REPORTABLE

IN THE HIGH COURT OF SOUTH AFRICA
(WESTERN CAPE HIGH COURT, CAPE TOWN)

CASE NO: 10416/04

In the matter between:

DUDLEY LEE Plaintiff

and

THE MINISTER OF CORRECTIONAL SERVICES Defendant

JUDGMENT

DE SWARDT, A J:

[1.] Pollsmoor Prison ('Pollsmoor'), as it is commonly known, is in fact a prison complex consisting of five different prisons : the admissions centre which is also known as the maximum security prison, the women's prison, the juvenile prison and the medium security prisons B and C for sentenced prisoners.

[2.] The plaintiff was detained in the maximum security prison for a period of approximately 4½ years from November 1999 to 27 September 2004 while he was on trial in the Regional Court (he was temporarily out on bail from January to April 2000). In June 2003, whilst he was incarcerated, he became ill and was diagnosed as suffering from pulmonary tuberculosis

('TB'). After the plaintiff's release from prison, pursuant to his acquittal on the criminal charges which had been preferred against him, the plaintiff instituted an action for damages against the defendant on the basis that the defendant's servants at the prison had by their conduct, whether acting dolus eventualis or negligently, caused him to become infected with TB. By agreement between the parties and in terms of Uniform Rule 33(4) the Court granted an Order that the merits of the plaintiff's claim were to be adjudicated upon separately, prior to the quantum of the plaintiff's alleged damages being dealt with.

[3.] The plaintiff was represented in the action by Mr I J Trengove, acting on instructions of Mr J C Cohen of attorneys Jonathan Cohen & Associates. The Defendant was represented by Mr I Jamie S C, assisted by Ms D Pillay, acting on instructions of Mr C J Benkenstein of the State Attorney.

[4.] The trial of the matter ran for a period of some 21 days from 2 to 10 December 2009 and from 1 to 25 February 2010. Argument was heard on 16 March 2010. The evidence and disputes between the parties will be dealt with herein as comprehensively, but succinctly, as is possible. The fact that a particular aspect of evidence or argument which was raised, is not dealt with expressly, however, does not mean that it has not been considered.

The Issues on the Pleadings

[5.] The Plaintiff alleged that the responsible authorities were employees of the State and of the Department of Correctional Services ('DCS'), who acted within the course and scope of their employment. The defendant, in his plea, inter alia, admitted responsibility for the control and management of the correctional facility where the plaintiff was detained, that he was responsible for the accommodation and management of all prisoners and that he was the employer of the persons who treated the plaintiff from about 23 November 1999 until 27 September 2004. Defendant, however, averred that the management of the prison and its inmates, inclusive of the policies which were applicable at the time, was conducted within the ambit of the Correctional Services Act 111 of 1998 and of the Constitution.

[6.] In terms of his amended Particulars of Claim, the plaintiff formulated his claim (as far as the merits are concerned) as follows:-

> '7. During the period of the Plaintiff's imprisonment:
>
> 7.1 It was common for prisoners in the prison, including the Plaintiff, to be congregated in close proximity to one another and to be housed in mass cells;
>
> 7.2 A considerable proportion of prisoners in the prison were actively infected with tuberculosis;
>
> 7.3 It was consequently inevitable that some of the prisoners actively infected with tuberculosis would infect non-infected prisoners in close proximity to them with tuberculosis.
>
> 8. During the period of the Plaintiff's imprisonment the responsible authorities were aware of the presence of tuberculosis in the prison and of the concomitant risk of non-infected prisoners being actively infected therewith, should infected prisoners come into and/or remain in close proximity with them.

9. During the period of the Plaintiff's imprisonment the responsible authorities could have:

   9.1 Eliminated or curtailed the spread of tuberculosis by creating conditions in the prison which made it impossible or difficult for tuberculosis to be spread;

   9.2 Avoided or minimised the risk of infection with tuberculosis by:

      9.2.1 separating actively infected prisoners from non-infected prisoners;

      9.2.2 Regular and effective checkups of prisoners to determine whether or not they were actively infected with tuberculosis, and if so, by providing regular and effective treatment for the control and elimination of the disease.

10. During the period of the Plaintiff's imprisonment the responsible authorities failed to take any or adequate steps:

   10.1 To eliminate or curtail the spread of tuberculosis; or

   10.2 To avoid or to minimise the risk of infection with tuberculosis.

11. During the period of the Plaintiff's imprisonment the responsible authorities instead:

   11.1 Failed to act and ignored (sic) and allowed tuberculosis to be spread amongst prisoners unabated; and

   11.2 Failed to adhere to the requests of prisoners for proper and/or adequate treatment to prevent and/or treat and/or cure those actively infected or potentially actively infected with tuberculosis.

12. The failure on the part of the responsible authorities to act as aforesaid was not necessary for the achievement of any of the purposes for which they were vested with their powers of control and management of the prison;

13. Throughout the period of the plaintiff's imprisonment:

   13.1 He was incarcerated in cells with more than one prisoner;

   13.2 It was always likely that he would become infected with tuberculosis by actively infected prisoners;

   13.3 He was consequently at risk of tuberculosis infection;

   13.4 He remained in constant close proximity to prisoners actively infected with tuberculosis;

   13.5 He was not specifically aware which prisoners were actively infected with tuberculosis;

14. During the period of the Plaintiff's imprisonment he became infected with tuberculosis. The Plaintiff does not know when this happened but became aware of it during or about June 2003.

15. During the period of the Plaintiff's imprisonment the responsible authorities:

   15.1 Failed to take any or adequate steps to protect the Plaintiff against the risk of tuberculosis infection;

15.2 Failed, once the Plaintiff had been diagnosed as actively infected with tuberculosis, to provide the Plaintiff with adequate medical treatment and/or medication to cure and/or prevent the further spread thereof;

15.3 Failed to adhere to the Plaintiff's numerous requests for adequate treatment for the cure of and/or prevention of the further spread of the tuberculosis with which he had become contaminated.

16. The conduct of the responsible authorities was unlawful in that:

16.1 The conduct of the responsible authorities during the period fo the Plaintiff's imprisonment violated the Plaintiff's rights described below, at common law, under the Correctional Services Act 8 of 1959 ("the Act") and under the Constitution.

16.2 Their conduct violated his common law rights to respect for and protection of his physical integrity during his imprisonment;

16.3 Their conduct violated his rights implied by the Act and particularly, Sections 2(2)a (sic), 2(2)b (sic), 23(2), 69(a) and 79(1)e (sic) thereof to respect for and protection of his physical integrity during his imprisonment. [These provisions of the said Act were still applicable until 31 July 2004 when the provisions of the new Correctional Services Act No 111 of 1998 with regard to the treatment of prisoners came into operation.]

16.4 Their conduct violated his rights under the constitution (sic) and particularly, the following:

16.4.1 His rights in terms of Section 35(2)e (sic) thereof to be detained under conditions consistent with human dignity, and to be provided with adequate accommodation, nutrition and medical treatment at state expense;

16.4.2 His rights in terms of Section 12(1) thereof to freedom and security of the person;

16.4.3 His rights in terms of Section 12(1)(d) and (e) thereof not to be subjected to torture of any kind, whether physical, mental or emotional, and not to be subjected to cruel, inhuman or degrading treatment or punishment;

16.4.4 His right to life, in terms of Section 11 thereof;

16.4.5 His right in terms of Section 10 thereof to respect for and protection of his dignity.

17. The responsible authorities knew during the period of the plaintiff's imprisonment that their conduct placed prisoners at risk of tuberculosis infection and, in the premises, they acted as they did dolus eventualis, alternatively negligently.

