SUPREME COURT OF APPEAL OF SOUTH AFRICA

JUDGMENT

Not Reportable

Case No: 20198/2014

In the matter between:

DR F KLUEVER	**First Appellant**
DR R H BHAWANI	**Second Appellant**
MINISTER OF DEFENCE	**Third Appellant**

and

MICHIEL JACOBUS DE GOEDE	**Respondent**

Neutral citation: *Dr F Kluever* v *De Goede* (20198/2014) [2015] ZASCA 105 (19 August 2015).

Coram: **Navsa ADP, Mhlantla, Leach, Mbha and Zondi JJA**

Heard: **08 May 2015**

Delivered: **19 August 2015**

Summary: Delict – medical practitioner – professional negligence – surgical procedure resulting in high riding patella – primary surgery improperly performed – medical practitioner negligent – defence of contributory negligence dismissed – third appellant vicariously liable to compensate respondent.

ORDER

On appeal from: Gauteng Division of the High Court, Pretoria (Van Niekerk AJ sitting as court of first instance):

The following order is made:

The appeal is dismissed with costs including the costs attendant upon the employment of two counsel.

JUDGMENT

Mhlantla JA (Navsa ADP, Leach, Mbha and Zondi JJA concurring):

[1] Michiel de Goede (Michiel) was a young and exceptional rugby player who had been offered and accepted a five year contract to play for the junior team of the Sharks Rugby franchise from 2008. On 5 April 2007 he sustained what is best described as a freak injury. It was sustained in the dying minutes of a rugby game after Michiel had been brought on as a substitute. It occurred without contact with any other player. Michiel was bending to receive a ball that had been passed to him and probably because of his weight, which was considerable for his age, his leg gave way. It is uncontested that he sustained a rupture of the patella tendon.[1] As a result he had to receive medical treatment at 1

[1]In Chapman and Madison: Operative Orthopaedics, 2nd edition, Volume 4, a patella tendon is described as a ligament connecting two bones- the tibia and the patella. A rupture of the patella tendon usually occurs at the inferior pole of the patella. It results in an inability to actively obtain and maintain full knee extension. If the tendon does not heal properly and at the correct length and tension, knee range of motion can be altered significantly and can prevent a return to pre-injury status. Immediate surgical repair is recommended for optimal return of knee function and power. See also Campbell's Operative Orthopaedics, 10th edition, Volume 3.

Military Hospital, Pretoria, which is under the control of the South African National Defence Force (SANDF) and the third appellant, the Minister of Defence (the Minister). Dr Khwitshana (Khwitshana) diagnosed a sprained knee. The error was discovered five days later after Michiel had consulted Dr Boetie Thiart, (Thiart) an orthopaedic surgeon at Unitas Hospital who diagnosed a patella tendon rupture.

[2] On 13 April 2007, the first appellant, Dr Felicia Kluever (Kluever), an orthopaedic surgeon employed at the hospital, performed surgery to repair the ruptured patella tendon. After the operation Michiel's leg was placed in a brace which was removed after six weeks on 25 May 2007. Kluever thereafter referred Michiel to Mr Phillip du Plessis, (du Plessis) a physiotherapist employed at the hospital, to commence with a rehabilitation programme.

[3] Du Plessis struggled to restore full flexion of the knee. This led him during September 2007, to refer and accompany Michiel for advice to Mr Cornelius Liebel (Liebel), a biokineticist who had been assisting Michiel with his sport conditioning prior to his injury. Liebel noticed that the right patella was slightly higher than the left and accordingly informed the two of them. Out of concern, du Plessis further took Michiel to the High Performance Centre in Pretoria. The physiotherapists there suggested that the circulage wire that had been inserted by Kluever during the surgical procedure referred to above, be removed. At that stage, it was thought that the wire might be hindering the flexing of the knee. Du Plessis reported this to Kluever who then scheduled a second surgical procedure to remove the circulage wire. This operation was performed on 1 October 2007 by the second respondent, Dr R H Bhawani (Bhawani).

