis conducted herself in a professional manner and displayed a clear understanding of her area of expertise. No questions were initially posed in cross examination of the witness. The Court allowed redirected questioning after certain questions were posed by the Court. This redirected questioning did not deter from the acceptability and reliability of the witnesses' testimony. Her testimony also aligned with her findings contained in her expert report and the joint expert report referred to herein before, rendering her evidence acceptable and reliable.

[26] Hereafter, the Plaintiff called Prof. J Anthony to testify. Prof. Anthony is a registered Maternal and Foetal Medicine subspecialist and a registered Obstetrician and Gynaecologist. He compiled a joint expert report in conjunction with the Defendant's expert, Dr. M Mbokota, a registered Obstetrician and Gynaecologist.

[27] Prof. Anthony confirmed his observations and findings as set out in his expert report and the joint expert report. It was put to Prof. Anthony during evidence in chief that the First Plaintiff was informed at the 36 – 38-week prenatal visit, that the baby was in a breech presentation. This evidence was not challenged as being untrue or not credible. Prof. Anthony confirmed that the breech presentation was correctly diagnosed when the sonar was taken at the hospital on the 19th of July 2019.

[28] He also testified that, to facilitate an uncomplicated birth, the largest structure must ideally be delivered first. This is the head. In some circumstances there may be a discrepancy between the head and the buttocks leading to the buttocks being stuck, but this does not jeopardize the baby's health.

[29] In a breech presentation, the problem is that the feet are delivered first, leading to the head being stuck in the vagina and being subject to compression. This is what causes the potential complications to the baby. Prof. Anthony furthermore testified that, *in casu* it was a feet breech presentation (as opposed to a buttock breech presentation), which would not have caused an excessive urge to 'push' or 'bear down'. There is no head or buttocks pushing down. In his view, even where the feet can be observed, a caesarean can still be performed and is, in fact, advisable to do specifically to avoid a situation where the head of the baby may be stuck, causing asphyxiation.

[30] With reference to the literature bundle presented by the Plaintiffs during the course of the trial, Prof. Anthony made specific reference to the Guideline for Maternity Care in South Africa: A Manual for Clinics, Community Health Centres and District Hospitals (4th Edition, 2015). He testified that this manual contained the principles that should be applied and that there is an expectation that the nurses and medical staff are familiar with it.

[31] According to Prof. Anthony's observation, the failure to detect the breech presentation led to a foreseeable chain of events. Had the First Plaintiff been correctly diagnosed at the clinic, she would have been referred to the hospital for counselling and to offer a caesarean. The manual referred to herein before explicitly provides for a course of management to be performed once a patient is diagnosed with a breech presentation in early labour. This includes the transfer of the mother from a clinic or community health centre to hospital and ensuring that the breech position is correctly diagnosed.

[32] Prof. Anthony also testified that the assessment that was done at approximately 4h38 am was incorrect as it is impossible for the head to be engaged and within a few hours for the baby to be a breech presentation. Assuming they diagnosed the breech presentation correctly, the doctor would have been called immediately, and the caesarean section would have been attended to shortly thereafter. At the time when the First Plaintiff was presumably informed that the minor child's feet are showing and that a caesarean is no longer available, the advice was also incorrect. The caesarean would only not be available once the torso is also out and only the head remains. It is clear that this was not the case with the First Plaintiff.

[33] As the minor child's head was stuck in the vaginal area, it resultantly led to asphyxiation as it is the part that sustains life. The failure to adhere to the minimum standard to be applied in instances of a breech presentation, directly caused the unfortunate resulting brain damage to the minor child. Prof. Anthony also testified that asphyxiation for a period exceeding 20 minutes may lead to brain damage in 85% of babies. It is thus foreseeable that such a child may suffer lasting damages. In Prof. Anthony's view, the documentation presented by the Defendant clearly shows that they did not do what they were supposed to do and when it was expected.

[34] During cross examination it was presented to Prof. Anthony that an inspection of a patient must only be conducted every 4 hours and this was indeed done. Prof. Anthony however highlighted that this applies only to normal uncomplicated birth scenarios. Once a breech presentation has been diagnosed, special precautions should be taken. In this instance, the failure to diagnose and correctly identify the breech presentation led to a chain of events that should have been foreseeable.

