

SOUTH AFRICA / JUDGMENT

S v Beale (SS10/2021) [2025] ZAGPJHC 209 (4 March 2025)

[2025] ZAGPJHC 209**COURT**

South Gauteng High Court, Johannesburg

BEFORE

Mudau, C Lazarus, J M Dippenaar

CASE / FILE NUMBER

SS10/2021

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Policy**FLYNOTES:****CRIMINAL**

– Murder – Surgery
on children –

Deaths

of three children – Fraud alleged in misrepresenting medical
conditions requiring procedures to be performed

– State

contending that accused suffered financial losses –

Motivation to perform unnecessary surgeries –

State witness

unreliable and discredited – Inferential reasoning to

argue dolus

eventualis –**Accused**

had genuine belief that operations were indicated – Evidence

showed accused to be financially secure at time

of operations –

Not guilty on all charges.

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

JOHANNESBURG
Case Number: SS10/2021
(1)
REPORTABLE: NO
(2)
OF INTEREST TO OTHER JUDGES: YES
(3)
REVISED: YES
DATE 4
March 2025

In the matter between:

THE
STATE
and
BEALE, PETER
GORDON
Accused
Criminal law-Fraud and
Murder charges following surgery related deaths- Intention
– dolus eventualis – Test
for dolus eventualis restated- it is whether accused
subjectively foresaw the possibility of harm ensuing from his
conduct, and whether he reconciled himself to that possibility-
dolus eventualis nor culpable homicide not established-
Circumstantial evidence – Insufficient proven facts.

JUDGMENT

MUDAU, J

- [1] The accused, Mr Peter Gordon Beale, a retired professor and paediatric surgeon, is on trial before me and two assessors appointed in terms of section 145(1)(b) of the Criminal Procedure Act 51 of 1977 (“CPA”). The charges against the accused arise from surgery-related procedures on three distinct occasions. The indictment consists of five charges, namely three counts of murder (counts 2,3, and 5) read with section 51(2) and Part II of Schedule 2 of the Criminal Law Amendment Act 105 of 1997 (“CLAA”), as amended, as well as two counts of fraud (counts 1 and 4).
- [2] The allegations regarding count 1 of fraud are that, on or about 16 March 2012, at or near Sandton, in the district of Johannesburg North, the accused unlawfully and with the intention to defraud, misrepresented to D[...] J[...] T[...]

(Mrs T[...]), the biological mother of E[...] S[...] T[...] (E[...]/the deceased in respect of count 2), that the pathology results of a rectal biopsy obtained from the deceased on 12 March 2012 at Park Lane Clinic by the accused confirmed that E[...] had Hirschsprung’s disease, necessitating surgical intervention in the form of a rectal pull-through procedure. As a result, Mrs T[...] consented to the procedure, acting to her and/or E[...]’s actual or potential prejudice. In truth and in fact, at the time the accused made the misrepresentation, he knew that there had been no

confirmation of Hirschsprung's disease in the rectal biopsy obtained from E[...] on 12 March 2012. Consequently, the rectal pull through procedure was neither necessary nor appropriate.

- [3] The allegations regarding count 2 (murder) are that, between 30 and 31 March 2012, at or near Morningside Medi-Clinic in the district of Johannesburg North, the accused unlawfully and intentionally caused the death of a three-year-old male child, E[...] S[...] T[...].
- [4] The allegations regarding count 3 (murder) are that, on or about 29 July 2016, at or near the Morningside Medi-Clinic in the district of Johannesburg North, the accused unlawfully and intentionally caused the death of a 21 month-old female child, A[.] S[...].
- [5] The allegations regarding count 4 (fraud) are that, between 10 September and the 11 October 2019, at or near the Parklane Netcare Clinic in the district of Johannesburg Central, the accused unlawfully and with the intention to defraud, misrepresented to Ms Z[...] V[...] (previously S[...] - the biological mother of Z[...] S[...]), Mr Mohammed S[...] (the biological father of Z[...] S[...]), Z[...] S[...] (the deceased in respect of count 5), and Dr J Kussel

(Z[...]’s paediatrician) that the pathology results of a distal oesophageal biopsy, obtained from Z[...] on 3 September 2019 by the accused, revealed that Z[...] had intestinal metaplasia. As a result of this misrepresentation, Ms V[...], Mr S[...], Z[...] and Dr Kussel accepted and believed that the presence of intestinal metaplasia necessitated a Laparoscopic Nissen Fundoplication procedure. Consequently, Ms. V[...] and Mr S[...], to their and Z[...]’s actual or potential prejudice, consented to the procedure being performed on Z[...] by the accused. In truth and in fact, at the time the accused made this misrepresentation, he knew that there were no features of intestinal metaplasia, nor any signs of dysplasia or malignancy, in the distal oesophageal biopsy obtained from Z[...] on 3 September 2019. Therefore, the Laparoscopic Nissen Fundoplication was neither necessary nor appropriate.

- [6] Finally, the allegations regarding count 5 (murder) are that, on or about 11 October 2019, at or near the Parklane Netcare Clinic in the district of Johannesburg Central, the accused unlawfully and intentionally caused the death of a ten-year-old male child, Z[...] S[...].
- [7] Adv EHF Le Roux and Adv SH Rubin represent the State, whereas the accused is represented by Adv B Roux SC and Adv IP Green SC. The accused pleaded not guilty to the charges. In terms of section 115 of the Criminal Procedure Act 51 of 1977 (“CPA”), he denies the essential allegations contained in the various charges. The accused provided the following explanation for his pleas, which are set out in detail below.
- [8] In relation to count 1, the accused explained that E[...] (“the deceased in count 2”) and his parents consulted him with a history of severe constipation, which had persisted for 18 months and had not responded to conservative treatment. E[...] had previously been treated by other medical practitioners, including Dr A Eyal, a general surgeon, who ordered a barium enema study that suggested a diagnosis of Hirschsprung’s disease. Dr Eyal suspected this diagnosis, and the barium enema study was made available to the accused. The deceased’s symptoms, along with the barium enema study, were consistent with

Hirschsprung's disease. On 12 March 2016, the accused performed a rectal biopsy on the deceased. The biopsy specimen was sent to Lancet Laboratories and analysed by Dr Anita Gildenhuys who telephonically informed the accused that her examination revealed the absence of ganglion cells, which is consistent with a diagnosis of Hirschsprung's disease. The accused then informed Mrs Teubes accordingly.

- [9] Subsequently, Dr Gildenhuys conducted further examinations of the biopsy specimen, which revealed no ganglion cells at initial levels, but occasional groups of ganglions cells at deeper levels. This finding, along with the deceased's overall clinical presentation, symptoms and radiological findings, was consistent with a diagnosis of a variant of Hirschsprung's disease. The symptoms and treatment of Hirschsprung's disease and its variants are the same, and the findings indicated the need for the surgical intervention that the accused performed. He denied that he made a misrepresentation and intended to defraud or prejudice Mrs Teubes and/or the deceased.
- [10] In respect of count 2, he explained that on 30 March 2012, he performed a rectal pull-through procedure on the deceased. The rectal pull-through procedure was appropriately indicated and properly carried out. He denied that any of his actions in the rectal pull-through procedure or thereafter caused the death of the deceased.
- [11] In respect of count 3, A[.] S[...] ("the deceased in count 3") was born with a serious congenital defect which had required medical and surgical treatment throughout her life. The deceased presented with symptoms consistent with GORD (gastro-oesophageal reflux disease) which required a surgical procedure known as a Nissen Fundoplication. On 29 July 2016, he properly performed this procedure on the deceased and denies that any of his actions in the operative procedure or thereafter caused the deceased's death. It subsequently transpired that the deceased suffered from an undiagnosed myocarditis which compromised her cardiac function.
- [12] In respect of count 4, he explained that Z[...] S[...] ("the deceased in count 5") had a longstanding history of reflux and vomiting, which became more frequent and severe. The deceased had previously been treated conservatively by other medical practitioners without success. On 29 August 2019, the accused consulted with the deceased and Ms V[...], examined the deceased, and recommended a gastroscopy and biopsy as part of his workup. On 3 September 2019, he performed both

procedures on the deceased. During the gastroscopy, he observed that the portion of the oesophagus closest to the stomach was red,

inflamed, and exhibited a wavy or tongue-like appearance. These findings were consistent with a diagnosis of GORD. The laboratory

report on the biopsy sample recorded:

"- Mild chronic oesophagitis, with inflamed squamoglandular junction derived mucosa observed."

- The morphologic features favour a reflux associated aetiology.
- No micro-organisms are identified...”

which was also consistent with a diagnosis of GORD.

[13] The accused explained that he told Ms V[...] that the results indicated the presence of oesophagitis, which was consistent with his observations and confirmed the presence of reflux. He accepts that he told Ms V[...] that the biopsy results had shown the presence of metaplasia which he believed to be the case at the time. However, he subsequently realised that he had misread the biopsy results, which did not indicate the presence of metaplasia. He denied intentionally misinforming Ms V[...] about

the metaplasia. At the time, he believed that the deceased suffered from GORD and that the Nissen Fundoplication was necessary based on the following: the history provided by Ms V[...]; the deceased's non-response to Nexium treatment; his clinical examination of the deceased; the biopsy results (apart from the metaplasia); and his observations during the gastroscopy. He denied that he committed fraud. He denied committing fraud, asserting that he genuinely believed the deceased suffered from GORD and that the operation was indicated.

[14] In respect of count 5, the accused explained that on 11 October 2019, he properly performed a Nissen Fundoplication procedure on the deceased and denies that any of his actions in the operative procedure or thereafter caused the deceased's death. It later emerged that the deceased suffered from an undiagnosed myocarditis, which compromised his cardiac function, and that there

was a missed anaesthetic complication.

[15] From the onset, the accused made formal admissions per (Exhibit A) that are recorded in terms of section 220 of the CPA. Regarding counts 1 and 2, the accused freely and voluntarily admitted that he, being a paediatric surgeon in practice, was consulted by Mr

and Mrs T[...] regarding E[...]’s medical condition on 29 February 2012 for the first time. On 12 March 2012, the accused performed a rectal biopsy on E[...]. The specimen retrieved by the accused during the rectal biopsy was dispatched to Lancet Laboratories where it was examined by Dr Anita Gildenhuys. E[...] was admitted at the Morningside Medi-Clinic on 29 March 2012 to undergo the rectal pull-through procedure on 30 March 2012.

[16] The accused performed the rectal pull-through procedure on 30 March 2012, from 14h52 to 16h34. During the rectal pull-through procedure, the accused excised a 12cm section of E[...]’s rectum. E[...] passed away on 3 April 2012 at 12h35. Dr Moeng conducted a postmortem on E[...]’s body and prepared a report with reference number DR 554/2012. The accused does not admit the truth, correctness or accuracy of the report prepared by Dr Moeng. The accused agreed that the available hospital records for E[...]’s

admission to Morningside Medi-Clinic during 29 March to 3 April 2012 could be handed in as Exhibit C1 154 but the accused did not admit the truth, accuracy, correctness or completeness of those hospital records.