[4] From October 2007 until December 2007, Liebel worked with du Plessis to rehabilitate Michiel's knee. No significant progress was made as they still could not achieve a complete range of movement of the knee. Early in 2008 Michiel joined the Sharks Academy in terms of the contract referred to above. Mr Jimmy Wright (Wright), a biokineticist employed at the Academy, attended to his rehabilitation. Despite Wright's efforts after rehabilitation, Michiel could not regain the full knee function he had prior to the injury. Wright therefore referred him to Dr de Vlieg (de Vlieg), an orthopaedic surgeon, who identified a 'high riding patella'[2]. On 16 September 2008, he performed a remedial operation known as the 'VY quadriceps plasty'[3] and brought down the patella. The damage found in the knee was irreversible and it became clear that Michiel's knee would never be fully functional for him to play rugby. Sadly, his career as a rugby player for the Sharks Rugby franchise came to an end.

[5] Consequently, Michiel instituted action against the appellants in which he claimed damages arising from injuries sustained during the surgical procedure performed on 13 April 2007. In his particulars of claim, he alleged that Kluever and Bhawani had been negligent when they performed the two surgical procedures referred to above. The Minister was sought to be held vicariously liable for the doctors' actions as they were in the employ of the SANDF and were executing their duties as such when performing these operations. This latter aspect is uncontentious.

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[2] According to Dr de Vlieg, a patella runs in a groove on the femur and functions when the knee is fully extended. The patella will sit above the groove and as the knee bends, the patella will move downwards and be captured by the groove. A high riding patella or patella *alta* occurs when the patella is situated or sitting well above the groove and its point of engagement is delayed during the bending of the knee.

[3] Dr de Vlieg testified that a VY quadriceps plasty operation is a technique of lengthening the muscle. The term "VY' refers to the shape as the surgeon will cut a V during surgery and when he or she pulls it down and suture it back up, it becomes a Y shape because it has been elongated.

[6] In their plea, the appellants denied negligence and pleaded that the medical services they provided to Michiel were performed with care and skill reasonably expected of medical personnel in their position. In the alternative, the appellants pleaded contributory negligence and averred that Michiel had failed to attend scheduled appointments with the medical practitioners and, contrary to the advice of Kluever, had undergone an extensive exercise programme that had impaired the healing process.

[7] The matter came to trial in the Gauteng Division of the High Court, Pretoria before Van Niekerk AJ. At the commencement of the trial, the learned judge, at the request of the parties, issued an order in terms of Uniform rule 33(4) separating the merits from quantum. The judge was therefore essentially called upon to determine the question of negligence. Both parties adduced evidence and called various witnesses including expert witnesses. At the conclusion of the trial, Van Niekerk AJ was unpersuaded by the appellants' defences. He concluded that Kluever had been negligent in that she had failed to place the patella in its correct position on 13 April 2007; further that she and Bhawani had failed to identify the issue after the primary surgery; and that this was the cause of the high riding patella and the condition of Michiel's knee as discovered by de Vlieg in September 2008. Moreover, the learned judge rejected the Minister's contention in relation to contributory negligence. He therefore declared the Minister liable to compensate Michiel for any damages suffered by him, arising out of injuries sustained by him, during the operation of 13 April 2007. The appellants appeal against these conclusions with special leave of this court.

[8] This appeal turns on whether the findings referred to at the end of the preceding paragraph are correct. Simply put, the question is: was there

negligence on the part of the medical practitioners at 1 Military Hospital which led to Michiel's present admitted disability?

[9] In order to arrive at a determination in relation to negligence, it is necessary to deal with the background facts in some detail. Michiel testified and relied on six other witnesses in support of his case, namely du Plessis, Liebel, Wright, Mr David Jacobus du Plessis, who is the deputy headmaster and head rugby coach of Eldoraigne High School, de Vlieg and Dr Anthony Birrel (Birrel), an orthopaedic surgeon. Kluever and Professor Kulule Lukhele (Lukhele), a chief orthopaedic specialist at Charlotte Maxeke Hospital, Johannesburg testified on behalf of the appellants. At the outset, it is necessary to record that there had been a misdiagnosis by Khwitshana which delayed the ruptured patella tendon from being attended to timeously. It was also agreed by all experts who testified that in order to obtain optimal rehabilitation of the knee, it was best that a diagnosis of a ruptured patella tendon be done timeously and preferably within a few days of the injury and the repair thereof immediately. The background facts are set out hereafter.

