IN THE HIGH COURT OF SOUTH AFRICA

KWAZULU-NATAL DIVISION, PIETERMARITZBURG

INQUEST NO.: 01/2024P

In the matter of:

**THE RE-OPENING INQUEST INTO THE DEATH OF CHIEF ALBERT JOHN MVUMBI LUTHULI**

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**JUDGEMENT**

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**RADEBE J**

INTRODUCTION

[1] This is a re-opened Inquest into the death of Chief Albert John Mvumbi Luthuli ("Chief Luthuli). The prosecuting team comprises of Adv. Dunywa (as the leader) Adv. Chuene, Adv. Msimango and Adv. Ngcobo, all from the NPA cluster. There is no opposing party. The Late Chief Luthuli died on 21 July 1967. His death came as an unexpected blow to his now late wife, Nokukhanya Luthuli, his children the community of his village in Groutville KwaDukuza (previously known as Stanger) his comrades; the African National

Congress ("the ANC") of which he was a distinguished President; his religious affiliation; and the International Community (amongst others). Chief Albert Luthuli's death was ascribed to an alleged goods train accident. The alleged train accident was reported to have occurred while Chief Albert Luthuli was crossing the Umvoti Railway bridge in Gledhow. The news of his death like spread like wild fire across the country, the continent and internationally. It was generally known that then South African government and its Security Cluster f the apartheid era had kept Chief Luthuli under constant surveillance, monitoring every movement of his, having him banned from communicating or being in the company of more than the "allowed" number of people. Even on this fateful day of 21 July 1967 Chief Luthuli was still under those banning orders.

THE 1967 INQUEST

[2] On 19 September 1967 a formal inquest (No. 76/1967) was held at Stanger Magistrates Court, presided over the resident Magistrates Court, presided over by the resident Magistrate, Mr C.I. Boswell, who happened also to be the one who was charged with the issuing of temporary permits to Chief Albert Luthuli should the latter have necessity to travel out of Stanger for his medical check-ups in Durban. This 1967 Inquest was preceded by a letter dated 11 September 1967 addressed by Boswell to the Secretary of Justice in Pretoria (an Executive arm of the apartheid government) advising the said Secretary that the Inquest would be held on 19 September 1967.[1] It did not end there, but Boswell went on to foretell that the outcome of the said inquest will be that Chief Luthuli's death was brought about by a train accident and that the members of the Luthuli family would likely not accept the outcome. Boswell, therefore, knew that the conclusion of the inquest would be, even before the formal inquest was held.

[1]. The witness Jeffrey Radebe, who testified in its re-opened Inquest described the said letter as an affront to the very principle and doctrine of separation of powers, a subversion of justice and rule of law.

[3] As would have been expected, the train driver, Mr Lategan, together with his crew consisting of the fireman, Mr Greyling and the train conductor, Mr Van Wyk, were amongst the witnesses who submitted affidavits and who testified *viva voce* at the 1967 Inquest. This is evidence that were sure of what the outcome would be – exonerating them as employees of the SA Railways department of any wrong-doing. Boswell's findings were:

"3.1 the deceased died of "fractured skull, cerebral hemorrhage and contusion of the brain sustained by the deceased when he was struck by a goods train accidentally"

3.2 As to whether the death came about by any act, or omission of the part of any person, Boswell stated:

> "The evidence does not disclose any criminality on the part of any of the employees of the South African Railways or anyone else."[2]

[4] The witnesses who were called to give *viva voce* evidence at the 1967 Inquest evidence at the 1967 Inquest were limited to:

4.1 in respect of medical practitioners – Dr GM Gregersen (senior/superintendent and Dr JJ Van Zyl (district surgeon). The other medical Practitioner Dr M.J. Joubert, a neurosurgeon, was not called to testify but submitted an Affidavit. (see exhibit A to C of the 1967 Inquest Record – p452)

4.2 In respect of the police – D/SGT CBP Lewis from the SA Rail Police in Durban Investigating officer) (see Exhibit D, E, F & G of the 1967 Inquest record) pp453,475 to 477 of Bundle B.

4.3 SA Railway Police officer Andries P. Burger whose statement was submitted as Exhibit P of the 1967 Inquest Record.

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[2]. Exhibits handed in during the 1967 Inquest ranged from Exhibits A to U, with Exhibit G supposedly depicting photographs but which could not be found or located for purposes of the re-opened inquest no. 1/2024.

4.4 SA Railways employees – Mr Lategan (the train driver; Mr D.L. Greyling the fireman) on board the train); Mr P.F. Ban Wyk (the train conductor on board the train); Mr N. Mataba, (a labourer of the SA Railways Administration)

4.5 there were other witness who submitted affidavits which were accepted into the evidence but who were not called to give *viva voce* evidence. These included the wife of Chief Luthuli, Mrs Nokukhanya Luthuli; Mr P.F. Papaya (the ambulance driver of Stanger Hospital; Mr E.T. Chili (a bus rank Manager); Ms E. Mfeka (an employee at Chief Luthuli's general dealer store in Groutville, and Ms Z. Gumede (an employee of Chief Luthuli at his sugar cane plantation.)

[5] The family of Chief Luthuli was never satisfied with, and never accepted the result of the 1967 Inquest. They were never satisfied with the lack of an in-depth investigation into the circumstances of his death, and have for the past 58 years continued to express their dissatisfaction in respect of finding by the Boswell who presided over the 76/67 Inquest. To them, Chief Luthuli's death was a well-ochestrated plan to eliminate him.

[6] The family and other interested parties approached the National Director of Public Prosecutions to have the death of Chief Luthuli re-opened. Pursuant to section 17A of the Inquest Act, 58 of 1959 (as amended) (the Act) the Minister of Justice the Honourable Mr Ronald Lamola directed that the inquest should be re-opened. Indeed, on 14 April 2025 the Court ordered that the Inquest be re-opened. As directed, after having satisfied itself that jurisdictional facts exist for the inquest to be re-opened.

## THE NATURE OF AN INQUEST

[7] The Act regulates inquests, including re-opened inquests section 17A of the Act provides:

> " 17 A
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> (1) The Minister, may, on the recommendation of the attorney-general concerned[3] at any time after the determination of an Inquest and if he deems fit necessary in the interest of justice, request a judge president of the Supreme Court to designate any Judge of Supreme Court to designate any judge of the Supreme Court of South Africa to re-open that Inquest, whereupon the judge thus designated shall *re-open such inquest.*
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> (2) An inquest referred to in subsection (1) shall subject to the provisions of this Act, as far as possible, be continued and disposed of by the judge so designated on the existing record of the proceeding and the provisions of section 17(2) shall, in so far as they are not contrary to the provisions of this section, shall apply *mutatis mutandis* to such inquest."

[8] As regards the recording of the findings as envisaged in section 17A(3)(b), section 16(2) & (3) of the Act provide:

> (1) ...
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> (2) The judicial officer holding an inquest shall record a funding upon the inquest –
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> (a) as to the identity of the deceased;
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> (b) as to the cause or likely cause of the death;
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> (c) as to the date of death;

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[3]. The Inquest Act makes reference to the Attorney-General but this designation has been replaced by the "National Prosecuting Authority Act of 1998 as amended)

(d) as to whether the death was brought about by any act or omission *prima facie* involving or amounting to an offence on the part of any person;

(3) if the judicial officer is unable to record any finding, he shall record finding, he shall record that fact.

An inquest is an inquisitorial *cum* investigation process, driven by the presiding officer.[4]

[9] The States contention right at the outset, was that a finding should be made by this court, which differs from the finding made by the 1967 Inquest court under case number 76/1967. The State then presented evidence by several witnesses to justify its contention that Chief Luthuli was murdered and that those responsible for his murder, alternatively culpable homicide and a crime against humanity in contravention of the relevant customary international law and section 233 of the Constitution of the Republic of South Africa, Act 108 of 1996, should be held liable by direct conduct or vicariously liable as authorities in charge of those who executed the crimes.

THE ISSUES FOR DETERMINATION

[10] This brings us to the 3-fold issues for determination, namely:

10.1 whether there exists evidence which was not presented before the initial inquest (76/67) necessitating that this Court makes a fresh finding in terms of section 17A (3) read with section 16(2) of the Act;

10.2 whether the proceedings conformed with the prescripts of the Act in ensuring that a thorough investigation into the circumstances around the death of Chief Luthuli was pursued by that Court under Inquest 76/67;

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[4]. The Re-opened inquest into the death of A.E. Timol, Inq. 01/2017; Timol vs The Magistrate of Johannesburg 1972(2) SA 281(T)

10.3 whether that court was presented with sufficient evidence to make credible *prima facie* findings in terms of section 16(2) of the Act;

In looking at the above-mentioned issues, this court is reminded of what was stated case of *Timol v The Magistrate of Johannesburg* (*supra*)[5] where CILLIE JP et MARIAS J said:

> "For the administration of justice to be complete and to instil confidence, it is necessary that, amongst other things, there should be an official investigation in everywhere a person has died of unnatural causes, and the result of such investigation should be made known. Therefore the Inquest Act provides that, if there is reason to believe that a death has occurred, that such death was not due to natural causes and that it was not followed by the institution of criminal proceedings, there shall be an inquest as to the circumstances of the death."

Therefore, the inquest must promote public confidence, as it was held in MARAIS NO v TILEY[6] where it was held that:

> "The underlying purpose of an inquest is to promote public confidence and satisfaction; to reassure the public that all deaths from unnatural causes will receive proper attention and investigation so that, where necessary, appropriate measures can be taken to prevent similar occurrences and so that persons responsible for such deaths may, as far as possible for such deaths may, as far as possible, be brought to justice ...To my mind it is axiomatic that public confidence and satisfaction would normally best be promoted by a full and fair investigation, publicly and openly held, giving interested parties an opportunity to assist the magistrate holding the inquest in determining not only the circumstances surrounding the death under consideration, but also whether any person was responsible for such death. A full and fair investigation presupposes adherence to basic principles of procedure, and would in the normal course require the hearing of *viva voce* evidence. That justice must be seen to be done is no less a truism in the holding of inquests than it is in the hearing of trials." *(foot notes omitted)*

[11] The State seeks an order which, in my view, is justified by the voluminous evidence that has been presented before me by various witnesses, whose details are listed in paragraph 12 *infra*. The order sought may be summarised as consisting of three parts; namely:

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5. 1972(2) SA 281 (T) AT 287 H to 288 A.
6. 1990 (2) SA 899 (A) at 901 F – 902 A-B

11.1 that the finding and ruling of the Magistrate, Mr C.I Boswell, dated 19 September 1967, at the Stanger Magistrate's Court under the Inquest No. 76/67 be set aside.

11.2 that the finding pursuant to section 16(2)(a) to (c) be made;

11.3 that a finding pursuant to section 16(2)(d) be made

Closing argument was presented to justify and to convince this court that indeed there is abundant evidence to justify the granting f the order sought. This judgement incorporates such closing argument without singling it separately, especially as there is no counter-argument for this court to find otherwise. I must express my gratitude and acknowledgement of the sterling work by the prosecuting team, of painstakingly presenting this case before me.

## SUMMARY OF EVIDENCE

As per mutual agreement with the prosecuting team, I shall not deal with the detailed evidence of all the witnesses who testified.

[12] The evidence tendered at this re-opened inquest included:

12.1 Oral and documentary evidence of three investigating officers who were assigned to investigate this matter from 2021 under the TRC / Apartheid Era Crimes Unit; witnesses in the persons of Captain Godisamana Frank Kgamanyane; Colonel Modimetsa Johannes Mothle; and, Lt. Colonel Thomas Johannes Adolf Steyn.[7] Collectively they traced the whereabouts of the 1967 personnel, doctors and police officers involved in the initial inquest. Lt. Colonel Steyn further traced the whereabouts of other potential eye witnesses, with the last notable one being Mbhemu Mnyandu who had

[7] Exh B, C,DD respectively

Abbreviations: DPCI – Directorate for Priority Crimes & Crimes against the State

been sent by his father T. Mnyandu to deliver a letter to Chief Luthuli on 21 July 1967, only to witness him being assaulted by the white men from the train which was stationary in the vicinity. (*much about this later*) (Refer to Exhibits "B", "C", "DD", "FF").

12.2 Oral and documentary evidence of a representative of the African National Congress (the 'ANC'), of which Chief Luthuli was the President General – with Oliver Tambo being Luthuli's Deputy; Mr Jeffrey Thamsanqa Radebe, a highranking member of the ANC gave evidence from a political perspective, detailing the political life of Chief Albert Luthuli. He outlined the political motive behind the killing of Chief Luthuli, dispelling the notion of a train accident. (Refer to Exhibits "L" & "M" of the record.) Mr Radebe testified about the role that Chief Luthuli played in developing, guiding and reshaping the thoughts of those who were oppressed by the Apartheid regime; how Chief Luthuli advocated and fought for the emancipation of the Black oppressed people of South Africa; how he pushed for the gradual shift from passive resistance to the armed struggle, despite the media portraying him as a passive lame duck who was under the Apartheid government oppression. He further enlightened the public about how Chief Luthuli was voted as the President General of the ANC in the presence and attendance of youth leaders such as Nelson Mandela, Walter Sisulu, *inter alia*, who all grew under the stewardship of Luthuli, reporting to him on all 'underground' operations pertaining to the ANC, even after it was banned in 1960. He further gave an overview of the struggle credentials of Chief Luthuli and his involvement in formations such as the Natal Indian Congress; the Congress of Democrats and the Coloured Congress. In 1955, under Chief Luthuli the Congress of the People was held, out of which the Freedom Charter was born. Chief Luthuli advocated against forced removals of Black from places like Sophia Town, Cato Manor and Mkhumbane, to name but a few. Banning orders were the order of the day, culminating in a number of people living under banning orders at specific times. This became even more evident in 1966 when the American Senator Robert Kennedy visited Groutville. Chief

Luthuli, however he could not speak to him in the presence of others. It was soon after this (June 1966)1967 visit by Senator Kennedy and in 1967 that Chief Luthuli was assassinated by forces of the Apartheid regime. This murder was covered up as a goods train accident. He cited extracts from books in the likes of "Comrade and Commander: The Life and Times of Joe Modise" (in reference to meetings held in the sugar cane fields chaired by Chief Luthuli in 1962); as well as the book titled "Let my People Go" symbolising the hardship and pain Chief Luthuli was going through, for which he paid the ultimate price of death. Chief Luthuli was regarded by the Apartheid era government as a slippery irritation whom they wanted to get rid of. Mr Radebe highlighted the animosity of the then Apartheid government, which was displayed when Chief Luthuli was awarded the Nobel Peace Prize in 1961.

12.3 Oral evidence by family and persons associated with Chief Luthuli and his family. These included:

12.3.1 Mrs Velheminah May Luthuli ('Veli'), a daughter-in-law; Mr Mthunzi Albert Luthuli, a grandson (eldest if the Luthuli grandsons); and Dr Albertina Nomathuli Luthuli, a 93 year old daughter of Chief Luthuli and who was a qualified medical doctor at the time of Chief Luthuli's death. The evidence of these close family members was to demonstrate that Chief Luthuli was fit and healthy, was not hard of hearing; and that his sight was not impaired, such that he would have heard the whistle and sound of an oncoming train; he would have been able to see the oncoming train and thus avoid colliding with it. They dispelled the notion of the train accident as the cause of the demise of Chief Luthuli. Through the use of photos extracted from the archives, Dr Albertina Luthuli testified that her father, Chief Luthuli's body was complete with no dismembered parts when he was buried. The clothes that he wore on 21 July 1967 were not torn. She further testified about the visit by Senator Kennedy in 1966, echoing Mr Radebe's sentiments, that it had

made matters worse, heightening the negativity, and culminating in Chief Luthuli's assassination in 1967. She further testified that even after Chief Luthuli's death, the family continued to suffer and be subjected to harassment, to the extent that in the year 1970 she and her husband Dr Ngakane who was also under a banning order, together with their children, went into exile, only to return to the RSA in 1991. It was only after her return that she followed up the matter and eventually got hold of a copy of the Post Mortem Report compiled by Dr Van Zyl (Exhibit "D") from Stanger Hospital. As a qualified medical practitioner, she raised "alarms" about the glaring short-comings in the report. To the best of her knowledge no family member was called upon to be present and give evidence at the 1967 Inquest hearing despite that they were still resident in Stanger.

12.3.2 Mrs Nozizwe Abigail Mhlongo-Mabasa (aged 67 years) and Elliot Fanyana Nxumalo (aged 89 years), testified about Chief Luthuli as an individual outside of his family setting, there and then providing this Court with a perspective of how highly Chief Luthuli was regarded in the community of Groutville. They also echoed the sentiments expressed by the Luthuli family on how they got ostracised as people closely associated with the family. Mrs Mhlongo testified that on certain school days she would deliver correspondence / letters that Chief Luthuli was sending to other 'underground' activists. As a school child she did not fully appreciate the importance of such communication as she never got to know the contents and was under strict warning by her mother not to open the bag containing the letters to and from Chief Luthuli. Mr Nxumalo testified that during the 1960's even talking about or mentioning the name of Chief Luthuli was taboo as it would attract trouble with the police. On the afternoon of the incident (21 July 1967) he accompanied Mabaso (father to Mrs Mhlongo) to the scene at uMvoti train bridge where they cleaned the blood of Chief Luthuli.