- [17] Regarding count 3, the accused formally admitted that he consulted A[...] and Ms S[...] on 13 July 2016. The accused told Ms S[...] that the treatment of A[...]’s GORD could consist of a surgical procedure known as a Nissen Fundoplication. A[...] was admitted to the Morningside Medi-Clinic on 29 July 2016. The accused performed the Nissen Fundoplication procedure from 15h35 to 18h48 on 29 July 2016. A[...] was taken to the recovery room at approximately 18:50. A[...], although a little pale, breathed spontaneously, and was initially stable in the recovery room. A[...] was declared dead at 20h57 on 29 July 2016.
- [18] The accused formally admitted that the body of A[...] sustained no further injuries from the time of her passing until a postmortem was conducted thereupon. Doctor Hestelle Nel (now van Staden) conducted a postmortem examination on the body of A[...] on 1 August 2016, and recorded her findings on a form GW7/15 with serial number DR1671/2016 and deposed to an accompanying affidavit, both of which were admitted as Exhibits E1 and E2. The accused agreed that the available hospital records for A[...]’s admission to Morningside Medi-Clinic on 29 July 2016 could be marked Exhibit F1–74 but did not admit the truth, accuracy, correctness or completeness of those hospital records.
- [19] Regarding counts 4 and 5, the accused formally admitted that, in attempts to obtain relief from the reflux and vomiting, Z[...] consulted Dr J Kussel, a paediatrician; Dr R Khan, a specialist paediatric pulmonologist; and Dr P Walabh, a paediatric gastroenterologist. The accused, being a paediatric surgeon, was consulted by Ms V[...] and Z[...] on 29 August 2019 for the first time. The accused performed a distal oesophageal biopsy procedure on Z[...] on 3 September 2019. The specimen

retrieved by the accused during the procedure was dispatched to Lancet Laboratories, where it was examined by Dr Charlotte Ray. Dr Ray signed off her final and only report on the specimen, designated as specimen number 19: LP067414, on 10 September

2019. This report forms part of Exhibit J109.

- [20] The accused formally admitted that Z[...] was admitted to Park Lane Clinic on 9 October 2019 and discharged on 10 October

2019. He was re-admitted on 11 October 2019 for a Nissen Fundoplication. The procedure began at 14h45, and the accused performed the surgery. Z[...] was transferred to the recovery room at approximately 18:46. After Dr Munshi re-intubated Z[...],

he suffered a cardiac arrest, and the accused assisted in resuscitation efforts. The accused admitted that Z[...] passed away at approximately 22h30 on 11 October 2019.

- [21] The accused formally admitted that the body of Z[...] sustained no further injuries from the time of his passing until a postmortem was conducted thereupon. The accused admitted that Dr Vergie performed a postmortem on Z[...]’s body and prepared a report with reference number DR 2734/2019. The accused agreed to Dr Vergie’s postmortem report and her affidavit being handed in as Exhibits H1 and H2 respectively. The accused did not admit the truth, correctness or accuracy of Dr Vergie’s report and her affidavit.
- [22] The accused agreed that the available hospital records for Z[...]’s admissions to Parklane Clinic on 9 and 11 October 2019 could be handed in as Exhibit J1-133 but did not admit their truth, accuracy, correctness or completeness. He admitted the authenticity of the patient file kept by Dr A Munshi and agreed it could be submitted as Exhibit K. He also admitted that Annexure ZS of A21 is a transcript of a conversation between him and Ms V[...] and that it could be handed in as Exhibit P. Additionally, he admitted the authenticity of the patient files kept by Drs Kussel, Khan, and Walabh regarding their patient, Z[...] S[,], which were submitted as Exhibits Q, R, and S, respectively.
- [23] The accused made further formal admissions in terms of section 220 of the CPA. He admitted that between the period 3 April 2008 and 20 February 2009, he invested a total of R2 204 000,00 (two million, two hundred and four thousand Rand) in an investment colloquially known as the Frankel Scheme, which was promoted by, amongst others, Mr Barry Tannenbaum (“the Investment/Tannenbaum Scheme”).
- [24] The accused admitted that during that period, he received payments from the Investment, R80 000,00 of which had to be returned to the liquidators of the Frankel Scheme in terms of section 29 of the Insolvency Act 24 of 1936. His net loss on the Investment was R1 564 000,00 (one million, five hundred and sixty-four thousand Rand). The State contends that this financial loss motivated the accused to perform unnecessary surgeries to recover his losses from the Tannenbaum Scheme.
- [25] This Court has heard both factual and expert evidence. A summary of the evidence follows.
- E[...]’s Case

- [26] The summary of E[...]’s case follows hereunder. His mother, Mrs T[,], testified for the State. E[...] and his twin brother, L[,], were born prematurely on 29 March 2009. The following facts are largely common cause. At 18 months, E[...] began suffering from constipation, which progressively worsened. His condition was accompanied by bouts of abdominal pain, and he would stop eating. From the time E[...] and Liam started eating solids at 18 months, E[...] lagged behind his brother in growth. E[...] was treated for constipation by a paediatrician on two occasions and had also been seen by his general practitioner. By October 2011, E[...] weighed 12kg, and by the time of the operation four months later, he had gained only 0.2 kg. In their efforts to manage his condition, E[...]’s parents consulted multiple doctors, tried

over the counter medications, implemented dietary changes, and sought help from a homeopath. They used suppositories and attempted an experimental fibre diet.

[27] The efforts by E[...]’s parents to deal with his constipation had some effect, but not enough, and the problem resumed. Matters reached crisis proportions on Sunday, 19 February

2012. That morning, E[...] woke up complaining of pain. His condition was concerning enough that his parents took him to their general practitioner, Dr Mohammed, despite it being a Sunday. Dr Mohammed, recognising the severity of E[...]’s condition, referred him to Dr Eyal, a specialist surgeon. Dr Eyal ordered an abdominal x-ray and administered an enema, but the enema had no effect. Dr Eyal then ordered a barium enema examination.

[28] The barium enema report (CL7) stated, “[f]indings are suspicious for Hirschsprung’s disease. Please correlate with rectal biopsy.” Based on these findings, Dr Eyal informed E[...]’s parents that there may be a surgical solution to his constipation. He explained the possibility of surgery and referred them to Dr Mapunda. However, for reasons not provided by E[...]’s parents, they did not consult Dr Mapunda and instead sought the opinion of the accused.

[29] It is common cause that the accused first saw E[...] on 29 February 2012 at his rooms in the Parklane Clinic. The consultation was attended by E [...], his twin brother L [...], and their parents. Liam served as a useful comparison for the accused

in assessing E[...]’s development and condition. At 36 months old, E[...] weighed only 12.2kg, placing him in the 8th to 10th percentile. He was 2kg lighter than his twin brother. During her testimony, Mrs T[...] presented a collection of 12 photographs, marked as Exhibit ZZK1-12, depicting the twins from infancy up to a week before E[...]’s passing.

[30] It is common cause that Mrs T[...] provided E[...]’s medical history during the consultation. As previously indicated, E[...] had suffered from constipation from 18 months of age, and various conservative treatments had been attempted. According to her version, they had only one consultation with the accused, which lasted approximately 15 minutes. Apart from the phone calls on 16 March 2012, when the accused informed her that E[...] had Hirschsprung’s disease, and another call before E[...]’s admission on 29 March 2012, their communication was limited. She also recalled a brief conversation with the accused on the morning of 30 March, a few hours before the operation.

[31] In her testimony, Mrs T[...] was adamant that the accused never properly examined E[...] during their first consultation. From the time of that consultation until the day of the operation, it was never explained to her that other conditions, such as hypoganglionosis or intestinal neuronal dysplasia (IND), could mimic Hirschsprung’s disease. She testified that if the accused had

informed her that E[...] did not have Hirschsprung’s disease, she would have had a choice to consult other doctors and possibly

considered alternative options. She further stated that she ultimately signed the consent form under pressure, as she did not want E[...] to suffer any further. According to her, she “consented” to the operation because she was falsely led

to believe that E[...] had Hirschsprung’s Disease.

[32] Whilst providing E[...]’s medical history, Mrs T[...] mentioned Dr Eyal, who had ordered abdominal x-rays and a barium enema examination. She had the radiologists’ reports and the x-ray film with her. The x-ray report indicated faecal loading but no bowel obstruction. The barium enema report noted that the results were suspicious for Hirschsprung’s Disease and recommended a rectal biopsy.

[33] As previously indicated, E[...] was admitted to the Morningside Clinic on 29 March 2012 and was taken to theatre at approximately 14h00. According to the hospital records, the surgery lasted from 14h52 to 16h34. Exhibit ZD is an animated representation of the procedure performed on E[...] subject to two qualifications:

- a. The video depicts cauterisations of the mesenteric vessels, whereas the accused clamped the vessel, placed ties on both sides, and then divided it. The ties used by the accused were made of vicryl, a suture material.
- b. E[...] was positioned on his back with his legs up during the procedure, whereas the video depicts the patient face down with buttocks up.

[34] The assistant surgeon was Dr Milan Gopal, and the anaesthetist was Dr Lynda Blesovsky. After the operation, the accused met Mr and Mrs T[...] outside the theatre. The accused informed them that the procedure had gone well, that E[...]

was in the recovery room, and that he would be transferred to the ward. While E[...] was in the ward, Mrs T[...]

testified that he already had a distended stomach by the time the accused did his rounds at 19:30. When she questioned this, the

accused attributed it to trapped gas following the procedure.

[35] There is a dispute regarding the quantity of water that Mrs T[...] was told E[...] could be given. Mrs T[...] stated that the accused told her E[...] could drink without any restriction on quantity. She estimated his fluid intake at approximately 100ml from a 300ml NUK bottle. She testified that she did not give E[...] a large amount of fluid but clarified that she gave him apple juice, not water. During cross-examination, she challenged the meaning of “small sips” and was non-committal when asked whether she understood that E[...] could have as much fluid as he wanted. We return to this aspect later in the

judgment.

- [36] The events of the evening of 30 March 2012 are best determined from the hospital records. In this regard, the State presented the evidence of Nurse Pretty Mankoe, who was then an enrolled nurse assisting Sister Charity Hines, who oversaw the ward that night. Nurse Mankoe's role was to record observations and report to Sister Hines. The hospital records serve as a contemporaneous recordal of events. While they may not capture every detail, as later became apparent, and while the timestamps may not be precisely accurate, they provide the most reliable evidence of what transpired that evening. For this reason, it is convenient to consider the events of the 30 March 2012 into the morning of 1 April 2012, with reference to the hospital records.
- [37] The relevant hospital records include the nursing notes for the evening of 30 March 2012 and the observation chart. Each of these documents was dealt with during the cross-examination of Nurse Mankoe. These records were also addressed during Nurse Mankoe's testimony on behalf of the State.
- [38] E[...] returned to the ward at 17:00 and was fully awake. No observations were recorded at that time. At 17:30, E[...] was given pain medication as prescribed, but no observations were recorded. At 18:00, E[...] was sleeping, with no observations recorded. At 18:15, his drip was running well with no redness. The observations, recorded at 18:13, noted that E[...]s respiration rate was 34, his oxygen saturation was 92% on room air, his pulse rate was 130, and his temperature was 36.3°C. At 18:30, E[...] vomited after being given medication but no observations were recorded. At 18:35, E[...] soiled his nappy, with no observations recorded. At 18:46, Dr Blesovsky was telephoned, and it was reported to her that E[...] had vomited. Dr Blesovsky advised the nurses that there was no cause for concern. At 19:05, observations were recorded: oxygen saturation was 90% on room air, pulse rate was 165, and his temperature was 36.2°C. At 19:20, E[...] appeared pale, and his oxygen saturation ranged between 88-90% on room air.
- [39] E[...] was then placed on 2 liters of oxygen. At 19:20, observations were recorded: his respiration rate was 36, oxygen saturation was 98% on 2 liters of oxygen, and his temperature was 37°C. Importantly, the pulse rate entry of 175 was annotated as "wrong entry". Nurse Mankoe stated that she made this annotation to indicate that she had mistakenly recorded the respiration rate at 19:20 and that it should have been entered in the next column at 20:30. Significantly, there is no indication that E[...]s respiration rate was elevated when he was seen by Dr Blesovsky and the accused at 19:30.
- [40] At 19:30, E[...] was seen by Dr Blesovsky and shortly thereafter by the accused. The entry regarding Dr Blesovsky's assessment is recorded under the 20:30 timestamp and annotated as a "late entry". Dr Blesovsky instructed the nursing staff to "observe patient closely". At 19:30, the accused ordered a full blood count and prescribed Valoron drops, an analgesic. At

20:15, E[...] was reported to be dyspnoeic, with flared nostrils. He was placed in the Fowler's position. There is no nursing note for 20:30, as this was the late entry for Dr Blesovsky's assessment. The observations at 20:30 recorded that

E[...]’s respiration rate was 38, oxygen saturation was 97% on 2 liters of oxygen, pulse rate was 175, and his temperature

was 37.1°C. At 21:30, the nursing notes recorded only E[...]’s vital signs, which matched the readings on the observation chart: respiration rate was 40, his oxygen saturation was 100% on 2 liters of oxygen, pulse rate was 166, and temperature was 37°C.