[35] It was furthermore put to Prof. Anthony that there were no prior diagnoses of breech presentation. He categorically stated that it was highly improbable that the recorded diagnosis was correct. The actions of the doctors and medical staff did not constitute an error of judgment. In re-examination he confirmed that an error of judgment is when it was a reasonable judgment, but it eventually turned out to be wrong. In *casu* there was no reasonable judgment that was exercised – the actions of the nursing and medical staff were simply wrong and substandard.

[36] This Court also formed a favourable impression of Prof. Anthony. His evidence was elucidating as to the fact that the records are incomplete, clearly showing that the minimum care and skill was not displayed. The Court has no basis to question the veracity of the evidence lead by this witness or that his expert opinion is justified and correct, having regard to the factual synopsis.

[37] The Plaintiffs hereafter closed their case.

[38] The Defendant only called one witness, being Dr Chinono Tshilindo, the medical practitioner who was on duty on the 19th of July 2019. She confirmed that shortly before 9h00 am she was called by Sister Dikgomo from the Maternity Ward. She conducted an examination on the First Defendant and saw that the baby was in a breech presentation. The First Defendant was approximately 3 cm dilated at that stage. Dr. Tshilindo advised that a

caesarean section should be performed. For purposes thereof they required at least three doctors. The First Defendant was re-examined by Dr. Kubjane who advised that the feet are already out and that labour should therefore be progressed with naturally.

[39] Dr. Tshilindo then took control of the First Defendant's delivery process. Once she realised that the head was stuck, she called Dr. Ledwaba to assist. Dr. Ledwaba took over the resuscitation of the neonate (minor child) after his birth.

[40] As to the monitoring of the foetal heartrate, she testified that she constantly monitored the heart rate although no record was kept hereof. According to her there was no paper in the machine and thus no reports could be printed.

[41] During cross examination, Dr. Tshilindo confirmed that, although she received training in breech presentation births, she had no personal experience therein. She also has no knowledge if Dr. Kutumela has any experience – she simply accepted the advice that the birth should progress vaginally. She also accepted that her failure to correctly note what transpired in detail, was wrong. There is thus no record as to when Drs. Kutumela and Ledwaba were called or what their observations or diagnosis was. Notwithstanding being confronted with the evidence from the expert witnesses, Dr. Tshilindo persisted in her view that the decision not to continue with the caesarean section was the correct decision at the time as the baby's feet was already out.

[42] Hereafter, the Defendant's case was also closed.

[43] The Court did not find the witness to be of exceptional assistance to the defence pleaded. The witness was obviously only performing instructions provided to her by a senior colleague. She did not properly justify her decision or rebut, in any way, the assumptions of negligence created by the expert testimony.

The Applicable Legal Principles:

[44] There is no dispute that the Plaintiffs bear the onus regarding the disputed issues. As to the question of negligence, the onus would be discharged were the Plaintiffs to establish, on a balance of probability, that a reasonable medical practitioner in the circumstances in which the nurses and/or doctors at the hospital found themselves would have foreseen the likelihood of harm occurring (in this matter the likelihood of harm occurring to minor child) and would have taken steps to guard against its occurrence, and the practitioners concerned failed to take such steps[1]. In the case of an expert, such as a surgeon, the standard is higher than that of the ordinary layperson and the court must consider the general level of skill and diligence possessed and exercised at the time by the members of the branch of the profession to which the practitioner belongs.[2]

[45] In ***Van Eeden v Minister of Safety and Security (Women's Legal Centre Trust as amicus curiae)***[3] it was clearly stated in respect of omissions:

> *'The appropriate test for determining wrongfulness [of an omission] has been settled in a long line of decisions in this court. An omission is wrongful if the defendant is under a legal duty to act positively to prevent the harm suffered by the plaintiff. The test is one of reasonableness. A defendant is under a legal duty to act positively to prevent harm to the plaintiff if it is reasonable to expect of the defendant to have taken positive measures to prevent the harm.'*

[46] In ***Minister of Safety and Security v Van Duivenboden***[4] Nugent JA said:

---

[1] See ***Kruger v Coetzee*** 1966 (2) SA 428 (A)
[2] See ***Mukheiber v Raath & Another*** 1999 (3) SA 1065 (SCA)
[3] 2003 (1) SA 389 (SCA) at 395

'[12] Negligence as understood in our law, is not inherently unlawful – it is unlawful, and thus actionable, only if it occurs in circumstances that the law recognizes as making it unlawful. Where the negligence manifests itself in a positive act that causes physical harm it is presumed to be unlawful, but it is not so in case of a negligent omission. A negligent omission is unlawful only if it occurs in circumstances that the law regards as sufficient to give rise to a legal duty to avoid negligently causing harm. It is important to keep that concept quite separate from the concept of fault. Where the law recognizes the existence of a legal duty it does not follow that an omission will attract liability – it will attract liability only if the omission was also culpable as determined by the application of the separate test that has consistently been applied by this court in Kruger v Coetzee, namely whether a reasonable person in the position of the defendant would not only have foreseen the harm but would also have acted to avert it. While the enquiry as to the existence or otherwise of a legal duty might be conceptually anterior to the question of fault (for the very enquiry is whether fault is capable of being legally recognized), nevertheless, in order to avoid conflating these two separate elements of liability, one might often be helpful to assume that the omission was negligent when asking whether, as a matter of legal policy, the omission ought to be actionable.'

[47] According to **Neethling and Potgieter**[5] the Appellate Division has now expressed itself in favour of a *flexible approach,* in terms of which there is no single criterion that can be applied to all situations.

[48] With reference to ***S v Mokgethi***[6] the learned writers stated that the basic question is whether there is a close enough relationship between the

---

[4] 2002 (2) SA 431 (SCA) at para [12]
[5] Neethling et al **Neethling – Potgieter – Visser Law of Delict** 7th edition Lexis Nexis at 200

wrongdoer's conduct and its consequence for such consequence to be imputed by the wrongdoer in view of the policy considerations based on reasonableness, fairness and justice. The reasonable foreseeability of the damages is therefore one of the factors that may be taken into consideration when determining if the alleged wrongdoer should be held liable as long as justice prevails in the end.

[49] This Court is of the view that the nursing and medical staff of the Defendant failed to correctly and timeously diagnose the breech presentation (first at the clinic and thereafter at the hospital), resulting in little to no preventative care being taken as contemplated in the prescribed procedures. If the breech presentation was properly identified and documented, it would have resulted in the correct treatment being applied. The Defendant had numerous opportunities to correct the course of treatment. The First Plaintiff was advised that a caesarean section should be performed, only to be informed thereafter that it was impossible as the birthing process has progressed too far. At this stage, only the feet were showing. It is evident from the expert testimony that this still allows for a successful caesarean section to be performed and, in fact, would have prevented the resulting brain damages suffered by the minor child.

[50] As to the testimony of the Defendant's sole witness, this Court is not convinced that her actions in continuing with a vaginal birth, constitutes an error of judgment. First and foremost, it was her testimony that she did not elect the course of action. She was essentially instructed by a senior doctor to do so. The Defendant elected not to call these critical witnesses to explain their reasoning behind the decision. The law pertaining to errors of judgment are clear:

---

[6] 1990 (1) SA 32 (A)

'If a surgeon fails to measure up to that standard in any respect ('clinical judgment' or otherwise), he has been negligent and should be so adjudged.' [7]

[51] It is evident from the expert evidence that the unfortunate turn of events could have been avoided. This Court agrees with the findings of the experts. The eventual damages were caused because of asphyxiation. If the minor child was born by means of a caesarean section, his head would not have been stuck in the vaginal area, as a result whereof he would have been born without any complications or adverse consequences. The actions of the employees of the Defendant simply fell short of what can be reasonably be expected from practitioners in their position and was negligent.

[52] The Court is therefore satisfied that the Plaintiffs have shown, on a balance of probabilities, that the omissions and acts of the Defendant have resulted in the Plaintiffs and the minor child suffering damages.