18. But for the conduct of the responsible authorities:

18.1 The Plaintiff would not have been exposed to prisoners actively infected with tuberculosis;

18.2 The Plaintiff would have had access to and sought proper treatment of active infection by (sic) tuberculosis;

18.3 The Plaintiff would not have become actively infected with tuberculosis;

18.4 The Plaintiff's active tuberculosis infection would have been treated and cured earlier;

19. In the premises, the conduct of the responsible authorities caused the plaintiff's active infection with tuberculosis.'

[7.] Defendant denied the aforegoing allegations made by the plaintiff in his Particulars of Claim and denied, in particular, that he or his employees, or persons or legal entities representing him, acted unlawfully, committed any negligent acts or omissions, or breached any statutory and/or common law duty vis-à-vis the plaintiff. In his plea, the defendant denied 'the allegations of widespread tuberculosis infection and spread of tuberculosis amongst prisoners' and alleged, inter alia, that:

5.1.1 In compliance with the provisions of the Act and the Constitutional framework, Defendant is responsible for the accommodation and management of all prisoners. [The Act referred to by Defendant is the new Correctional Services Act No 111 of 1998]

5.1.2 Defendant provides primary health care services in line with the requirements of the National Department of Health.

5.1.3 In administering, controlling and minimising the general risk of tuberculosis infection, Defendant utilises the national health policy and treatment guidelines issued by the relevant health authorities.

5.1.4 Defendant's health and medical policies, procedures and implementation strategies are in full compliance with the National Tuberculosis Control Programme.

5.1.5 At all material times, prisoners, including Plaintiff, who exhibit symptoms of tuberculosis infection and/or are diagnosed with tuberculosis infection, are henceforth confined and treated within the medical units of the correctional facility until the period of such infectivity elapses.

...

6.1.2 At all material times Defendant provides and dispenses medical treatment to prisoners in accordance with the provisions of the Act and Constitution.

6.1.3 In dealing with tuberculosis specifically Defendant implements the National Tuberculosis Control Programme, and utilises the following procedures and policies in minimising the risks of tuberculosis infection and preventing further proliferation:

6.1.3.1 Defendant pleads that early detection or diagnosis of tuberculosis occurs when prisoners show or display symptoms of the (sic) active tuberculosis.

6.1.3.2 Following upon the diagnosis of tuberculosis infection, the prisoner is immediately quarantined in the medical unit, away from other prisoners, and a treatment phase commences.

6.1.3.3 Medical officers in control of the medical units within the correctional facility monitor and treat infected prisoners during the isolation period and the treatment phase.

6.1.3.4 Prisoners are sent to the normal prison units and/or communal area once the customary period of risk of infection to other prisoners has passed.

6.2 Defendant pleads that at all material times hereto Defendant and/or Defendant's employees utilise (sic) all reasonable care and diligence in implementing relevant health procedures and policies, including abiding by the national health procedures and policies, in order to minimise the risk of infection and proliferation of tuberculosis amongst prisoners.

...

7.1.4 Plaintiff was diagnosed with tuberculosis on or about 10 June 2003 .

7.1.5 Plaintiff was confined to the medical unit and began tuberculosis treatment on the same day. The abovementioned medical section is separate and generally isolated from other prison sections and general communal areas.

7.1.6 The tuberculosis treatment was successfully completed within six months of commencement. Plaintiff responded to all treatment and various sputum tests conducted after completion of Plaintiff's treatment yielded negative results for tuberculosis infection.

7.1.7 Defendant pleads that it utilised all reasonable care and diligence during Plaintiff's imprisonment and in the diagnosis and treatment of the plaintiff's tuberculosis infection.'

The Nature and Treatment of TB

[8.] It was common cause between the parties' respective experts that TB is a contagious infection which is caused by an airborne bacterium, mycobacterium tuberculosis. It is a disease which has been a serious public health problem for hundreds of years. It is found world wide, although it appears to be more common in developing countries such as, for example,

South Africa, where the majority of the population tends to be poor and tends to live in crowded conditions that are conducive to the spread of the disease. Indeed, South Africa appears to have one of the highest incidence rates of TB in the world.

[9.] A person who is actively ill with the disease is able to transmit the disease, because bacteria would be expelled from the body during sneezing, coughing, or spitting. The bacterium is vulnerable to sunlight and fresh air, but if it is expelled in a closed environment such as, for example, by someone coughing in a poorly ventilated room, it can drift around for hours. Similarly, if phlegm is spat onto the ground and is not cleaned by means of special anti-bacterial antiseptics in circumstances where there is a lack of sunlight and a good draught of air, it could remain infective for an extended period of time. Some persons who are ill with TB shed more bacteria than others and are known as 'super shedders'.

[10.] Not every person who has been exposed to the TB-bacterium becomes ill with the disease. Indeed, if a person is exposed to the bacterium, one of three things may happen: (1) the body's immune system may destroy the bacterium, in which event there will subsequently be no sign that the person was ever exposed to it; (2) the body's immune system could wall off the bacterium in a tiny piece of scar tissue, referred to as a granuloma. In such event, the bacterium would remain dormant and the person would not be

aware of the fact that infection has occurred. The sub-clinical infection would, however, remain and the dormant bacterium could subsequently become active, even many years later. In the latter event, the person would become ill with the disease; (3) the bacterium could take hold and multiply, causing the person to become actively ill with TB.

[11.] It is notionally possible to establish whether or not a person has in the past been infected with the TB-bacterium even if he/she did not become ill with the disease. A skin test may be performed, which entails the injection of an extract made of the cell wall of the bacterium under the skin of the forearm. Such injection causes a swelling to appear and approximately 36 hours later, the swelling is measured in order to establish whether or not a positive result has been obtained. In the normal course of events, however, persons are not subjected to skin tests, inter alia, because it involves an invasive procedure. When a person becomes ill with TB, it is accordingly not usually possible establish definitively whether such illness is the result of dormant bacteria having become active (referred to in evidence as re-activation), or whether it is the result of a fresh infection (referred to in evidence as reinfection).

[12.] There are also 3 factors that have a bearing on whether or not a person who has been exposed to the TB bacterium may develop a sub-clinical infection or become actively ill with the disease: (1) the virulence of the bacterium; (2) the dose of the bacterium which has been inhaled - the larger the number of

bacteria which have been inhaled, the greater one's chances of developing the disease; and (3) the resistance of the person concerned to the offending bacterium - persons whose immune system have been compromised, or who suffer from another illness that might contribute to the lowering of their immunity, such as, for example, those suffering from diabetes mellitus, cancer or HIV - are at greater risk for developing the disease. Smokers also have a higher risk for developing TB.

[13.] Pulmonary TB is diagnosed by means of sputum tests and cultures, as well as X-Rays of the lungs. X-Ray findings on their own are, however, not necessarily conclusive. Sputum samples are accordingly normally sent off to a laboratory for analysis. The laboratory first performs a microscopic analysis of the sputum sample. Such procedure takes a trained technician approximately 1 hour to perform. Microscopic analysis reveals whether or not the bacterium is present and the laboratory customarily provides a preliminary report once such analysis has been completed, usually within a period of approximately 2 days. Microscopic analysis, however, does not disclose whether the bacterium is alive or not. If bacteria are present, these are accordingly grown in a culture, a process which can take up to 6 weeks, because the TB bacterium is very slow growing. If the culture yields a positive result, it is indicative of active TB infection.

[14.] The standard treatment for TB consists of a combination of 4 different

antibiotics, referred to as 'Regimen I'. Multi-drug resistant TB ('MDR-TB') is treated with different antibiotics which are referred to as 'Regimen II'. After two weeks of treatment with such antibiotics, the patient would no longer be contagious or infective, but patients on Regimen I have to continue taking the medication on 5 days of the week for a period of six months. If patients do not continue treatment for the full period of six months, the disease could flare up, causing them to become infectious again. More importantly though, failure to complete the full course of antibiotics over 6 months could cause the bacterium to become resistant to the antibiotics which are normally used. In such a case, the patient would develop MDR-TB. Patients with MDR-TB have to continue treatment for a period in excess of 6 months. There is even a further condition known as XTR-TB (extreme resistance TB), which is particularly difficult to treat.