12.3.3 Mr Thulani Stanley Thusi, is employed at the Luthuli Museum situated at the former home of Chief Luthuli. He gave interviews and pointed out valuable points to a photographer or from the LCRC (Constable Luxwazi) and to W/O Burgess of the Forensic Reconstruction Unit of the SAPS. This has been confirmed by W/O Burgess (Exhibit "F1"). These points pertained to the daily or regular routes that Chief Luthuli walked from his home to his shop (KwaNonhlevu) and to his cane fields, including the walk over the uMvoti Railway Bridge (Exhibit "N"). He referred to a steel railway bridge running over the Ntshaweni River near Gledhow Sugar Mill and said this is similar to the old uMvoti River Bridge, which was subsequently demolished after the demise of Chief Luthuli. He further, at a later stage in the proceedings, testified in respect of the photographs of the procession of Chief Luthuli's funeral.

12.3.4 Mr Brian Xaba testified with reference to his affidavit (Exhibit "O") and told the Court that the 1967 Inquest documents were downloaded with his assistance and these were handed to Captain Kgamanyane. The duplicates of these documents are kept at the Luthuli Museum in Groutville.

[13] Oral evidence of Mr Mohamed Haniff Manjoo (aged 81 years) ('Manjoo') who was present as an admission clerk at the Stanger Hospital when Chief Luthuli was wheeled in, lying in a stretcher on 21 July 1967 at 11H30. He knew Chief Luthuli very well since about 1959 when he was a young boy. Manjoo frequently drove Chief Luthuli back to his home after the latter had been meeting with Manjoo's father Mr E.V. Mohamed, a bookkeeper and friend of Chief Luthuli. His evidence is that on 21 July 1967 whilst on duty, he received a phone call (he was on duty as an out-patient clerk) from the Station Master of Gledhow Railway Station, requesting for an ambulance to be sent to the station for a "native" who had been knocked down by a train. His recollection is that it was a certain Mr Zwane who was dispatched to drive the ambulance, (and not Papaya - as the 1967 Inquest records). When Zwane came back into the out-patient unit, Manjoo

immediately recognised Chief Luthuli as the patient who was being wheeled in. Chief Luthuli was unconscious. Manjoo did not see any bruising or bleeding on the face or head, however he conceded that if there was bleeding at the back of the head he would not have seen it. In due course Chief Luthuli was taken into the examination room and one Dr G. Msira, a district surgeon was called into attend to the injured Chief Luthuli Dr Gregasen, the Senior Superintendent was also in attendance. Manjoo found this strange that Dr Gregarsen, as the Senior, Superintendent in attendance as she was not expected to attend to patients, especially Black patients (See also his statement – Exh. R)

[14] Oral documentary and real evidence presented by expert witnesses, namely: Warrant Officer BC Burgess; Warrant Officer Sunet Nel; Mr Gert Willem Van Tonder; Mr Leslie Charles Labuschagne; Dr Sibusiso Johannes Ntsele. It is trite that an occurrent of a train or a motor vehicle or for what matter an aeroplane requires evidence of a technical, forensic and pathological nature to be led to prove: firstly, that there was such an accident; and, secondly it is probable cause. In this re-opened inquest evidence was led of two train experts, a reconstruction expert, a similation expert and of a specialist forensic pathologists. It would be remembered that no such expert evidence was adduced in the 1967 Inquest. The expert witnesses that were called at this re-opened inquest had the mamoth task of determining if a train accident did indeed occur and if so, whether the injuries found on the body of Chief Luthuli were consistent with those of a train accident.

[15] The official who was assigned to reconstruct the alleged train accident is Warrant Officer Burgess – that is, after attempts to engage a private reconstruction expert failed. Burgess gathered information from Mr Lesley Labuschagne and Mr Gert Van Tonder, who are train experts. For purposes of simulation he used Warrant Officer Sunette Nel, who happened to be of the same height and weight as Chief Luthuli. For the forensic analysis of the post mortem report, he engaged the services of Dr Ntsele.

[16] For the sake of expediency, I will not rehash their evidence since they all came to one conclusion. Suffice to say that Dr Ntsele, with reference to his report, marked as Exh. Y of the record, evaluated the Post Mortem Report compiled by Dr Van Zyl in 1967 and noted the following:

16.1 the injuries indicated on the said Post Mortem do not resonate with the injuries that would have been expected from a pedestrian involved in a train accident;

16.2 that generally a person who was struck by a train would sustain multiple fractures on different regions of the body;

16.3 that generally a person struck by a train would sustain multiple abrasions, bruises and/or lacerations;

16.4 that the injuries recorded on the face of the Post Mortem Report are grouped without providing specific distinctive details about the injuries in relation to wound measurements and specific locations within anatomical sites;

16.5 that it is not revealed how may and how big the scalp lacerations and bruises were;

16.6 that there was insufficient description relating to the extent and severity of the factures sustained by Chief Luthuli;

16.7 that there was no diagramic description of the location of the injuries on the body of Chief Luthuli;

16.8 that there was no documentation of the clothing of the deceased, and therefore it was not possible to obtain cues, the presence of debris (like grass, sand or soil) which could prouce an idea as the where the person could have been when he was injured.

16.9 that the post mortem examinations was so hurried that it was conducted 90 minutes after the death and whilst the body was still warm; There were no

cultural or religious reasons necessitating the examination to be done so soon after the death, even before rigor mortis had completed.

16.10 with reference to Dr GRegassen's evidence in the 1967 Inquest;

16.10.1 Dr Ntsele observed that: the X-ray records were omitted. This was done deliberately to conceal vital evidence of the actual injuries.

16.10.2 Dr Gregersen omitted to state whether the fracture on the left elbow was simple complex or complicated. Had this been detailed, then it would be possible to ascertain the amount of blunt force which could have contributed to this fracture.

16.10.3 that, given the distribution and nature of the injuries, one would have expected the clothing to be full of blood. However Dr Gregasen had noted that there were no signs of dragging on the body but that the clothes were torn and dirty.

16.10.4 that there was no physical evidence to suggest that Chief Luthuli was thrown some distance away on impact, yet Dr Gregerson confirmed to the conclusion reached by the evidence leader in 1967 that Chief Luthuli was thrown away some distance on impact.

16.11 that Dr Jouberts' conclusion that Chief Luthuli died as a result of head injuries as well as chest injuries does not make sense, for the reason that Dr Joubert, on the other hand, concluded that *"it was not possible to determine whether there was an associated haemothorax"*.

16.12 that the quality of medical attention given to Chief Luthuli is riddled with a number of omissions. These include, for instance the failure to immediately transfer Chief Albert Luthuli to King Edward Hospital in Durban, but instead retain him for close of two hours at the Stanger hospital which was not

properly equipped to treat patients with head injuries, who needed neurosurgery intervention.

[17] After careful analysis of the injuries sustained by Chief Luthuli, including the final condition of his body and clothing, Dr Ntsele was of the opinion that Chief Luthuli was assaulted and died as a result thereof on the same date, being 21 July 1967. His conclusion is as follows:

> "The presence of bruises on the dorsal aspect of both the left and the right hands, as well as the fracture on the left proximal ulnar bone, may signal defence injuries which would normally occur when a victim of assault instinctively raises hand and arms to protect their eyes, face and head."[8]

OTHER VITAL LINKS OF AN EYE WITNESS

[18] As a result of the re-opened inquest being widely publicized through various media platforms, witnesses started coming forward. One Mr Bafi Isia Mdletshe, aged 70 years of age, came forward to testify as follows:

18.1 he became aware of what actually befell Chief Luthuli on the fateful day of 21 July 1967 through what the late Phothwayo Barnabas Mnyandu who died 5 years ago (around 2019 or 2020) related to him. His affidavit was subsequently taken down in writing by the investigating officer Lt. Col. Steyn, and has been accepted onto the record as Exh. AA.

18.2 the late Phothwayo Mnyandu was a son of the Late Thomas Mnyandu, an Induna in Genezano area, La Mercy KZN. The Black people were involved in an on-going Land claims dispute, which is still alive to this day. Mdletshe was in due course earmarked to take over as the Chairperson of the Land Claims Committee. It was during the process of the take-over during 2015 that the elderly Phothwayo Mnyandu shared with him the vital information

[8]. Record of the Re-opened Inquest – 14 May 2025, pp 38 & 39 lines 23-25 and 1 - 12

Thomas Mnyandu had shared with him-the vital information about an eye-witness who observed Chief Luthuli being assaulted by White men from the train that was stationary at the uMvoti River bridge on 21 July 1967.

18.3 This eye-witness was the younger brother of the Late Phothwayo Mnyandu. It later turned out during this re-opened inquest that the name of this younger Mnyandu was Mbhemu Mnyandu, as per information obtained by the investigating officer, Lt. Col. Steyn from an elderly lady, Mrs Nxele (aged 84 years) on 25 June 2025.

18.4 The said Mbhemu Mnyandu had possibly witnessed the incident of assault of Chief Luthuli when he has been sent to deliver a letter to him at his home in Groutville only to be directed to the canefields where Chief Luthuli was supposed to have gone. Mbhemu rode his bicycle and purported to go to the canefields to deliver the letter. Fortuitotously he saw Chief Luthuli being assaulted with a shovel by the White men from the goods train. When the assailant realized that they were being watched, one of them gave chase to Mbhemu, who fled the scene in his bicycle. Once can conclude that the assailants were disturbed and could not complete their assault.

18.5 A few days after 21 July 1967, police officers from either Tongaat or Verulam came to the Mnyandu homestead and took Mbhemu Mnyandu with them, as if they were going to take a witness statement from him. To this day the said Mbhemu Mnyandu has never returned home.

[19] Mr Sibongile Elizabeth Ndimande (born Mnyandu) also echoed the sentiments expressed by Mdletshe about the activities of her grandfather Thomas Mnyandu as well as the disappearance of Mbhemu Mnyandu. This event about Mbhemu's disappearance became one of those topics that are never spoken about lout in the family gatherings, for fear of negative repercussions.

THE IMPACT OF CHIEF LUTHULI'S DEATH ON THE FAMILY

[20] Mrs Lindiwe Nana Ngobese-Nxumalo read into the record a report, Exh. CC, which had been crafted by the living grandchildren. The report detailed the impact that Chief Luthuli's death had on his family. It is evident from the reading of the said report that the entire family still feel a lot of pain. Had proper prosecution been done in 1967, the family would have felt vindicated in seeing those responsible for Chief Luthuli's death being brought before appropriate criminal courts.

Chief Luthuli had a number of grandchildren, I shall deal mainly with those referred to in the report.

20.1 The Ngakane children, born of Dr Albertina Luthuli and Dr Pascal Ngakane feel that they were forced to live in exile as a result of the killers of Chief Luthuli and the institutions associated with those killers;

20.2 The Gcabashe grandchildren have suffered far- reaching effects and fear;

20.3 The Ngobese grandchildren (their mother is the author of the aforesaid report – Exh CC) painfully reflected on their grandfather and how he suffered to his death. They equate any attempt to eraise Chief Luthuli's death to actually erasing it from the history of Africans at large. (I must add that today we have several government buildings, road and other institutions named after Chief Luthuli, almost every big city) to demonstrate how difficult it is to erase his memory)

20.4 Christian and Cynthia also separately echoed the sentiments of loss.

20.5 The children of Velheminah and Edga Luthuli were also seriously affected. We saw and heard Mthunzi Albert Luthuli testifying before this re-opened inquest. His demeanour demonstrated that he still feels heavy pain as a result of the loss.

FINAL EVALUATION

[21] In assessing the evidence presented to this Court in the re-opened Inquest I bear in mind that the standard of proof is not astringent as what in a criminal case in respect of which the test is proof beyond any reasonable doubt; nor is it the standard of proof on a balance of probabilities, as is the case in civil trials.

[22] In RE GONIWE AND OTHERS,[9] ZIETMAN JP, dealing with the standard of proof required for a positive finding to be made in terms of s16(2)(d) of the Act said the following:

> "An inquest is held where it appears that a death has occurred, that such death was not due to natural causes and where criminal proceedings have not been instituted in connection with the death. In the case of Marias No v Tiley 1990 (2) SA 899 (A) Smalberger JA stated at 901 E-G:
>
> > 'The function of an inquest is to determine the identity of the deceased person; the cause of death; the date of death; and whether the death was brought about by any act or omission involving or amounting to an offence on the part of any person; The latter determination would include insofar as this possible, a finding as to who the responsible offender is or offenders are). The underlying purpose of an inquest is to promote public confidence and satisfaction; to ensure the public that all deaths from unnatural caused will receive proper attention and investigation so that, where necessary, appropriate measures can be taken to prevent similar occurrences, and so that person responsible for such deaths, may, as far as possible, be brought to justice.'

[23] In TIMOL AND ANOTHER[10] this sentiment was again echoed by Cillie JP and Marais J. Similarly, in the DE'ATH (SUBSTITUTED BY TILEY) vs ADDITIONAL MAGISTRATE, CAPE TOWN[11] Van dee Heever J stated:

> "... An inquest is not aimed at proving anyone's guilt, but is most certainly aimed at ensuring that if possible, where guilt exists it will not remain hidden."

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9. 1994(2) SACR 425 (SE) at 427 (b)
10. *Supra* – 287-288
11. 1988 (4) SA 769 (c) at 775 (G)

[24] The above quoted decisions, amongst many others, mean that even where those who are found to be responsible for the death of a person are no more, their identity in some form should never remain hidden forever. In *casu,* all the culprits have since died as Lt Col. Steyn has testified and /or submitted his affidavit to that effect.

[25] An in-dept analysis of the technical evidence presented at the 1967 Inquest and of the re-opened 2025 inquest has been done through the evidence by the train experts, the simulation experts as well as the medical experts. The 1967 inquest as Advocate Chuene is riddled with lies and inconsistencies. The persons of authority, from the presiding Magistrate Mr Boswell, to the medical personnel and the police officers like D/Sgts Burger and Lewis and the SA Railway labourer were all hell-bent on covering up the circumstances leading to the death of Chief Luthuli, and to present false evidence that Chief Luthuli was struck by a goods train.

[26] Dr Ntsele as I have highlighted above, in his evidence before this re-opened inquest, testified about discrepancies in the evidence of the three medical practitioners involved in the 1967 inquest. The police officials (Burger & Lewis) have also been shown to have not done proper preservation of the scene of the so-called train accident. This shows that there was no train accident in the first place. Also concerning, is that the Gledhow Station Master Mr Pretorius would allow Lategan, Gryling and Van Wyk to proceed with the goods train journey to Durban even before the injured Chief Luthuli was removed by ambulance to hospital. The railway labourer, Nsakani Mathaba, who was said he was working on the new bridge that was constructed nearby, told the 1967 Inquest that the whistle of the train was not blown, and he later conceded that he could have been prevented by the strong wind blowing from South Westerly direction, from hearing the whistle. There was no blowing of the whistle, regard being had to the contradictory evidence of the train driver Letegan, Greyling (the fireman) and Van Wyk (the conductor). There are also time discrepancies between the evidence of all the Railway employees involved, vs the evidence of the ambulance driver, Mr Papaya.

[27] The 1967 Inquest proceeding were flawed. The court in (1967) failed to thoroughly evaluate the evidence presented by the persons at the scene; and to compare it with the conflicting evidence of the witnesses who were not present at the scene, like Eness Mfeka, Ziphi Gumde, Eric Chili. At the end of the day, reading of 1967 Inquest records reveals that Chief Luthuli was not provided with much needed emergency medical care.

[28] The evidence of the expert witnesses who testified in this re-opened inquest to shows that:

28.1 the experts are competent to express the particular facts or opinion;

28.2 they have personal knowledge of the topics they testified on and have experience on their respective topics;

28.3 they relied on the knowledge and experience of other acceptable experts in their respective fields;

28.4 they demonstrated that they have grounds upon which they base their opinions or facts.

In short, they met all the requirements expounded in the case of MANDAY v PROTEA ASSURANCE.[12]

[29] It is true, from the evidence adduced in this re-opened inquest, that, as Adv Msimango submitted, that there was and perhaps even currently, an entrenched culture of lying about the true facts where the murder of a political activists is involved; and that apartheid was institutionalized with law being the primary tool used to give effect to apartheid. We consider here the actions of the medical practitioners stationed at the Stanger Hospital and those of Dr Joubert, a neurosurgeon stationed at Wentworth and King Edward Hospitals. In isiZulu I would say "*wafika e Stanger Hospital wazomqedela.*" We consider also that even Magistrates in the law courts, used law to push a clandestine

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[12]. 1976(1) SA 565 (EC)

agenda. Consider the actions of Mr Boswell. Mr Msimango further referred to the cases of:

- Griffiths Mxenge
- Hafejee
- Timol
- Imang Haroon, name but a few.