- [41] At 21:50, Sister Hines telephoned the accused to inform him of the full blood count test results he had ordered. She reported that E[...]’s haemoglobin level was 10.9, which the accused did not find concerning. It is common cause that this was the last communication with the accused until he was telephoned by Sister Hines at 04:26 on 31 March 2012.
- [42] At 22:30, E[...] was intermittently asleep. His abdomen was distended, and he was tachypneic. The nursing notes record a pyrexia of 38.4°C, and a blanket was removed from him. His observations showed a respiration rate of 36, oxygen saturation of 99% on 2 liters of oxygen, a pulse rate of 176, and a temperature of 38°C. Despite the deteriorating trend in E[...]’s vital signs, the nurses did not inform the accused or Dr Blesovsky, nor did they contact Dr Obor, the paediatrician on call.
- [43] At 23:00, the nursing notes recorded that medication, including Perfalgan, was administered to E[...]. Perfalgan is paracetamol, which would have treated E[...]’s pyrexia. E[...] was also given Augmentin, a broad-spectrum antibiotic, routinely prescribed following abdominal surgery. Normally this would have controlled an infection. At 24:00, the nursing notes recorded that E[...]’s temperature was re-checked and the results were reported by Nurse Mankoe to Sister Hines. E[...]’s observations showed a respiratory rate of 48, oxygen saturation of 100%, a pulse rate of 180, and a temperature of 38.4°C. At 01:00, the nursing notes reported that E[...] appeared to be sleeping and breathing well.
- [44] At 01:30, E[...]’s observations showed a respiratory rate of 44, oxygen saturation of 99%, a pulse rate of 190 and a temperature of 37.1°C. The drop in temperature may have been the effect of the Perfalgan. At 02:00, the nursing notes recorded that E[...] was in pain, scored as 6/10, and was given Valoron drops. At 03:00, the nursing notes recorded that E[...] was still complaining of pain and was tachypneic and tachycardic. His pulse was noted as 168, and his respiration is 48. E[...]’s observations at this time showed a respiratory rate of 66, oxygen saturation of 96%, a pulse rate of 198, and a temperature of 38.4°C. At 04:00, the nursing notes recorded that E[...] was awake, complaining of abdominal pain, and that his abdomen was distended. He was also noted to be tachypneic and tachycardic and appeared disorientated. The notes indicate that the accused was telephoned; however, it is accepted that the recorded time is incorrect. It is common cause that the accused was only telephoned at 04:26.

[45] When the accused was telephoned, he was informed that E[...]’s abdomen was distended, and he instructed Sister Hines to insert a nasogastric tube into E[...]’s stomach. The accused also ordered an abdominal x-ray. The note recording the accused’s instruction to insert the nasogastric tube is timestamped 04:10 on the nursing notes. At 04:20, the nursing notes recorded that

the nasogastric tube was inserted, and 250 ml of light brown fluid was drained, which is consistent with the entry on the fluid balance chart.

[46] At 04:30, E[...]’s observations showed a respiratory rate of 64, his oxygen saturation of 98%, a pulse rate of 168, and a temperature of 39.4°C. There is no note in the nursing records for 04:30. At 04:40, the nursing notes recorded that E[...] convulsed, and the accused was notified. The telephone records show that this call was made to the accused at 04:58, and he stated it was made while he was on his way to the hospital. At 04:44, the nursing notes recorded that the accused prescribed Valium for the seizure.

Other nursing notes for 05:00. record that a “code blue” was activated, that E[...] stopped convulsing, that Dr Karen from ICU had seen E[...] but did nothing to him, and that E[...] was seen by the Emergency Room doctor and a chest and abdominal x-ray was carried out. This is the x-ray the accused had ordered. The State concedes that, in this case, there can be little doubt that Sister Charity Hines should have acted sooner rather than later.

[47] Dr Nancy Obor testified and confirmed that she was on call at the Morningside Medi-Clinic on 31 March 2012 when she received a telephone call from the accused at approximately 06:00, requesting that she assess E[...]. She was briefly informed that E[...] had undergone a distal rectal dissection for the treatment of Hirschsprung’s Disease on the evening of 30 March 2012. The accused advised her that the deceased was in marked respiratory distress, which he suspected was due to aspiration of oral fluids administered contrary to his instructions. She examined E[...], who was in the general ward, at approximately 06:10 in the presence of his parents and grandparents. On examination, E[...] appeared pale, cold, and clammy to the touch. She testified that his abdomen was distended but not tense, and appeared to be filled with air; however, with no bowel sounds detected.

[48] Neurologically, E[...] was floppy and moribund. He was not opening his eyes spontaneously. E[...]’s vital signs were also abnormal: his oxygen saturation levels on the monitors were 87% and his heart rate was 196 beats per minute. Additionally, E[...]’s pulse was not palpable on his wrists or feet, and a blood pressure reading was therefore not detectable. It was apparent that the deceased was in hypovolaemic shock and in severe respiratory distress by the time that Dr Obor arrived at the general ward, approximately ten minutes after she received the call from the accused. She immediately commenced resuscitation by increasing the oxygen flow to 8ml per minute, and the saturations improved after the increase in oxygen.

- [49] Dr Obor further reviewed a chest x-ray taken at approximately 05:30. The x-ray revealed a gas bubble in the abdomen and a markedly distended loop of bowel crossing the abdomen. Gas was also detected within the distal bowel. At the time, the nasogastric tube was visualised in the midline of the chest, but the tip was not visualised in the abdomen. She wheeled E[...], with the assistance of Nurse Mankoe and a porter, to the ICU ward, even though the ICU bed was not yet available.
- [50] E[...] was admitted in the ICU at approximately 07:15. Dr Obor intubated him on arrival at the ICU. The x-ray taken at 08:43 shows the presence of an endotracheal tube, confirming that E[...] was intubated. This is consistent with Dr Obor's note, which she timestamped as 07:15. She remained at the E[...]’s bedside, monitoring his condition and making relevant adjustments to his treatment. It is undisputed that at approximately 09:00, E[...] suffered a cardiac arrest.
- [51] At the Morningside Clinic, there is a dedicated resuscitation team known as “Code Blue”. They were immediately contacted. By 09:09, the deceased was already intubated and bagged, with chest compressions being performed by Dr Piakowski. A few minutes later, at 09:11, Dr Gottlich arrived to assist with the resuscitation.
- [52] Prior to the cardiac arrest at 09:00, E[...] had shown some improvement, and his ventilation seemed to be acceptable. According to Dr Obor’s version, the blood results collected at 09:18 were drawn before the arrest. The blood results were indicative of severe sepsis and/or bacterial infection. Shortly before 09:30, the E[...]’s heart rate started dropping again; resuscitation was commenced immediately. E[...], however, had a sustained bradycardia followed by a second cardiac arrest. Dr Gottlich was present during this resuscitation, and they alternated between chest compressions and bagging. The nursing notes describe the second cardiac arrest as “more respiratory as (endotracheal tube) was not in the correct place”.
- [53] Dr Obor contacted the accused for assistance. During the resuscitation, she noted that there was poor air entry to the chest and reduced chest movements. She then re-sited the endotracheal tube to ascertain whether the poor response was due to the tube being dislodged during resuscitation. There was still no response to the resuscitation. It is common cause that when the accused arrived in the ICU during the resuscitation following the second cardiac arrest, Dr Gottlich asked the accused to check E[...]’s airway, which he did using a laryngoscope. The endotracheal tube was inserted into E[...]’s oesophagus and not his trachea. The accused, as a result, re-sited the endotracheal tube into E[...]’s trachea. It is this endotracheal tube that is shown on the x-ray taken at 10:43, which is slightly too deep, with its end going into the origin of the right main bronchus.
- [54] By 1 April 2012, E[...] remained in intractable shock and was passing minimal urine despite medical interventions. His abdomen was distended with free fluid in the abdominal cavity. He was comatose (Glasgow coma scale of 3/15) and unresponsive, with fixed dilated pupils.

His blood sugar continued to drop, and he failed to maintain body temperature even after gradual rewarming. By 2 April 2012, E[...] remained in critical condition. His respiratory status was still poor, with oxygen saturation levels at 75%. His kidney function continued to deteriorate. By 3 April 2012, E[...]’s clinical condition remained critical, with no significant improvements. There was no spontaneous respiration. His pupils were fixed, dilated, and he was unresponsive. His abdomen was silent and continued to drain fluid. E[...]’s parents, therefore, opted to make the difficult decision to withdraw treatment.

[55] It is common cause that E[...] was certified dead at 12:35 on 3 April 2012. Dr Obor opined that E[...] died of peritonitis, not pulmonary pneumonitis. She testified that aspiration would not cause infection, and certainly not cause bacteria to grow in the abdominal cavity. She testified further that E[...] should have been admitted to the ICU after the operation,

given that he had undergone a major surgery. The hospital's policy was adjusted afterwards with respect to paediatric surgical cases.

[56] However, during the cross examination of Dr Obor, she conceded that E[...] was found to be brain dead following several investigations, and it was on that basis that his medical team recommended that life support be withdrawn. From the evidence, it would seem the brain damage had been sustained during the resuscitation following the 09:30 cardiac arrest, when E[...] was intubated into his oesophagus, which would have resulted in him being deprived of effective ventilation for a considerable period.

The Post-mortem of E[...]

[57] The State argued that there was a defect in the surgery and that the defect is evidenced by the post-mortem observations of Dr Moeng. In her report, Dr Moeng states:

“Intestine and Mesentery: Show evidence of surgery across the rectum, evident on internal examination. The sutures appear loose, with no tightly adequate

approximation of the wound edges. There is an organizing haematoma in the surgical area across the rectum, revealing a 25mm unsutured

defect, just below the suture line. There is a fibrino-purulent exudate in the area of the surgery. The intestinal contents are

yellow and gelatinous, with no formed stools.”

It must be recalled that the State did not call Dr Moeng as a witness and sought to explain that through the investigating officer, W/O Chris Muller, who testified that he could not locate her.

[58] The State presented the evidence of Professor Banieghbal about a conversation that he had with the accused at a conference in support of the allegations of fraud and murder charges. In this regard, Professor Banieghbal says that the accused raised the losses he had suffered in the Tannenbaum Scheme and suggested that he would even act as an assistant surgeon. This statement was deposed to

in October 2023 and deals with a conversation that is alleged to have taken place in June 2009. The discussion that Professor Banieghbal

referred to took place on the first night of a conference in Austria, at a social gathering where food and alcohol were served.

[59] According to Professor Banieghbal, the accused said that he would even assist other surgeons to recoup his losses. However, in cross-examination, when it was proposed that this could not have been seriously intended, Professor Banieghbal acknowledged that both he and the accused would have had a drink in hand at the time of the conversation. It was two colleagues having a social chat at a welcoming function at a convention. When this was put to Professor Banieghbal, he said, “[i]t is quite possible, but I remembered because of this unusual comment about assisting other surgeon[s] in private practice, not in government hospital[s].”

[60] Regarding E..., he testified that he reviewed the hospital records and the two histology reports of Gildenhuys and Harrison, concluding that E[...] did not have Hirschsprung's disease or hypoganglionosis and, therefore, did not require the rectal pull-through procedure performed by the accused. In coming to this conclusion, he had access to the complete police docket regarding this matter, specifically Exhibit D2. He opined, as per exhibit D2 and in his oral evidence, that the accused “ignored a normal rectal biopsy report and embarked on a complex and complicated operation for a non-existing disease while convincing the

parents that the procedure was relatively simple. The outcome of this decision was fatal for his patient”. Further he stated that “surgery was unnecessary”, but the accused “ignored the rectal biopsy result to secure a monetary reimbursement. The less likely alternative is that [the accused] was mentally unstable and on heavy sedation impairing his clinical judgement at that period”.

[61] The State was constrained to concede that Prof Banieghbal's testimony was not without criticism. During cross-examination regarding E..., Banieghbal made several concessions, which impacted his evidence in chief. For example, he conceded that his approach to Hirschsprung's, it's diagnosis, and treatment may be simplistic— either you have it, or you don't, which was his “approach”. He then suggested his approach was the approach of most paediatric surgeons. Prof Banieghbal conceded that there may well be other paediatric surgeons who have a different opinion.

[62] Prof Banieghbal conceded that, whereas he has a personal preference that differs from the paediatric surgeon who considers a variant of Hirschsprung's, he was in no position to say that one or the other is correct or incorrect. In summary, he conceded that, there is a group of paediatric surgeons who, when exercising their clinical judgment, would reasonably have concluded that E[...] suffered from a functional disease that required surgery to treat it. He was also constrained to concede the existence of a body of literature that deals with variants of Hirschsprung's disease, authored by experts in the field.