[10] After Michiel's injury, he was immediately taken to the hospital. An x-ray image of the injured leg was taken and as already stated Khwitshana told him his knee was sprained. He was given medication for pain and swelling and was instructed to return after two weeks for a check–up. The pain in his knee did not subside.

[11] On 10 April 2007, Liebel assessed Michiel. He suspected a serious injury and referred him to Thiart. The latter examined Michiel and diagnosed a patella tendon rupture. He sent Michiel for ultra sound imaging (the scan). The results of the scan confirmed his diagnosis.

Michiel had to be treated at 1 Military Hospital because his father is employed by the SANDF. Thiart therefore called Dr Van der Spuy, an orthopaedic surgeon employed at the hospital, who advised him of Michiel's condition and his diagnosis. He referred Michiel to Dr Van der Spuy and provided the hospital with the results of the scan. Armed with these results, Michiel and his father returned to the hospital and presented the scan to Dr Van der Spuy. Michiel was informed that an operation on his knee would be performed on 13 April 2007. It is common cause that Thiart's diagnosis was never explored nor was Michiel's knee examined by Kluever before she performed the primary surgery nor had she seen the scan taken at Unitas Hospital. Kluever relied on a hearsay diagnosis by another doctor.

[12] On 13 April 2007, the primary surgery was performed by Kleuver. She qualified as an orthopaedic surgeon the year before she performed the operation. She met Michiel at the theatre. He related to her how he had sustained the injury and pleaded with her to repair his knee as he wanted to carry on playing rugby. It is common cause that the exchange with Michiel took place immediately before surgery and lasted no more than a few minutes. Kluever proceeded to perform the operation in order to repair the ruptured patella tendon. She followed what she termed 'the standard procedure' during surgery which was: She determined the height of the patella by feeling the left knee with her hand. She used an anterial incision over the knee joint. She identified the infra patella tendon which was severely frayed and used circulage wire to approximate the ends of the tendon. She repaired the tendon in layers with a non-absorbable suture material known as Ethibond 2 and also repaired the paratendon, which is the top layer that surrounds the tendon. Upon completion, she applied a bandage and a brace which she fixed in full extension. She instructed

Michiel to wear the brace for six weeks.

[13] After the operation, Michiel was monitored by Dr Alberts, who was also in attendance at 1 Military. He was discharged on 15 April 2007. Thereafter Kluever saw Michiel again as an out-patient on 24 April 2007 and removed the suture clips. She recorded in the hospital file that the brace would be removed after six weeks. On 25 May 2007, she removed the brace and referred Michiel to du Plessis for rehabilitation. On his next visit, on 20 July 2007, Kluever recorded that Michiel did not have any complaints and was attending physiotherapy. His range of movement was at a level of 70 degrees. She told Michiel that he should continue with physiotherapy sessions and that she would allow him to attend biokinetics once his range of movement had reached 90 degrees. It does not appear that she had any concerns during these visits about the height of the patella. It also does not appear that she scrutinised the height of the patella.

[14] Du Plessis struggled to get full flexion of the knee and decided to seek advice. During September 2007, he took Michiel to Liebel who noticed that the right patella was slightly higher than the left one. Du Plessis took him to the High Performance Centre for assessment. The therapists at the centre suspected that the circulage wire in the knee prevented Michiel from flexing the knee beyond 90 degrees. They suggested that the wire be removed. Du Plessis reported this to Kluever who scheduled an operation for the removal of circulage wire. On 1 October 2007, Dr Bhawani removed this wire.

[15] Liebel corroborated du Plessis's testimony regarding the visit during September 2007 as well as his observation and advice. He noticed

that Michiel's knee and quadriceps were quite wasted. His sessions with Michiel commenced during October 2007 after the circulage wire had been removed. They focused on light exercises. No significant progress was made. He submitted a report to Wright shortly before Michiel moved to Durban.

[16] At the beginning of 2008, Michiel joined the Sharks Academy. Wright continued with his rehabilitation programme. However, Michiel could not regain the full knee function he had prior to the injury. As there was no improvement, he referred Michiel to de Vlieg who identified the high riding patella.