Mr Msimango further submitted that in the case we are about here, there was care planning that involved even demolishing uMvoti bridge and constructing a similar bridge nearly.

[30] Advocate Ngcobo gave us the Internal law perspective, rehashing that it was in 1966, a year of specific resolution of the United Nations General Assembly that Chief Luthuli was visited by Senator Robert Kennedy. Gravely concerned at the intensification of the policies as apartheid in SA, the General Assembly noted with concern, and expressly condemned what was happened in SA. They were saying what was happening was a crime. Chief Luthuli was subjected to such crime against humanity. He echoed the sentiments expressed by Adv. Dunywa (the leading prosecutor) who referred me to the most recent decision of THE STATE vs MFALAPITSA EPHRAIM AND TWO OTHERS[13] when he said those responsible for murder, alternatively culpable homicide and a crime against humanity in contravention of the relevant Customary Internation law and Section 233 of the Constitution should be held liable by direct conduct or vicariously liable as authorities in charge of those who executed the crimes. Advocate Ngcobo further referred to the article by Professor John Durgard in alluding to the fact that apartheid was officially criminalized in 1973, as a crime against humanity, and that inhuman acts resulting from the policies and practices of apartheid and similar polices and practices of racial segregation and discrimination are internation crimes. The apartheid convention refers directly to SA circumstances. The persecutions of Chief

[13]. Unreported case [2025] ZAGPHC 410 dated 14 April 2025

Albert Luthuli as well as other persons opposed to apartheid therefore amounts to a crime against humanity and so does his murder.

[31] Advocate Dunywa, in closing submitted that the evidence presented is sufficient for this court to set aside the findings of the 1967 Inquest and to substitute same with a finding which I shall now make.

[32] From the body of the evidence adduced before me this Court it can be accepted that there exists evidence which was not presented before the 1967 Inquest, which was not presented before the 1967 Inquest, which necessitates that this Court makes a fresh finding in terms of s17A(3) read with s16(2) of the Act; that there was no thorough investigation into the circumstances around the death of Chief Luthuli and Court was not presented with sufficient evidence to make a credible *prima facie* finding in terms of section 16(2) of the Act.

ORDER

1.

(a) The finding and ruling of the magistrate Mr. C.I. Boswell dated 19 September 1967 at Stanger Magistrate's Court under Inquest No. 76/67 is set aside.

(b) In terms of Section 17A(3) read with Section 16(2) of Inquest Act 58 of 1959 as amended, the following orders are made:

(i) In terms of section 16(2) (a) the deceased is Chief Albert John Mvumbi Luthuli, an African male and the President of the African National Congress.

(ii) In terms of section 16(2) (b) as to the cause or likely cause of death it is found that the deceased died as a result of "Fractured skull, Cerebral Hemorrhage and Contusion of the brain associated with an assault";

(iii) In terms of section 16(2)(c) as to the date of death, it is found that the date and time of death is approximately 14h25pm on Friday 21 July 1967;

2. In terms of section 16 (2)(d) as to whether the death was brought about by any act or omission *prima facie* involving or amounting to an offence on the part of any person, it is found as follows:

2.1 That the death is attributable to cumulative acts and omission of the following:

2.1.1 Assault by members of the Security/Special Branch of the SAP (South African Police) acting in concert and in common purpose with employees of the South African Railway Company.

2.1.2 That the following persons committed the crimes/offences of defeating the ends of justice, perjury and being accessories after the fact to the crime of murder:

a) Mr Albertus Stephanus Lategan (locomotive driver whose whereabouts cannot be ascertained);

b) Mr. Daniel Lessing Greyling (Fireman whose whereabouts cannot be ascertained);

c) Mr. Pieter Francois van Wyk (Train Guard, whose whereabouts cannot be ascertained);

d) Detective Sergeant Andries Petrus Burger (Railway police from Stanger, whose whereabouts cannot be ascertained);

e) Detective Sergeant Charles Barend Petros Lewis (Railway Police from Durban, whose whereabouts cannot be ascertained);

f) Andries Lodewicus Hilhelmus Pretorius (Gledhow Station Master, whose whereabouts cannot be ascertained);

g) Mr. Steyn (The Gledhow Station Foreman, whose whereabouts cannot be ascertained) and

h) The members of the South African Police who are alleged to have pursued and eventually kidnapped Mbhemu Mnyandu in connection with having witnessed the assault on Chief Albert Luthuli.

3. It is further ordered that:

   a recommendation is hereby made that the Director of Public Prosecutions fully investigate the circumstances of the kidnapping/forced disappearance of Mbhemu Mnyandu following his witnessing of the assault on Chief Albert John Mvumbu Luthuli.

4. That it be recognized that the institutionalization of Apartheid, which was already a crime in 1948 according to International common law, and with respect to which the case of Chief Albert John Mvumbi Luthuli was handled, is evident from the acts and omissions of members of the following government departments:

   (a) Health
   (b) South African Police
   (c) South African Railway
   (d) Justice.

**RADEBE J**

**DATE: 30 October 2025**

## ANNEXURE "A" TO THE JUDGMENT

## RE-OPENED INQUEST INTO THE DEATH OF CHIEF ALBERT JOHN MVUMBI LUTHULI

**Analysis of technical evidence presented at the initial Inquest held on 19 September 1967 and the current re-opened Inquest which commenced on 14 April 2025**

Introduction

It is pertinent to provide an analysis of technical evidence presented at the initial Inquest held on 19 September 1967 and the current re-opened inquest which commenced on 14 April 2025. Through this analysis this court will be able to overturn the ruling of the 1967 Inquest with respect to the death of Chief Albert John Mvumbi Luthuli. The overturning of that ruling would amount to a just verdict with respect to the circumstances which led to the death of the deceased.

1.

The analysis of the technical evidence which was led at this re-opened Inquest is compared with the evidence led at the 1967 Inquest which commenced on 19 September 1967.

2.

It is important to set out the evidence which was provided by train experts, re-construction and simulation experts as well as the medical experts during these current re-opened proceedings and juxtapose this evidence against all evidence presented at the initial Inquest in 1967. This is done as an indication of the web of lies which were spun by witnesses and persons in authority in respect of the 1967 Inquest as well as the extent and measures which were taken to cover up circumstances leading to the death of the deceased.

3.

At the initial Inquest of September 1967, proceedings commenced with oral testimony from two medical practitioners, followed by the testimony of the investigating officer, the testimony of a

labourer from the South African Railways as well as testimony from the occupants of the locomotive which allegedly struck the deceased.

4.

Other evidence brought before the court was in the form of written affidavits from various witnesses. For context, we provide a summary of evidence presented by each witness at the inquest proceedings of 1967 and later we outline key aspects arising from expert evidence presented at the current re-opened inquest proceedings.

Evidence from medical practitioners at the 1967 inquest proceedings

5.

The following medical practitioners were called upon to provide oral testimony at the initial inquest:

1. Dr Gewndolyn Mary Gregersen who was a registered medical practitioner and Senior Superintendent of Stanger Hospital. Her written affidavit was also read and submitted as exhibit A during the proceedings.[1]
2. Dr Jacobus Johannes van Zyl who was a registered medical practitioner and District Surgeon for Stanger District. He compiled a postmortem report in respect of the deceased which was read and submitted as exhibit C.[2]

6.

The other doctor, Dr Mauritius Johannes Joubert, a neurosurgeon from Durban, who is said to have made medical findings in respect of the deceased, Dr Mauritius Johannes Joubert was not called to testify, however, his affidavit was submitted as exhibit B in the proceedings.

Evidence from the police at the 1967 inquest proceedings

7.

Detective Sergeant Charles Barend Petrus Lewis from the South African Rail Police in Durban gave oral evidence at the initial inquest. He presented himself as the investigating officer of the

[1] 1967 Inquest Record Paginated 452
[2] 1967 Inquest Record Paginated 452

case. During the proceedings, the record indicates that his written statement was read, handed in and marked as exhibit D. Other documents which he compiled were also handed in: a plan marked as exhibit E, a key to plan marked as exhibit F and photographs marked as exhibit G.[3]

8.

It is submitted that the evidence of this witness is of a technical nature because he recorded a key to plan wherein, he recorded several measurements[4] in respect of the incident, the details of which shall be analysed at a later stage in this address.

9.

Another statement by one Andries Petrus Burger from the Stanger Railway Police was also submitted as exhibit P, however, it is submitted that his evidence is not of a technical nature but will at a later stage and for the sake of completeness, be summarised and analysed.

Evidence from the locomotive driver at the 1967 inquest proceedings

10.

The driver of the train is said to have been Stephanus Albertus Lategan. In an affidavit he provided details with respect to the locomotive type, dimensions of the locomotive, its load and tonnage as well as the speed at which the locomotive was travelling when it allegedly struck the deceased[5].

Other versions presented by witnesses at the 1967 inquest proceedings

11.

Technical evidence of witnesses cannot be analysed in isolation without considering the versions which were presented by other witnesses who either submitted statements or oral evidence in respect of the incident at the initial 1967 inquest. It is also important to note any possible circumstantial evidence. In that respect, the evidence of the following witnesses will also be analysed:

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[3] 1967 Inquest Record Paginated 453

[4] 1967 Inquest Record Paginated 475 to 477.

[5] 1967 Inquest Record Paginated 475 to 504.

1. Daniel Lessing Greyling who was a fireman on board the locomotive.
2. Pieter Francois van Wyk who was the conductor on board the locomotive.
3. Andries Lodewicus Hilhelmus Pretorius who was the Station Master of Gledhow Train Station.
4. Nsakani Mataba who was a labourer employed by the South African Railways Administration.
5. Peter Francis Papaya who was the ambulance driver for Stanger hospital.
6. Andries Petrus Burger who was a detective sergeant of the South African Railways Police stationed at Stanger.
7. Eric Thembinkosi Chili who was a bus rank manager.
8. Nokukhanya Luthuli who was the wife of the deceased.
9. Eness Mfeka who was an employee of the deceased's general dealer store in Groutville.
10. Ziphi Gumede who was employed by the deceased to work at his sugar cane plantation.

We proceed to present a summary of the evidence presented by each witness at the 1967 inquest proceedings:

Summary of evidence and injuries observed by Dr Gwendolyn Mary Gregersen (page 465 to 466 exh D)

12.

When Dr Gregersen attended to the deceased who was still alive upon admission at the hospital, she noted certain injuries on the head and body as well as regions from which there was bleeding.

Injuries on the head:

1. Fracture on the base of the skull. She stated that the bleeding of the ear suggested a fracture at the base of the skull.[6]
2. Jagged laceration at the base of the skull on the left-hand side which was about 4 to 5 inches long (approximately 12 centimetres long),
3. A three-inch (approximately 7 centimetres long) laceration on the centre of the occiput,
4. An abrasion on the right perital region,

[6] 1967 Inquest Record Paginated 452.

5. A laceration of an inch (approximately 2.5 centimetres long) on the same right perital region.

Injuries on the body:

1. Fractured ribs on both sides
2. A fractured left elbow,
3. A fractured left hand,
4. Laceration on the right lower leg (length of laceration not provided).

Summary of bleeding:

1. Bleeding from the right ear
2. Bleeding from head injuries

Condition of clothing according to Dr Gregersen was torn and dirty.

13.

Medical journals define a fracture is defined as a break or crack in the bone[7] whilst a laceration is defined as a wound caused by a tear or cut in the skin or other soft tissue[8]. Abrasions are defined as a type of open wound caused by the skin rubbing against a rough surface[9].

14.

Therefore, according to Dr Gregersen the total injuries on the head which she observed were three lacerations and one skull fracture at the base. On the body she noticed fractures on both sides of the rib and two fractures on the left upper limb namely the hand and elbow. There was one laceration on the right lower leg.

15.

According to Dr Gregersen, there were no signs of the body having been dragged.

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[7] https://www.hopkinsmedicine.org Fractures John Hopkins Medicine
[8] https://www.msdmanuals.com Skin lacerations - Injuries
[9] https://www.healthline.com Abrasion Symptoms

16.

Medical treatment that was given to the patient included blood transfusion and oxygen. The patient was also given a cardia stimulant and his wounds were sutured (stitched). X-rays were also taken from the patient.

17.

Dr Gregersen stated that she attended to the patient at **11:30 am** on 21 July 1967 and that the patient died on the same day at **2:25pm** which was 5 minutes after a neurosurgeon from Durban, Dr Joubert, had arrived to see the patient. Dr Joubert saw the patient at **2:20pm**.

18.

A postmortem examination was conducted on the deceased on the same day he died although it is not apparent from the evidence of Dr Gregerson as to what time this examination was done. She confirmed that she was present when the said postmortem examination was conducted by Dr J.J. van Zyl whom she described as the District Surgeon of Stanger and that she identified the body to van Zyl as that of Chief Luthuli.

19.

On 24 July 1967, she was at Stanger Mortuary where a second identification of the body of the deceased was done by Mr S.A. Lategan whom she described as the driver of the train that struck the deceased on the morning of 21 July 1967.

Summary of evidence and injuries observed by Dr Jacobus Johannes van Zyl (page 468-471 of exh D)

20.

On 21 July 1967 at **4pm**, Dr van Zyl conducted a postmortem examination on the body of Chief Luthuli. He testified that the deceased sustained multiple injuries which were caused by him being struck with a very heavy object[10]. He further testified that he noted two lacerations on the head: one on top and one at the back[11].

[10] 1967 Inquest Record Paginated 453.
[11] 1967 Inquest Record Paginated 453.

21.

Dr van Zyl noted the following injuries on the deceased's head[12]:

1. Fracture of the base of the skull based on blood oozing from the right ear.
2. Multiple lacerations on the skull which were sutured (no mention of exactly how many neither is there a mention of how deep or the length(s) of these lacerations).

22.

Dr van Zyl noted the following injuries on the body[13]:

1. Fracture of both the left and right ribs
2. Fracture of the Ulna proximal end
3. Multiple bruises on the left and right hand – dorsal aspect
4. Laceration on the right shin
5. Puncture mark on the right cubital vein caused by an I.V. drip

23.

Dr van Zyl further noted on his report that the body appeared to be that of a 70-year-old Bantu male, whose height was 5 foot and 10 inches (approximately 177.8 centimetres) and weighed approximately 170 pounds (approximately 77kg) [14]. The death occurred approximately one and a half hours prior to the examination and the cause of death was cerebral haemorrage and contusion brain[15]. The body was identified as being that of Albert John Luthuli by Eric Chili, Peter Papayya and Dr Gregersen[16].

24.

Observations by Dr Mauritius J. Joubert[17] (page 467 of exh D):

Dr Joubert did not testify but submitted an affidavit describing himself as a neurosurgeon from Durban who, on 21 July 1967, was summoned by Dr Gregersen to attend to Albert Luthuli. At this stage we would like to point out that it is curious as to why Dr Gregersen decided to summon the neurosurgeon from Durban, who arrived close to two hours and fifty minutes later, if we are to

[12] 1967 Inquest Record Paginated 468.
[13] 1967 Inquest Record Paginated 468.
[14] 1967 Inquest Record Paginated 470.
[15] 1967 Inquest Record Paginated 468.
[16] 1967 Inquest Record Paginated 468.
[17] 1967 Inquest Record Paginated 467.

work with the admission time of 11:30 am as she had stated. It is clear that Chief Luthuli was in need of specialist neurological care, therefore it is curious as to why he was not immediately transferred to King Edward Hospital in Durban which is said to have had the best facilities to cater for critical patients.

25.

Dr Joubert did not state as to what time he arrived at Stanger Hospital and at what time he examined the deceased. It is submitted that this was a deliberate omission on the part of Joubert. He did this in order not to expose his negligence for not attending to the deceased timeously. Arguments shall be advanced at a later stage to indicate that the admission time for Chief Luthuli at Stanger hospital was around 12:40 and not 11:30 as stated by Gregersen. We submit that even with this added advantage of time, it is curious why it took Dr Joubert 1 hour and 45 minutes to travel to Stanger Hospital which is approximately an hour away from Durban. Dr Joubert arrived at Stanger Hospital at 14:25. It is curious why it took him an extra 45 minutes to get to Stanger Hospital.

Dr Joubert noted the following with respect to the deceased:

1. He was in a deep coma
2. He was not responding to any form of stimulation
3. His pulse was feeble, and his blood pressure could not be recorded.
4. His breathing was shallow and irregular.
5. His conjunctivae were very pale.
6. His left pupil was obliterated by a chronic scar and cataract.
7. His reflexes were absent.

26.

Dr Joubert observed x-rays which were conducted on the deceased and noted the following:

1. Extensive skull fractures (no mention of the number of fractures and their extent).
2. Fracture of the left elbow
3. Fracture of the right 9$^{th}$ rib.

27.

