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

testing. The latter process required a lot of training and experience. None of these measures were implemented in any effective manner during the time that Dr Theron served at Pollsmoor.

[88.] Dr Theron testified that screening could not be performed properly by an inmate. It would even be difficult for a trained nurse to perform the screening process adequately, because on average 60 persons would return from the courts between 5 and 6 pm, which meant that the work had to be performed in an hour or two. Dr Theron recommended the mass screening of prisoners from time to time, because it had been used in the past as a means of identifying people with active TB. One of the ways in which a mass screening could be performed, was by using a portable X-Ray machine. Such screening never occurred, because there were problems in obtaining the particular X-Ray machines and because the objection was that one would only pick up some of the TB cases and not all.

[89.] When Dr Theron originally started working at the prison, a doctor screened prisoners en masse upon their admission. The doctor would go from one prisoner to the next, listening to chest sounds with a stethoscope and would screen a large number of prisoners in this manner in a very short time. It was, however, only possible to do such a screening whilst the military form of discipline was applied in the prison. Once the democratic process was adopted, such screening could no longer be conducted. Whereas it was

notionally possible for a doctor to line up every inmate in E-section to check him for TB, such procedure was not very efficient, would be exhausting for the doctor and would require good nursing and clerical teams as back-up. If an organised system had been in place and sufficient numbers of nurses and security staff had been available it would, however, have been possible to screen all of the inmates in the prison. One could have called prisoners out in small groups, could have identified each one and could then have checked for TB, much as one would do in triage. With adequate education, it would have been possible to produce a team of qualified people who were able to identify the majority of TB cases in the prison, which would have facilitated the gaining of control over the spread of the disease.

[90.] Dr Theron stated that if the factors which he had highlighted had been addressed in a consistent and effective manner, the incidence of TB as well as the risk of contracting TB in the prison would have been greatly reduced. The health system at Pollsmoor was, however, not efficient. The doctors as well as the nurses struggled to manage the situation which Dr Theron described as 'a nightmare that none of us could wake up' from.

[91.] Dr Theron conducted a clinical examination of the plaintiff on 17 November 2009 to establish whether or not the plaintiff had suffered trauma as a result of his arrest and incarceration which contributed to his vulnerability and subsequent TB infection, to investigate his present health and to evaluate his

future health prospects relative to his incarceration experience. He found that the plaintiff still suffers from cough with phlegm and wheeze, which signs suggested an ongoing disability related to the original TB.

[92.] According to Dr Theron, the plaintiff did not fit the TB patient profile that he had developed over the years of his practice. He explained that every medical condition that a doctor encounters in practice, including TB, has a set of guidelines as to the probability of that condition. So, for example, males in their mid 40's who complained of swelling in the inguinal area (the area next to the scrotum), were likely to have an inguinal hernia. He could identify persons with a susceptibility for TB at a distance, inasmuch as certain clinical features would suggest that a person either had TB or was in danger of developing the disease. Specific features that he would watch out for were persons who, by their bodily habitus, appeared to be broken down in terms of their ability to cope and persons who appeared to be thin, underweight and undernourished. He had recently seen a patient who had been referred by the High Court and at a distance of 5 metres identified him as probably having TB. A subsequent X-Ray confirmed that the patient suffered from the disease. His profiling of potential TB patients was nothing other than a clinical assessment and evaluation of a patient in terms of his risk for developing TB, just as he would, for example, perform a clinical assessment of patients in terms of their risk of developing heart conditions or diabetes, in the course of making a differentiated diagnosis.

[93.] Dr Theron never saw the plaintiff before he became ill with TB, but his retrospective examination showed that the plaintiff did not fit the TB patient profile. The plaintiff appeared to have been relatively robust and well nourished. Dr Theron was of the opinion that the plaintiff would not easily have become ill with TB in the outside world, but that the situation in prison made him vulnerable to TB. This assessment was based on his experience as well as his clinical know-how and expertise.