[63] In addition, he conceded, upon confrontation with the Prem Puri article on variants of Hirschsprung's[1], that a biopsy should be approached with caution. He testified that the volume of fluid drained from the stomach, even if one accepts

that it is around 500ml, although excessive, is not unusual. Importantly, during cross-examination following his criticism of the

surgery, when asked if his evidence on the surgery should be ignored until Dr Moeng had explained her report, he said "yes".

[64] It is common cause that, in E[...]s case, proceedings took place before the Health Professions Council of South Africa ("HPCSA"), the body established to assess the conduct of doctors. These proceedings involved charges against the accused relating to informed consent, the indication for surgery, and the post-operative treatment. Notably, the accused was found not guilty on these charges, a conclusion with which Professor Banieghbal, who served on the panel, agreed. During cross-examination, Professor Banieghbal conceded that he had not received any new or additional facts in this trial that were not available at the HPSCA hearing. He further conceded that, based on this, his opinion as expressed in the HPCSA finding ought not to change as he sought to do in this trial.

[65] Dr Paula Eyal (Exhibit ZE) also testified in E[...]s case. At the request of Mr Teubes, she re-examined the specimens previously assessed by Dr Gildenhuys and Dr Harrison. In her expert opinion, neither the original rectal biopsy nor the subsequent rectal resection specimen exhibited features consistent with Hirschsprung's Disease or any other disorder. Significantly, during cross-examination, Dr Eyal conceded that it is entirely possible for two pathologists to reach differing conclusions when assessing a biopsy, a phenomenon recognised as inter-observer variability.

The Accused's Training and Experience (as per Exhibit ZZP)

[66] The accused was born on 5 August 1946 and was 77 years old at the time of his testimony. He was 73 at the time of Z[...] S[...]s death, 69 at the time of A[...] S[...]s death, and 65 at the time of E[...] T[...]s death. In 1970, he graduated with an MBChB degree from the University of Pretoria Medical School. During the first six months of 1971, he was an intern in the surgery department at what is now Steve Biko Hospital. In the second half of 1971, he interned at Baragwanath

Hospital in the Obstetrics and Gynaecology department. In the first six months of 1972, he served as a senior intern in Internal Medicine at Steve Biko Hospital, and in the latter half of the year, he was a senior house officer in Surgery and Neurosurgery.

[67] In 1973, the accused was appointed as a registrar in general surgery in the Surgery Department at the University of Pretoria, rotating between Steve Biko and Kalafong Hospitals. At the end of 1977, he wrote the College of Medicine exams for surgeons and qualified as a Fellow of the College of Surgeons of South Africa (FCS SA), followed by the MMed (Surgery) exam at the University of Pretoria. He also wrote the surgical examinations

in Edinburgh, Scotland, and was admitted as a Fellow of the Royal College of Surgeons Edinburgh, (FRCS Edinburgh).

- [68] In 1978, he joined the University of the Free State as a consultant in the General Surgery Department and was eventually appointed as the head of a general surgery unit. He was assigned responsibility for paediatric surgery. During his 18-months tenure at the University of the Free State, he also worked at Universitas and Pelonomi Hospitals. During this period, he performed and taught both general and paediatric surgery. In July 1979, he joined the University of the Witwatersrand as a senior registrar in paediatric surgery, providing services at Charlotte Maxeke Hospital, Baragwanath Hospital and Rahima Moosa Mother and Child Hospital. During this period, he performed Nissen Fundoplication operations, which were conducted as open surgical procedures, as endoscopic surgery was not yet available. The accused has been performing Nissen procedures on paediatric patients since 1979.
- [69] From January to July 1981, he worked as a senior clinical resident at the Children's Hospital in Seattle, United States, where he gained additional experience in paediatric surgery, completing the requirements for registration as a paediatric surgeon with the HPCSA. In July 1981, he returned to the University of the Witwatersrand and was employed as a junior consultant in the Paediatric Surgery Department on what is known as the "Wits Circuit", which included the Charlotte Maxeke Johannesburg Academic Hospital, Helen Joseph Hospital, Rahima Moosa Mother and Child Hospital, and Chris Hani Baragwanath Hospital. During this period, his primary focus was children's surgery, but he was also involved in the Wits transplant unit, performing renal transplants in both children and adults. He remained a member of the transplant unit for 30 years, during which he performed approximately 1500 renal transplants, 360 of which were in children.
- [70] In March 1983, the accused was appointed as a Senior Consultant in the Department of Paediatric Surgery. In March 1992, he was appointed as a Principal Specialist in Paediatric Surgery and was later appointed as the Head of the Department. In January 2002, he was appointed as an Adjunct Professor in the School of Medicine, specialising in paediatric surgery. From December 2004 to September 2013, he served as the Chief Specialist in the Department of Paediatric Surgery and was actively involved in surgical procedures on a daily basis. In his capacity as Head of the Department, he was also responsible for teaching and training.
- [71] Given his ongoing academic involvement, the accused also served as the convenor of the paediatric surgery examinations in Johannesburg and was appointed as an examiner at the College of Medicine for paediatric surgeons. Over the years, he has presented numerous academic papers at both local and international conferences and congresses. In 2007, he received an award from the HPCSA in recognition of excellence in healthcare.
- [72] Around 1990, he commenced what is he termed as a "limited private practice". Upon retiring from the University of the Witwatersrand at the age of 67, he continued his private practice.

The Accused's Version in Respect of E[...]

[73] According to the accused, after examining E[...], he informed E[...]'s parents that his clinical assessment was consistent with the possibility of Hirschsprung's disease. He explained that Hirschsprung's disease is a condition where nerves are absent in the distal part of the bowel, preventing it from working properly and causing functional constipation. He further explained the treatment of Hirschsprung's disease to E[...]'s parents. He explained that the procedure was known as a short segment

trans-anal endorectal pull-through, which involved cutting the bowel and pulling the upper section of normal bowel down to the anus. He also explained the main risks of the procedure, including the possibility of a leak, which he said might seldom occur and infection.

[74] The biopsy was performed on 12 March 2012, at Linksfield Hospital without complications. During the procedure, the accused removed an ellipse-shaped section measuring approximately 2mm in width and 10mm in length. It was a full thickness biopsy. The sample was sent to Lancet Laboratories. The accused recalls contacting Lancet Laboratories to inquire about the pathologist assigned to the sample and was informed that it had been allocated to Dr Gildenhuys, whom he knew professionally from the Wits Medical School.

[75] It is noted that although Dr Gildenhuys was on the State's witness list, she was not called as a witness. After the accused spoke with Dr Gildenhuys, he had a conversation with Mrs T[...]. Mrs T[...] stated that this conversation took place on Friday, 16 March 2012. According to the accused, he had not yet seen the Lancet report at that stage. The biopsy report was sent to the Johannesburg General Hospital (Charlotte Maxeke) and to the Linksfield Clinic, where the biopsy procedure had been performed, but

not to the Parklane Clinic, where he held his rooms. The accused was away at a congress after 16 March 2012, over the weekend of 17 and 18 March 2012.

[76] When the accused eventually reviewed the biopsy report, it stated that Dr Gildenhuys had identified occasional groups of ganglion cells in the deeper layers of the biopsy. Upon receiving the report, the accused contacted Dr Gildenhuys to inquire whether her findings were consistent with hypoganglionosis. According to the accused, Dr Gildenhuys responded that, while she had not measured the distance between the groups of ganglion cells, she believed her analysis was consistent with hypoganglionosis.

[77] Hypoganglionosis is a condition characterised by a decreased number of ganglion cells in the bowel. According to the accused, hypoganglionosis, like Hirschsprung's Disease, leads to intractable constipation and presents a clinical picture similar to that of E[...]. The treatment for hypoganglionosis, as stated by the accused, is the same as for Hirschsprung's disease. On his version, the key difference between Hirschsprung's Disease and hypoganglionosis is that, in Hirschsprung's Disease, there are no ganglion cells, whereas in hypoganglionosis, there are too few ganglion cells. The outcome is the same: the bowel fails to function properly. Hypoganglionosis is a recognised variant of Hirschsprung's disease.

- [78] Given that there was no difference in the treatment regime, the accused explained that he chose not to inform Mrs T[...] that Dr Gildenhuys had identified occasional groups of ganglion cells and believed her findings were consistent with hypoganglionosis. In making this decision, he aimed to avoid confusing Mrs T[...].
- [79] E[...] was admitted to the Morningside Clinic on 29 March 2012. Upon his admission, the accused prescribed Kleen Prep to be administered as bowel preparation. This was necessary to clear any faecal matter from the bowel, which assists with infection control during and after the operation, and ensures a clean operative field. On the evening of 29 March 2012, the accused visited E[...]
- in the ward, where he met Mrs T[...].
- [80] The accused explained to Mrs T[.] that he had prescribed bowel preparation and that, if it did not have the desired effect, a bowel washout procedure might be required. Mrs T[...] inquired whether the procedure should be done under general anaesthetic. He explained that general anaesthesia was not required and that it was the equivalent of an enema. The accused further explained that, to lighten the mood and in jest, he remarked, “sometimes it's the mom that needs the sedative”.
- [81] According to the accused, the procedure was uneventful and uncomplicated. After the operation, he met with the parents and, upon their enquiry, advised that E[...] may have sips of water to keep his mouth moist.
- [82] When doing his rounds, he saw E[...] at around 19:30 in the ward and noted that he looked a little pale. Otherwise, there was nothing that concerned him. However, he did order a full blood count. He further testified that Et[...]'s stomach was not distended, and that his breathing was normal. The accused was only called 04:26 the following morning, by which time E[...] was already in deep trouble.
- [83] Another expert, Professor Moore (Exhibits ZZY and ZZZ), testified on behalf of the accused. He stated briefly that, upon reviewing Dr Govender's report on the barium enema conducted on E[...] on 22 February 2012, he agreed with the assessment that the findings were suspicious for Hirschsprung's Disease. In his conclusion, he was of the opinion that surgery was indicated in E[...]’s case under the circumstances.
- [84] It is significant to note that the events concerning E[...] took place in February, March and April 2012 — more than 11 years before any of the witnesses testified based on their recollection of the events leading to his demise.

A[...] S[...]’s Case

- [85] The mother, Mrs M[...] S[...], retired nurse Tara Ramjee, and Professor Loveland testified on behalf of the State. The assistant surgeon, Dr Germon, did not give evidence. The accused and Professor James testified in his defence. The following facts are common cause:

A[...] was born on 7 October 2014 with oesophageal atresia, which was surgically repaired at birth. She suffered from complicated gastro-oesophageal reflux disease (GORD). The accused informed Mrs S[...] that A[...] needed to undergo a Laparoscopic Nissen Fundoplication. At the age of 21 months, on 29 July 2016, she was admitted at the Morningside Medi-Clinic, where the accused, the operating paediatric surgeon, performed the procedure with the help of the assistant surgeon, Dr Germon, and the anaesthetist, Dr Linda Blesovsky, who is now deceased.

- [86] There is no dispute that the indication for this procedure was appropriate. Surgery commenced at 15:00 and concluded at 18:50, lasting approximately four hours. According to Prof Loveland, this is a significantly long operative time for the procedure, suggesting considerable difficulty. The complexity of the procedure was exacerbated by the loss of a suture needle, which, although eventually retrieved, caused additional delay. There were also multiple power outages and difficulty in suturing. The most significant complication, however, was an iatrogenic injury to an accessory or replaced left hepatic artery, which runs through the gastrohepatic ligament and is at risk of injury during this operation.
- [87] Prof Loveland, as per Exhibit G1 and in his testimony, opined that, “[w]hilst the intra-operative course and complications are recognised morbidities, these were poorly managed”. In his view, this constituted negligence on the part of the anaesthetic and surgical teams, resulting in an avoidable operative death. Furthermore, the failure to document the impact of blood loss during the operation — either by requesting an urgent haemoglobin level or by performing an intra-operative arterial blood gas — and, consequently, the failure to identify haemorrhagic shock and treat it with an urgent blood transfusion, constituted negligent conduct.
- [88] According to the accused, Dr Blesovsky had been the anaesthetist for his surgeries for approximately 24 years, and he had no reason to doubt her abilities. The accused denied that he nicked the aberrant left hepatic artery, as suggested by the State, and stated that he had visualised the left hepatic artery and avoided it. He described the artery that was nicked as being contained within inflammatory hypervascularity surrounding the inflamed oesophagus tissue and maintained that it was not a known artery. When the artery was nicked, the accused informed Dr Blesovsky of the incident and set about stopping the bleed by tamponading it. As he began this, a power failure occurred, and there was a delay of a few minutes until the hospital's emergency generator switched on. During the power failure, he lost sight of the operative field, and the insufflation of A[...]’s abdomen was lost. This delay prolonged the time required to manage the bleed. In all, power was lost about three times during the operation.
- [89] On the accused’s version, the blood loss was measured and recorded by Dr Blesovsky and the nursing staff as 200ml. After he had stopped the bleeding, Dr Blesovsky did not inform him that A[...] was haemodynamically unstable, nor did she instruct him to stop the procedure for any other reason. However, he requested that Dr Blesovsky perform a haemoglobin test. The accused

explained that he requested the haemoglobin test because he was sufficiently concerned about the blood loss.