He further stated that it was not possible to ascertain whether there was an associated haemothorax or peritoneal haematoma. He further stated that besides supportive measures having been instituted, the patient demised. He, however, did not state the type of supportive measures which were instituted and neither did he record the time of death. Haemothorax or peritoneal haematoma is defined as a collection of blood in the pleural cavity, most commonly occurring following chest trauma[18].

Based on the statements of the three medical practitioners, a number of discrepancies can be highlighted.

28.

Discrepancies in the evidence of the three medical practitioners

1. Dr Joubert who observed the factures on an x- ray noted only one injury on the right rib, namely the 9th rib whilst both Dr Gregersen and Dr van Zyl stated that both ribs of the deceased were fractured. They do not however, elaborate on the extent of the injuries and how it is that they were able to observe these fractures.

2. Dr Joubert does not make mention of any lacerations on the head of the deceased whilst Dr Gregersen makes mention of three lacerations and Dr van Zyl refers to multiple lacerations without indicating an exact number.

3. Dr Joubert does not specifically mention the fracture of the base skull; he only refers to multiple fractures. Both Dr van Zyl and Dr Gregersen concluded that the deceased had a fracture on the base of the skull because he was bleeding from the right ear. None of these observations were made by Dr Joubert including bleeding from the right ear. We pause to mention that as a neurosurgeon who is a specialist when it comes to skull injuries, this facture at the base of the skull should have been noted by Dr Joubert, at the very least, the bleeding from the right ear. We are left wondering why this injury was not noted by Dr Joubert to the extent of wondering whether this fracture was indeed present.

[18] https://www.emedicine.medscape.com

4. Dr Gregersen said that the deceased's left hand was fractured but that aspect was neither noted by Dr van Zyl nor Dr Joubert. She also mentioned an abrasion on the right perital region which was not noted by either Dr van Zyl nor Dr Joubert.

5. Both Dr van Zyl and Dr Gregersen noted a laceration on the lower right leg of the deceased, but this aspect was not noted by Dr Joubert.

6. On the record, Dr Gregersen noted bruising although it is not clear where she saw bruising. Dr van Zyl noted bruising on the dorsal part of each hand. This aspect was not noted by Dr Joubert.

7. The clinical observations made by Dr Joubert were not noted by Dr Gregersen and it is not clear whether she was present when Dr Joubert examined the patient.

29.

The only injury which all three doctors noted without contradiction is the fracture of the left elbow, although Dr van Zyl referred to it as a fracture to the ulna proximal end.

30.

We pause at this stage to submit that it is curious as to why Dr Joubert, who was the last person to have seen the deceased alive, was never called to testify and to place on record the exact measures he undertook to save the life of the deceased. We are informed that he was especially called to attend to the deceased based on, what can only be assumed, were his specialised skills, however, we are none the wiser as to whether he even bothered to administer those skills onto the deceased.

31.

Evidence of police personnel

As stated earlier, two policeman submitted written affidavits, Detective Seargeant Charles Barend Petrus Lewis (Lewis) and Andries Paul Burger (Burger). Only Lewis was summoned to testify at the 1967 inquest. We proceed to present a summary of evidence of both policemen.

32.

Summary of evidence of Detective Sergeant Charles Barend Petrus Lewis (page 472 to 473 of exh D)

He testified that he started investigating the matter on 22 July 1967. He read his statement into the record which was then submitted as exhibit D. According to his statement, both he and detective sergeant A.P. Burger (Burger) of the South African railway Police went to the scene of the accident on the Umvoti River Bridge with the locomotive driver, S.A. Lategan (Lategan) on 24 July 1967. Lategan and Burger pointed out to Lewis where the deceased lay after the alleged accident. Lategan further pointed out where the front of the locomotive engine was when the deceased entered the bridge as well as where the rear of the van attached to the locomotive came to a stop after the accident. Lategan informed him that the rear of the van stopped at the 46.5 miles mileage board. He noted down measurements between various points which he illustrated on a sketch plan as well as a key to the sketch plan.

33.

He stated that the bridge was a straight bride which measured 963 feet (approximately 293.5 meters long) with no obstructing structures. There were people working on the construction of a new bridge to the west which was about 100 yards (approximately 91 meters away) from the scene, however none of them saw the alleged accident.

34.

Further investigations indicated that the deceased left his store at **10:00 am** stating that he was headed to his sugar cane plantation. However, he never arrived at the said plantation. He was informed by Lategan that the alleged accident occurred around **10:38 am** when the deceased was walking towards the approaching locomotive on the bridge. Lewis concluded that there was no evidence to show any negligence on the part of any of the staff on board the locomotive.

35.

During his oral testimony, Lewis indicated that when the train crosses the bridge, the engine overlaps the steel footplate (which is often used by pedestrians) by 10 to 10.5 inches (approximately 26 centimetres)[19]. He was further asked to comment on a newspaper photograph which appeared in the Sunday Tribune on 30 July 1967. Lewis confirmed that the picture was an

[19] Inquest record page 454 lines 28-29

indication of how the engine of the said locomotive overlaps the footpath although he could not confirm if the engine depicted thereon was the same as the one which was involved in the accident.[20] We pause to submit that this is an indication that Lewis never made any efforts to ascertain the whereabouts of the train, he was essentially the investigator of a train accident for which the alleged train involved was unknown to him. This, as it shall be pointed out later, points to an indifference on the part of the police to thoroughly investigate the matter.

36.

Lewis was not able to confirm how long the train was[21]. We pause to submit that this, once again, is proof that Lewis had never seen the train, which was said to be involved in the accident, nor did he bother to trace it. Lewis did, however, establish through the train staff that the train hauled 60 axles and weighed over 700 tons. He further established that the train was travelling from South to North.[22]

We now move to summarise the evidence of the other police official, Sergeant Andries Petrus Burger.

37.

Summary of evidence of Detective Sergeant Andries Petrus Burger (page 494-495 of exh D)

On 21 July 1967, he was on duty at South African Railways, Stanger station when he received a call from one Steyn who was the Station Foreman of Gledhow station. The call came through at **10:55 am** informing him of an accident which occurred at Umvoti River bridge involving a train and a Bantu man. The Station foreman further informed him that the Bantu man who was struck by the train was Ex Chief Albert John Luthuli. On his way to the accident scene, he met an ambulance en route to Stanger hospital, driven by P.F. Papayya. He and someone else, whom he does not mention by name, were informed by the said ambulance driver that Ex Chief Luthuli was being transported to the hospital. It is not clear how the ambulance driver informed him of this fact, it can only be inferred that Burger stopped the ambulance and enquired about the patient on board. Burger then proceeded to the accident scene and arrived there at **11:20 am**. We pause to submit at this stage that it is curious why Burger would stop an emergency vehicle. It is also

[20] Inquest record page 454 lines 30-36
[21] Inquest record page 454 lines 37-41
[22] Inquest record page 454 line 10

curious how he knew who the ambulance driver was, unless he stopped the ambulance and enquired from the driver what his name was. However, this too is quite strange, because surely what was at stake was the life of an injured man, not to make conversation about such a man. One can only wonder how long the conversation between Burger and Papayya took.

38.

Burger states that upon his arrival at the accident seen, he met the station Master who pointed out the place where the head of the deceased allegedly was. He was told that the deceased's head was next to the rail where there was a large pool of blood. It is not clear who at the accident scene informed him of this, it can only be assumed that it was the Station Master who informed him. He was also shown the steel plate upon which the body of the deceased was placed until the arrival of the ambulance.

39.

Later the same day he was informed, although he does not state by whom, that Ex Chief Luthuli had died in hospital. He stated that he made marks at the scene of the accident with respect to where the deceased was found after the alleged accident as well as the point where he found blood. We pause to submit that it is curious as to why he would point out where the deceased was found when according to his statement, he arrived at the scene after the deceased had already been transported by the ambulance to the hospital. It is expected that such pointing out would have been made by the Station Master. Burger further stated that the train had already departed but he was able to establish that the train driver was S.A. Lategan who was together with Fireman Greyling and Guard P.F. van Wyk. He stated that he could not locate anyone who witnessed the accident.

40.

On 24 July 1967, Burger went to the scene with Lewis and pointed out the points which he had marked on 21 July 1967. We pause to submit that it is curious why the Station Master, van Wyk, Greyling and the station foreman, Steyn were not present to make the pointings in light of the fact that these were the people who were present at the scene.

We now move to highlight improbabilities, inconsistencies and aspects of gross negligence inherent in the statements of Lewis and Burger.

41.

Analysis of evidence presented by Lewis and Burger

An analysis of evidence presented by Lewis, points to a glaring omission with respect to the manner in which the investigations were conducted in this matter, especially regarding the locomotive. Firstly, there is no indication whether the station master was interrogated with respect to reasons behind the train driver and his staff having left the accident scene before the arrival of the ambulance and police. Secondly, there is no indication whether any efforts were made by Lewis to trace the locomotive which is said to have been involved in the accident or whether any investigations were done to check if any forensic evidence could be obtained therefrom. Further, no questions were posed to Lategan and Greyling as to why they risked further possible injury to the deceased by moving him before the arrival of the ambulance.

42.

There is no indication of whether or not the scene was cordoned off on 21 July 1967 to preserve it for purposes of collecting evidence. Official investigations relating to the scene were only done on 24 July 1967, 3 days after the event. There is also no indication that the bridge was closed off by South African Railways between 21 and 24 July 1967 therefore the probability of the scene having been contaminated during that period is very high. The likelihood of forensic evidence being present at the scene on 24 July 1967, was close to nil. As was evident during these re-opened inquest proceedings, the scene was contaminated, albeit not intentionally, by persons such as Elliot Nxumalo and his brother-in-law, Mabaso, when they went to clean the blood of the deceased. Clearly, the scene was never cordoned off.

43.

There is no indication that an investigation into the track conditions was ever done nor of the train which was alleged to have been involved in the incident. This information would have been crucial in assisting the court to determine a possible cause of the alleged accident and identifying potential contributing factors, such as mechanical failures, human error, or environmental conditions.

44.

It is submitted that accident scene preservation by the police is important for purposes of ensuring accurate evidence collection. Maintaining the integrity of the accident site allows for proper analysis of physical evidence, witness testimonies, and potential contributing factors. This

meticulous approach is vital for establishing liability and potentially preventing similar accidents in the future.

45.

No proper accident reports were compiled either by South African Railways or the police in order to provide detailed accounts of the accident. No efforts were made to trace the train to ascertain whether there was any damage thereto and the only photographs that were taken by Lewis was on 24 July 1967. No photographs were taken by Burger on 21 July 1967 as the first policeman on site. The absence of photos of the scene from 21 July 1967 therefore resulted in a situation where it was not possible to ascertain the impact of the alleged accident.

46.

It begs the question therefore how it is that the inquest court, in 1967, could have come to any conclusion pertaining to the death of the deceased when the inquest was littered with such glaring investigative omissions and/or gross negligence on the part of the police. We submit however, as it will be elaborated on at a later stage, that none of the crucial investigative steps were embarked upon by the police because there was no train accident which occurred on the Umvoti River Bridge on 21 July 1967.

47.

Aspects relating to the measurements taken by Lewis can only be analysed in conjunction with independent reconstruction evidence. Such evidence was provided in the current re-opened inquest proceedings by Warrant Officer Brenden Craig Burgess of Crime Scene Management in Pretoria. His evidence will be outlined and juxtaposed against that of Lewis at a later stage during this address.

48.

Eyewitness accounts

According to evidence presented at the 1967 inquest, the only person who claimed to have seen what happened to the deceased is the driver of the locomotive, Stephanus Albertus Lategan. Two other persons who were on board with him on the locomotive, Daniel Lessing Greyling and Peter Francois van Wyk, stated that they did not see how the train struck the deceased. They did, however, submit statements and testified to their experiences onboard the locomotive when it was crossing the Umvoti Bridge as well as when it stopped just after the bridge.

For the sake of completeness and for cross referencing at a later stage, we move to summarise the evidence of those who were on board the train; the train driver Stephanus Albertus Lategan, the fireman Daniel Lessing Greyling and the conductor/guard Peter Francois van Wyk.

49.

Summary of evidence of the locomotive driver - Stephanus Albertus Lategan (page 505 to 506 of exh D alternatively exh V:

His written affidavit stated that on 21 July 1967 he was the driver of a Class 15CA locomotive with model number 2045 and train number 332 which departed from Stanger at 10:29 am. It was a goods train with 60 axles and weighed 767 tonnes. Whilst his train was passing over the Umvoti bridge which was about 60 yards (approximately 55 meters) from the southern end of the bridge, he saw the deceased enter the bridge and started walking on the narrow steel plate. Lategan stated that when he first saw the deceased, he was wearing a khakhi coloured overcoat and he sounded the whistle of the train when he saw the deceased enter the bridge. Lategan further stated that the deceased walked facing the oncoming train and after he had walked about 15 to 16 paces (approximately 12 meters), the train then struck him.

50.

According to Lategn, the deceased was struck by the corner of the cab on his right shoulder which caused the deceased to spin around, loose balance and fall between the right-hand side of the bridge and the moving train. This is when, according to Lategan, he immediately applied the brakes of the locomotive. He stated that he could not have applied the brakes in time to avoid a collision, and even if he had done so, because the deceased did not turn his body sideways, it was inevitable that the train would have struck him. Upon stopping the locomotive, Latega stated that he noticed that the guard van (the rear cabin of the locomotive) was about 10 feet (3 metres) away from the end of the bridge. At the time of the incident, his train was travelling at about 25 miles an hour (approximately 40 km/h).

51.

Upon stopping the train, the train driver ran back to where the deceased was lying, at that stage the deceased was unconscious. He found that the guard was present with the deceased. **The deceased was lying on his back with his head hanging between the side of the rail and sleepers and one arm also hanging over a sleeper.** He had a big laceration on the top of his

head in the middle. The train driver stated that lifted the head of the deceased and placed his body onto the steel plate.

52.

According to the train driver, the station master then arrived on the scene and identified the deceased as Chief Albert Luthuli. The station master then told the train driver to depart the scene and that he would remain behind until the arrival of an ambulance. The train driver stated that the delay time between the collision and the departure of the train was 40 minutes. As the train departed, he saw an ambulance arrive. He later heard over the wireless ( which in nowadays is referred to as a radio) that Luthuli had died at Stanger Hospital.

53.

On 24 July 1967, Lategan identified the body of the deceased at Stanger Mortuary in the presence of Dr Gregersen and Sergeant Lewis. He further accompanied Lewis to the scene. At the scene, he pointed out the place where the deceased was lying after the collision as well as the approximate point of where the front end of the locomotive was when the deceased entered the bridge. He stated that the deceased may have used a foot path on the right-hand side of the bridge before he had entered the bridge to cross over the Umvoti river.

54.

During his testimony the train driver stated that he did not have time to slow down and that the deceased was walking in the middle of a footplate which was only 2 feet wide (approximately 61 cm) and that the side of the engine had knocked down the deceased[23].

55.

Summary of evidence of the locomotive fireman – Daniel Lessing Greyling (page : (page 483 to 484 of exh D):

In his written affidavit Daniel Lessing Greyling (Greyling) confirmed that on 21 July 1967 he was on board the Class 15CA locomotive as fireman or stoker together with Lategan who was the train driver. He further confirmed that the said locomotive left Stanger around 10:30. He heard Lategan blow the whistle of the locomotive as the train was crossing the Umvoti River bridge near the

[23] 1967 Inquest record page 464 line 12

south exit of the said bridge. He states that whilst the whistle was being blown, he could not see anything in front of the train on his side which was on the left side of the train, even though he was looking outside his window all the time. We pause to submit a presumption that when he states this, it means that from the time the train left Stanger, he was keeping a constant look out of his window.

56.

Shortly after the whistle had been blown by Lategan, Greyling states that he then saw Lategan pull the brakes. We pause to highlight that the time interval of "shortly" is not explained. When the train stopped, Lategan informed him that he suspected that they had knocked someone over. He and Lategan then got off the train and walked back towards the entrance of the bridge on the south side. This is where he saw the deceased.

57.

On paragraph 4 of his statement, Greyling stated that the deceased was clad in a Khakhi coloured jacket, pants and a coat. The deceased had sustained head injuries and blood was coming out of his mouth. According to Greyling, the deceased, although unconscious at the time, **was lying on his back with his head directly on the track and his feet towards the railing side of the bridge.** There is however, a contradiction in a subsequent sentence where he stated "**the Bantu lay with his body on the footplate**". He stated that he assisted Lategan to place the deceased more comfortably on the steel foot plate. We submit that in respect of his statement wherein he stated that the "Bantu lay with his body on the footplate", suggests that upon arrival, Greyling saw the deceased on the footplate in an uncomfortable position and thus he and Lategan took the decision to place him more comfortably upon the said footplate.

58.

Greyling did not make mention of the guard having been on the scene when he and Lategan arrived, he only mentioned seeing the conductor or guard going towards Gledhow Station. This is in contrast to Lategan having stated that upon his arrival at the site where the deceased lay, the train conductor was present.

59.