[15.] By reason of the fact that TB is an airborne disease, its spread is facilitated if many people live in close proximity to each other. Poor ventilation and inadequate sunlight further contribute to the spread of the disease. Poor nutrition also plays a role in the transmission of TB, inasmuch as persons who are malnourished frequently suffer from a compromised immune system.

[16.] TB is a notifiable disease. If a person is diagnosed as being ill with TB, such fact must be reported to the authorities - in the instant case, to the Medical Officer of Health of the City of Cape Town.

[17.] In 2000, the Department of Health ('DOH') at National level published a manual entitled 'The South African Tuberculosis Control Programme Practical Guidelines' ('the guidelines'). The guidelines acknowledge that the cure rate for detected smear-positive cases of TB has not exceeded 50% in many parts of the country and that this is a serious problem. The guidelines recognise that '(A)n important factor contributing to a low cure rate is poor patient compliance in detected cases. Once the symptoms of tuberculosis lessen, patients find it difficult to continue treatment. Incomplete treatment can result in infectious patients with chronic tuberculosis who continue to transmit the infection. It may also lead to the development of drug resistant strains of tuberculosis. Therefore, it is important to increase patient compliance.'

[18.] The guidelines for the treatment of tuberculosis are based on a Directly Observed Treatment Short-course Strategy ('DOTS'). According to the guidelines:

> 'DOTS puts the priority on curing infectious patients and its core elements are:
> - sustained TB control activities.
> - Sputum smear microscopy to detect the infectious cases among those people attending health care facilities with symptoms of TB, most importantly cough of three week's (sic) duration.
> - Standardized short-course anti-TB treatment with direct observation of treatment.
> - An uninterrupted supply of TB drugs.
> - A standardized recording and reporting system which allows assessment of treatment results.
>
> ...
> Short-course chemotherapy is a combination of potent anti-tuberculosis drugs (isoniazid, rifampicin, pyrazinamide, streptomycin and ethambutol). It has an initial intensive phase of 2-3 months and a continuation phase of 4-7 more months. Every dose of rifampicin should be observed, at least in the intensive phase of the treatment. ...'

[19.] The DOTS system of treatment, as the name implies, is calculated to ensure

that every TB patient has the support of another person 'to ensure that they swallow their medication daily'. Such a supporter need not be a health care professional, but any responsible member of the community may act as such.

[20.] In terms of the DOTS system, each person who is diagnosed as being ill with TB, receives a Patient Treatment Card (such as Exhibit K) which, in the instant case, was green. The card has been designed to reflect the patient's personal details, such as his/her name and identity number, whether the person is a new patient or one who has previously defaulted, the result of sputum tests, the identity of the treatment supervisor and, most importantly, a daily record of the medication being administered. The patient is supposed to carry this card. In addition to the patient treatment card, the clinic or hospital treating the patient is also supposed to complete a Clinic/Hospital Card (such as Exhibit L) which, in this case, was blue. The hospital card has been designed to reflect information similar to that provided for on the patient treatment card, but in addition is intended to provide, inter alia, a record of other medical conditions and progress notes.

[21.] Hospitals and clinics apparently also use a 'TB Treatment Wheel' (such as Exhibit N) to keep track of treatment. The treatment wheel consists of 3 plastic coated circles of paper which have been clamped together. The centre circle contains details of the months and weeks of the year, much like a calendar, printed on both sides. On either side of the calendar so provided

is another circle - one dealing with the treatment of new patients and the other dealing with re-treatments. The treatment wheel has been designed so as to show at a glance the dates when follow-up sputum smears would be due and the dates when adjustments would need to be made to the medication.

The Witnesses

[22.] The plaintiff testified in support of his case and four witnesses were called on his behalf - Drs Theron and Craven, two medical doctors who had been employed as part-time district surgeons at Pollsmoor prison; Mr Frans Muller, a male nurse formerly employed at the prison; and Mrs Judy Anne Caldwell, a TB Project Manager employed by the City of Cape Town. Two witnesses testified on behalf of the defendant - Mr Jerome Gertse, a professional nurse who still works at the maximum security prison and Professor Paul David van Helden, a professor in the employ of the University of Stellenbosch, who specialises in tuberculosis research.

[23.] The plaintiff was 63 years old at the time of the trial and would turn 64 on 13 April 2010. As a child, he lived in Edenvale until he reached standard 1. Somewhat later, he moved to Sedgefield before relocating to Cape Town in 1996. In Cape Town, he initially lived in Harfield Village, Claremont, for a period of 2 or 3 years, whereafter he moved to Plumstead (a middle class suburb South of Cape Town), where he shared a house with a friend.

[24.] The plaintiff was self-employed. He had a carpet and upholstery cleaning business and sold watches, which brought him an income of at least R10,000 per month. He also bought pre-owned cars, repaired these and sold them on. The plaintiff liked to play darts and pool and spent a fair amount of time in pool halls and bars.

[25.] Dr Paul Alexander Theron obtained a BSc degree in Medicine from the University of Cape Town in 1969 and obtained the degrees MB ChB from the same university in 1974. He has been a qualified medical practitioner for 35 years and was employed as a part-time district surgeon (now referred to as a clinical forensic practitioner) for the Wynberg area in Cape Town for a period of 24 years. In his aforesaid capacity, he worked at Pollsmoor from 1997 to 2007. He was an employee of the Provincial DOH as well as of DCS.

[26.] Dr Theron commenced his practise of medicine in the rural hospitals in Kwazulu Natal. One of these was the Charles Johnson Hospital where a Dr Anthony Barker was in charge. Dr Barker was highly regarded in the medical community for his work with TB patients and although it was a small, low cost, community hospital, it attracted doctors from all over the world. Dr Theron worked there on three separate occasions for two to three months at a time. There was a high incidence of TB in the community and during the course of his work at such hospital, Dr Theron was exposed to Dr Barker's approach to the prevention and treatment of TB.

[27.] Dr Theron was essentially employed in the 'Medium A' prison. He was, however, also involved with the maximum security prison where the plaintiff was detained. He was the chairperson of the Clinical Forensic Practitioners Association for the period 1998 to 2008. The members of the aforesaid Association held meetings on a regular basis and the situation at Pollsmoor was discussed at these meetings. He was accordingly informed with regard to the health situation in the different sections of the prison and, in his capacity as the chairperson of the Association, liaised with the authorities in this regard. Dr Theron also worked in the maximum security section of the prison from time to time when he stood in for Dr Craven. Indeed, Dr Theron worked in all of the prisons at Pollsmoor at one time or another.

[28.] Dr Theron came into conflict with the DCS over the health issues at Pollsmoor which were reported to the Portfolio Committee of Parliament and to the Inspecting Judge of Prisons. Litigation followed and in settlement thereof he was appointed to Somerset Hospital in February 2008.

[29.] Dr Theron considers himself to be an expert in regard to the contracting, transmission and spread of TB and has had many years of experience in the treatment of the disease. He has lectured on the topic at university level.

[30.] Dr Stephen Adrian Craven qualified at the University of Oxford in England in 1970. He has been practising as a medical doctor for a period of 30 years.

He is a licentiate of the Royal College of Physicians, as well as a member of the Royal College of Surgeons. After obtaining his medical qualifications, he worked in England before spending 7 months in general practice in Lagos, Nigeria. Subsequently, he worked in England again, spent some time as a ship's surgeon for the Union Castle line and acted as locum for a doctor in Cape Town, whereafter he moved to Algeria and eventually moved to South Africa permanently. He has worked for the Provincial Administration in various capacities, both on a full time and part-time basis at Groote Schuur, at a hospital in Port Elizabeth and at the Brooklyn Chest Hospital, where he was in charge of TB patients. In 2003 he was appointed as an honorary lecturer in family medicine at the University of Cape Town.