[90] When the accused asked Dr Blesovsky about the haemoglobin results, she replied that she had not been able to draw a blood sample for testing. Afterwards, he broke the sterile field, drew a blood sample for haemoglobin testing, and handed it to Nurse Mathete to be sent to the laboratory. After the surgical procedure, Dr Blesovsky transferred A[...] to the recovery room and handed

her over to Nurse Ramjee.

[91] The accused gave evidence that it was not standard practice to pre-operatively order type-matched blood for the type of surgery performed on A[...]. Hospitals keep universal donor blood in their emergency departments, which is available for use in theatre in case of an emergency. However, in A[...]'s case, the hospital had not replenished its stocks of emergency blood in the

emergency department after it had been used two days prior to her surgery.

[92] Based on the common cause evidence, the accused spoke with Mrs S[...] after the surgical procedure. However, a discrepancy exists regarding what was communicated. Mrs S[...] testified that she was told that A[...] had lost a lot of blood, whereas the accused denied using the term “lots” but acknowledged that he told her that A[...] had lost blood.

[93] It is common cause that the accused and Dr Blesovsky had another patient to attend to after A[...], so they returned to the theatre and began operating on the next patient. While operating on this subsequent patient, a nurse called Dr Blesovsky to attend to A[...] in the recovery room. It is common cause and not seriously disputed that a patient in the recovery room, is managed by the anaesthetist rather than the surgeon. When Dr Blesovsky returned to the theatre, the accused testified that she told him that A[...] was “okay”. At that time, the accused as indicated by the common cause evidence remained in a sterile operative field and was unable to check on A[...]. He further testified that he had no reason to doubt Dr Blesovsky's assessment of A[...]'s condition in the recovery room.

[94] According to Nurse Ramjee, she became concerned about A[...] because she had not woken up, prompting a call for Dr Blesovsky. In her statement, Nurse Ramjee indicated that this occurred at 19:40 — about 50 minutes after A[...] had been taken to the recovery room. She added that Dr Blesovsky “came almost immediately”, examined A[...], stated that A[...]

needed to be ventilated and admitted to the ICU, and then requested that Nurse Ramjee make the necessary arrangements. After making these arrangements, Nurse Ramjee returned to the recovery room, where Dr Blesovsky said she was going to intubate A[...] and requested anaesthetic medication to facilitate the intubation.

[95] Dr Blesovsky began to intubate A[...] and, although she struggled at first, she eventually succeeded; however, during the intubation A[...]’s oxygen saturation dropped to 84%. It appears that A[...] suffered a cardiac arrest. Resuscitation efforts were commenced by Dr Blesovsky and the accused, and Dr Taylor Smith arrived to assist. The State has suggested that some significance should be attached to the fact that Nurse Ramjee stated that the accused was called from the tea-room, whereas the accused denied this, stating that he was elsewhere in the hospital. Nothing turns on this matter, and in any event, as the defence contended, the

accused was nearby.

[96] It is common cause that the resuscitation of A[...] was unsuccessful, and she sadly died.

[97] Testifying in defence of the accused, Professor James opined that the blood loss was not the cause of death. He stated that a person losing an amount of blood such as 200ml will exhibit physiological signs “but will not be a life threatening risk”. In the same vein, he maintained that a post-operative haemoglobin level of 7 is not life threatening. Professor James was adamant that blood loss was not the cause of death and that the haemorrhagic shock theory advanced by Professor Loveland could not be sustained. In his view, an anaesthetist cannot administer an infinite amount of crystalloids, and excessive crystalloid therapy is associated with increased patient deaths. He testified that the rule of thumb is to administer 40ml of crystalloid per kilogram of body weight. In this case, A[...] weighed 10 kilograms, so she should have received no more than 400ml of crystalloid therapy. ‘He

further emphasised that crystalloid fluids should not be administered in a single dose but instead be titrated.

[98] Dr Blesovsky’s report records that she administered 800ml of crystalloid fluid. Professor James described that as “huge”, comparable to giving an adult 6 or 7 litres of fluid which, in his view, would have many adverse effects. He regarded the resulting fluid overload as unacceptable. The administration of more than 400ml of fluid to A[...] resulted in fluid overload, with the excess fluid leaking from the circulatory system and causing oedema. Significantly, in A[...]’s case, this excess fluid leaked into her lungs, leading to pulmonary oedema.

[99] For example, A[...]’s potassium was recorded as 9.6, which James opined was a “startling measurement” and a “near lethal concentration”. The importance of potassium is that if it becomes too high, it will stop the heart. Additionally, her glucose was recorded as 1, which he described as “very dangerous low blood sugar” that was “certainly going to cause unconsciousness”.

[100] In essence, Professor James opined that the cause of death was the mismanagement of A[...]’s physiology during the anaesthetic by Dr Blesovsky, who failed to monitor A[...]’s glucose levels and allowed her to become energy depleted, thereby permitting potassium to leak from her cells. He emphasised that the surgeon manages the anatomy while the

anaesthetist manages the physiology — a very clear-cut distinction. This was compounded by Dr Blesovsky's fluid overloading of A[...], which compromised her lungs and inhibited her ability to absorb oxygen. When A[...] was in the recovery room, Dr Blesovsky did not identify her low glucose, high potassium nor her fluid overloaded status.

- [101] From the evidence, Professor James was not alone in his criticism of the glucose and potassium levels in A[...]. When Professor Lundgren testified and was asked about the blood gas, she identified the glucose and potassium levels as being problematic. Professor Lundgren described the potassium as “terrible” and the glucose as “brain damaging”. The post-mortem report recorded the cause of death as myocarditis. Because A[...] suffered from myocarditis, she was unable to cope with stresses that a person with a healthy heart could have managed. Regarding the State's contention that the accused should have followed up on the haemoglobin test results, but, even if one accepts the State's argument that blood loss was the cause of death, the circumstances were such that there was no blood available in the hospital for A[...]. That can hardly be attributed to any fault on the part of the surgeon.
- [102] Significantly, the pathologist, Dr Nel, stated in her postmortem report (Exhibit E2) that the complication of arterial haemorrhage was addressed in a timely and appropriate manner, as evidenced by the absence of free blood in the peritoneal cavity.
- [103] It is common cause that the HPCSA investigation into the management of A[...] S[...] by the accused established no fault on his part; his explanations were accepted. Simply put, there was no evidence of unprofessional conduct on his part.

The Evidence in Respect of Z[...]

- [104] Dr Kussel, one of Z[...]’s paediatricians, testified that Z[...] had been his patient since July 2013. Since then, he had seen Z[...] for a variety of childhood illnesses. Over the years, various consultations, examinations, and tests were performed and prescriptions were given accordingly. On 8 October 2019, he was contacted by Z[...]’s mother who explained that she was on her way to sign a medical consent for Z[...] to undergo an operation performed by the accused. Ms V[...] then requested that he contact the accused. He did so on 8 October 2019, and the accused advised him that Z[...] required surgery for the following reasons: the biopsy findings indicated cellular changes with the potential for malignancy, rendering the biopsy abnormal; the esophagoscopy revealed an abnormal lower end of the oesophagus; and prior measures to control Z[...]’s vomiting had not succeeded.

[105] After his discussion with the accused, Dr Kussel contacted Ms V[...] and explained the accused's findings, as relayed to him, indicating that surgery was necessary for Z[...]. He also testified that he requested a copy of the Lancet report a few days after Z[...]’s passing, which he subsequently discussed with Ms V[...]. Upon a reading of the report, he was surprised

to find that it did not reflect that Z[...] had metaplasia, as had been suggested. Had he known the contents of this report before the operation, he testified that he would never have advised the parents to proceed with the surgery.

[106] During cross-examination, however, Dr Kussel stated that there would be months-long interruptions where he would not see Z[...]. His parents would then return to him, recounting “stories of what other doctors had said and other doctors had done and asked for my comments on it”.

[107] He was also not aware that Ms V[...] had reported that Z[...] had been suffering from vomiting since the age of three. He confirmed that he had written a letter to Z[...]’s nursery schoolteacher in March 2014, stating that Z[...] had anxiety episodes. However, he acknowledged that this letter was written without having diagnosed Z[...] as suffering from anxiety. Significantly, he was unaware that Dr Walabh had diagnosed Z[...] with reflux oesophagitis. It is common cause that he was

also unaware that Z[...] had been seen by a child psychologist and a psychiatrist since 2018.

[108] In his testimony, Dr Kussel confirmed, significantly, that he had previously prepared an affidavit (Exhibit ZV) with the assistance of attorneys. The affidavit was prepared in response to questions posed to him by the State. In the affidavit, Dr Kussel explained what the accused had conveyed to him during the telephone conversation, as well as the reasons why Z[...] required surgery. Dr Kussel recorded three reasons given to him by the accused: firstly, the biopsy results indicated cellular changes that could become malignant; secondly, the oesophagoscopy revealed an abnormal lower end of the oesophagus; and thirdly, measures to control Z[...]’s vomiting had been unsuccessful. Dr Kussel also confirmed that, based on the information provided by the accused, he

agreed that surgery was necessary.

[109] There is no doubt that, as the defence also contended, Dr Kussel's evidence was not a complete account of Z[...]’s medical history. It follows that the views he expressed regarding oesophageal reflux and psychological care were made without the knowledge of Z[...]’s full medical history.

[110] Ms V[...] testified that the deceased suffered from reflux, which became more severe after their return from Turkey in July

2019. It caused him to vomit regularly. Consequently, she took him to several doctors in an endeavour to ascertain the source of this problem and to resolve it. She took Z[...] to Dr Kussel, at the Park Lane Clinic in Parktown. Dr Kussel works in association with another paediatrician, Dr Riaz Khan, who also treated him. Z[...] missed a lot of schooling because the vomiting continued.

[111] On 7 August 2019, Z[...] was extremely dehydrated. As a result, he was admitted by Dr Khan to the Park Lane Clinic, where he remained until 8 August 2019 for treatment of vomiting, diarrhoea, and abdominal pain. Z[...] was also admitted to hospital on 10 August 2019 for persistent vomiting and abdominal pain. On 15 August 2019, Ms V[...] took Z[...] to

see Dr Moosa, a paediatrician at Garden City Clinic. Dr Moosa attributed Z[...]’s vomiting to anxiety. On 19 August 2019, Ms V[...] sent a picture to Dr Khan of the toilet bowl into which Z[...] had vomited, describing it as containing a “lot of blood”.

[112] Mrs V[...] explained that, later, she did not think it was blood after all. She had panicked after seeing it and sent the picture to the doctor. To quote her words, “so if he had beet root, if he had curry, if he had ice-cream, if he had an Energade, it would come out that colour”. Z[...] was subsequently readmitted to the Parklane Clinic by Dr Khan. Dr Khan then referred Z[...] to Dr Priya Walabh, a paediatric gastroenterologist at Sunninghill Hospital, as he continued to vomit. Dr Walabh prescribed Nexium, which, according to Ms V [...], did not alleviate Z[...]’s condition.