[94.] Dr Theron agreed with Prof Van Helden in so far as the latter's report related to scientific descriptions and standard medical opinion relating to the manner in which TB is contracted and spread. Dr Theron also agreed that infection with the TB bacterium in the Western Cape commonly occurs during the first two years of life. Such infection is referred to as the primary infection/focus or the Ghon focus (named after a pathologist, Anton Ghon). He parted company with Prof Van Helden in so far as the professor was of the opinion that conditions in the prison had been ideal. In this regard, he pointed out that Prof Van Helden himself made it clear that poverty and similar socio-economic stress could cause people's immune systems to break down so that disease can take hold. Dr Theron also differed from Prof Van Helden inasmuch as Dr Theron was of the view that re-activation of sub-clinical TB which had remained dormant in the body, is less likely than re-infection, i.e. a fresh TB infection. Most human beings, however, have an innate or basic immunity against TB, as is alluded to in Prof Van Helden's work. Both re-

activation and re-infection would require a break-down of the patient's immune system before active disease would result and in Dr Theron's opinion, the environment within which the plaintiff found himself in the maximum security prison, was a factor in him becoming ill with TB, inasmuch as the concentration of TB in the environment and the virulence of the bacteria were important factors in the development of the disease.

[95.] Prof Van Helden was of the view that the plaintiff's exposure to TB cases in prison was probably very low or non-existent. As is evident from his report, he came to such conclusion on the basis of information provided to him by officials of the DCS to the effect that the plaintiff had been detained in a single cell for most of the time, that the persons with whom he shared such cell did not appear to have active TB at any stage and that the plaintiff had little contact with other inmates. Dr Theron held an opposing view. He testified that from his experience in walking the corridors of the prison, there were large numbers of prisoners moving about. One needs only one person with active TB to spread the bacteria and it was likely that one would be exposed to active TB in the course of moving about in the prison.

[96.] Dr Theron emphasised that the risk of persons being infected with TB bacteria increased in a closed environment, such as a prison cell, where there was an absence of fresh air and sunlight. Bacteria coughed out in a cell where the air was stagnant and polluted could drift around for hours, infecting and

reinfecting every person exposed thereto. Moreover, in prison people live right next to each other and disease is accordingly easily spread. For these reasons, he differed from Prof Van Helden's view that individuals exposed to active TB bacteria in open society experienced the same risk as those who were incarcerated. Dr Theron held the view that although the TB guidelines did not require isolation, sound clinical principles dictated that prisoners who were ill with TB be isolated at the onset of the disease and during the infectious stage, because the closed environment within which prisoners found themselves, coupled with the fact that they lived in close proximity to each other, facilitated the spread of the disease.

[97.] Dr Theron also took issue with Prof Van Helden's opinion that active TB cases were moved to a separate facility which removed the risk of infection for other inmates. Dr Theron's evidence in this regard was that prisoners suffering from active TB were not effectively isolated from others. In the hospital section, for example, there were cells which had been earmarked for isolation purposes, but if the solid metal door was shut, the inmate in such cell was unable to have normal contact with others and did not have adequate ventilation. In practice therefore, the solid metal doors were not normally shut and prisoners in those cells were separated from others only by a barred gate. No formal barrier was in place to prevent the spread of TB bacteria. Dr Theron also stated that he never saw any single cells being used for the purpose of isolating inmates, but he could not categorically state that this was not done.

[98.] Prof van Helden, in his expert summary, stated that it was not possible to determine scientifically whether the plaintiff's TB episode resulted from reactivation or reinfection. To the extent that Prof Van Helden implied that the plaintiff's detention in prison had nothing to do with him becoming ill with TB and that the plaintiff's TB just happened to occur while he was incarcerated, Dr Theron held a different view. He referred to a letter published on the internet by the American Röntgen Ray Society in which it was pointed out that recent molecular epidemiologic studies provided definitive evidence that reinfection contributes substantially to the TB disease burden. Studies using a special fingerprinting technique established that most infections causing active TB in adults from TB-endemic areas, represent currently circulating strains that were recently transmitted. Studies have also shown that more than 50% of recurrent disease occurring in endemic settings results from reinfection. Dr Theron was of the opinion that the plaintiff's illness with TB resulted from reinfection, rather than reactivation of an earlier infection. In his view, it does not matter much, however, whether the plaintiff's illness with TB resulted from reactivation or reinfection, inasmuch as reactivation normally only occurred in circumstances where a person's immune system was severely compromised. Environmental stressors or pressures could cause the immune system to break down and, in his view, the peculiar circumstances of the maximum security prison caused the plaintiff's immune system to become compromised, so that he succumbed to the disease.