[31.] Dr Craven worked as a part-time district surgeon at the maximum security prison from 1988 to September 2003. His working hours were confined to 5 hours in the morning on weekdays. He is currently engaged in a private medical practice in Wynberg, in addition to being the principal medical officer at the Lady Michaelis, a Provincial day hospital where primary medical care is provided. He still comes across TB-patients at the day hospital, but patients who are diagnosed as being ill with TB, are referred elsewhere for treatment.

[32.] Dr Craven acquired his knowledge and experience in regard to TB at medical school, by attending lectures and reading text books, by working at the Brooklyn Chest Hospital for a period of approximately 18 months and through

his work at the prison.

[33.] Dr Theron and Dr Craven testified as factual witnesses, but also as experts in relation to the treatment and prevention of TB.

[34.] Mr Frans Muller, a professional nurse, was employed at Pollsmoor for a period of 10 years as the Area Co-ordinator, Health Care. He is currently working as a temporary employee at the D P Marais Hospital in Retreat, Cape Town, a TB-hospital. He testified that he has been unable to accept a permanent position, because he is still in dispute with the DCS.

[35.] Mr Jerome Gertse qualified as a professional nurse in 1998, completed a course in primary health care in 2002 and in 2003 he completed a course in TB management. He started working at Pollsmoor as a junior nurse in February 2001, after having worked at Voorberg Prison in Porterville and at Goodwood Prison. In 2006 he was deployed to the Medium C-prison at Pollsmoor where he worked with Dr Theron. Mr Gertse is currently still employed by the DCS at Pollsmoor, where he is in charge of the hospital in the maximum security prison.

[36.] Prof Paul David van Helden obtained a BSc-degree in Biochemistry, Chemistry and Microbiology from the University of Cape Town in 1973, as well as a BSc Honours-degree in Biochemistry in 1974 and a PhD in Biochemistry in 1978.

From 1979 to 1981 he was the Senior Professional Officer at Tygerberg Hospital in the Department of Medical Physiology and Biochemistry of the University of Stellenbosch. He remained in the employ of the University of Stellenbosch and in 1992 he became the Chair of the Department of Medical Biochemistry and Director of the Medical Research Council's Centre for Molecular and Cellular Biology. His research has been focussed on TB for the past 20 years and he has been involved in many papers which have been published in peer review journals such as, for example, the New England Journal of Medicine.

The Plaintiff's Evidence

[37.] The plaintiff testified that he was tested for TB once or twice when he was a child. A van used to come around in Edenvale and all of the children were subjected to X-Rays. He could, however, not recall whether any sputum tests were conducted at that time. He was always a fit and active person and boxed for many years. Apart from some trouble with his heart and prostate, he was healthy and he had never been ill with TB prior to his incarceration. He cooked, as did his house mate and he looked after himself, because he had been taught to look after his body. He did, however, admit that he was a smoker prior to being detained at Pollsmoor prison and during the period of his incarceration.

[38.] The plaintiff denied that he was a chain smoker. Whilst in prison, he cut down from 30 to 5 cigarettes per day at one stage, but he testified that one generally tends to smoke more in prison and that smoking was very prevalent. As he put it, 'everybody and his brother smokes there' and the prison reeked of smoke. The plaintiff stated that some of the inmates made cigarettes out of newspaper, some smoked dagga wrapped in newspaper and some made a 'hondjie' out of toilet paper. (Dr Theron described a 'hondjie' as consisting of tightly rolled up toilet paper which is lit and left to smoulder so that prisoners can light up their cigarettes.) The 'hondjie' stinks and closes one's chest. Smoke from the cells in a section of the prison, drifts down the corridor. Dr Craven advised him to stop smoking and he stopped for a long time, but he was under much pressure prior to the trial taking place, which caused him to start smoking again.

[39.] Upon arriving at Pollsmoor for the first time, the plaintiff was taken to a holding cell in the administrative section of the maximum security prison. One of the inmates, a Trevor Blignault, conducted a basic screening procedure by, inter alia, asking persons who had medical conditions to step forward and to make themselves known. Thereafter, Blignault also conducted the registration process and the plaintiff was issued with a prison card. Although Mr Gertse averred that the nurses took turns to do duty at admissions and that the screening was conducted by the nurse who was on duty, the plaintiff stated categorically that he never saw a nurse doing so on any of the occasions

when he came back to the prison from court.

[40.] Upon completion of the necessary administrative process, the plaintiff was admitted to the hospital in the maximum security prison, because he suffered from a heart condition. The following morning he went on medical parade and saw Dr Craven, whom he informed of the medication he was using at the time. Dr Craven issued a prescription for such medication and officially booked him into the hospital, where he stayed until he was released on bail in February 2000. He was described as 'well obese' in his medical record and Dr Craven put him on half rations.

[41.] After being re-arrested, the plaintiff was sent back to the maximum security prison where he was detained in a holding cell in the reception area, before spending the night in a holding cell in C-section. He described the cell as having been filthy and disgusting, so much so that he sat on his clothes during the night.

[42.] The plaintiff thereafter spent some time in communal cells in the prison, but eventually succeeded in being placed in a single cell, which he shared with two other inmates. He testified that one of the inmates in the prison had told him to have himself checked for TB every six or 12 months and he therefore regularly had sputum tests performed. The results of all of these tests were negative until 2003.

[43.] In 2003 the plaintiff experienced heaving coughs which continued for weeks. In addition, he started losing weight and experienced night sweats. He became concerned and asked for a sputum test to be conducted, but the test results were negative. When the cough still persisted, he had another sputum test, which also produced negative results, shortly before he sustained a hernia which caused him to be admitted to Victoria Hospital. He said that one afternoon when he came back from court, he 'felt something go' in the lower part of his abdomen, near the scrotum. The following morning (27 May 2003 according to the note in his hospital file) he was taken to see Dr Craven at the prison hospital, who referred him to Victoria Hospital for surgical repair of an inguinal hernia. Prior to surgery being conducted at the said hospital, X-Rays were taken of his chest and stomach and the X-Ray of the lungs revealed that he suffered from TB.

[44.] The plaintiff was discharged from Victoria Hospital approximately 3 days after surgery and was then admitted to the hospital in the maximum security prison, where he was placed in a communal cell with 8 or 9 other prisoners. The following day, Dr Craven called for another sputum test and such test yielded a positive result for TB. He was placed on medication which he had to take from Monday to Friday of each week. After spending approximately 10 days in the hospital section of the prison, he went back to the single cell which he shared with two other prisoners. Whilst he was in the hospital section, he was not at any stage separated from the other patients there and

he testified that he was not aware of an isolation section, whether in terms of a separate ward in the hospital or any separate cell(s) in the section which was designated for TB patients. Although the plaintiff's hospital records tend to show that he remained in the hospital for a period of approximately 5 months at one time, he could not clearly recall that, but was prepared to accept that he might have stayed in hospital for up to 4 months.

[45.] The plaintiff accepted that sputum tests were performed for prisoners who asked to be tested for TB and that the nurses, if they thought someone was suffering from TB, would cause that person to be tested. He did mention, however, that the gang influence was strong. As he put it, the gangsters 'run the prison, the warders are there just to lock the doors'. If the gang members decided that any particular person would not be permitted to undergo a sputum test, that was the end of the matter. Moreover, prisoners who were diagnosed with TB tended to keep quiet about it, because there was stigma attached to the condition. Consequently, he was not in a position to know who had TB and who did not. Coughing was no reliable indication, because almost everybody in prison coughed as a result of the smoking.

[46.] The plaintiff also agreed that a complaints register was maintained in the prison. The book was kept in the office of the section head and if any inmate had a complaint or request, it would be noted in the register. He made one or two requests himself and these had been attended to.