[113] The uncontested evidence is that, on 20 August 2019, Dr Walabh treated Z[...]. Z[...] was diagnosed as suffering from reflux oesophagitis and chronic constipation with faecal loading. Contrary to Ms V[...]’s evidence, Dr Walabh denies diagnosing that Z[...] had constipation lumps. The situation did not improve. Instead, on 26 August 2019, Ms V[...] returned to Dr Khan, and it was during that consultation that Dr Khan suggested that Z[...] be taken to the accused. On 28 August

2019, Ms V[...] sent a WhatsApp message to Dr Khan saying she had decided to go ahead with the scope and asked for it to be done the next day.

[114] It is common cause that the accused performed the biopsy on 3 September 2019. Ms V[...] then left for Cape Town with Z[...] on holiday. On 10 September 2019, according to Ms V [...], the accused called her and informed her that, from the results of the scope, her son had intestinal metaplasia and pre-malignant cancerous cells and that he had to undergo an operation. She looked up the terms on the internet and then telephoned her ex husband to tell him what the accused had said. Whilst in Cape Town, Z[...]’s condition improved to the extent that he stopped vomiting. However, that was only temporary, as the vomiting resumed upon their return from Cape Town.

[115] Upon their return to Johannesburg, on 6 October 2019, Ms V[...] sent a WhatsApp message to the accused stating that Z[...] had been vomiting non-stop and requested an appointment to see the accused the following day. This message was sent at 22:08. It is common cause

that the accused consulted with Z[...] and Ms V[...] on 7 October 2019, during which they discussed the upcoming Nissen Fundoplication operation. Following this consultation, Z[...] was scheduled to undergo the procedure on 8 October 2019. However, on 8 October 2019, the accused was informed by the nursing staff that Z[...]’s parents had cancelled the operation.

[116] Later, on 8 October 2019, Ms V[...] telephoned the accused and requested that the operation proceed, However, as it was too late, the operation was rescheduled for Friday, 11 October 2019. On 9 October 2019, Ms V[...] brought Z[...] to the accused because his vomiting was uncontrolled. Concerned about Z[...]’s condition, the accused admitted him to the hospital. However, the deceased’s parents took him home on 10 October 2019 and returned for the operation on 11 October 2019. The operation did not last the anticipated 90 minutes but instead took almost 4 hours to complete. According to Ms V[...], the accused informed them (the parents) after the operation that the extended duration was due to Z[...]’s excessive weight.

[117] Ms V[...] testified that, as the accused was about to leave, Dr Munshi approached him and indicated that he suspected a tension pneumothorax. When asked what this meant, the accused assured them it was not serious and that Dr Munshi could handle it. Despite the accused being called back to the hospital, Z[...] passed away shortly thereafter following a failed resuscitation attempt. A few days later, Ms. V[...] called the accused and recorded the conversation. The relevant part of the cell phone recording reads:

“MRS S S[...]: You said he had metaplasia and he didn’t even have metaplasia. What was that about?”

DR P BEALE: I just told you what the pathologist said.

MRS S S[...]: Sorry?

DR P BEALE: I just told you what the pathologist said, that’s all, what’s in the pathology report.

MRS S S[...]: Did he have the metaplasia? Did you see it [there] in the report? Did he have it? Did he even need the op?

DR P BEALE: He had whatever I told you he had. It’s in the pathology report.

MRS S S[...]: So what is metaplasia exactly? What is it? You said that’s the premalignant cells, is that correct? Is [that] true? Did he have it?

DR P BEALE: He had intestinal metaplasia, yes.”

[118] It is apparent from this exchange that the accused believed at the time that Z[...] had intestinal metaplasia. Significantly, Ms. V[...] conceded under cross-examination that the accused never admitted during the recorded telephone conversation that he was aware of the pneumothorax while in theatre.

[119] Mr S[...] testified and broadly repeated part of MS V[...]’s evidence. He stated that when he spoke to the accused on 11 September 2019 “[he] explained to me what it meant in medical terms which was above my paygrade.” Significantly, he did not claim that the accused told him Z[...] would die. This is clear from the following extract of the record:

“So he [Professor Beale] says well it [the vomiting] is going to come back, it is not going to stop. So obviously when you hear something

like that, that your child could possibly die you cling onto any hope of help of sorting out the issue and that was basically the long and short of the conversation on the 11 September.”

Clearly, Mr S[...] believed that Z[...] would die following his conversation with the accused on 11 September 2019. Exhibit ZP was introduced. ZP contains a message from the late Dr Munshi to a colleague, Dr Beeton, explaining developments post-surgery. The relevant parts of the message read:

“Slow Deterioration started when extubated as he could not generate enough negative pressure to inflate the good lung. My differential was atelectasis. So needed a cxr to decide what to do next. Unfortunately waiting for cxr was golden time being lost, and by the time the lcd was inserted though he was awake and even distressed, there was worsening acidosis, low cardiac output and hypoxia developed from the tension pneumothorax, these I thought will immediately improve with the lcd, but he then arrested

Regret I should have kept him in theatre intubated and done cxr on table, before moving to recovery, but was awake and wanted ett out, so thought will be fine, got to recovery with initial sats of 92 on oxygen, BP 90/50. There was gradual subsequent deterioration while waiting for cxr...”.

The witness could not comment on the WhatsApp message.

[120] Dr Riaz Khan also testified and confirmed that he had treated Z[...] from approximately 2017, up to the period before his death in 2019. Z[...] had a history of vomiting after meals since the age of three, along with constipation and signs of anxiety. Dr Khan also confirmed that he eventually referred Z[...] to Dr Walabh and subsequently to the accused for a biopsy. He further

testified that, upon receiving the toilet bowl photo via WhatsApp, he was unsure whether it was blood or something Z[...] had eaten. He was called to the hospital on the night of Z[...]’s passing and, upon arrival, assisted with Z[...]’s resuscitation, but to no avail. When he read Z[...]’s Lancet report, he was surprised because there was no mention of the presence of intestinal metaplasia.

[121] In her testimony regarding the Lancet report, Dr Ray stated that she did not find any features of dysplasia or malignancy in the biopsy specimen. However, she identified mild chronic oesophagitis with an inflamed squamoglandular junction, which, as she explained, was at the lower end of the oesophagus. Dr Ray was confronted with various extracts from an article published in the Journal of Gastrointestinal and Digestive System. The article

emphasised — an assertion with which she agreed — that the early diagnosis of GERD/GORD is crucial, as it is a key risk factor for the development of Barrett’s oesophagus.

[122] Regarding Z[...], Prof Banieghbal (Exhibit L) testified based on his evaluation of the patient files from Drs Kussel and Khan, as well as the histology report by Dr Ray. He opined that there was no indication for surgery in the first place and considered Z[...] to be a psychogenic vomiter. He criticised the accused for conveying to the parents a finding that was contrary to Dr Ray’s findings in her Lancet report, alleging that this was dishonest and done for financial gain. In his view, Z[...]

should have been referred to a psychologist or a psychiatrist for treatment instead. He further testified that had he received a histology report indicating that a child of Z[...]’s age had intestinal metaplasia, he would have re-examined the report and contacted the pathologist to query the result, as he would have suspected an error in the analysis. This, he explained, was because intestinal metaplasia is extremely rare in children. However, the defence contended that the better approach is to recognise that paediatric surgeons exercise their judgment on a case-by-case basis and will recommend surgery if they deem it appropriate. Nonetheless, Professor Banieghbal was presented with a series of facts concerning Z[...], which were not seriously challenged in this case:

“509.1 A biopsy identifying chronic oesophagitis.

509.2 The visualisation of an inflamed oesophagus and wavy tongue like features during the esophagoscopy.

509.3 Z[...] had persistently vomited for seven years.

509.4 Specialist paediatricians had treated Z[...] and had been unable to resolve his condition.

509.5 A paediatrician had referred Z[...] to Professor Beale and had considered that surgery might be required.

509.6 Other doctors had recorded that Z[...]’s reflux was problematic.

509.7 Z[...]’s reflux had not responded to proton pump inhibitor medication.

508.8 A Nissen Fundoplication operation effectively stops vomiting;

509.9 Z[...]’s life was miserable, he was vomiting all day and was missing school.”

Professor Banieghbal was constrained to concede that that surgery may be helpful in that case.

[123] Prof Loveland testified for the State and confirmed his report as per Exhibit M. In his report, he noted:

“From a professional perspective it is important to first make a categorical diagnosis of Gastro Oesophageal Reflux, and thereafter to determine whether this is simple reflux (which is a normal physiological process), or whether it is Gastro Oesophageal Reflux

Disease (GORD). The former is managed by adjusting lifestyle, including weight loss, and potentially with the addition of medical

management, including the prescription of a PPI. The latter, GORD, is categorised as being uncomplicated or complicated, with complications

of GORD either being oesophageal or extra-oesophageal. Uncomplicated GORD is best managed medically, as described above, with surgery only reserved for complicated GORD”.

Regarding this matter, Professor Loveland was of the opinion that the diagnosis of Gastro Oesophageal Reflux in Z[...]’s case was highly questionable and, if present, did not meet the diagnostic criteria for GORD. In his opinion, surgical intervention was not indicated, and initial management should have focussed on lifestyle modification, particularly weight loss. He was equally concerned that the accused did not make any notes on the biopsy procedure performed on Z[...].

[124] Prof Loveland was highly critical of the Netcare Parklane Clinic, expressing the view that it is not an appropriate facility for major operative procedures on children. While the facility has a reputable Neonatal Intensive Care Unit, it lacks a Paediatric Intensive Care Unit (PICU) and Paediatric Intensive Care specialists. Furthermore, the hospital is not equipped for high volume general paediatric surgery. He attributed this issue to individual hospitals and hospital groups, which, in his view, push for the provision of all medical specialty services at all of their facilities, even where those facilities are not adequately equipped.

[125] Prof Loveland was also highly critical that of the response to the intra-operative pneumothorax. He stated that when the pneumothorax first presented, neither the Accused nor Dr Munshi took steps to temporarily cease operating in order to diagnose and definitively treat the pneumothorax, a recognised and acceptable morbidity. The appropriate response, in his view, would have been to insert an intercostal drain; however, instead of taking this step, the operation continued for a further two hours. He further criticised Dr Munshi’s post operative management of the patient, stating that it was inadequate and further delayed, ultimately leading to irreversible cardiac arrest and death. As a result, the later involvement of the Adult Intensive Care Unit and the adult physicians, Drs Khan and Moola, was, in his words, “too little too late”.

[126] Professor Lundgren, who testified for the State, was of the view that it would have been preferable to manage Z[...] further in theatre, rather than move him to the recovery room. In her view, although a pneumothorax is a common complication during a Nissen Fundoplication procedure, it is often clinically asymptomatic. However, she acknowledged that it can be lethal in up to 25% of children in Z[...]’s age group. She testified that once a tension pneumothorax is suspected, it constitutes an emergency that must be treated with the necessary urgency. She further stated that the appropriate course of action — insertion of an intercostal drain — is a joint responsibility of both the anaesthetist and the surgeon. She also testified that a tension pneumothorax is diagnosed clinically and that one does not wait for an x-ray, as was done in this instance.

- [127] Dr Elliot also testified and her written report is recorded as Exhibit ZZL. As the State suggests, the essence of her evidence can be summarised as follows: Dr Munshi mentioned a suspected pneumothorax towards the end of the operation. Both Dr Elliot and the accused were equidistant from Dr Munshi when this was said, and she heard it clearly. She stated that she did not know whether Z[...] was stable at that moment, but Dr Munshi appeared less concerned as they were finishing the procedure.
- [128] Dr Vergie testified regarding Z[...]’s post-mortem, which she compiled as Exhibits H, ZZG, and ZZH. As indicated from the outset, she concluded that the primary cause of death was consistent “with a history of a pneumothorax in a person with reported severe gastroesophageal reflux disease”. She subsequently compiled a histology report (Exhibit ZZG), in which her findings were consistent with interstitial pneumonitis in the lungs and a viral myocarditis. Furthermore, she observed “dense

areas of chronic inflammation” in a section of Z[...]’s oesophagus. According to Exhibit ZZH, which she confirmed:

“The postmortem examination further revealed marked pallor (a pale colour of the skin and internal organs which can be caused by illness, shock or anaemia and this is consistent with a low haemoglobin level) of the internal organs and a markedly enlarged heart (the normal range of heart mass for a 10 year old is 140g to 154g; the deceased’s heart mass was 200g)”.