Greyling then stated that shortly afterwards, the station foreman and station master arrived on the scene. Again the period shortly is not defined in seconds, minutes or hours. Therefore it is not clear how long afterwards, were they joined by the Station Master and Staton Foreman. Further,

Greyling did not state as to how long the station foreman and master was with him and Lategan at the scene. Greyling stated that he then returned to the locomotive but was then joined at a later stage by Lategan, although he does not state how long after he had gone back to the locomotive, Lategan joined him. Lategan then informed him that the person who was knocked down was Luthuli whom he did not know.

60.

Greyling was of the opinion that the deceased should have seen the train and heard the tremendous sound that the train normally makes when it moves over a bridge. Further, he stated that it was a clear day and visibility was good.

61.

Summary of evidence of the locomotive guard/conductor – Peter Francois van Wyk (page 487 to 488 of exh D):

In an affidavit, Pieter Francois van Wyk (van Wyk) confirmed that on 21 July 1967, he was a conductor onboard a locomotive driven by Lategan. He confirmed that the train was a goods train which consisted of 60 axles and weighed 767 tons. During oral evidence he stated that the train consisted of 15 wagons carrying sugar and syrup. In his affidavit he stated that he suddenly felt the brakes of the train being pulled when such train was crossing the Umvoti bridge. The train stopped just over the bridge with the conductor's car having stopped directly opposite the 46.5-mile marker. During oral evidence when asked whether the driver of the locomotive blew his whistle, van Wyk testified that the driver did blow his whistle at the crossing and just as the last wagon, which was the guard wagon, came onto the bridge.

62.

Further in his affidavit he stated that when he looked back onto the bridge from the window on his right-hand side, **he saw the deceased lying on the walkway of the bridge.** He then alighted the locomotive to protect the train and whilst doing so, he went past the deceased. He noticed that the deceased was wearing a pair of brown shoes, a khaki shirt, trousers and a coat. He was not sure whether the deceased was dead or unconscious. He saw blood coming from the mouth of the deceased. He did not mention seeing any other injuries on the deceased. The deceased was lying about 40 feet (approximately 12 meters) away from the south entrance of the bridge.

63.

Van Wyk stated that he protected the train using petards and telephoned the Station Master and Foreman from a telephone box at the Af Huis, informing them of the incident. He then went back to where he had placed the petards. After this, he joined the Station Master and foreman at the scene where they stood for 15 minutes. The Station Foreman then left to go to the Station. Upon his return (it is not clear after how long), the Station Foreman informed van Wyk that the man who was hit by the train appeared to be a certain Luthuli. We pause to submit that this suggests that when the Station Foreman saw the deceased for the first time, he did not know who the deceased was. Van Wyk, only became aware of the identity of the deceased when the Station Foreman returned to the scene for a second time. Who then at the station informed the station foreman about the identity of the deceased? As was shown in these re-opened inquest proceedings, Chief Luthuli was under constant surveillance. It is therefore submitted that the Station foreman was informed by state agents who were constantly watching Chief Luthuli. These people were on a constant look out for every move made by the deceased and therefore we submit that they knew exactly what happened to Chief Luthuli on 21 July 1967. The question begs, if the death of Luthuli was not a cover up by the then Apartheid Government, why is it that those who were tasked with keeping a constant eye on him did not come forward to the police with versions of what they saw happen to Chief Luthuli?

64.

As will be shown later, according to the statement of the Station Master, he was aware of the identity of the deceased upon arrival at the scene. What is curious, however, is why the identity of the deceased was not made known to van Wyk by the Station Master whilst they were together at the scene for more than 15 minutes, why is it that van Wyk only became aware of the identity of the deceased after the return of the Station Foreman? It is curious as to what was being discussed for 15 minutes by the three individuals at the scene. We would like to bring it to the attention of this Honourable court that van Wyk did not make mention of either Lategan or Greyling being present with him at the scene.

65.

Van Wyk then stated that he was approached by the station foreman, the station foreman then relayed that he was instructed by the Station Master to take over the protection points and that the Station Master would remain on the scene until the ambulance arrived. It is not clear where and when this instruction to the station foreman was given, and it is not clear if van Wyk had left

the scene when this message was conveyed to him by Steyn, whom it is said was, the station foreman.

We now move to highlight points of inconsistency between the evidence of the train staff, Letegan, Greyling and van Wyk.

66.

Points of inconsistencies between the evidence of Lategan, Greyling and van Wyk

The first point of inconsistence stems from the description provided by the train staff in respect of the position of the deceased on the bridge after the alleged accident. From the description of how Lategan found the body of the deceased on the bridge, he describes the body of the deceased as having been on the railway track of the bridge[24]. Greyling on the other hand provides two conflicting versions to state that the body was on the tracks and the steel plate. Van Wyk, who according to the evidence was the first person to be with the deceased immediately after the so-called accident, categorically stated that the body was on the footplate. Van Wyk states that **he saw the deceased lying on the walkway of the bridge[25].** It should be noted that this description relating to the position of the body having been on the walkway, corresponds to that of Greyling's later description: "**he was lying on the steel plate used by pedestrians to walk across this bridge"[26].** Lategan stated that the body of the deceased was on the railway tracks and that he then moved the body of the deceased onto the walkway. Therefore, in accordance with Greyling and van Wyk's statements, the deceased, after the alleged accident, was found lying on the walkway as opposed to the tracks as testified to by Lategan.

67.

It is submitted that these three different versions presented by the train staff indicate the extent to which the incident was being covered up.

68.

Secondly, there is a contradiction in the time interval provided by van Wyk and Lategan with respect to the stopping of the train and its subsequent departure. Lategan stated that the interval was 40 minutes whilst van Wyk stated that it was 20 minutes.

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[24] 1967 Record paginated 505 para 1
[25] 1967 Record paginated 487 para 2
[26] 1967 Record paginated 483 para 4

69.

Thirdly, there were three occupants on the train, however, Lategan did not even once try to alert either Greyling or van Wyk that there was a pedestrian on the bridge who was not moving out of the way even whilst the whistle was being blown.

70.

Fourthly, if the train was 55 metres away from the Southern end of the bridge when the deceased first entered the bridge, we submit that it is highly improbable that Greyling would not have seen the deceased if he was looking out the window the whole time.

71.

Fifthly, nowhere in his affidavit does van Wyk make mention of Lategan having blown the whistle of the train, he only mentions it after being probed during cross examination by Mr Wilson (the lawyer representing the Luthuli family at the 1967 inquest) that the whistle was blown twice: at the crossing and just when his wagon came onto the bridge. It is submitted that this suggests a tailoring of evidence.

72.

Sixthly, Lategan does not indicate that he was assisted by Greyling to "move the body into a more comfortable position on the footplate". We can however accept that, if indeed this movement of the body did occur, and given the weight and height of the deceased, Lategan would not have been able to move the body alone without assistance.

73.

Seventhly, only Lategan describes having seen a laceration on top of the head of the deceased whilst Greyling and van Wyk only described blood coming out of his mouth.

74.

Eighthly, nowhere in his affidavit does Lategan talk about the presence of the Station foreman being at the accident scene. He only talks about the station master whilst Greyling and van Wyk talk about the station foreman having been present at the scene.

75.

It is submitted that these witnesses should have been confronted with the above-mentioned inconsistencies by the 1967 inquest court in order to ascertain the true version of events. As was

argued earlier, the 1967 inquest proceedings were haphazard and rushed. It is evident that the court had no keen interest in finding out the real cause behind the death of Luthuli and whether anyone could be blamed for Luthuli's death.

We now move highlight evidence presented by other witnesses at the inquest court held in 1967.

76.

Other witnesses present at the scene

The 1967 inquest records indicate that there were other people who attended to the scene just after the alleged train accident had occurred. Such persons are the Station Master (Andries Lodewicus Hilhelmus Pretorius), the Station Foreman Steyn (however, the statement of this person was not filed and neither was he called by the court to present evidence), a labourer working on a nearby bridge (Nsakani Mataba) and an ambulance driver (Peter Francis Papayya).

77.

For the sake of completeness and for cross referencing at a later stage, we move to summarise the evidence of each witness.

78.

Summary of evidence of the Gledhow Station Master – Andries Lodewicus Hilhelmus Pretorius:

In his written affidavit he confirmed that on 21 July 1967 train number 332 passed through Gledhow Station at 10:36 am. He stated that shortly afterwards (it's not clear exactly how long afterwards) a phone message was received at the station informing them that a Bantu man had been struck by train 332 on the Umvoti River bridge. He immediately proceeded to the scene where he found Lategan and van Wyk standing next to an injured man on the southern end of the bridge. According to Pretorius, the injured man was lying on his back, on the steel plate. The injured man had head injuries from which he was bleeding and was also unconscious. Pretorius immediately recognised the injured man as ex Chief Albert Luthuli.

79.

On arrival at the scene, Lategan informed him that the train struck the deceased whilst he was walking over the bridge. Pretorius stated that saw blood at the place where the deceased lay but there were no drag marks on the scene. We pause to bring it to the attention of this honourable court that the Station Master did not make mention of seeing any blood on the tracks which we

submit should have been the case if the deceased was lying on the railway tracks as had been described by Lategan, the train driver. The Station Master only makes mention of blood on the footplate. After he had obtained particulars from the train crew, Pretorius stated that he authorised for the train to depart. Pretorius then reported the incident to "Trains Operating in Durban". It is not clear who or what "Trains Operating in Durban" is and why a report was submitted to it/them.

80.

Persons on board the train, the policeman Burger and one Mataba (whose evidence will be summarised shortly) stated that there was a strong wind blowing, however, Pretorius states that there was no wind.

81.

Summary of evidence of South African Railways Labourer – Nsakani Mataba:

Nsakani Mataba who shall be referred to as Mataba going forth, presented oral evidence and a written affidavit with respect to the incident. In his affidavit he stated that on 21 July 1967, he was working on the construction of a new bridge near the Umvoti River bridge where the alleged accident took place. According to his oral testimony, he was together with another person, when he saw a train coming from Stanger entering the Umvoti River bridge. He was adamant that when the train entered the bridge, the whistle of the train was not blown, however he conceded that he may not have heard the whistle blow because he was concentrating on his work and there was a strong wind blowing from a south westerly direction.

82.

Mataba stated that just after 10:30 am, he saw the Station Master of Gledhow Station come from the direction of Gledhow and walking towards the bridge. He stated that the Station Master called him to accompany him. According to Mataba, he accompanied Pretorius to the Durban side of the bridge and close to the end of the bridge, he saw an injured and unconscious Bantu male lying on his back on a steel plate. Once again, we sibmit that Mataba is another person from whom there is no mention of the presence of blood on the railway tracks. Mataba stated that the man had sustained head injuries and there was a lot of blood on the steel plate.

83.

He stated that when he and the Station Master arrived at the scene, there were three other Europeans at the scene, the train driver, the fireman and the guard.

84.

Mataba stated that he remained on the scene until the ambulance arrived and assisted certain persons to carry the deceased on a stretcher to the northern side of the bridge where the ambulance was waiting. It is not clear who these persons are who he assisted in carrying the deceased on a stretcher.

85.

During oral evidence, Mataba testified that he had on previous occasions been on the footplate of the bridge when the train passed and that the train makes a lot of noise and would cause the bridge to shake. This is reference on page 461 lines 26-41. He further testified that he always heard trains whistle when they entered the bridge but with this particular train, he did not hear the whistle blow. This is referenced on page 462 lines 1-16. Mataba further confirmed that he is the individual portrayed on exbibit J which was a photograph taken by the Sunday Tribune on 30 July 1967. He informed the court that the place where he is standing on the photograph, is the place where the deceased was lying when he first saw him. Referenced from page 462 lines 39-41 and page 463 line 1.

86.

Summary of evidence of Ambulance Driver – Peter Francis Papayya:

Papaya stated in an affidavit that on 21 July 1967 whilst on duty at Stanger Hospital, a telephone call was received at **10:40 am** for an ambulance to be dispatched to Gledhow Station. We pause at this stage to remind the honourable court that according to the statement of the Station Master, Pretorius, the train passed Gledhow station at 10:36 am. It is curious therefore, how it is that there was a four minute interval between the train passing Gledhow station and the phone call being received by the hospital. We shall elaborate on this improbability at a later stage in this address.

87.

Papaya stated that he proceeded to Gledhow Station with an ambulance assistant and arrived there around 11:00. On arrival at Gledhow Station he was told of an injured Bantu man on the bridge. He and the ambulance assistant then proceeded to the bridge together with the Station Foreman. We pause to submit that it is curious to note why the station foreman would at this stage proceed together with the ambulance crew to the scene of the accident when in accordance with the statement of van Wyk (the train conductor), the station Foreman had given an undertaking to take over the protection points. As shall be seen later, in accordance with the evidence of one of the locomotive experts who testified in these re-opened inquest proceedings, Mr Lesley Labuschagne, the person who takes over the protection points is not supposed to leave those points until such time he receives authorisation and information that the accident scene has been cleared. Mr Labuschagne further informed this court that protecting the train would on average take an hour. This can be reference from the record of the current re-opened inquest proceedings dated 7 May 2025 on page 34 lines 10-11. We submit therefore that it would not have been possible for Steyn to have been at the station to meet up with Papaya at 11:00. We also point out to this honourable court the duration pertaining to the following events:

1. Time spent by Van Wyk to walk to the telephone box at the Afhuis,
2. Time spent by the station master and foreman to walk to the scene in order to ascertain what happened.
3. The 15 minutes which was spent at the scene by those present, including the station foreman
4. The time it took for the station foreman to walk back to the station.
5. The time it took for the station foremen to return to the scene where he informed van Wyk about the Station Master having informed him that the train can depart and the Station Master will await the arrival of the ambulance.

All of this, we submit, could not have occurred within 22 minutes (that is the time it is alleged the accident happened, 10:38, the Papayya's allegation that the ambulance arrived at 11:00).

88.

Papaya further stated that he, the station foreman and the ambulance assistant, parked the ambulance on the northern side of the bridge and proceeded to walk to the southern end with a stretcher.

89.

Upon arrival at the scene, he found the Bantu man lying on a steel plate. Papayya immediately recognised the injured man as ex Chief Albert Luthuli. It is not clear how Papayya knew Luthuli to have identified him. According to Papayya, the patient was unconscious, suffered multiple head injuries and had blood on his face. He was informed (it is not clear by who) that Luthuli had been struck by a train whilst on the bridge. Pappaya did not make mention of seeing a train, it is apparent that at this stage the train had already departed.

90.

The patient was then loaded onto a stretcher and carried over to the northern end of the bridge where the ambulance was waiting. The patient was transported to Stanger Hospital where he was **admitted at 11:45 am. We pause at this stage to remind the honourable court that this is inconsistent with the statement of Dr Mary Gregerson who stated that she attended to the patient at 11:30am.**

91.

Papaya stated that he was informed later that day that the patient had died at Stanger Hospital and he was present at the Stanger Hospital Mortuary to identify the body of the deceased. The identification occurred on the same day the patient died, 21 July 1967.

92.

We now move to elaborate on points of inconsistencies and improbabilities between the evidence of the train staff and the evidence of witnesses who arrived at the scene after the alleged train accident, especially in relation to time.

93.

Firstly, it was reported by the train staff that the accident occurred at 10:38 and Papayya stated that the telephone call which the hospital received informing them of the accident occurred at 10:40. This is an interval of two minutes between the occurrence of the so-called accident and the receipt of the call by the hospital. It is submitted that this is highly improbable. Evidence shows that van Wyk, the guard, first went to inspect the deceased as he was lying on the bridge, then he went to telephone the station master (Pretorius) at the telephone box informing him of the accident. It is submitted therefore that this alone would have taken more than two minutes.

94.

The most probable time that van Wyk would have made the phone call to the Station Master, it is submitted, would have been around 10:50 am. This is because when one takes into account that the telephone box which was at the Af Huis signal would have been 200 meters away from Gledhow Station[27], it is probable that it would have taken van Wyk a total of two to five minutes to alight the train and then inspect Luthuli as he was lying on the bridge. He most probably would have taken a further 5 minutes to get to the telephone box to ring the station. Therefore a 10-minute interval from the time the alleged accident occurred to the time the telephone call to the station was made, it is submitted, is most probable.

95.

According to the statement of Pretorius[28] as soon as he received the report from van Wyk, he immediately proceeded to the accident scene. Van Wyk saw both the Station Master and Station foreman approaching the scene. It is submitted that both Pretorius and Steyn would have left the station around 10:51 am. Taking into account that the walking distance between Gledhow station and the southern end of the Umvoti River bridge would have taken approximately 10 minutes[29] and perhaps 5 to 7 minutes brisk walking, Pretorius and Steyn would only have arrived at the scene at around 11:00am. It is therefore highly improbable that Papayya would have met Steyn at the train station at around 11:00am; we submit that this is the time which Steyn would have been at the accident scene.

96.