[17] On 16 September 2008, almost 18 months after Kluever had performed the primary surgery, de Vlieg performed remedial surgery on Michiel's right knee. He found a high riding patella and fibrous scar tissue below the patella. He found the repair mechanism performed by Kluever to be still intact. She had used suturing material known as Ethibond 2 to suture the tendon. He regarded this as being suturing material of the wrong strength and was adamant that she should have used Ethibond 5.0. He regarded her technique as inappropriate considering Michiel's specific physical attributes. In his view, Kluever did not give adequate consideration to the fact that Michiel was physically large and was a rugby player. He concluded that the reason why the patella was found to be situated too high was due to the fact that the tendons were proximated by Kluever without taking into account the correct height of the patella, the elongated nature of the torn tendon and without performing augmentation[4]. In his view, the core problem was that

[4] According to Dr De Vlieg augmentation is a technique that is used to improve the grip of the suture material within the tendon. This is done to reinforce the repair.

at the time that Kluever performed primary surgery to repair the ruptured patella tendon, she did not take care to ensure that the patella was placed properly. This was due not only to the fact that she did not place it back in the groove precisely but also because she had not resorted to augmentation, which would have facilitated the proper placing of the patella within the groove. De Vlieg said he would have physically measured the patella height using a ruler as well as compared it to the right knee to ensure that it was similarly placed. He stated that the damage he found in the knee was caused by the wrong height of the patella and that it had started an osteoporotic process within the knee. He further stated that it was irreversible and that it would not have happened had the primary procedure by Kluever been performed using the appropriate technique and that this was foreseeable.

[18] Dr Birrel's views were that the procedure performed by Kluever was inappropriate. According to him, she inter alia, failed to take a proper history of Michiel's injury and failed to properly prepare for the surgery. She did not perform augmentation. She should have confirmed the correct height of the patella either during the operation or thereafter by requesting x-rays to be taken and that had she done so, she would have been able to rectify the situation by repairing the high riding patella.

[19] Prof Lukhele was called by the appellants to negate causality. In his testimony, he made very important concessions, namely: he would have debrided the torn edges of the ruptured patella then approximated the edges and augmented the suture had he performed the surgery. If Michiel's knee was left with a high riding patella since the primary surgery, then the damage would ensue and such damage would be irreversible and it would be foreseeable. He confirmed that if the tendon

was left elongated during the primary surgery, the patella would resultantly be too high. He accepted that a ruptured tendon would lead to that tendon to be already attenuated. He reserved what he termed the 'guestimate' of the patella height to experienced surgeons who have at least five years' experience and that have acquired that particular skill.

[20] The expert witnesses de Vlieg, Birrel and Lukhele prepared a joint minute. They agreed on two points, namely: (a) that a successful patella tendon repair required a treating surgeon to perform the procedure in the appropriate manner; (b) the removal of the circulage wire could not have had any effect on the patella and could not have caused the high riding patella, especially since that wire was removed six months after the repair when the tendon was expected to have healed. Lukhele further stated that the only possibility for the patella to have become high riding would be if the suturing and/or repair of the tendon had failed.

[21] They disagreed on the other issues. In this regard, de Vlieg and Birrel were of the view that the standard procedure followed by Kluever was inappropriate. Furthermore they stated that Michiel would have had a better prognosis had the surgery been performed in the manner they considered correct and lastly, that had the primary surgery been properly performed, strenuous exercise by Michiel would not have caused the patella to move upwards.

[22] On the other hand, Lukhele felt that the procedure performed by Kluever was proper. He considered her method to be the standard method. However, during his testimony, he did concede that it was necessary to individualise the patient and apply the applicable methods depending on the patient. He contended that a better prognosis after

surgery depended on biological factors. He did not contest the view that strenuous exercise would not have caused the patella to move upwards.

[23] Therefore, the first issue to be determined is whether Kluever and Bhawani were negligent. The applicable legal test for determining medical negligence was set out a century ago by Innes ACJ in *Mitchell v Dixon*,[5] as follows:

'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; and he is liable for the consequences if he does not.'

[24] Innes CJ restated this principle in *Van Wyk v Lewis*,[6] and went on to say:

'And in deciding what is reasonable the court will have regard to 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.'