[99.] Dr Theron also differed from Prof Van Helden's view that one could not prevent TB. Dr Theron stated that one could prevent TB by applying appropriate measures such as, for example, screening and the provision of proper ventilation. As has been alluded to above, the screening of individuals would have identified those who were vulnerable to TB and they could then have been assisted in becoming less susceptible to the development of the disease. In this regard, Dr Theron pointed out that Prof Van Helden is not a medical doctor and that his approach is accordingly less practical. Medical doctors have, for centuries, identified people who were at risk and have adopted appropriate measures to minimise such risk.

The Evidence of Dr Craven

[100.] Dr Craven worked at the maximum security prison from 1988 to September 2003. He was the doctor responsible for the primary medical care of all of the inmates at such institution.

[101.] According to Dr Craven, disease management was well run when he was first appointed to the prison. There was an adequate number of well trained nurses and he was confident that his requests would be carried out. In the late 1990's, however, the system slowly started to deteriorate. The deterioration of the system was an important event, because disease management is dependant upon team work and in a prison setting the team

includes nurses as well as warders.

[102.] Eventually, the deterioration in the management system reached such a stage that Dr Craven started to keep a daily contemporaneous record of management failures or 'derelictions of duty', as he called it. These derelictions of duty included, for example, prisoners not being re-paraded (i.e. brought for follow-up consultation) on due date, specimens not being collected promptly, laboratory reports not being presented to him promptly with the patient's folder so that he could take action, TB treatment not being supervised and recorded, etcetera. Dr Craven made notes of these failures at the time when it came to his attention in the ordinary course of his duties. The notes were made in duplicate and he would leave the top copy at the prison each day in the hope that management would take appropriate action and in order to provide the prison governor (the head of the maximum security prison, Mr Jansen) with evidence to motivate for more staff and fewer prisoners. When he went home, he transferred the notes he had made to his computer and for purposes of the trial he extracted all of the information relevant to the management of TB. This extract was attached to the summary of his evidence, included entries regarding 947 prisoners, ran to 44 pages and constituted a record of deficiencies in the management of certain TB patients and the management of TB in the prison.

[103.] Under cross-examination, Dr Craven acknowledged that he had not seen the relevant files since leaving his position at the prison, that he had no independent recollection of individual cases and that the context within which the notes were made, were of relevance. His notes were somewhat difficult to interpret when he was in the witness box.

[104.] Dr Craven attributed the large number of 'derelictions of duty' which he recorded to the fact that there was a shortage of staff among warders as well as nurses. There were simply not sufficient warders to bring persons to the hospital section and there were too few nurses to perform the tasks that were required of them.

[105.] Dr Craven was employed to work at the maximum security prison for 5 hours per day from Mondays to Fridays. He admitted that he sometimes left early for private commitments and testified that he had in each such case given advance notice of the fact. He also sometimes left early when the noise at the hospital was such that he could not perform his job and became so irritable that he would become abusive. He explained that prisoners were frequently so noisy in the vicinity of the hospital that he could not hear a patient's chest or blood sounds, which impinged upon his ability to treat his patients. He admitted that he demanded absolute silence while he was seeing patients and stated that he was by no means unreasonable to expect silence, it had been the norm in the old, military

style, of management at the prison.