- [129] Exhibit ZZH further records that:

“The effect of the myocarditis would be to decrease the heart muscles’ ability to pump at a normal rate and rhythm. If the body’s oxygen requirements increase (as in this case, oxygen deprivation as a result of the collapsed left lung), the heart might be unable to respond at a rate commensurate to the increased oxygen demand of the body. Interstitial pneumonitis was diagnosed histologically as part of the post mortem examinations. Interstitial pneumonitis, an inflammatory disorder of the mesh-like walls of the air sacs of the lung could decrease the lungs’ ability to exchange carbon dioxide for oxygen). This would cause an increase in the carbon dioxide content of the blood and a decrease in the oxygen content of the blood”.

- [130] During cross-examination, it was pointed out that Z[...] had an enlarged heart, to which Dr Vergie agreed. She further conceded that myocarditis and the interstitial pneumonitis impaired good oxygenation within Z[...]. However, she was of the view that myocarditis and interstitial pneumonitis could not have been the primary cause of death but were contributory factors.

- [131] The accused testified in his defence. The summary of his evidence as follows: He asserted that he had no reason to conduct the procedures for financial gain but rather based on the indications in each case. Regarding the Tannenbaum Scheme, the accused testified that he did not need to cancel holidays due to the loss of his investment. He explained that Tannenbaum, a pharmacist by profession, had invested in the scheme with the aim of acquiring raw materials for the manufacture of antiretrovirals. According to the accused,

the Tannenbaum Scheme was not a “get rich quick” scheme. He further stated that he was not the only person to lose money; approximately 800 others, including prominent businesspeople, also suffered financial losses. He testified that he did not have to sell his house or take any other extreme measures as a result of the loss.

[132] As of 2009, the accused’s career had been financially successful, and he had been very busy professionally. He testified that he was disappointed and angry about losing money in the Tannenbaum Scheme, which led to a period of reactive depression lasting a few months, from which he eventually recovered. In 2009, he earned between R4 million and R5 million annually from his employment

at Wits and from his private practice. At that time, his joint estate with his wife was valued at approximately R40 million, excluding

their unbonded house in River Club, Sandton. The accused also owned a 50% share in a holiday home at the San Lameer Estate, an upmarket golfing estate on the South Coast of Kwa Zulu Natal.

[133] The accused further testified that he had made some successful investments. He had invested in an aircraft in which he held a 40% share, and because aircraft investments are denominated in US Dollars, it performed very well. Additionally, he invested in the Linksfield Clinic Hospital by signing as surety when the Clinic first opened. When the Clinic was eventually taken over by Netcare,

the accused was allocated shares worth R1.9 million. Alongside the capital value of his investments, he receives a pension, which he described as “a very good pension”. He was divorced from his wife in 2020, after separating in 2018. At the time of the divorce, his capital base was still approximately R20 million. The accused’s evidence regarding his financial position was not seriously challenged by the State and must therefore be accepted as true.

[134] Regarding the Z[...] matter, as the State pointed out, there is little dispute concerning the sequence of events from the date of the first consultation up to Z[...]’s death. Z[...] previously consulted other paediatricians without success. Following the referral, the established histology, and subsequent consultations, the accused considered that a Nissen Fundoplication might be a solution but decided to do a biopsy first. It is common cause that the biopsy was conducted on 3 September 2019.

[135] He testified that when he performed the biopsy on Z [...], he observed at the lower end of the oesophagus, extending several centimetres — approximately four centimetres — from the gastroesophageal junction, there was an area of inflammatory change with obvious redness and inflammation of the oesophagus. There was also a wavy pattern at the proximal end, which he described as tongue-like extensions. He subsequently informed the mother that his finding was consistent with reflux oesophagitis, but they would need to wait for the biopsy report to confirm.

[136] The biopsy results became available on 10 September 2019. Upon receiving the Lancet report, he mistakenly identified intestinal metaplasia as being present and informed Ms V[...] that Z[...] had this condition. He later realised that he had misread the biopsy results, which did not indicate the presence of metaplasia. He did not intentionally misinform Ms V[...] regarding the metaplasia. According to the accused, his focus was on the oesophagitis, and that he would not have altered his course of treatment for Z[...]’s condition based on this misinterpretation.

[137] According to the accused, Z[...]’s life was miserable. He was vomiting all the time, in pain, and he had not responded to medical treatment, which was a clear indication that he needed that procedure. The misdiagnosis of intestinal metaplasia was incidental, and the anti-reflux procedure would have reversed that process and prevented any further progression.

[138] Upon their return from Cape Town, Ms V[...] informed him that Z[...] had initially improved while they were in Cape Town, where he has been taking Nexium 40mg daily. However, upon returning to Johannesburg, he had experienced recurrent symptoms and had not returned to school. She showed him videos of Z[...] retching, referred to as “spewing into a toilet”, and

they discussed the possibility of a laparoscopic Nissen procedure. On the morning of 11 October 2019, he received a text from Ms V[...], which read: “[m]orning Prof, Z[...] has croup, he is coughing badly, will he still have the op? Is it going to be on? Ok?”

[139] He responded as follows: “[b]ring him prepared at twelve, the anaesthetist will assess.” This was because the anaesthetist is responsible for determining whether the patient is fit for anaesthesia, and he left the decision to Dr Munshi. Dr Munshi reported that he was satisfied with Z[...]’s condition, noting that any upper respiratory symptoms were likely related to acid reflux and persistent vomiting rather than any other cause.

[140] The accused described the operation as longer than usual due to Z[...]’s overweight condition but maintained that it was otherwise uncomplicated. Approximately 1 hour and 15 minutes into the operation, the procedure was briefly interrupted for approximately 5 to 10 minutes at Dr Munshi’s request, who informed him that “the oxygen saturations are down, and the

pulse rate has gone up”. Regarding Dr Elliot’s testimony that she heard Dr Munshi express concern about a possible pneumothorax

towards the end of the operation, the accused testified that he did not hear this.

[141] After the operation, he spoke to the parents and reassured them that everything had gone according to plan. He also spoke to Dr Munshi in the recovery room, who was attending to Z[...]. Dr Munshi noted that Z[...] had decreased air entry in the left

lung and requested an x-ray, suspecting a pneumothorax or atelectasis. The accused offered to wait in the tearoom, but Dr Munshi said he could leave, which he did, having full confidence in Dr Munshi's abilities. He told Dr Munshi that he lived only ten minutes away and could return if Z[...] required a drain or further assistance. Just as he reached the entrance of his home, he received a call from Ms V[...] and promptly returned to the hospital.

[142] Upon returning to the recovery room, Dr Munshi had placed an intercostal drain on the left side, which appeared to be bubbling. Z[...] had recovered as expected following the drainage of a pneumothorax. The x-ray had been completed, revealing a pneumothorax on the left side with a degree of tension. The accused immediately placed a second intercostal drain, ensuring both drains were in the pleural cavity. Z[...] was subsequently transferred from the recovery room to the ICU by Dr Muller. Despite efforts to resuscitate Z[...] over the next few hours, he did not survive. As in the other cases, the accused denied that the operation had been performed for financial gain.

[143] Professor Coetzee testified in the accused's defence, analysing the anaesthetic trend print-out, which recorded several of Z[...]’s vital signs. It was confirmed that Z[...] anaesthetised 15:00, and ventilation was established at 15:27. At 16:09, his heart rate slightly increased to 121, and at 17:09, it had risen further. At 17:39, the heart rate increased to 149, with oxygen saturation remaining stable, but blood pressure dropped to 73/42, and oxygenation increased from 31% to 61%. Blood pressure instability persisted from 17:39 to 17:51.

[144] Professor Coetzee in his testimony on behalf of the accused agreed with Professor Lundgren that, had Z[...] not been suffering from myocarditis, he would likely have been able to cope with the stress caused by the tension pneumothorax. It is common cause that the myocarditis and enlarged heart could not have been detected prior to the surgery.

[145] In its closing submissions, the State sought the conviction of the accused on all charges, except count 3, murder in respect of A[...]. For count 3, the State sought the conviction of the accused on the competent charge of culpable homicide.

[146] The applicable legal principles make it clear that the accused bears no onus to prove the truth of any explanation he provides. As stated in *Rex v Difford*:^[2]

"If he gives an explanation, even if that explanation be improbable, the Court is not entitled to convict unless it is satisfied, not only that the explanation is improbable, but that beyond any reasonable doubt it is false. If there is any reasonable possibility of his explanation being true, then he is entitled to his acquittal."

[147] In the frequently cited case of *S v Van der Meyden*,^[3] it was stated:

"The onus of proof in a criminal case is discharged by the State if the evidence establishes the guilt of the accused beyond reasonable

doubt. The corollary is that he or she is entitled to be acquitted if it is reasonably possible that he might be innocent (see, for example, *R v Difford* 1937 AD 370 especially at 373, 383). These are not separate and independent tests, but the expression of the same test when viewed from opposite perspectives. In order to convict, the evidence must establish the guilt of the accused beyond reasonable doubt, which will be so only if there is at the same time no reasonable possibility that an innocent explanation which has been put forward might be true. The two are inseparable, each being the logical corollary of the other.”

[148] In relation to the murder charges, the State is to prove not only that the accused’s actions were the factual cause of the deaths, but also that they were the legal cause.

[149] Regarding expert testimony, the trite position is that a Court should not blindly accept the evidence of an expert witness, but must decide for itself whether it can safely accept the expert’s opinion.[4] An expert witness is expected to assist the Court by offering an objective, unbiased opinion on matters within their expertise. An expert witness in the High Court should never assume the role of advocate. Furthermore, an expert witness must disclose the facts or assumptions underlying their opinion and must not disregard material facts that might undermine their concluded opinion.[5]

[150] Wessels JA, in *Coopers (South Africa) (Pty) Ltd v Deutsche Gesellschaft für Schädlingbekämpfung Mbh* remarked as follows:[6]

“As I see it, an expert’s opinion represents his reasoned conclusion based on certain facts or data, which are either common

cause, or established by his own evidence or that of some other competent witness. Except possibly where it is not controverted, an expert’s bald statement of his opinion is not of any real assistance. Proper evaluation of the opinion can only be undertaken if the process of reasoning which led to the conclusion, including the premises from which the reasoning proceeds, are disclosed by the expert.”

[151] I return to evaluating the totality of the evidence, taking into consideration the applicable legal principles referred to above. An issue that underlies the entirety of the State’s case, as the defence pointed out and is supported by the charges, is that the accused performed unnecessary surgeries for financial gain. As counsel for the accused contended, without the alleged financial motive — stemming from the need to recover losses incurred due to the Tannenbaum Scheme — the State’s entire case collapses.

[152] It must be recalled that Professor Banieghbal’s evidence began with a conversation he had years ago with the accused at a conference. According to Professor Banieghbal, the accused mentioned the losses he had suffered in the Tannenbaum Scheme and even suggested that he would even act as an assistant surgeon. However, it was put to Professor Banieghbal that this could not have been seriously intended. Rather, it was suggested that it was merely a casual conversation between two colleagues at a social event during the convention. Professor Banieghbal conceded this when this was put to him.

[153] There is no direct evidence supporting the allegations of murder in any of the related charges. The legal principle governing inference-based

reasoning is based on two cardinal rules of logic. First, the inference sought must be consistent with all the proved facts. If it is not, the inference cannot be drawn.[7] Second, the established facts should exclude every reasonable inference except the one sought to be drawn. If alternative reasonable inferences remain, there must be a doubt as to whether the sought inference is correct.

[154] The State relied on inferential reasoning to establish intent in the form of *dolus eventualis* for the murder charge. The test for the element of intention, specifically *dolus eventualis*, required for a murder conviction, was outlined by Holmes JA in *S v Sigwahla* as follows:[8]

“1. The expression ‘intention to kill’ does not, in law, necessarily require that the accused should have applied his will to compassing the death of the deceased. It is sufficient if the accused subjectively foresaw the possibility of his act causing death and was reckless of such result. This form of intention is known as dolus eventualis, as distinct from dolus directus.