[47.] The plaintiff testified that during his hospitalisation he would receive his medication daily. Once he was sent back to his cell, however, he experienced some difficulty in obtaining his medication. He denied that a nurse handed out medication in the section on a daily basis. According to his recollection, a nurse would conduct 'pill parade' in the section once a week, but if there was a staff shortage, a week or two would sometimes pass without any pill parade being conducted. Indeed, on one occasion prior to becoming ill with TB, he did not receive any of his chronic medication for a period of 3 weeks. This fact was noted on his medical file after he had complained to Dr Craven.

[48.] Getting to the hospital was also no simple matter. In the normal course, one day per week was reserved for prisoners in each section to see the doctor. Prisoners had to be accompanied by a warder and had to pass through about 7 gates to get to the hospital section. Sometimes the plaintiff managed to go through to the hospital for his medication in the mornings when the diabetic prisoners were taken through for their insulin injections and on other occasions he bribed one of the warders to take him through. The plaintiff had been warned that he could be reinfected and could develop drug resistant TB if he failed to take the medication as prescribed for the full period of six months and he accordingly 'begged, bullied and bribed' to get his medication. The nurse in the hospital trusted him and if she was going to be off duty, he would ask her for a few days' supply of medication, which she would hand over to him. At times he had as much as a week's supply of his TB-

medication in the cell with him.

[49.] The plaintiff admitted that on occasions when he received his TB medication at the hospital, he would have to swallow the tablets in the presence of the nurse. However, on occasions when he went to court, or when he was not taken to the hospital, nobody supervised him so as to ensure that he took his medication. The plaintiff denied that he had ever received a green patient treatment card and said that he had not known that he was supposed to be in possession of such a card.

[50.] The plaintiff attended court in excess of 70 times during the period of his incarceration. The standard routine was that prisoners would be woken up at 04h30 or 05h00 to get ready to go to court. They were then taken to the corridor near the kitchen where they received breakfast, from where they were taken to reception. There they were held in separate holding cells depending on the court they were to attend, before being loaded onto trucks or vans which took them through to court. Prisoners going to the Cape Town court were 'stuffed into vans like sardines'. At the court, they were placed into cells which were 'jam packed' and prisoners who had to appear before the regional court were taken to a separate, smaller cell, which was not overly full. The plaintiff initially appeared in the lower court and once his trial started, in the regional court.

[51.] Upon arriving back at the prison after court, prisoners are counted and searched before being let into the reception area and the communal cells where they had waited to go to court in the morning. New prisoners are registered and existing inmates are taken to the overnight cell. The plaintiff stated that on occasions when he was not feeling well, some of the warders would, however, make a plan to get him back to his cell. He readily acknowledged that the warders assisted him as much as they could.

[52.] The plaintiff was detained in E-section almost throughout the period of his incarceration and was in a single cell (occupied by himself and 2 other prisoners) for most of the time. At one stage, however, the whole section was moved to the Medium B-prison where he was detained in a communal cell with about 25 Moslem prisoners for a while. On being moved back to E-section, he was held in a communal cell again, until he managed to buy himself a space in a single cell once more.

[53.] Prisoners, such as the plaintiff, who are incarcerated while on trial, spent up to 23 hours a day in their cells. Weather permitting, they would be taken out into a concrete yard for exercise for 30 to 60 minutes. The concrete yard was always 'packed' and at times other sections were let into the yard at the same time as E-section. When prisoners lined up to go to the exercise yard, they were confined in close proximity to each other in a passage leading to the yard. The plaintiff complained, because he got robbed outside in the yard and

he was eventually allowed to exercise inside the section.

[54.] Food was brought to the sections. Prisoners would fetch the food and eat in their cells. Lockdown came at around 16h00 or 16h30. That meant that not only the barred gate to the cell would be closed, but also the solid metal door. The door would remain shut until the next morning.

[55.] The Plaintiff readily admitted that after he had become ill with TB, he frequently stated that he would be taking the defendant to court after his release from prison.

The Evidence of Mr Frans Muller

[56.] Mr Muller came to testify pursuant to having received a witness subpoena. In his capacity as the Area Co-ordinator : Health Care, he was responsible for co-ordinating health care between the 5 different prisons at Pollsmoor. His duties included the optimal utilisation of staff at each of the prisons and he had to ensure that each institution was adequately staffed. Health services at the maximum security section also ultimately fell under his supervision.

[57.] Each of the 5 prisons at Pollsmoor also had a Centre Co-ordinator who was responsible for managing the daily operations in that particular prison. Mr Muller, however, was in overall charge of nursing services at Pollsmoor and, in the ordinary course of performing his duties, he visited each of the prisons

on a regular basis. He was accordingly aware of any incidents which had occurred and knew which members of staff were on duty.

[58.] Mr Muller testified that there was a critical shortage of nursing staff at Pollsmoor throughout the time of his employment there and that the number of staff members had been inadequate to deal with the workload. The problem was particularly severe in the maximum security prison which was over-populated and where each of the staff members had to carry the workload of 3 or 4 persons. This frequently caused them to be off work due to illness which, in turn, placed an even greater burden on those staff members who remained. Mr Muller had direct knowledge of conditions at the maximum security prison inasmuch as he had to stand in on occasion when other staff members were not at work.

[59.] As the person in charge of nursing services at Pollsmoor, Mr Muller was responsible for ensuring that an acceptable health standard was maintained. The shortage of staff militated against the maintenance of proper standards. For that reason, he regularly took up the issue relative to staff shortages with his superiors. He not only held discussions with the area commissioner in this regard, he wrote several letters to the responsible authorities, bringing this matter to their attention. So, for example:

[59.1] On 4 February 2000 he wrote a letter to the Area Manager, Pollsmoor,

the Provincial Commissioner and the Commissioner of Correctional Services bearing the heading 'CRITICAL SHORTAGE OF NURSING PERSONNEL ; POLLSMOOR MANAGEMENT AREA'. In this letter, he highlighted, inter alia, that the staff was overworked and that additional posts for registered nurses which had been approved after discussions in 1997 and 1998, had not been filled. The letter referred to the fact that the average daily lockup total was 3200 and that although 15 posts for registered nurses had been approved pursuant to a work study having been conducted, only 7 registered nurses were employed and the 'infrastructure and over population' made it difficult for nursing staff to do their work effectively. He also pointed out that although the admissions centre (maximum security prison) was under staffed, staff members working there had to help out in the other prisons on the property on a regular basis. Overall, the Pollsmoor Management Area operated with 22 approved posts for registered nurses, although the staff establishment, according to a Work Study which had been performed, required 40 registered nurses. This equated to 55% of the number of staff members required. In summary, Mr Muller's letter stated, inter alia, that '(W)e are sitting on a time bomb. Members are overworked and frustrated.'

[59.2] On 25 July 2000 Mr Muller wrote to the Area Manager, Provincial Commissioner and the Commissioner again. The letter reiterated that

there was a drastic staff shortage and pointed out, in particular, that 'personnel are exposed to many Medico-Legal hazards that can lead to severe embarressment (sic) for our department' and that '(D)uring 1998, posts for 18 additional registered nurses were approved, but nothing happened subsequently. The 3 vacant posts in our current establishment are still not filled although candidates were interviewed in February 2000.' In the summary provided at the foot of the letter, Mr Muller stated, inter alia, that 'although the prison population has increased drastically since 1996, the nursing staff has decreased by almost 40%'. Under the heading 'RECOMMENDATION' he stated 'we are sitting on a time bomb. Please let us avoid the explosion.'