Costs:

[53] There is no reason why the cost order should not follow the outcome of the proceedings. Both parties made use of senior counsel in this matter. Having regard to *inter alia* the nature of the matter, the level of expertise required and the importance of the case to the parties, costs consequent upon the appointment of two counsels on Scale C is warranted.

Order:

[54] **In the result the following order is made:**

[7] Per Lord Edmund Davies in ***Whitehouse v Jordan*** [1981] 1 All ER 267 at 121, cited with approval in ***Pringle v Administrator, Transvaal*** 1990 (2) SA 379 (W)

54.1 **In terms of the provisions of Rule 33(4) the issues arising from the following paragraphs of the Plaintiffs' particulars of claim and the Defendant's plea thereto, are hereby separated for initial determination:**

54.1.1 **Paragraphs 1, 2, 3, 4, 5, 6, 7 and the introductory portion of paragraph 8 (up to and including "suffered the injury and consequent conditions" in that paragraph) and paragraph 14;**

54.1.2 **Paragraph 2 to 39 (insofar as paragraph 39 deals with the introductory portion of paragraph 8 of the particulars of claim) of the Defendant's amended plea;**

54.1.3 **The remaining paragraphs of the Plaintiffs' particulars of claim dealing with the quantum of the plaintiffs' claim, and the remaining paragraphs of the Defendant's plea, including any future amendments to these paragraphs, to be postponed *sine die.***

54.2 **The Defendant is liable for 100% of the Plaintiffs proven or agreed damages in the First Plaintiffs' personal and representative capacity and the Second Plaintiffs' representative capacity as parents of the minor child, T[...] N[...] B[...] B[...], who was born on the 19th of July 2019, which damages were suffered as a result of the injury sustained by the minor child and consequences as pleaded in the paragraphs of the particulars of claim referred to in paragraph 1.1 above.**

54.3 The Defendant is ordered to pay the Plaintiffs' taxed or agreed party and party costs on the High Court Scale up to date of this order, which costs will include, but not be limited to:

54.3.1 The costs consequent upon obtaining the medico legal reports and expert summaries and the reasonable qualifying fees (if any) of:

54.3.1.1 Prof. J Lotz, neuro-radiologist;
54.3.1.2 Dr. S O'Hagan, neuro-radiologist;
54.3.1.3 Prof J Anthony, specialist obstetrician and gynaecologist and maternal and fetal specialist;
54.3.1.4 Dr. D du Plessis, nursing expert;
54.3.1.5 Prof. J Smith, paediatrician and neonatologist;
54.3.1.6 Dr. M Lippert, paediatric neurologist;
54.3.1.7 Dr. G Gericke, paediatrician and geneticist;
54.3.1.8 Dr. I Ferreira, pathologist

Of whom the Plaintiffs have given notice in terms of the provisions of Rule 39(9)(a) and (b);

54.3.2 The costs consequent upon the employment of two counsel on Scale C.

54.4 The following provisions shall apply regarding determination and payment of the Plaintiffs' abovementioned taxed costs:

54.4.1 The Plaintiffs' attorney shall timeously serve the notice of taxation on the Defendant's attorney of record;

54.4.2 **The Plaintiffs' attorney shall allow the Defendant 30 (thirty) days to make payment of the taxed costs from date of settlement or taxation thereof;**

54.4.3 **Should payment of the Plaintiffs' taxed or agreed costs not be affected timeously, the Plaintiffs will be entitled to recover interest at the mora interest rate, calculated from the 31st calendar day, after the date of the Taxing Master's allocatur, or after the date of settlement of the costs, up to date of final payment.**

M BRESLER AJ
ACTING JUDGE OF THE HIGH COURT,
LIMPOPO DIVISION, POLOKWANE

APPEARANCES:

FOR THE PLAINTIFFS	:	**Adv. NGD Maritz SC** **Adv. MM Lingenvelder SC**
INSTRUCTED BY	:	**Josephs Inc** **Johannesburg** **mjoseph@josephs.co.za** **marinda@josephs.co.za** **benhardt@prattluyt.co.za**
FOR THE DEFENDANT	:	**Adv. LM Montsho-Moloisane SC** **Adv. M Kgare**

INSTRUCTED BY	**:**	**The State Attorney** **Polokwane** **NonMnisi@justice.gov.za**