[106.] Typically, Dr Craven would start his day by attending to incoming correspondence such as, for example, laboratory reports and letters from prisoners, their solicitors or the courts. He would then attend to any prisoner who was paraded, i.e. brought from the section, processed by the nurses and brought to see him. The nurses would assess any prisoner who said that he wished to see the doctor or any prisoner whom they observed to be obviously injured or ill. As he understood the system, in theory a nurse was supposed to go to the appropriate section each morning to ask if anybody had medical problems and a nurse ought to have been available in the afternoons to assess incoming prisoners who came from the courts.

[107.] In the ordinary course of performing his duties, Dr Craven would make a note on the patient's file if he had to come back for a follow-up consultation. The nurse would have to work with the relevant warder to ensure that the patient was re-paraded on the appointed day. If Dr Craven wanted samples such as, for example, sputum or blood, to be sent to the laboratory, he would similarly make a note in the patient's file and the nurse would have to collect the specimen and send it off to the laboratory. The laboratory sent a runner to the prison on a daily basis to collect specimens and to deliver reports. It was accordingly reasonable to expect a report to be tabled within 2 days after the date upon which the report had been

prepared. It was important that reports be presented to him promptly so that he could take appropriate action at an appropriate time.

[108.] Once the sick parade had been completed, the prescriptions for medication which Dr Craven had prepared, would be sent to the pharmacy so that the medication could be issued. There was only one pharmacist who was responsible for all of the prisons at Pollsmoor, as well as some of the country prisons and this frequently resulted in the issuing of medication being delayed. Even if medication was issued on the same day, prisoners were locked up at 4 o' clock and sometimes the nurse had gone home by then so that prisoners only received the medicine the following day. Prisoners often complained that they never received the medication that had been prescribed.

[109.] Dr Craven testified that the management of TB is different to the management of other diseases such as, for example, pneumonia, because TB is a formidable infectious disease. The law requires that the Medical Officer of Health be notified and the National DOH has prescribed guidelines for the treatment of TB which require that the taking of every tablet be supervised. The patient must be watched while taking the medication, the person supervising must check the patient's mouth to make sure that the tablets have been swallowed and must then tick off the relevant box on the patient's treatment card. In the outside world, the supervision is not

normally required to be performed by a nurse. A family member, friend, neighbour or colleague acts as supervisor.

[110.] Dr Craven testified that the practice in the outside world is for somebody to visit the home of a newly diagnosed TB patient in order to test the other members of the household for TB. He did not know whether this was done in the maximum security prison, but he was aware of the fact that some prisoners were paraded after having been identified as possible TB patients by one of the nurses. On his visit to the maximum security prison during the course of the trial, he was shown so-called 'suspect registers' which contained details of persons who had been suspected of having TB and in respect of whom sputum tests were obtained. The registers that he saw, however, related to the time period subsequent to his employment at the prison.

[111.] Dr Craven corroborated the evidence of Dr Theron in regard to the manner in which TB is diagnosed. The first step in making a diagnosis, involves the taking of a history to determine what symptoms the patient has noticed. A clinical examination is then performed. Such examination consists of observing the patient to determine whether he is well nourished or emaciated and whether he is coughing. The patient's temperature would be taken and a physical examination would be conduced by, inter alia, percussion of the chest and by listening to the chest with a stethoscope to

ascertain whether air was moving in and out of the lungs on both sides equally. On percussion a normal chest sounds hollow and if there is solid material it sounds dull. If air flow is not equal on both sides, it is indicative of underlying pathology in the lung. After the physical examination an X-Ray may be taken and, if TB is suspected, two sputum samples are obtained which are sent for laboratory analysis and, if appropriate, culture. If a prisoner at the maximum security prison required an X-Ray, he would be sent to Victoria Hospital as soon as transport and guarding could be arranged.