[59.3] On 27 September 2001, more than a year after the letter referred to in the immediately preceding paragraph, Mr Muller forwarded a report to a Mr J Sinclair at the Provincial Commissioner's office by facsimile, after a meeting with the Portfolio Committee. In the report, he pointed out, inter alia, that the 'critical shortage of nursing personnel' left the staff to cope with 'an enormous workload under difficult conditions' and that the 'massive overcrowding increases the pressure on our nursing staff and aggrevates (sic) the poor conditions under which our inmates are detained.' At that stage, 6 approved posts for registered nurses remained vacant, which included 3 vacant posts at the maximum security prison. None of the 15 additional

posts which had been approved for the maximum security prison in 1998 pursuant the work study which had been performed, had been filled. Posts had been advertised in August 2001 but no interviews had been held.

[59.4] On 28 November 2001 Mr Muller addressed a letter to Ms M Magoro, the Director: Health and Physical Care, at the head office of the DCS asking that the appointment process be speeded up in view of the critical shortage of nurses.

[59.5] On 16 January 2002 Mr Muller, once again, took up the cudgels in writing when he wrote to Ms Maria Mabena, the National Health Care Co-ordinator at the said head office in regard to the critical shortage of personnel and the failure to fill vacant posts. It appears from the letter that after the vacant posts had been advertised in August 2001, interviews were held from 29 October until 2 November 2001, whereafter the list of candidates was sent to headquarters for approval. At that time, 6 posts were vacant at Pollsmoor. No appointments had, however, been made and a further 4 nurses had resigned in the mean time, bringing the total number of vacant posts to 10.

[60.] Mr Muller testified that the situation had not improved much by 2002 and

2003, although additional nurses had been employed on a temporary basis. Indeed, the vacant posts on the staff establishment were not filled during his entire term of employment at Pollsmoor. The maximum security prison was no exception. It had only approximately 50% of the nurses who were required and, as has been referred to above, not all of the nurses who were employed were at work. Only one nursing sister was on standby duty for the night shift, i.e. after 16h00 in the afternoon and such nursing sister had to cover all 5 of the prisons at Pollsmoor. In the result, screening of prisoners who came into the prison from court could not be conducted by the nurse. Indeed, the screening of incoming prisoners did not form part of the duties that the night nurse was expected to perform. Instead, the warders had to ensure that persons who had medical problems were referred to the doctor the following morning and if someone was obviously ill or injured, the warder had to summon the nurse who was on duty. If the standby nurse lived on the property, he/she would remain at home until summoned. If not, the standby nurse would do duty at the prison where he/she normally worked until he/she was called out to one of the other prisons. Mr Muller was the person who prepared the duty roster for the night shift and accordingly had direct knowledge of the staff position after hours as well as of the duties which the night nurse was expected to perform.

[61.] Mr Muller confirmed that the ideal in so far as treatment for TB was concerned, was that clinics would be conducted in each of the sections of the

prison and that the DOTS system be applied. In practice, however, there weren't enough staff members available and it frequently happened that staff could not reach the sections on a daily basis. In such instances, warders had to take inmates to the hospital in order to obtain their medication.

[62.] Mr Muller could not recall whether the 'suspect register' which contained the details of persons who were suspected of having TB, was maintained during 2002 and 2003. He did confirm, however, that all TB test results, whether positive or negative, ought to have been referred to the attending doctor in order that the patient's case might be managed. He also confirmed that persons who were in the infectious stage of TB ought to have been separated from other inmates, but that in practice it was not logistically possible to do so, because there was insufficient accommodation available. The number of single cells available were also inadequate to cope with the demand.

The Evidence of Doctor Theron

[63.] Dr Theron testified that he learnt from Dr Barker during the time he worked with the latter in 1971 to 1973, that control of TB was a relatively simple and inexpensive matter. The hospital ran by Dr Baker, despite being a low cost, community facility, had great success with the treatment of TB, because people were motivated to deal with the problems which underpinned the disease. Emphasis was placed on the early identification of persons who were

deteriorating and who would become vulnerable to TB, on early diagnosis of the disease and on proper nutrition.

[64.] Dr Theron explained that the diagnosis of TB is, in the first instance, based on symptomatology - if a patient were to report a certain pattern of symptoms, the doctor would be alerted to the fact that he/she may possibly have TB. The second level of diagnosis involves the physical examination of the patient and, in particular, a chest examination, as well as determining the patient's height and weight. The third level of diagnosis involves a sputum test and one needs trained staff to assist in obtaining the sputum samples. If a sputum test yields positive results, treatment would start. At that stage, the patient would be infectious and would present a risk of passing the disease on to others. In an institution such as Pollsmoor, one could control the process of infection by isolating people immediately upon them being suspected of having an active TB infection, or upon being diagnosed as such and by keeping them isolated until such time as they had been on treatment for long enough.

[65.] Dr Theron testified that before 1997 there were no cases of TB at the Medium A-prison where he worked. The situation changed dramatically with the change of the Medium A prison from an adult sentenced prison to a juvenile facility. The maximum security prison did not undergo such a change, but the latter prison had always been subjected to seriously high pressures in terms

of numbers and the management of patients was in the hands of the warders rather than of the nursing staff. There were frequent problems in getting access to people with TB, in isolating them and in providing treatment for them, not because the warders were deliberately obstructive, but because there was insufficient co-operation for a variety of other reasons. The maximum security prison is a massive building which is controlled by various gates and access points. The hospital section lies at the far end of the building on the lower level. In order to get there, one has to walk through the entire prison and pass through 6 or 7 gates. Inmates are scattered throughout the prison and are identified not by their names, but by numbers which appear on a list which is held at different points within the prison. It was accordingly extremely difficult to get hold of a particular prisoner, because the exercise was dependant on the full co-operation of the security staff. Such co-operation was not always forthcoming, due to staff shortages and the nature of the duties that warders had to perform. Warders were not in a position to know whether a prisoner who was coughing consistently was doing so as a result of smoking, or because he was ill with TB and they could not always bring prisoners to the doctor. Dr Theron had several cases in the Medium A-prison, as well as in the maximum security prison, where prisoners with active TB and symptoms of TB had been incarcerated for 3 or 4 months without having been referred to hospital, because of difficulty with access.

[66.] In cross-examination it was put to Dr Theron that Mr Gertse would testify that

warders as well as nursing staff co-operated well and that there was no resistance to getting inmates suspected of having TB to the doctor, because they (the warders and nurses) would be putting themselves at risk. Dr Theron disagreed. He stated that he had seen many cases where people had been coughing for months without getting to the hospital, that it was very difficult to move around without security staff and that the lack of full co-operation by security staff was a persistent problem.

[67.] According to Dr Theron, there was a direct correlation between the breakdown of the health system in the prison and the increasing spread of TB. In order to obtain good control over TB, one needs a good nursing team, made up of a sufficient number of doctors and nurses, to follow an agreed protocol in order to reduce the pool of infection by keeping a cordon around those who are being treated and by preventing new cases from coming in without control, through adequate screening procedures. Such protocol is dependant on nursing staff. At Pollsmoor, there were simply not enough members of staff to conduct adequate screening procedures or to administer the necessary medication according to the DOTS system, nor was it possible to get to persons who were ill with TB, or to isolate them, consistently. Dr Theron explained that the aforesaid problems existed not only in the Medium A prison where he normally worked, but also in the maximum security prison. He was au fait with the conditions in the maximum security prison, because he stood in for Dr Craven from time to time when the latter could not be on

duty and because, in his role as chairman of the Clinical Forensic Practitioners Association, he was in and out of the maximum security prison on a regular basis in the performance of his duties and had regular contact with the nursing staff and the administration at Pollsmoor prison.

[68.] Dr Theron referred to Chapter 3 of the Standing Correctional Orders ('the Standing Orders') which have been compiled so as to give effect to the provisions of the Correctional Services Act. The Standing Orders deal, inter alia, with health services and the physical care of prisoners. Clause 4 of the said chapter deals with the screening of prisoners and provides, inter alia, that:

> '4.1 Admissions
> (a) All admissions to the prison, including parolees, transfers from other prisons, persons under 48 hour incarceration and babies/children should be seen on admission by a registered nurse in privacy, with the police/custodial staff in waiting, for the following:
> - any medical problems, either acute or chronic; ...
> - present treatment; ...
> - documentation (screening form to be filled and be attached to the medical file during the medical examination process).'