[25] In *Whitehouse v Jordan and another*,[7] the House of Lords concluded that the statement that 'a mere error of judgment' on the part of a medical practitioner does not constitute negligence was an inaccurate statement of the law. Lord Fraser said:

'….[T]he statement as it stands is not an accurate statement of the law. Merely to describe something as an error of judgment tells us nothing about whether it is negligent or not. The true position is that an error of judgment may, or may not, be negligent; it depends on the nature of the error. If it is one that would not have been made by a reasonably competent professional man professing to have the standard and type of skill that the defendant held himself out as having, and acting with ordinary care, then it is negligent. If, on the other hand, it is an error that a man acting with

[5] *Mitchell v Dixon* 1914 AD 519 at 525.
[6] *Van Wyk v Lewis* 1924 AD 438 at 444.
[7] *Whitehouse v Jordan and another* [1981] 1 All ER 267 (HL) at 281.

ordinary care, might have made, then it is not negligence.'

[26] Regarding the manner in which the evidence of an expert should be evaluated, Mthiyane JA in *Louwrens v Oldwage*,[8] held:

'What was required of the trial Judge was to determine to what extent the opinions advanced by the experts were founded on logical reasoning and how the competing sets of evidence stood in relation to one another, viewed in the light of the probabilities.'

[27] In *Medi-Clinic v Vermeulen*,[9] Zondi JA, when considering the manner in which the expert evidence should be evaluated, referred to the decision of *Michael & another* v *Linksfield Park Clinic (Pty) Ltd & another* 2001 (3) SA 1188 (SCA) paras 36 to 39 and said:

'. . . what is required in the evaluation of the experts' evidence is to determine whether and to what extent their opinions are founded on logical reasoning. It is only on that basis that a court is able to determine whether one of two conflicting opinions should be preferred. An opinion expressed without logical foundation can be rejected. But it must be borne in mind that in the medical field it may not be possible to be definitive. 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 to simply 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.'

[28] Before us, counsel for the appellants, submitted that Kluever and Bhawani exercised care and skill when they performed the operations on Michiel and that the methods and/or procedure adopted by Kleuver during the first operation were within the standard required of the medical

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[8] *Louwrens v Oldwage* 2006 (2) SA 161 (SCA) para 27.
[9] *Medi-Clinic v Vermeulen* (504/13) [2004] ZASCA 150 (26 September 2014) at para 5; 2015 (1) SA 241 (SCA).

profession. He further contended that the patella was brought down to the correct height during the primary surgery.

[29] This submission is against the weight of the evidence. There is an incremental accumulation of mishaps. First, on 5 April 2007 the medical staff misdiagnosed the injury as a sprained knee and told Michiel to return after two weeks. Secondly, the conduct of Kluever before the operation leaves much to be desired. She testified that she had qualified as an orthopaedic surgeon in 2006 and conceded that she was not a knee specialist, yet she did not adopt any measures to combat her relative inexperience. On her own testimony, she confirmed that she saw Michiel for the first time in theatre shortly before the surgery. She was aware that Michiel was a rugby player. This factor was not given adequate consideration. He was physically large and greater attention should have been paid to the force that would be exerted on his knee. The strength of the sutures ought to have been considered. She did not regard it necessary to take x-ray images of the injured knee prior to or after the surgery. She failed to take a proper history of Michiel's injury nor did she examine him. The consultation with him was superficial. She never considered the x-ray image that had been taken on 5 April nor did she see the scan sent by Thiart. She relied on the hearsay diagnosis of the injury by Thiart. She obtained this information from a colleague of hers who had been briefed by Thiart. She never consulted a senior colleague or Thiart to discuss his diagnosis or precautionary steps. Eight days had elapsed before the surgery was performed. This too had a negative impact on Michiel's treatment. The need to perform surgery to repair this type of injury immediately is highlighted in the literature provided by the parties. In this case the misdiagnosis and the delay had a negative impact on a better prognosis.

[30] During the operation phase, Kluever determined the height of the patella by feeling the left knee with her hand and thereby determined what the correct height of the patella of the injured knee should be. All the orthopaedic surgeons were ad idem that her method in that regard was incorrect. Lukhele called it a 'guestimate' but reserved it for surgeons with at least five years' experience who must have acquired that particular skill. Birrel and de Vlieg were adamant that she should have used either a measuring device, such as a ruler or employed x-rays. She performed surgery on a man that weighed 125 kilograms and who was a rugby player, yet she used suturing material of an inferior strength when she should have used Ethibond 5 and performed augmentation. She did not take into account the correct height of the patella after the operation.