According to van Wyk[30] he, the Station Master and the Station Foreman were at the scene for 15 minutes and after that, the Station Foreman returned to the station. It is submitted that it was at that stage when the foreman returned to the station that the phone call was made to summons the ambulance and the police to the scene. According to the statement of Burger, when he received a phone call from Steyn who was the station foreman, at "around 10:55 am", Steyn informed him that the person who had been knocked down by a train was Ex Chief Albert Luthuli[31]. It is submitted, however, that Steyn would not have been aware of who the injured man was prior to him attending the scene. This is because Steyn and the Station Master, Pretorius, first went to

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[27] 2025 re-opened inquest evidence of Labuschagne record 7 May 2025 page 29 lines 18-19
[28] 1967 Record paginated 489 para 2
[29] 2025 re-opened inquest evidence of Nel record 13 May 2025 page 18 lines 15-17.
[30] 1967 Record paginated 487 para 4
[31] 1967 Record paginated 494 para 2

the scene to ascertain what was going on. They then stood there for 15 minutes and after that, Steyn returned to the station.

97.

When Steyn returned from the station, he informed van Wyk of the identity of the deceased and that the station master will await the arrival of the ambulance. It is submitted that the only inference which can be drawn is that Steyn summoned the police and ambulance at the station before his return to the scene. His arrival at the station would have been well after 11:00am taking into consideration the 10-minute walking distance between Gledhow station and the northern end of the Umvoti bridge.

98.

We wish to remind this honourable court of the evidence presented at the 1967 inquest proceedings wherein witnesses informed the court that the "accident" occurred on the southern end of the Umvoti bridge. The length of the bridge was calculated by Sergeant Lewis as having been 296 meters. This would have entailed an extra walking distance from the northern end to the Southern end and suggests that the walk from the station to the southern end of the bridge would have been longer than 10 minutes.

99.

However, to work measurement that is clear and has been tested by Warrant officer Sunette Nel, we submit that based on the 10-minute walk calculation between the Gledhow station and the bridge, the station foreman would have arrived at the station at around 11:25 am because he would have left the scene around 11:15 am, which takes into account the 15 minute duration that Steyn and others spent at the scene. The ambulance and the police were therefore only called at around 11:25 am. Therefore, the version tendered by Burger in his statement to say that he received a call at 10:55 am is incorrect and the same goes for Papayya; the hospital could not have received a call at 10:40 am. This was done to cover up the true version of events.

100.

To further cement the argument that the ambulance was not called immediately after van Wyk's report, Pretorius in his statement when he describes the sequence of events, first talks about being on duty and then receiving a call from the telephone box informing him of a train accident on the bridge. Subsequent to the phone call, he talks about immediately going to the scene of the said accident to see what happened and then after wards, he talks about an ambulance being

summoned. It is common cause that in those days there were no cellular phones from which one could make an instant phone call. We submit that the call to the hospital would only have been made from one of two places, either the telephone box at the Afhuis, which according to evidence is normally placed 200 meters away from the station or at the station itself. According to Burger, the call was received from the station. These sequence of events as described by Pretorius, would have, as per our earlier submissions taken a considerable amount of time.

101.

The question to be answered is why the Station Master, Station Foreman and the train staff stood there for 15 minutes before the Station Foreman went back to the station to summon the police and ambulance. It is at this stage, we submit, that a plan was hatched to cover up the real circumstances of the event. Part of the plan to cover up what really happened, was to ensure that the train is not found on the scene. Arguments will be advanced at a later stage with respect to why it was deemed important for the train not to be at the scene.

102.

The second inconsistency and or improbability relates to the time when Luthuli would have been admitted to the hospital. Even though in our arguments above, we have dismissed the fact that the telephone call to the hospital would have been received at 10:40, for purposes of calculation of the time it would have taken the ambulance to leave the hospital and arrive at the Gledhow station, it is submitted that indeed it would have taken 20 minutes as intimated by Papayya in his statement. A quick search on a map would indicate that the distance between Stanger Hospital and Gledhow station is 4,9 km via the Gledhow Mill Road and King Shaka Street. Travelling on gravel road would therefore most probably have resulted in a vehicle taking approximately 20 minutes to travel that distance.

103.

If this court were to agree with our earlier submissions that the ambulance was only summoned at around 11:25 am, then the ambulance would have arrived at Gledhow station at approximately 11:45 am and perhaps taken another 5 minutes to arrive at the northern end of the bridge. This would mean the ambulance arrived at approximately 11:50 am at the northern side of the bridge. Pappaya, his assistant and the Station Foreman had to walk across the bridge to the southern end with a stretcher. It has been established that the length of the bridge is 963 feet long[32]

[32] 1967 Record paginated 472 statement of Lewis para 5

(approximately 296.57 meters), therefore practically, we submit, it would have most probably taken them 3-4 minutes to walk across the bridge[33] and possibly a further 5 minutes to lift the deceased off the steel plate and strap him onto the stretcher. Then another 5 minutes to walk back to the northern end of the bridge carrying the deceased and loading him onto the ambulance. Therefore probability dictates that, the total time which would have been spent on and off the bridge would have been approximately 14 minutes. The ambulance would then have proceeded to Stanger Hospital at around 12:04 pm and possibly reached the hospital between 12:30 pm and 12:40 pm and not 11:45 am as stated by Papayya.

104.

The third inconsistency relates to the presence of the train when Mataba and Papayya arrived on the scene. Neither of these two witnesses make reference to having seen the train when they arrived at the scene. In the case of Papayya, when the report was made to him about a train having struck the deceased, it is submitted that he would have intimated at having seen the train which struck the deceased depart upon his arrival. Mataba as well, on his arrival at the scene, he only talks about seeing the deceased and being at the said scene until the arrival of the ambulance. He does not talk about the departure of the train or the train being there at the scene. What is further confusing about the evidence of Mataba in contrast to that of the station master Pretorius, is that Mataba stated that he went to the scene with Pretorius. If this was the case, we submit that Mataba would have seen the train because according to Pretorius, he (Pretorius) authorised for the train to depart after he had been on the scene with the train staff.

105.

When analysing the statement of Papayya, one gets the impression that upon his arrival, there was no train which was departing as stated by Lategan, Greyling and van Wyk. In fact, there is no mention by the station Master, Pretorius, of the train departing upon or just before the arrival of the ambulance. It is therefore submitted that the train staff tailored their evidence to make it seem as if the deceased was provided with urgent medical care when this in fact was not the case. As argued above, the incident occurred at around 10:38am but medical attention by the ambulance staff was only provided to the deceased between 11:55 and 12:00 and by the time the deceased received this medical attention, the train had already departed. It is submitted that

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[33] htpps://www.sciencedirect.com Walking Distances to Public Transport in Smaller and Larger Norwegian Cities , Transportation Research Part D: Transport and Environment, Volume 103 (February 2022) accessed on 12 July 2025.

instructions were given for the train to depart before the arrival of the ambulance and police so that probing questions by those acting in good faith, would not be raised with respect to exactly how the accident occurred. We submit that those acting in good faith, upon seeing the train, would have established that the train was not involved in a collision with a pedestrian.

We now move to discuss the evidence of witnesses who were not present at the scene.

106.

Evidence of witnesses not present at the scene

As mentioned earlier in this address, other written affidavits were submitted during the 1967 inquest court proceedings by the prosecutor, these were statements of Thembinkosi Eric Chili marked as exhibit Q, Nokhukhanya Luthuli marked as exhibit R, Eness Mfeka marked as exhibit S and Ziphi Gumede marked as exhibit T. We proceed to summarise the statements of each witness is for purposes of completeness and cross referencing at a later stage.

107.

Summary of statement by Eric Thembinkosi Chili (page 496 to 497 of exh D)

Eric Thembinkosi Chili (Chili) described himself as a bus services rank manager of Groutville bus services. He further described himself as the grandchild of the deceased.[34] He stated that on 21 July 1967 he had seen the deceased standing at a bus stop at 06:30 am wearing a khakhi suit and hat. According to Chili, the deceased was also wearing an eye shield over his right eye and he stated that the deceased was hard of hearing to the extent that one would have to raise his/her voice when talking to the deceased.

108.

Chili stated that whilst he was at his workplace, a female aid from Stanger Hospital informed him that Chief Luthuli had been admitted to hospital as a result of an accident. He was requested by this aid to proceed to Groutville and inform the family of the accident. Chili stated that upon arrival at the home of the deceased at 12:20 pm, no one was home. He waited until 2pm and left without having seen anyone of the deceased's relatives. He then proceeded to Stanger Hospital and upon

[34] 1967 Record statement of Chili paginated 496 para 4.

arrival was informed that Luthuli had died. He accompanied members of the South African railway police to Stanger Hospital mortuary where he identified the body of the deceased as being that of his grandfather Chief Albert John Luthuli. He did not mention what time he arrived at the hospital, with whom of the South African Railway police he went with to the mortuary and who at the hospital had informed him of the death.

109.

Summary of statement by Nokukhanya Luthuli (page 498 to 499 of exh D)

In her affidavit, Nokukhanya Luthuli described herself as a housewife and the widow of the deceased who was 68 years old at the time. She stated that the deceased had left his home at 08:30 am on 21 July 1967 stating that he was first going to the shop which he owned near the Gledhow Station on the northern side of the Umvoti river and thereafter to his plantation which was on the southern side of the bridge. The reason why he needed to visit his plantation was to monitor how the cane was being cut by the field labourers.

110.

When he left home, the deceased was of good health. The sight of his left eye was impaired to the extent that he could not see with it, but his right eye was extremely sharp, and she opined that this one eye could see better than both of her eyes, especially when he was reading. His hearing was not impaired at all. She stated that her husband was wearing khaki trousers, shirt, jacket, black shoes and a hat. She could not remember if he was wearing an overcoat.

111.

At around 1:05 pm whilst at St Aidans Hospital in Durban waiting for her daughter, Nokukhanya Luthuli stated that both her son-in-law and daughter informed her of the deceased having been involved in an accident. The daughter and son-in-law had been advised of this by another daughter of the deceased who worked at the McCord Zulu Hospital in Durban. The information they had received was that the deceased was sent to Kind Edward VIII Hospital in Durban. Nokukhanya and her children then proceeded to King Edward Hospital only to be informed that the deceased was not brought to Kind Edward Hospital. They were informed that the deceased was transported to Stanger Hospital and that a neurosurgeon was sent to go attend to the deceased at Stanger Hospital. She and her children then proceeded to Stanger Hospital and arrived at 2:25 pm. At 2:30 pm a neurosurgeon from Durban, Dr Joubert, informed her of the death of the deceased.

112.

She stated that on 19 July 1967, she had advised the deceased to use the new bridge to cross over the river as she considered this to be a safer route. She is not certain why the deceased did not heed to her advice. She stated that in her own mind and that of her family, they were satisfied that the death of the deceased was as a result of a pure accident.

113.

Summary of statement by Eness Mfeka (page 500 to 501 of exh D)

She described herself as an employee of the deceased's general dealers store in Groutville. On 21 July 1967 she was working at the store when the deceased arrived at 09:30 am. She stated that the deceased left the store at around 10:00 am saying that he is going to his sugar cane plantation. When the deceased left the store, he was in good health wearing khakhi trousers, jacket, overcoat and a grey coloured hat.

114.

About an hour later, Eness Mfeka stated that one of the customers entered the store and informed her and others present that a Bantu male was involved in an accident on the bridge. The customer did not mention who this Bantu male that was involved in an accident was. Shortly afterwards, another customer came to the shop to confirm that the Bantu male was Chief Albert Luthuli. We pause at the stage to bring it to the attention of this honourable court that none of these persons ever mentioned Luthuli being transported to hospital, the report to Mfeka about a person being involved in an accident occurred around 11am "about an hour later". This again ties in with our earlier submission that the deceased would only have been taken by the ambulance to the hospital at around 12:00 pm because if indeed the deceased was fetched by the ambulance at around 11:00, it is most probable that one of the two customers who walked into the shop would have informed Mfeka of that fact.

115.

Later one of the other employees of the store who had gone to the scene of the accident, returned to report that Luthuli had been removed to the hospital. It is not clear as to when later is, however, the reading of the statement suggests that a long interval of time occurred between when Mfeka received the first report about a Bantu man being involved in an accident and the report about

Luthuli having been removed to the hospital. It will be noted that the word "shortly" is used between the first report about the Bantu man and the second report which confirmed the Bantu man to be Luthuli. This suggests that the interval between these two particular reports was rather short, however the use of the word later, between the time when it was reported that the injured man is Luthuli and him being removed to hospital, suggests that there was an extended period of time between the two reports. This ties in with the above argument that the ambulance only arrived later at around 12:00 pm and not at around 11:00 am as they would have liked the court to believe. Later again that same day, Mfeka was informed that Luthuli had died in hospital. Again, this suggests a prolonged period between receiving information of his removal to hospital and the news of his death.

116.

Mfeka stated that Luthuli visited his plantation every day and would normally use the Umvoti rail bridge to get to this plantation. According to Mfeka, the deceased's left eye was sightless, but his right eye could see very well in that he was able to read and write letters without aid. Further, his hearing was also very good.

117.

Summary of statement by Ziphi Gumede (page 502 to 502 of exh D)

Ziphi Gumede described herself as a housewife and someone who was well known to the Luthuli family. She stated that on 21 July 1967, she and two men had started working together at Luthuli's sugar cane plantation from 06:30 am. The Umvoti River bridge was visible from where they were working.

118.

At about 11:00 am, she saw a goods train stop on the railway on the Durban side of the bridge, not too far from where they were working. She then saw the guard get out of the guard van and walk fast towards the bridge. We pause to submit that this implies that the train had wholly passed the bridge. Gumede stated that when the guard got to the end of the bridge, she saw him bend down. After that, she saw the guard run towards the direction of Gledhow station. She then saw the engine driver and another European get off the train and start walking towards the bridge. Shortly afterwards, she saw two Europeans return to the bridge with the guard from the direction of Gledhow Station. She then saw one Bantu coming from the Durban side of the bridge approaching towards where the Europeans had gathered on the bridge. We submit that this would

have been the direction from where the train driver and fireman alighted the train. Gumede stated that this Bantu then walked back in the same direction he came from (Durban). He was with the Europeans only for a short while. We submit once again that this ties in with the above argument that the ambulance could not have arrived at 11:00 because according to Zipi Gumede, the train only stopped at around 11:00am.

119.

Shortly afterwards, Gumede stated that she saw the train driver and the European who was with him when they alighted the train, go back into the train and the train departed the scene. Shortly after the train had departed, she saw somebody being carried on a stretcher by the Europeans who had come from Gledhow station as well as two other people wearing white (the race of these two people is not mentioned). She did not see an ambulance but was informed that an ambulance had arrived to take the person to hospital.

120.

At about midday, an unknown Bantu woman informed her and others that the person who had been picked up from the bridge was Albert Luthuli and that he had been struck by a train. Ziphi Gumede stated that she did not witness this accident. She further stated that Luthuli never came to the plantation on that day even though his arrival at the said plantation was expected. Gumede stated that it was a clear day but there was a strong wind blowing. She further stated that the two gentlemen who were with her also witnessed what she had described in her statement.

We now move to highlight points of inconsistency between the evidence of witnesses who were present at the scene and those who were not present at the scene.

Points of inconsistencies: contrasting evidence of witnesses not present at the scene vis a vis evidence of witnesses present at the scene

121.

Eric Chili stated in his affidavit that when he saw the deceased on the morning of 21 July 1967, it was at a bustop at 06:30 in the morning. He stated that the deceased was wearing an eye shield over his right eye. It is submitted that this would have been highly improbable and an exaggeration on the part of this witness because evidence had been presented that it was the left eye of the

deceased which was sightless and not his right eye. Further, no other witness had described Luthuli as having worn an eye patch. Eric Chili is also the only witness to have stated that the deceased was hard of hearing. Other witnesses who knew the deceased, his wife and his employee at the shop, stated that the deceased's hearing was good.

122.

Chili further stated that he arrived at the Luthuli homestead at 12:20, however if the court is to accept our earlier submission that the deceased was in fact admitted at the hospital at around 12:40 pm, then this statement by Chili is clearly false along with his assertion that he was the grandchild of the deceased. In the current re-opened proceedings, family members of the deceased have denied knowing the existence of Chili[35]. It is submitted that the only reason why the affidavit of Chili was submitted into evidence at the 1967 inquest proceedings was to cover up the State's negligence in that they had failed to inform family members about the alleged accident. Having realised this omission, they thought it best to fabricate this statement of Chili in order to make it seem as if all efforts were made to inform the family of the deceased. But it is evident that this never happened because Mrs Nokukhanya Luthuli and her children were informed by another daughter of hers who worked at the McCord Zulu Hospital.

123.

The exact whereabouts of the deceased were also not clearly communicated to the family, especially the daughter who worked at the McCord Zulu Hospital. This daughter was incorrectly informed that the deceased was at King Edward the VIII Hospital. It is unfortunately not clear who communicated this information to the daughter working at McCord Zulu Hospital. Worse still, as per the evidence of one of the remaining daughters of Mrs Nokukhanya Luthuli Luthuli, Dr Albertinah Luthuli, information relating to the alleged accident involving her father, Chief Luthuli, was heard on the news over the radio.