[At this stage it must be mentioned that both parties treated the extract from the Standing Orders, which was before Court as part of Exhibit A, as the Standing Orders which had been in force at the time of the plaintiff's incarceration and illness. During the course of preparing this judgment, it became apparent that the said extract from the Standing Orders contained numerous cross references to the Correctional Services Act No 111 of 1998, but that no mention was made of the Correctional Services Act No 8 of 1959

('the 1959-Act'). The provisions of the new Act which deal with the treatment of prisoners had, however, not been put into operation until 31 July 2004, i.e. subsequent to the plaintiff becoming ill with TB. The problem was brought to the attention of the parties' legal representatives and plaintiff's attorney of record made further enquiries to the DCS. On 28 January 2011 Mr Carel Paxton, the Director : Code Enforcement of the DCS advised that the Standing Orders in terms of the 1998 Act are identical to those that applied in terms of the 1959- Act, only the cross references had been changed to reflect the corresponding provisions in the later Act. Such information was placed before me by agreement between the parties' legal representatives.]

[69.] Dr Theron described the screening order as the most important of all of the provisions of the Standing Orders with regard to health. Screening (which is also referred to as 'the admission procedure'), means that a nurse who is suitably qualified by training and experience, interviews incoming prisoners, identifies those with health problems, removes those who are suffering from severe injuries or active health problems which might endanger others and refers them to the hospital. A prescribed procedure had to be followed and an official form had to be completed during the screening process. Such form had to be attached to the medical notes. If the screening process had been in place and had been maintained in the proper manner, it would have ensured that those with medical problems were not only identified, but also received appropriate medical care. Effective screening would have prevented

persons who were ill with TB from entering the general prison population and would therefore have played an important part in preventing the spread of the disease. In Dr Theron's experience, such procedures were, however, not implemented in Medium A where he worked, other than right at the beginning of his tenure of office and right at the end. From the information he had been able to obtain, he believed that the process was also not performed in the recommended manner at the maximum security prison.

[70.] Dr Theron brought the unacceptably high incidence of TB in Pollsmoor to the attention of the authorities of the DCS, as well as of the Provincial DOH. After repeated requests for action over a period of approximately a year, an assessment of the prison was eventually conducted by the DOH in 2000. Certain recommendations were made, a special task team was set up and various people were educated in the implementation of the DOTS system. In practice, however, the persons who were appointed to supervise the taking of TB medication, at least in the Medium A prison where he worked, were inmates. Such a system was bound to fail, because sooner or later the gangs would take over and would use the medication for their own purposes, so that very few prisoners were getting their medication as prescribed. Prisoners smoked almost everything, including drugs. Dr Theron agreed that DOTS may work very well outside of prison and that it would work in prison if one had enough nurses to carry it out, but in 2000, 2003 and 2004 there were not enough nurses to go round at Pollsmoor in order to perform ordinary nursing

tasks, so that DOTS was not practised on a wide scale.

[71.] Dr Theron testified that despite the formation of the task team referred to in the immediately preceding paragraph and the submission of reports, no changes in the system were effected. When he enquired about the lack of response, the head of the prison told him that he (Theron) was not permitted to approach the Minister (i.e. the defendant) and he then resigned from the task team. Dr Craven had a similar problem at the maximum security prison - there were discussions, but no effective changes were made. The problem came, not from the authorities at Pollsmoor, but from higher up, because head office permission was required to make changes and such permission was not forthcoming. Dr Theron was aware of the fact that money was spent to repair ablution blocks, dormitories and the like, but no adequate health plan was developed or implemented.

[72.] The number of nurses employed at the hospital during the 10-year period that Dr Theron worked there, steadily declined. Indeed, from approximately 35 or 36 nurses, the numbers eventually declined to 2. There was actually only 1 nurse on duty on the day when the Inspecting Judge conducted an inspection at the maximum security prison and that person was not a qualified nurse, but only a nurse assistant. Dr Theron stated that there were enough doctors at Pollsmoor, but that TB treatment, in particular, required consistent application of the treatment protocol or policy. It was impossible to

implement or to maintain such protocol without sufficient numbers of nurses and security staff (the security staff were needed to bring the patients to the hospital in order to get medical attention or treatment). Unless sufficient numbers of nurses were available, the chain of support was broken, persons no longer received their treatment and as a result, they were re-infected or became resistant to the usual drug regimen. The fact that nurses were also obtained from an outside agency to fill positions temporarily did not provide for continuity of treatment, which was essential in the management of TB.

[73.] In Dr Theron's view, Pollsmoor 'exhibited a disastrously poor control of TB'. MDR-TB had become prevalent within Pollsmoor, which was indicative of the breakdown of the health care system (one of the staff members died of complications to her lungs which were caused by MDR-TB). Indeed, both MDR-TB and XTR-TB were present in Pollsmoor. The presence of XTR-TB was indicative of the fact that there was a large number of patients who had been inappropriately treated. Some people with MDR-TB or XTR-TB could clearly have come from outside of the prison, but that is why screening ought to have been conducted effectively so that those persons could have been treated appropriately.

[74.] Around 2002 or 2003 the doctors and nurses working at Pollsmoor requested the City of Cape Town to give assistance with the control of TB. Certain changes were introduced, inasmuch as the nurses subsequently had clear

guidelines to follow and registers which had been falling into disuse were re-introduced. These changes, however, produced only marginal improvements and were not maintained, because the number of nursing staff continued to decline. The authorities had also not co-operated to provide any support system.

[75.] Dr Theron had raised issues around health care in the Medium A prison with the authorities since 1999. Eventually, he made contact with the Inspecting Judge of Prisons and a member of the Parliamentary Portfolio Committee in order to report in person on the poor management and control of health at Pollsmoor. The problems which he had highlighted in respect of the Medium A prison were not unique and Dr Craven was, at the same time, raising issues about health management in regard to the maximum security prison. All of the prisons forming part of Pollsmoor were having problems in managing TB.

[76.] In January 2002 Dr Theron, in his capacity as the chairperson of the Cape Clinical Forensic Practitioners Society, prepared a report for Dr L S Bitalo, the official responsible for the district surgeons' service at Provincial level. The report was written with the collaboration and co-operation of all of the doctors who worked at Pollsmoor and applied to the whole of the Pollsmoor prison complex. In the report, Dr Theron highlighted the issues that were problematical in providing health care such as, for example, gross overcrowding, under staffing, gang related behaviour and the correctional

services hierarchy. So, for example, the report referred to the fact that the numbers of both nursing staff and security staff had declined. More importantly though, the report suggested solutions based on the creation of a new partnership between the DCS and the DOH in terms whereof the DOH would provide staff and health facilities within the prison system.

[77.] The aforesaid report appeared to have some positive results. The DOH came to Pollsmoor to educate the nurses in regard to the management of TB and to draw up a programme aimed at improving TB medication and TB control throughout the various prisons at Pollsmoor. Unfortunately, these initiatives broke down again, because of the shortage of nursing staff.

[78.] In describing the type of overcrowding that occurred at the maximum security prison, Dr Theron relied on the average figures provided by the DCS. These indicated that the average overcrowding in 2003 was around 234% to 236%. Overcrowding meant that disease could be spread more easily and, as far as TB was concerned, the more people were packed into a cell, the greater the prospects that bacteria which were coughed up would infect other inmates. Dr Theron regularly saw overcrowded cells in the maximum security prison, also during the course of 2003, and testified that his first impression was one of dinginess and squalor, because blankets are often used to protect or cover up places within a cell. He described the situation as dehumanising.