2. The fact that objectively the accused ought reasonably [to] have foreseen such possibility is not sufficient. The distinction must be observed between what actually went on in the mind of the accused and what would have gone on in the mind of a *bonus paterfamilias* in the position of the accused. In other words, the distinction between subjective foresight and objective foreseeability must not become blurred. The *factum probandum* is *dolus*, not *culpa*. These two different concepts never coincide.
3. Subjective foresight, like any other factual issue, may be proved by inference. To constitute proof beyond reasonable doubt the inference must be the only one which can reasonably be drawn. It cannot be so drawn if there is a reasonable possibility that subjectively the accused did not foresee, even if he ought reasonably to have done so,

and even if he probably did do so.”

[155] In this case, it must first be established that the initial requirement for liability is met, namely, that the accused directed his will towards committing the crime (before considering foreseeability). As the defence argued, if this requirement is overlooked, every surgeon whose patient dies during surgery would be guilty of murder based on *dolus eventualis*, since every surgeon is aware that death may occur in the course of an operation. In this instance, the State failed to demonstrate that the accused knew that the intra-operative act was not indicated, considering the totality of the evidence. Consequently, the necessary knowledge of unlawfulness, which is required for criminal intent, is absent, and foreseeability does not come into the picture. The State also failed to prove that the accused foresaw that E[...] could die as a result of the intra-operative act and that he recklessly disregarded this possible outcome.

[156] Regarding the competent verdict of culpable homicide, negligence will be found if the conduct of the accused deviated from that of a reasonable doctor performing the medical intervention under those particular circumstances. The standard is based on what a reasonable doctor would have foreseen in the circumstances and the care such a doctor would have exercised to prevent the outcome, without the benefit of hindsight. Culpable homicide is a competent verdict if the accused performed the operation negligently, thereby causing the death of E[...], A[...], and Z[...]. Additionally, if the accused failed to provide the required post-operative care, which led to E[...], A[...], and Z[...]'s deaths, culpable homicide may also be found.

[157] The undisputed evidence shows that when the accused visited E[...] post operatively on the evening of the operation, there was no need for medical intervention, other than possibly following up on E[...]’s progress. Nurse Mankoe, on behalf of the State, confirmed that when the accused attended to E[...] at about 19:20, “there was no reason for concern”.

The nursing staff assured the accused that E[...] was fine, which was consistent with Sister Hine’s assessment. The accused was contacted around 4:20 regarding E[...]’s deteriorating condition. He immediately departed for the hospital, where upon arrival, the code blue team and Dr Obor had already attended to E[...], and the accused took over.

[158] Contrasting evidence before the Court does not assist the Court in determining with any degree of certainty whether E[...]’s rapid deterioration in the ward was because of peritonitis due to an anastomotic leak or from aspiration of gastric content into the lung. Complications are part of everyday surgical practice, Their detection and management form part of every surgeon’s

training and practice. E[...]’s complication, whether primarily abdominal or pulmonary should have been detected earlier

and managed appropriately. That this did not happen is primarily due to the inadequate number of experienced nursing staff in the ward on the night of E[...]’s surgery who neglected to report to the accused the deteriorating situation of E[...] on time. When they finally did so in the morning, it was too little too late.

[159] Regarding the fraud charge, the totality of evidence shows that the accused genuinely believed the operation was indicated, even with a diagnosis of a variant of Hirschsprung’s Disease. This variant presents with the same symptoms and functional difficulties, necessitating the same operation. The State’s star witness, Professor Banieghbal, whose testimony as an expert was critical, was proven to be unreliable and discredited, failing to meet the standards expected of an expert witness. This was due to the fact that he had previously been part of the unanimous decision by HPCSA panel to find the accused not guilty of charges relating to the absence of informed consent and the non-indication of surgery for E[...]. Professor Banieghbal, as the paediatric surgeon on the panel, provided an inconsistent position, which the defence argued was inexplicable,

particularly in the absence of any new facts.

[160] In this Court, Professor Banieghbal failed to provide an explanation for the discrepancy between the finding in the HPCSA heading and his testimony here. The State did not prove beyond a reasonable doubt that the accused intended to mislead Mrs T[...] into consenting to the operation, knowing that she would not have consented had she been fully informed.

[161] The undisputed evidence shows that E[...] suffered from a serious functional disease that could only be treated surgically. E[...]’s parents consented to the operation to address this functional problem. The State’s key witness, Professor Banieghbal, acknowledged that E[...] may have been suffering from a functional disease, a variant of Hirschsprung’s Disease, as supported by existing literature on the condition (Exhibit W), a point that Prof Banieghbal was constrained to concede.

[162] The evidence before this Court clearly established that that there is a group of paediatric surgeons, including the accused, who, in exercising their clinical judgment, would reasonably have concluded that E[...] suffered from a functional disease that required surgery. The accused’s approach in this case was further supported by Dr Gildenhuys’ report, whom the State

failed to call, recording the presence of occasional groups of ganglion cells.

[163] As for the surgery itself, Dr Banieghbal initially criticised the procedure performed by the accused on E[...]. However, when asked whether his evidence on the surgery should be ignored until the pathologist, Dr Moeng, had explained her report, he conceded, thus making a vital concession. As indicated, Dr Moeng was never called by the State. The accused specifically disputed Dr Moeng’s post-mortem report. Dr Moeng’s report refers to the “defect” being in the rectum, whereas, according to the accused, the operation was performed on the anal canal, as demonstrated in his testimony. Given the accused’s testimony and his demonstration of how the surgery was conducted in E[...]’s case, Dr Moeng’s post-mortem report cannot be relied upon, notwithstanding the

provisions of section 212(4) of the CPA.

[164] Significantly, both Professor Banieghbal and Professor Loveland — as the defence pointed out — accepted that while one paediatric surgeon may have a more optimistic assessment of whether surgery will assist a patient, another paediatric surgeon may take a more conservative view. In instances such as this, where clinical judgment is involved, neither surgeon can definitely state that the other is wrong.

[165] Contrary to Professor Banieghbal’s evidence and insinuations, the uncontested evidence, as the defence pointed out, is that at the time the surgeries were performed on E[...], A[...], and Z[...], the accused was financially secure. Furthermore, following his divorce, his estate was valued at approximately R20 million, excluding his holiday home in San Lameer. He was not reliant on his assets for daily expenses, as he received a substantial pension. It therefore follows, as the defence counsel contended, that his denial of performing

unnecessary surgeries for financial gain must be accepted.

[166] In the fraud charges relating to E[...], the State alleged that Mrs T[...] was not informed that E[...] did not have Hirschsprung's Disease but rather a variant of the condition. Similarly, in Z[...]’s case, it was alleged that Ms V[...] was told Z[...] had intestinal metaplasia when, in fact, he did not. The accused explained why he did not inform Mrs T[...] about the variant of Hirschsprung's Disease and admitted that he misread the biopsy report for Z[...]. There is nothing to contradict these explanations, and in the absence of a financial motive, there is no reason to doubt them. To suggest that the accused intentionally recommended unnecessary surgeries is therefore unsubstantiated.

[167] The recorded cell phone conversations referenced above, which took place after Z[...]’s death, clearly establish that until that point, the accused genuinely —but mistakenly— believed that the biopsy report confirmed the presence of intestinal metaplasia. There is no evidence that the accused knowingly made a misrepresentation in relation to E[...] and Z[...], nor that he did so with the intent to sustain the allegations proffered by the State. Furthermore, Dr Kussel could have easily accessed the laboratory report, which would have exposed any alleged falsehood or intentional misrepresentation. This further validates the accused’s version that the discrepancy was due to a mistake rather than an intention to deceive. The State bears the onus of proving beyond a reasonable doubt that the accused intentionally sought to deceive the alleged victims in the fraud charges. As the defence argued, the evidence does not support such a finding.

[168] The defence contended — with which we respectfully agree — that in E[...]’s and Z[...]’s cases, there is no dispute that the accused informed the parents of the procedure to be performed. Whether Mrs T[...] was specifically told about hypoganglioneurosis while under the impression that the diagnosis was Hirschsprung’s Disease is not an informed consent issue. This is because, in both cases, the procedure and associated risks are the same. Informed consent focuses on the risks of the procedure.

[169] In Z[...]’s case, his parents were aware that a Nissen Fundoplication would be performed. The fact that the accused misread the pathology report did not alter the recommended surgical procedure or the risks associated with it. As a result, the misreading of the pathology report is irrelevant to the issue of informed consent.

[170] As for the murder charges, this Court was referred to Principles of Criminal Law the learned author states:[9]

“In terms of principle, where mens rea in the form of intention is required, liability is dependent upon the existence of intention in respect of every circumstance or

consequence of the crime in question. Since unlawfulness is an essential element of every offence, logic dictates that knowledge on the part of the accused that his conduct was unlawful is a prerequisite of liability.”

In this case, the accused subjectively believed that the operation was indicated. Accordingly, the State failed to establish the element of intention, premised on its allegation of *dolus eventualis*.

[171] Regarding the requirement of causation in relation to the murder charge in Z[...]’s case, both the accused and Dr Munshi were unaware, and could not have reasonably been aware, that Z[...] was suffering from underlying myocarditis, which undoubtedly

complicated the surgical process. Based on the common cause evidence and viewed objectively, had Z[...] not been suffering from myocarditis, he would likely have been able to withstand the stress imposed by the tension pneumothorax, as suggested by the expert testimony referred to above. The crime of murder is only complete when the victim dies. It is only at that moment that the cause takes effect and becomes effective as the cause of death.[10] This principle applies to all the murder charges in this case.

[172] In sum, the State called for the conviction of the accused for culpable homicide in A[...]’s case. Regarding causation, there is no evidence connecting A[...]’s death to any wrongful actions by the accused. There is nothing to show that

his conduct deviated from that of a reasonable person (paediatric surgeon) in the circumstances. As the defence contended, given that the onus is on the State to prove the offence beyond a reasonable doubt, even on circumstantial evidence — the State’s case falls short of the requisite proof and is seriously wanting.

[173] In conclusion, we are satisfied that the State has failed to prove, beyond a reasonable doubt and considering the totality of the evidence, any of the various charges proffered against the accused, including competent verdicts where applicable.

Order

[1] The accused, Professor Beale, in respect of count 1, is found NOT GUILTY of fraud.

[2] In respect of count 2, the State has failed to prove beyond a reasonable doubt that the accused, Professor Beale, intentionally or negligently killed Et[...] T[...]. He is found NOT GUILTY.

[3] In respect of count 3, relating to A[...] S[...], the accused, Professor Beale is found NOT GUILTY.

[4] In respect of count 4, fraud, the accused, Professor Beale, is found NOT GUILTY.

[5] Lastly, in respect of count 5, the State has failed to prove beyond a reasonable doubt that Professor Beale intentionally or negligently killed Z[...] S[...]. The accused, Professor Beale, is found NOT GUILTY.

- [6] There remains another matter: the accused, stated that he regretted leaving when Z[...] S[...]’s condition was reported to him, but chose to do so. Because of this conduct and admission, this judgment is to be referred to the HPCSA for consideration, in the event the accused considers pursuing his practice.

MUDAU J

Judge of the High Court

Johannesburg

I agree

Professor C Lazarus

Professor J M Dippenaar

APPEARANCES

Counsel for the State: Adv. EHF Le Roux and Adv SH Rubin

Instructed by: National Prosecuting Authority

Counsel for the Accused: B ROUX SC and IP GREEN SC

Instructed by: MacRobert Attorneys

Dates of hearing: first term 2024

Date of closing submissions: 18 & 19 November 2024

Date of Judgment: 4 March 2025

- [1] Prem Puri & Jan-Hendrik Gosemann, Variants of Hirschsprung Disease, Seminars in Pediatric Surgery (Nov. 2012).

- [2] 1937 AD 370 at p 373.

- [3] 1999

- (2) SA 79 (W) at 80H-J.

- [4] See R v Nksatlala [1960] 3 All SA 377 (A).

- [5] See PriceWaterhouseCoopers Incorporated and Others v National Potato Co-operative Ltd and Another [2015] ZASCA 2; [2015] 2 All SA 403 (SCA).

- [6] 976

- (3) SA 352 (A) at 371F-H.

- [7] See R v Blom 1939 AD 188 at p 201-2.

[8] 1967

(4) SA 566 (A) at 570B-F.

[9] Burchell, J. (2016). Principles of Criminal Law (5th ed.), Chapter 26, p. 386. Juta & Company Ltd.

[10] See *S v Dlamini and Others* [1984] 1 All SA 33 (N).

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Prepared on 9 October 2026 · Esheria