124.

According to Lategan, the accident occurred around 10:38 am and he immediately applied the brakes of the train upon impact with the deceased. In contrast, Ziphi Gumede states that she saw the train stop at around 11:00 am. There is a twenty-to-twenty-two-minute difference between when Lategan states the train stopped and when Ziphi Gumede saw the train stop.

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[35] 2025 re-opened inquest evidence of Mthunzi Luthuli record 24 April 2025 page 44 lines 5-8.

125.

According to evidence led at the 1967 inquest proceedings, there was only one Bantu male at the bridge with the Europeans, Nsakani Mataba. Based on this, it is submitted that the only inference which can be drawn is that Ziphi Gumede was referring to Nsakani Mataba as the Bantu male she saw on the bridge. According to Mataba, the station manager called him to accompany him to the scene, which contradicts what Ziphi Gumede saw. According to Ziphi Gumede, the Bantu male came from the Durban side of the bridge and not from the side of the Gledhow Station. Gledhow Station is the direction from which van Dyk, Pretorius and the Station Foreman came. The Bantu male, according to Ziphi Gumede, was only with the Europeans on the bridge for a very short time and went back in the direction from which he came, the Durban side. Mataba on the other hand stated that he remained at the accident scene until the ambulance arrived. There are clear contradictions between the evidence of all these witnesses.

126.

Ziphi Gumede stated that she did not see an ambulance arrive, perhaps it could be because the ambulance was parked on the northern end of the bridge whilst she and the other labourers where working on the fields which were closer to the southern end of the bridge.

127.

Overall submission with respect to the evidence presented at the 1967 inquest

It is submitted that the court failed to thoroughly evaluate the evidence presented. No thorough investigation to probe the statements and testimonies of the witnesses was done by the court and witnesses were not cross examined on the discrepancies highlighted earlier in this address. It is submitted once again that the proceedings were hurried and handled in a haphazard manner to ensure that no fault is imputed upon any person/s.

128.

We move on now to evaluate evidence which was presented at the current re-opened inquest proceedings into the death of Albert John Mvumbi Luthuli.

129.

Analysis of technical evidence presented by train experts, medical experts as well as reconstruction and simulation experts

As outlined in earlier submissions and in our opening address on 14 April 2025, we made an undertaking to the court that we shall present evidence to the court relating to the ideological premise from which the apartheid government operated to promote a fascist system which undermined African people regardless of their stature in society. No government institution was immune from implementing this fascist system and we submit that through the evidence of all the witnesses who were called to testify, including experts, we were able to indicate to the court how various government systems covered up the circumstances surrounding the death of the deceased.

130.

To prove the improbabilities inherent in the evidence presented at the 1967 inquest court, witnesses were called to testify, and such witnesses included two train experts, namely, Mr Gert van Tonder and Mr Lesley Labuschagne. A specialist chief forensic pathologist practicing in the province of KwaZulu Natal, Dr Sibusiso Ntsele was also called to provide this court with an opinion on the medical evidence that was presented at the 1967 inquest. Warrant Officer Brendan Burgess was called as a reconstruction expert who was to provide evidence pertaining to the probability of whether the train accident did indeed occur. Warrant Officer Sunette Nel was called to provide a pictorial aspect of the evidence which was presented to the 1967 inquest as well as to testify on methods conducted to test the veracity and probability of evidence presented during the 1967 inquest proceedings.

131.

An expert witness was defined by the court in S v Gouws 1967 (4) SA 527 (C) which held that

*"an expert witness is a witness who possesses knowledge in a specialised field and whose function is to assist the court in arriving at a correct decision".*

132.

In *Manday v Protea Assurance* 1976 (1) SA 565 (EC) the court outlined the requirements for admissibility of expert evidence as follows:

1. It must be shown that the expert is competent to express the particular fact or opinion

2. It must be shown that the expert has personal knowledge of the topic or has experience on the topic in question or
3. It must be shown that the expert has relied on the knowledge or experience of other acceptable experts in the particular field and
4. It must be shown that the expert has grounds upon which the opinion or fact is based.

We submit that the evidence of Dr Sibusiso Ntsele, Mr Lesley Labuschagne, Warrant Officer Brendan Burgess, Warrant Officer Sunette Nel and Mr Gert van Tonder, met the requirements as enunciated by the court in Manday v Protea Assurance.

133.

In our heads of argument submitted to this honourable court, the evidence of each expert witness was summarised and thus we will not attempt to repeat same in this address, however, we wish to bring to the attention of the court several important aspects testified to by each expert.

134.

During his testimony Warrant Officer Brendan Burgess (Burgess) stated that he agreed with Tulani Thusi of the Luthuli Museum that the bridge which runs over the Ntshaweni river is indeed a similar bridge, in design, to that of the old Umvoti Bridge. He based this on a picture published in the Sunday Tribune of 30 July 1967. which featured Mataba, who had testified at the 1967 inquest. It was a picture of Mataba standing on the steel plate where he stated he had found the deceased after the alleged train accident. It is the same picture which was confirmed by Mataba at the 1967 inquest which the court had accepted as exhibit J. The picture also formed part of the Luthuli Museum archives which is attached to the statement of Thusi marked as exhibit N in these proceedings. Further, the measurements of the walkway of the similar bridge compared to those of the old bridge had a minute difference of 4 centimetres[36]. It is therefore submitted that calculations done by Burgess for reconstruction purposes having used the similar bridge, are credible. The bridge running over the Ntshaweni river, thus became the basis for the reconstruction of the scene as well as other source documents.

[36] 2025 re-opened inquest evidence of Labuschagne record 6 May 2025 page 31 lines 19-23

135.

Burgess took it as a fact that the alleged incident took place on the southern end of the Umvoti River bridge because all witnesses who were present at the scene place the scene at that point.

136.

Burgess then analysed the injuries noted by the three medical practitioners; Dr Gregersen, Dr van Zyl and Dr Joubert. Burgess then plotted the injuries noted by each doctor onto a diagram of a body and made comparisons.

137.

After examining he injury patterns of the deceased, Burgess criticised the eyewitness account of the locomotive driver, Lategan. Burgess observed that there was no injury on the right shoulder of the deceased and yet Lategan stated that the deceased was struck on the right shoulder by the corner of the cab. In light of the position of the buffer on the class 15CA locomotive, Burgess formed the opinion that the deceased would first have been struck by the buffer located in front of the train, before being struck by the corner of the cab.

138.

The next step which Burgess followed was to establish if an accident did indeed occur. Burgess determined that the only way in which an accident could have occurred resulting in the type of injuries that were sustained by the deceased is if the deceased was walking in the same direction as the locomotive, with his back to the locomotive and not walking towards the train[37]. For this to have occurred, the accident would have been on the northern end of the bridge and not the southern end as described by witnesses in the 1967 inquest proceedings.

139.

An analysis of the description which Lategan gave in respect of how the deceased was found on the track, Burgess testified that the deceased would have had to have fallen between the coaches in order to be in that position. But to do that without sustaining injuries all over his body including the face, the deceased would have had to fall between the carriages at the exact same speed that the train was travelling at. Based on his expert opinion, Burgess believes that it is highly unlikely that the deceased would have fallen between the coaches of the train. We therefore

[37] 2025 re-opened inquest evidence of Labuschagne record 5 May 2025 page 53 lines 3-6

submit that it is improbable that the body of Chief Albert Luthuli was lying on the railway tracks as described by Lategan.

140.

The next factor which Burgess wanted to determine was the possible point of impact.

141.

Taking into consideration where the train actually stopped, Burgess calculated that the train driver Lategan, would have applied the brakes between 170 and 180 meters from the north entrance of the bridge, he could not have applied the brakes at the point of having struck the deceased as he claimed. Burgess was of the opinion that Lategan must have seen something or someone already lying on the train tracks and then applied the brakes at that point which would have been between 170 and 180 meters before the entrance to the northern side of the bridge. However, Burgess further states that for the train to have stopped where it did, the train would have had to travel at a speed of 20 kilometres per hour and therefore the probability of the impact having occurred on the southern side of the bridge is highly unlikely. We submit therefore that a train accident did not occur, the deceased did however, endure a ruthless assault which we will substantiate at a later stage, We further submit that the deceased was assaulted or attacked somewhere else other than on the bridge and that his body was placed on the bridge to make it look like he was the victim of an accident.

142.

Burgess also attacked the credibility of the version provided by Lategan with respect to the motions of the deceased when he was allegedly struck by the train. Lategan stated that he saw the deceased spinning and falling between the tracks. Burgess was of the opinion that seeing this would be highly improbable taking into account that the view towards the back of the locomotive is not very good and also based on Lategan's version that as soon as he struck the deceased, he applied the brakes. Burgess opined that it would be improbable for Lategan to have executed both these actions simultaneously[38].

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[38] 2025 re-opened inquest evidence of Labuschagne record 6 May 2025 page 36 lines 17-25

143.

Based on the scientific and mathematical evidence presented by Burgess to this court, we submit that there was no factual basis to conclude that a train accident occurred on 21 July 1967 and that Chief Luthuli was a victim thereof[39].

144.

As a qualified and experienced locomotive driver, Charles Lesley Labuschagne (Labuschagne) testified that he has extensive knowledge of regulations pertaining to driver behaviour as well as the behaviour of all staff onboard a steam locomotive. He was therefore able to comment on the versions provided by the locomotive driver (Lategan), the fireman (Greyling) and the conductor/guard (van Wyk) in the statements which were submitted at the 1967 inquest. A number of important discrepancies with the respect to the version presented by the train staff at the 1967 inquest proceedings, were noted by Labuschagne:

145.

Firstly, train and locomotive regulations provide that before approaching a bridge and when the train is at the point where there is a white whistle board, the driver of the train must blow the whistle to warn any pedestrians near the bridge that a train is approaching[40].

146.

Secondly, with respect to the fireman, Greyling, who stated that he was looking outside of the train the whole time, Labuschagne submits that Greyling would have seen a person walking on the bridge if there was indeed one[41].

147.

Thirdly, with the Umvoti River bridge being a straight bridge, it is expected that if there was a pedestrian walking across that bridge, such pedestrian would have been clearly visible to the train driver and the fireman, right up until at least 5 meters from the end of the bridge[42]. This would have been the same for the guard, van Wyk, even though he would have been seated right at the

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[39] 2025 re-opened inquest evidence of Labuschagne record 6 May 2025 page 49 lines 5-7
[40] 2025 re-opened inquest evidence of Labuschagne record 7 May 2025 page 11 lines 8-18
[41] 2025 re-opened inquest evidence of Labuschagne record 7 May 2025 page 12 lines 1-12
[42] 2025 re-opened inquest evidence of Labuschagne record 7 May 2025 page 21 lines 13-15

back of the train[43].He too, is expected to keep a constant look out of the window from his van[44]. This is also the reason why there are brakes in the guard van where the guard can also hit the brakes in instances where the train driver for whatever reason is not able to do so. Based on the fact that the train driver would have had a clear view of the bridge right up until at least 5 metres from the end of the bridge, Labuschagne formed the opinion that the train driver would have applied his brakes long before the actual impact took place[45].

148.

Fourthly, the position of the guard van having stopped on the other side of the bridge indicates that the train was standing in the correct place from when the driver applied the brakes. Had the driver seen somebody on the bridge, the train would have stopped on the bridge and not after the bridge[46].

149.

Fifthly, train and locomotive regulations provide that both the driver and fireman cannot leave the footplate at the same time, at least one of them must remain on the footplate for safety reasons[47]. The train driver, Lategan and the fireman, Greyling, disregarded these regulations when both of them alighted the train.

150.

Sixthly, it has been established that the steam locomotive was travelling at a speed of 40 kilometres per hour and in the opinion of Labuschagne, any individual who was to be struck by a steam locomotive travelling at that speed would sustain serious injuries to an extent that the limbs of such individual would be dismembered. Further, it would be impossible to identify the clothing of the individual[48]. The impact of the steam locomotive with an individual on a bridge like that of Umvoti, would have caused the body of the individual to be knocked against the balustrade of the bridge and then immediately back underneath the train[49]. This is what would have caused the body to have serious injuries and be dismembered. The corner of the cab, if it had indeed struck

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[43] 2025 re-opened inquest evidence of Labuschagne record 7 May 2025 page 40 lines 15-20.
[44] 2025 re-opened inquest evidence of Labuschagne record 7 May 2025 page 41 lines 10-11.
[45] 2025 re-opened inquest evidence of Labuschagne record 7 May 2025 page 12 lines 16-24
[46] 2025 re-opened inquest evidence of Labuschagne record 7 May 2025 page 13 lines 3-11
[47] 2025 re-opened inquest evidence of Labuschagne record 7 May 2025 page 13 lines 16-25.
[48] 2025 re-opened inquest evidence of Labuschagne record 7 May 2025 page 15 lines 12-18.
[49] 2025 re-opened inquest evidence of Labuschagne record 8 May 2025 page 33 and 34 lines 24-25 and 1-4.

Chief Luthuli on his right shoulder, the arm would have been removed from the shoulder blade[50]. There are also other items on the side of the train like stepladders which would invariably have hooked the body of Chief Luthuli and carried the body even further down the tracks[51]. It is submitted therefore that there should have been drag marks present but according to the statement of Pretorius, the Station Master, "there were no drag marks on the bridge to indicate that the deceased had been dragged along by the train after he was struck"[52].

151.

Seventhly, according to Labuschagne, when a steam locomotive passes over a steel bridge, it is extremely loud, and it would be impossible for one not to hear it unless one was completely deaf. This is especially because the sound of the whistle is uninhibited by any buildings or tress when it crosses over a river bridge[53]. Labuschagne testified to the effect that even if there was a strong wind blowing over the area of the Umvoti River on 21 July 1967, the sound of the whistle coming from the train would still have been very loud. He gave an example of trains operating in Mossel Bay, Cape Town where there are strong winds, but the whistle of the trains can still be heard[54]. The whistle must be blown for five to ten seconds when entering a bridge[55]. Further, when a steam locomotive is about to enter a bridge, there is a tremendous vibration that goes through the steelwork on the bridge, therefore at the very least, if Chief Luthuli was walking along the bridge, he would have felt the vibrations which would have alerted him of the oncoming train.

152.

Eighthly, Labuschagne submits that the measurements given by Lategan to the investing officer, were too coincidental, especially the measurement of the guard van having stopped directly at the 46.5-mile marker. He submits that this is coincidental taking into account the coefficient friction and brake force of the locomotive[56]. Labuschagne was of the opinion that those measurements were given in order to coincide with the version of the driver.

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[50] 2025 re-opened inquest evidence of Labuschagne record 7 May 2025 page 16 lines 16-18.
[51] 2025 re-opened inquest evidence of Labuschagne record 7 May 2025 page 53 lines 17-21.
[52] Statement of Pretorius page 489 paragraph 5.
[53] 2025 re-opened inquest evidence of Labuschagne record 8 May 2025 page 9 lines 9-13.
[54] 2025 re-opened inquest evidence of Labuschagne record 8 May 2025 page 9 lines 21-25.
[55] 2025 re-opened inquest evidence of Labuschagne record 8 May 2025 page 12 lines 13-14.
[56] 2025 re-opened inquest evidence of Labuschagne record 7 May 2025 page 24 lines 6-12.

153.

Ninthly, regarding the distance which the guard would have covered in protecting the train, the distance would have been a total of 3320 meters[57] coupled with all the conversations which he would have had with the station master and foreman, would in all probability have taken an hour[58]. Labuschagne further testified that it was highly irregular for the guard to have left the protection point to go back to the scene of the alleged accident. According to Labuschagne, the guard was to have remained with his red flag at the protection point until such time he receives a written and verbal instruction to remove the protection point[59]. The purpose of the guard remaining at the protection point with a red flag is to warn any approaching train that there is a stationary train ahead. Therefore, the assertion by van Wyk (the guard) in his statement that the period between the stopping and departure of the train took 20 minutes, we submit, is highly improbable.

154.

Tenthly, Labuschagne disputes Lategan's ability to have observed the sequence of what happened to the body of Chief Luthuli upon impact with the train. He disputes that the train driver would have been in a position to see the body of Chief Luthuli being spun and thrown between the bridge and the right-hand side of the train, whilst he simultaneously drove the train and applied brakes. To see all of that, the train driver would have had to look out the window and down below[60] Labuschagne testified that this would be highly improbable[61].

155.

Lastly, given the speed of the locomotive, the impact having been at 40 kilometres per hour, the body having been knocked between the side of the bridge and the train, Labuschagne maintained that it would have been impossible for Chief Luthuli to have still been breathing when personnel arrived at the scene. According to Labuschagne, the impact would have killed him killed instantly[62].