[79.] Dr Theron testified that the size of cells in the maximum security prison varied, but a fairly standard cell with 40 to 60 people in it, would have inmates crowded one on top of the other, sitting on their double or triple bunks, with very little place for them to move. In addition to the cells being dingy and dirty, they were usually filled with cigarette smoke. Prisoners also used toilet paper to make a 'hondjie' - toilet paper would be taken off the roll and would then be tightly rolled up, twisted and compressed, whereafter it would be lit and left to smoulder so that it could be used as a perpetual cigarette lighter. The hondjie would burn for several hours and when it burnt low, it would be replaced by another. It produced a pungent, toxic, gas which was irritating to the respiratory tissues and accordingly added to the risk of getting TB.

[80.] The overcrowding contravened the provisions of the Standing Orders with regard to the accommodation of prisoners. So, for example, clause 2 of Chapter 2 of the Standing Orders provides that the minimum permissible cell area per prisoner, excluding areas taken up by ablution facilities, walls, pillars and personal lockers which have not been built in, must be 3,344m^2 in respect of ordinary communal cells and 5,5m^2 in respect of ordinary single cells. Although Dr Theron had not taken any measurements in this regard, he was sure that these requirements could not have been complied with in circumstances where the overcrowding ran to 234%. The mere fact that there were 3 persons in a single cell was indicative of the overcrowding and

the holding cells where prisoners were detained when they returned from court, housed from 60 to 120 persons.

[81.] Dr Theron stated that overcrowding was 'discussed ceaselessly, from the time that I was there, right through until the time I left'. Many options were suggested to improve the situation, such as, for example, setting prisoners free who were unable to pay the bail amounts set by the courts and liaison with the courts so as to ensure that fewer prisoners came to Pollsmoor on trivial charges. There was some reduction in the overall prison population, but the actual overcrowding was not reduced in any significant way. Prisoners would frequently be sent to smaller prisons in the Western Cape, but the number of persons so diverted was small, because the smaller prisons only accepted a limited number of prisoners.

[82.] Dr Theron stated that both he and Dr Craven had regular discussions with a Mr Engelbrecht, the Area Manager of Pollsmoor, who was in overall charge of the Pollsmoor prison complex. During these discussions, Mr Engelbrecht was apprised of the prevailing conditions at the maximum security prison and he made numerous attempts to get the Head Office and the Regional Office of the DCS involved. So, for example, on 22 January 2002 Mr Engelbrecht forwarded a facsimile to the Commissioner dealing with the critical shortage of nurses and the appalling working conditions at Pollsmoor (Exhibit A, p 29 - 80). At that stage, Mr Engelbrecht recommended, inter alia, that 10

Professional Nurses be appointed immediately. Dr Theron stated that from the level of Area Management down, nobody disagreed with his criticism of the health system or with the comments of Mr Muller, who was in charge of nursing services.

[83.] Dr Theron stated that the nurses were, generally speaking, dedicated and effective. Inadequate training and education of nurses in regard to TB and its management, however, caused effective treatment to break down. Nurses worked for the DCS on a full time basis and doctors were coming in part time. This meant that doctors were not integrated into the system and that there was inadequate opportunity for discussing problems. As a consequence, instructions given by the doctors were easily disregarded if the nurses thought these to be inappropriate. Dr Theron's view was that the guidelines were not clear enough, because the prison environment presented a more difficult situation in regard to the management of TB than the outside world. Education would have helped to bridge the divide between doctors and nurses and that, in turn, would have facilitated better management of TB.

[84.] Dr Theron referred to the work study which recommended a staff complement of 53 nurses for Pollsmoor. This was in fact never achieved during the period of his employment there. The steady decline in the number of nurses employed at the prisons was brought to the attention of the authorities, but the situation failed to improve. Pursuant to an inspection by the defendant

in 2000, it was recommended that a full time doctor be appointed for Pollsmoor, but this recommendation was also not carried through. In 2001 one Dr Trope was appointed on a full time basis to visit Pollsmoor regularly, to monitor the situation and to liaise with Dr Jano, the Chief Medical Officer at the Provincial Administration : Western Cape. After spending one morning at the maximum security prison in the place of Dr Craven, Dr Trope left, never to return.

[85.] In cross-examination, Dr Theron was confronted with a table, prepared by the Defendant's officials, reflecting the employment statistics at Pollsmoor during the period March 2002 to December 2004. These statistics showed that the number of nursing and support personnel varied from 18 to 29 during the said time. Dr Theron stated that he had 'every reason to doubt' the statistics, inasmuch as these could not be verified by reference to any supporting documentation. He was not prepared to accept any figures that did not correlate with the figures that Mr Muller had supplied. He stated that he had 22 years' experience of working in the system and that the treatment he had been subjected to showed him that 'any means' would be employed to discredit persons who brought uncomfortable things to light. He was a victim of such a process, as was Dr Craven, Mr Muller and Mr Slinger (the head nurse in charge of the maximum security prison hospital who had spoken out about the circumstances at Pollsmoor before the Parliamentary Portfolio Committee). In the absence of the original documents from which the

statistics had been compiled, he was unable to evaluate, or to trust, the figures that were provided. The original documents were, however, not produced at the trial.

[86.] Dr Theron was at pains to explain that he had no wish to criticise the DCS, he just wanted to be realistic. He did not have any personal difficulty with the DCS and was mindful of the fact that he needed to be careful, circumspect and guarded in his evidence, while being objective, because he was an expert witness. He admonished himself to give the best account that he could. His concern was for the truth and he had to be as balanced in his evidence as he could manage.

[87.] In summary, Dr Theron stated that:

[87.1] Conditions at the maximum security prison were conducive to the spread of TB inasmuch as:

(a) Overcrowding increased the risk that the disease would spread, because it concentrated and/or increased the pool of bacteria emanating from persons suffering from active TB. Persons subjected to the overcrowding get less rest and are more pressurised, so that their immune systems may be negatively affected, making them more susceptible to becoming ill with TB.

Overcrowding made it difficult for security staff and for nurses to get into the back of cells to check on inmates and to administer medication. Moreover, it made it difficult for inmates to reach the doctor or medical clinic, so that patients' symptoms were not reported on a daily basis as one would expect;

(b) Adequate nutrition is vital to maintain the body's immune system and gangs stole food or took it away;

(c) The indoor environment is more friendly to TB bacteria, because these bacteria are vulnerable to sunlight and fresh air. The most common feature of a cell, apart from the overcrowding, was that the air was virtually unbreathable as a result of the smoking habits of prisoners. In addition to the smouldering 'hondjies' which polluted the air, prisoners smoked the short ends of cigarettes or 'endjies' which tended to emit pungent and toxic waste into the air. The prevention of smoking and the provision of proper ventilation was crucial. On a visit to the maximum security prison during the course of the trial, Dr Theron noticed that special ultra violet lights, which are used to kill bacteria, had been installed in the TB ward at the maximum security prison. The installation of these lamps had been under discussion whilst he worked at the prison, but had not been

introduced at that time. During the aforesaid visit, he also noticed that the ward was better organised, blankets were of good quality and that there was a well ordered atmosphere in the ward. He described these as significant changes;

(d) Bacteria which are expelled by spitting or coughing land on the floor. Unless the floor is cleaned immediately with a germicidal antiseptic, the bacteria become airborne as the sputum dries out, a process which can, in Dr Theron's opinion, continue for up to 2 or 3 months. Spitting was common, it had not been the habit to clean the cells with a germicidal antiseptic and Dr Theron's visits to cells both in the Medium A and maximum security prisons, revealed that there was no consistency about hygiene.

[87.2] The control of TB in the prison was dependant upon the effective screening of inmates upon their admission so that those who were ill with TB, or were in danger of developing TB, could be isolated. Effective screening was not possible without adequate numbers of properly trained nursing staff. Nurses had to be able to perform the screening process when persons were admitted to the prison, to advise inmates of the symptoms of TB, to identify those inmates in the sections who might have active TB and to collect sputum for