[31] When she was asked to comment about an allegation that she failed to place the patella back in its proper place after the surgery, her response was:

'Well, I don't think I left the patella high. Because of the principles that I used when I performed the surgery which is not always documented if its normal principles that you are using. So my normal principles when suturing the intra patella tendon is to be able to feel the quadrilateral side which in this case was the left knee, so once you've pulled it down with your stitches you feel the patella on the one side and then compare it to the left'.

[32] In my view, this was a serious allegation that should have been met with an unequivocal and confident response refuting the allegations. Instead, she left one in the dark.

[33] Lukhele when confronted with the undisputed fact that when de

Vlieg opened the knee, the repair of Kluever was still intact, but the patella was sitting high, responded that there could only be two reasons for the high riding patella: Either the initial placement of the patella was incorrect and was left too high when the operation was done by Kluever; or there was attenuation in the period between the operation and the time that de Vlieg operated in the patient. In my view, since the original repair was still intact when the corrective surgery was done, the most probable cause is that the patella was not left in the correct position during the operation performed by Kluever. Thereafter, Liebel identified the high riding patella during September 2007. Wright noticed it early in 2008 and it was eventually restored by de Vlieg in September 2008.

[34] Lastly, Kluever had an opportunity to identify the high riding patella when she received a report from du Plessis after his visits to Liebel and the High Performance Centre. However, she failed to do so. She, again, did not examine Michiel's knee but merely scheduled an operation which was conducted by Bhawani on 1 October 2007. Bhawani, too did not bother to examine the knee and determine why it could not flex beyond 90 degrees. All he did was remove the circulage wire.

[35] Cumulatively, and having regard to the effect of the misdiagnosis, the improper procedure, the failure thereafter to detect and identify the high riding patella, and the evidence of all the orthopaedic surgeons including Prof Lukhele, it is quite clear that Michiel's present disability was due to Kluever's negligence referred to above. The failure by Kluever to place the patella properly during the primary surgery and the subsequent failure by her and Bhawani to recognise and/or identify and/or repair the high riding patella subsequent to that operation caused Michiel

to continue to suffer pain in his knee. Furthermore, this is the cause of the irreversible damage to his knee as found by de Vlieg. The repair of Michiel's patella tendon could have been successful had the operation been performed with the necessary skill and care and/or the high riding patella had been timeously identified especially since du Plessis continuously reported to and raised his concerns with Kluever.

[36] Regarding the plea of contributory negligence, counsel for the appellants submitted that the patella had migrated upwards because the original repair of the patella tendon failed to heal properly due to strenuous exercise. Furthermore, he submitted that Michiel's patella tendon became attenuated during the period between the operation by the Kleuver and the one performed by de Vlieg.

[37] I disagree. Michiel was, upon his discharge, immobile for six weeks. Therefore, there can be no basis to suggest that he caused the high riding patella at that stage. Once the brace was removed, he was in the care of du Plessis. Similarly, any argument that the patella was damaged during this stage will not assist the appellants because the physiotherapist was in the employ of the Minister. Be that as it may, the evidence of the physiotherapist and the biokineticists, that they did not perform strenuous exercises but concentrated on the upper body, remained unchallenged. By September 2007, five months after the operation, the high riding patella was identified.

[38] Kluever speculated as to why the patella was high riding five months after the operation and stated that the circulage wire might have stretched under strenuous exercise albeit there was no evidence of a compromised wire. She further surmised that it could have been due to

strenuous exercise. Her evidence in this regard is unsupported by any evidence. Furthermore, de Vlieg found her repair still intact 18 months after the operation. In my view, the repair would not have been in that condition if Michiel, the physiotherapists and biokineticists had done strenuous exercises as alleged by Kluever. In any event, this was mere speculation on her part.

[39] Therefore, I am satisfied that any exercises performed during the sessions could not have caused the patella to become elongated. This is dispositive of the plea of contributory negligence.

[40] In the result, the court a quo correctly upheld Michiel's claim. The appeal therefore fails.

[41] Consequently I make the following order:
The appeal is dismissed with costs including the costs attendant upon the employment of two counsel.

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NZ MHLANTLA
JUDGE OF APPEAL

APPEARANCES:

For Appellant:	A T Ncongwane SC (with him I P Ngobese)
Instructed by:	The State Attorney
	Pretoria
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	Bloemfontein
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