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[57] 2025 re-opened inquest evidence of Labuschagne record 7 May 2025 page 36 line 1.
[58] 2025 re-opened inquest evidence of Labuschagne record 7 May 2025 page 34 lines 5-11.
[59] 2025 re-opened inquest evidence of Labuschagne record 7 May 2025 page 31 lines 14-20.
[60] 2025 re-opened inquest evidence of Labuschagne record 7 May 2025 page 52 lines 20-21.
[61] 2025 re-opened inquest evidence of Labuschagne record 7 May 2025 page 50 and 51 lines 20-25 and lines 1-3.
[62] 2025 re-opened inquest evidence of Labuschagne record 7 May 2025 page 56 lines 19-22.

156.

In his statement, the train driver, Lategan, states that he had been driving along this stretch of the railway track for the past 20 years. This suggests, we submit, that Lategan knew that stretch of the railway track very well. Even if it were to be believed that there was indeed a train accident, the fact that the driver failed to follow regulations by ensuring that he slows down before entering the bridge and slows down even further upon entering the bridge, indicates that there was negligence on his part because he could have avoided the collision. We submit that it is rather unfortunate that the inquest court in 1967 neglected to probe these aspects in order to ascertain if there was indeed negligence on the part of the driver and train staff. We submit that it is curious as to how the court concluded that there was no negligence on the part of the railway personnel without having probed whether train regulations were adhered to by the train staff on the day in question.

157.

We have only highlighted eleven discrepancies which Labuschagne noted in respect of the statements tendered by the train staff, however, there were many others. In light of all of these discrepancies noted by Labuschagne, it is abundantly clear that the train accident as alleged by the train staff, did not occur.

158.

Gert van Tonder spoke to the issue of when a train is authorised to depart the scene of an accident. He testified that the train driver would be issued with a roadworthy certificate by the boiler maker and steam feeder before departure. When an accident occurs, the train driver is expected to immediately report the accident to his supervisor and wait for the arrival of the police, ambulance and other railway officials. He is further required to depose to a written accident statement before departing the scene[63]. Injured persons on the scene are not allowed to be removed until such time they are attended to by the ambulance personnel.

159.

It Is clear from the evidence of Mr van Tonder that the train staff on 21 July 1967, if one were to believe that there was indeed an accident whereby Chief Luthuli was struck by the said goods

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[63] 2025 re-opened inquest evidence of Labuschagne record 12 May 2025 page 18 lines 10-25.

train, acted negligently in the handling of the body and the failure to follow proper procedures after the immediate occurrence of an accident.

160.

To test the veracity of the evidence presented by various witnesses at the inquest proceedings in 1967, Warrant officer Sunette Nel, with the assistance of Burgess, conducted various tests.

161.

One of the tests which were conducted was to ascertain if the corner of the cab of the locomotive would have indeed struck the right shoulder of Chief Luthuli. It was established that Nel was of the same height as Chief Luthuli[64]. During the test it was noted that the length of her shoulder was lower than the alleged point of impact. Therefore, the deceased could not have been struck on the right shoulder by the locomotive[65].

162.

One of the other tests which were conducted was to establish how long it would have taken the deceased to walk from the shop to the train station. It was established that it would have taken approximately 10 minutes for him to do so. Equally, the walk from the train station to the bridge would have taken approximately 10 minutes[66]. Therefore, if the deceased left his shop at 10:00 am, it is expected that he would have arrived at the bridge at around 10:25 if one were to include the possibility that the deceased may have stopped to have a quick 5-minute chat with the station master before proceeding to the bridge. However, the accident is said to have taken place at 10:38, which amounts to a time difference of approximately 13 minutes.[67] Nel testified that the purpose of this test was to indicate whether there was sufficient time for the deceased to have been assaulted by perpetrators and in the opinion of Nel, a 13 minute interval was indeed sufficient time for an assault on the deceased to take place[68].

163.

The inconsistencies which were noted by Labuschagne with respect to the evidence presented by the train staff at the 1967 inquest were also noted by Nel. Nel also agreed with the testimonies

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[64] 2025 re-opened inquest evidence of Nel record 13 May 2025 page 11 lines 21-22.
[65] 2025 re-opened inquest evidence of Nel record 13 May 2025 page 10 lines 5-11.
[66] 2025 re-opened inquest evidence of Nel record 13 May 2025 page 18 lines 5-17.
[67] 2025 re-opened inquest evidence of Nel record 13 May 2025 page 19 lines 19-25.
[68] 2025 re-opened inquest evidence of Nel record 13 May 2025 page 20 lines 7-17.

of Labuschagne and van Tonder that the train occupants ought not to have removed the deceased from his original position on the bridge as that would constitute interfering with the crime scene[69]. She further conceded that it is possible that the original position of the body of the deceased could have been on the walkway and not necessarily on the tracks[70]. She therefore expressed how bizarre it is that the train driver would stop for an object that was not impeding the train as the object was not necessarily on the actual railway tracks.

164.

Based on the many inconsistencies inherent from the statements and evidence presented at the 1967 inquest proceedings as well as improbabilities based on tests which Nel conducted, her conclusion is that the whole incident was a cover up to hide the truth behind what really happened to the deceased on 21 July 1967.

165.

Upon receipt of a copy of the postmortem report of Chief Albert Luthuli, Dr Ntsele immediately identified that the injuries indicated on the said report do not resonate with injuries that would have been expected from a pedestrian involved in a train collision[71]. He testified that generally a person who was struck by a train would sustain multiple fractures on different body regions and would sustain multiple abrasions, bruises and/or lacerations[72]. He further noted a number of discrepancies from the face of the postmortem report.

166.

Firstly, the injuries are grouped without providing specific distinctive detail about the injuries in relation to wound measurements and specific locations within anatomical sites[73] . Further, it is not known how many and how big the scalp lacerations were. The same applies to the bruises[74].

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[69] 2025 re-opened inquest evidence of Nel record 13 May 2025 page 85 lines 19-22.
[70] 2025 re-opened inquest evidence of Nel record 13 May 2025 page 86 lines 23-25.

[71] 2025 re-opened inquest evidence of Ntsele record 14 May 2025 page 7 lines 15-19.
[72] 2025 re-opened inquest evidence of Ntsele record 14 May 2025 page 43 lines 13-18.
[73] 2025 re-opened inquest evidence of Ntsele record 14 May 2025 page 9 lines 14-19.
[74] 2025 re-opened inquest evidence of Ntsele record 14 May 2025 page 9 lines 20-25.

167.

Secondly, there was insufficient description relating to the extent and severity of the fractures suffered by the deceased[75]. There was no description of the injuries on a diagram to properly illustrate the observations made at examination and no specimens were collected at autopsy for further investigation[76].

168.

Thirdly, the status of the clothing of the deceased was not documented on the postmortem report. Dr Ntsele testified that the importance of this is to obtain various clues; the presence of debris like grass or sand or soil could provide an idea as to where the person could have been[77].

169.

Fourthly, seeing that the postmortem was conducted 90 minutes after the death of Chief Luthuli, Dr Ntsele was of the opinion that the said examination was hurried. He opined that there seemed to be no cultural or religious reason to have necessitated the examination so soon after Chief Luthuli's demise[78].

170.

Dr Ntsele also analysed the evidence presented at the 1967 inquest proceedings. With respect to the evidence of Dr Gregersen, he noted that she omitted to observe the x-ray records even though from her statement, she had ordered for them to be done. Dr Ntsele stated that "this was a measured omission, since it would have illustrated the number and location of rib fractures"[79]. X-rays also provide an objective observation of internal injuries. Further, the failure by Dr Gregersen to state whether the fracture on the left elbow was "simple, complex or complicated", did not help in ascertaining the amount of blunt force which could have caused that type of injury[80]. Dr Gregersen, who is said to have been the treating clinician, also failed to mention how many units of blood transfusion was administered to the deceased. According to Dr Ntsele, this was important for her to mention so that the deceased's level of cardiovascular deterioration could be ascertained.

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[75] 2025 re-opened inquest evidence of Ntsele record 14 May 2025 page 10 lines 4-6.
[76] 2025 re-opened inquest evidence of Ntsele record 14 May 2025 page 10 lines 12-16.
[77] 2025 re-opened inquest evidence of Ntsele record 14 May 2025 page 50 lines 15-21.
[78] 2025 re-opened inquest evidence of Ntsele record 14 May 2025 pages 10 and 11 line 23 and lines 7-10.
[79] 2025 re-opened inquest evidence of Ntsele record 14 May 2025 page 14 lines 10-13.
[80] 2025 re-opened inquest evidence of Ntsele record 14 May 2025 page 14 lines 17-23.

171.

On the aspect of clothing, Dr Gregersen had averred that there were no signs of dragging on the body, but his clothes were torn and dirty. Dr Ntsele opined that given the distribution and nature of the injuries recorded by Dr Gregersen, he would have expected the clothes of the deceased to have been bloodied[81]. Dr Ntsele further opined that there was no physical evidence to suggest that the deceased was thrown some distance away after impact and therefore Dr Gregersen was therefore misguided in confirming the insinuation propelled by the evidence leader that the deceased was thrown a distance away after the impact. We digress to mention that given the evidence which was presented at the 1967 inquest proceedings that the accident occurred on the bridge, it is submitted that the possibility of the deceased having been thrown at some distance by the impact, is extremely farfetched. Dr Ntsele states that evidence of the deceased having been thrown some distance by the impact would have been in the form of dragging abrasions, extensive bruises, varied lacerations all over the body as well as a fracture of the skull cap[82].

172.

In analysing the statement of Dr Joubert, the neurosurgeon, it could be ascertained from his observations of the the x-rays that the deceased suffered extensive skull fractures, a fracture of the left elbow and ninth rib. In the opinion of Dr Ntsele, it is apparent that the rib fractures were not significant to have led to the death of the deceased[83]. However, Dr Ntsele found it surprising as to how Dr Joubert could have concluded in his statement that the deceased not only died as a result of head injuries, but as a result of chest injuries as well. Dr Joubert himself stated "it was not possible to ascertain whether there was an associated haemothorax". This means he was not able to ascertain if there was bleeding in the chest, the only injury he could see was a fracture to the ninth rib. It was the respectful submission of Dr Ntsele that the conclusion reached by Dr Joubert did not make sense. It is submitted by the State that this conclusion which was reached by Dr Joubert, Dr Gregersen and Dr van Zyl, was an attempt to paint a picture of severe injuries to the chest having been suffered by the deceased in order for it to tie in with the notion that the deceased was indeed struck by a train.

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[81] 2025 re-opened inquest evidence of Ntsele record 14 May 2025 page 19 lines 6-11.
[82] 2025 re-opened inquest evidence of Ntsele record 14 May 2025 page 20 lines 2-16.
[83] 2025 re-opened inquest evidence of Ntsele record 14 May 2025 page 21 lines 20-22.

173.

Despite the paucity of detail and the hurried manner in which the postmortem examination was done by Dr Joubert wherein horizontal lines were just drawn through entire sections of the said report , Dr Ntsele also criticized the manner in which the 1967 inquest court dealt with the evidence of Dr van Zyl. He opined that the fact that Dr van Zyl was only asked two questions during the inquest proceedings, was unusual[84]. Further, in the opinion of Dr Ntsele, the court failed to ask clarity seeking questions from Dr van Zyl so that he could supplement the shortcomings which were evident from the face of the postmortem report[85]. Further, the court did not ask him to comment on the presence or absence of internal injuries on other parts of the body. Dr Ntsele was of the opinion that the postmortem report as a whole, was substandard[86] and also lacked detail with respect to the type of brain haemorrhage which was suffered by the deceased. This information, according to Dr Ntsele, would have been crucial in ascertaining the possible cause of the haemorrhage[87]. Further, the extent to which the internal organs were affected, was not noted by Dr van Zyl.

174.

In analysing the statement of Papayya who is said to have been the ambulance driver, Dr Ntsele criticises the fact that clinical records by the ambulance crew were not attached to the statement of Papayya. Dr Ntsele states that this information would have assisted in ascertaining what the deceased's clinical status was when he was being treated by the paramedics[88].

175.

Regarding the quality of medical attention, which was provided to the deceased, Dr Ntsele believed the deceased should have been transferred to King Edward Hospital in Durban which was better equipped to handle patients who had suffered head injuries. He testified that this was quite evident from the fact that a decision was reached by the treating doctors that a neurologist had to be called. It shall be argued later that the decision not to transfer the deceased to King Edward Hospital was deliberate.

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[84] 2025 re-opened inquest evidence of Ntsele record 14 May 2025 page 29 lines 4-8.
[85] 2025 re-opened inquest evidence of Ntsele record 14 May 2025 page 29 lines 12-15.
[86] 2025 re-opened inquest evidence of Ntsele record 14 May 2025 page 29 lines 20-24.
[87] 2025 re-opened inquest evidence of Ntsele record 14 May 2025 page 30 lines 1-7.
[88] 2025 re-opened inquest evidence of Ntsele record 14 May 2025 page 33 lines 14-15 and lines 19-21.

176.

In commenting on the version of the train driver to say that Chief Luthuli was struck on his right shoulder by the corner of the cab, Dr Ntsele testified that he would have expected the whole arm of Chief Luthuli to fall off given the speed at which the train was travelling as well as its weight. Alternatively, Dr Ntsele would have expected there to be fractures in the area around the right shoulder which would damage the blood vessels and lungs[89].

177.

Having analysed the injuries which are said to have been sustained by the deceased, Dr Ntsele was of the opinion that the deceased was assaulted. Dr Ntsele testified that "the presence of bruises on the dorsal aspect of both the left and right hands, as well as fracture on the left proximal ulnar bone, may signal defence injuries which would normally occur when a victim of assault instinctively raises their hands and arms to protect their eyes, face and head[90]. In doing so, the chest area becomes vulnerable to being attacked which could explain the fracture of the ninth rib. He was therefore of the opinion that the deceased was a victim of an assault rather than of a train collision.

Overall submissions with respect to expert evidence presented during current re-opened inquest proceedings

178.

It is evident from the reading of the 1967 inquest proceedings that Chief Mvumbi Albert John Luthuli was not provided with much needed emergency medical care. All state departments whose duty it was to see that emergency medical care was administered, deliberately failed in their duty. The Gledhow station master who was informed about the alleged accident, instead of immediately phoning the hospital and police, elected to first go to the scene. Surely if a train accident did indeed occur wherein there was a victim, the first call of action would be to summon an ambulance to the scene. It is expected that van Wyk would have alerted Pretorius to an accident. A lot of time was wasted before an ambulance was summoned to the scene.

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[89] 2025 re-opened inquest evidence of Ntsele record 15 May 2025 page 8 lines 5-15.
[90] 2025 re-opened inquest evidence of Ntsele record 14 May 2025 page 38 and 39 lines 23-25 and lines 1-12.

179.

It is puzzling as to why the ambulance driver, Peter Pappaya allowed himself to be pulled over by Burger when he was transporting a patient in need of emergency medical care. In that situation, every second and every minute would have been the difference between life and death for the patient. The only inference that can be drawn is that Papayya did indeed allow himself to be pulled over by Burger because Burger stated that whilst driving to the scene of the alleged accident, the ambulance driver had confirmed that he is transporting "ex Chief Luthuli to Stanger Hospital".

180.

Upon arrival at the hospital, it is quite clear that the attendant medical practitioners had diagnosed the injuries sustained by Chief Luthuli as serious, however, they failed to ensure that he is transferred to King Edward VIII hospital which would have been better equipped to handle the injuries. However, in the defence of Dr Mary Gregerson, perhaps she did indeed want to transfer the deceased to King Edward Hospital by making the necessary call but someone at the said hospital refused for the transfer to occur and opted to rather send a neurosurgeon to attend to Chief Luthuli. This is the institutionalisation of apartheid which we reference to in our earlier submission; Chief Luthuli was deliberately denied emergency medical care because of the colour of his skin and because he was an irritant to the then Apartheid Government.

181.

We submit that Chief Luthuli was a victim of the typical systematic attack which was perpetuated on political opponents by the apartheid regime. Apartheid was an institutionalised regime of systematic oppression and domination, by one racial group over other racial groups with the intention of maintaining that domination, especially over non-whites.[91] This is the very system which Chief Luthuli fought against all his life, whether passively or aggressively. To supress his behaviour, various banning orders were placed on Chief Luthuli, however, he constantly outsmarted the Apartheid government. We submit therefore, that a plan had to be hatched to eliminate him, however in such a way that the government would not be blamed in fear of possible sanctions and resistance from the international community who had a year earlier, awarded Chief Luthuli with the Nobel Peace Prize.

[91] S v Mfalapitsa and Others (Gauteng Local Division) case no. SS70/2021 (unreported).

As Apartheid was declared a crime against humanity by the United Nations General Assembly in 1966, we submit that the death of Chief Luthuli was as a result of the institutionalisation of apartheid wherein various agents of the state as mentioned earlier, especially South African Railways, the police and health departments deliberately ensured that he did not get adequate emergency medical care which ultimately contributed to his demise. The South African Police who constantly surveyed the movements of Luthuli, went to great lengths to cover up the truth behind what led to his death by roping in officials from South African Railways and department of Health. We submit therefore that Chief Luthuli was a victim of apartheid, a crime against humanity.