[112.] Dr Craven testified that his decision whether or not to send an inmate for a chest X-Ray would depend on the clinical state of the patient. If he was not sure that the patient had TB after performing a clinical examination, he would wait until the sputum test result was obtained. If the clinical examination revealed signs of TB, he would send the patient for an X-Ray straight away. Likewise, the stage at which Dr Craven would prescribe medication would depend on the results of the clinical examination. If the clinical examination revealed strong evidence of TB, he would start treatment before the laboratory results came to hand. The decision would be made in each case in light of the patient's condition. Once a prisoner was diagnosed with TB and received his medication, he would be sent back to the section, because the isolation section in the prison hospital was usually chock-a-block. Under cross-examination Dr Craven did, however,

concede that TB patients, upon being diagnosed, were separated as far as was possible.

[113.] Dr Craven used to visit the sections in the maximum security prison as part of his public health inspections. He stated that there was severe overcrowding, to the extent that he would regularly see up to 4 prisoners in a cell designed for occupation by 1 person and up to 60 persons in a cell designed for occupation by 20. The cells had narrow slatted windows along one outside wall. The door to the cell was situate on the opposite side of the cell and had a solid steel door as well as a barred gate or grille. Once lock down occurred at approximately 16h00, the steel door was closed, so that there was no cross-ventilation until such time as the door was opened the following morning.

[114.] Chapter 2 of the standing orders provide for the minimum permissible cell area per prisoner in terms of floor space and air space. During the visit to the prison which was conducted by the plaintiff's legal advisors and experts, Dr Craven measured some of the cells where the plaintiff had been detained, more particularly a single cell, an overnight communal cell where prisoners were detained when returning from court and an ordinary communal cell. He then used those measurements to determine the number of prisoners which ought to be housed in those cells according to the standing orders. Dr Craven found that if one applied the formulae

provided in the standing orders, different results were obtained depending on whether one had regard to surface area or volume. The overnight cells yielded a maximum capacity of 17 when calculated with reference to surface area and 23 when calculated in terms of volume. A single cell which had been occupied by the plaintiff (as well as 2 other inmates) yielded a maximum of 1 inmate when calculated with reference to surface area and 2 inmates when calculated in terms of volume and a communal cell in the section yielded results of 12 and 16 respectively.

[115.] Dr Craven was referred to a letter under the hand of, inter alia, Mr Engelbrecht (the Area Manager at Pollsmoor), Mr Jansen (the head of the maximum security prison) and Mr Muller, which had been forwarded to the defendant and the Commissioner of Correctional Services by facsimile on 3 October 2003. The subject heading of the letter read: 'POLLSMOOR A HEALTH HAZARD FOR WESTERN CAPE'. The letter stated, inter alia, that the approved accommodation of the maximum security prison at 100% occupancy was 1619 prisoners, but that the lock-up total for the previous day was 3052 which constituted 189% occupation. Dr Craven confirmed that he had not personally verified these figures, but that they were consistent with his observations. Dr Craven testified that he had visited other prisons, such as Goodwood and a privatised prison at Bloemfontein. What had struck him about both of those, was the lack of overcrowding.

[116.] Dr Craven testified that application of the DOTS system was extremely important, because prisoners often did not want to take the TB medication. There were two main reasons for their reluctance to take the prescribed drugs. Firstly, nausea was a common side effect of the medication and secondly, prisoners frequently did not understand the need to take the medication. As far as they were concerned, they were not ill, they simply had a cough. Failure to take the medication for the prescribed period caused patients to suffer a relapse which, in turn, caused them to become infective again and, in addition, could lead to them developing MDR-TB which was extremely difficult to treat.

[117.] Dr Craven expected the administration of the TB medication in prison to be performed by a nurse. Indeed, he expected the nurse to issue the tablet, to give the patient a glass of water, to watch the patient swallow the tablets, to inspect the patient's mouth and then to tick off the box on the treatment card and on the hospital folder. Treatment also had to be recorded in a treatment register which was held in quadruplicate. The bottom copy was retained in the clinic and one copy was to be sent off to the Medical Officer of Health. In many cases, however, Dr Craven found that the documents which were supposed to have been forwarded to the Medical Officer of Health were still in the register. The DOTS system was also not applied consistently. So, for example, treatment cards were sometimes completed in advance of the medication having been supplied,

or subsequent thereto and sometimes patients did not receive their medication at all. Rifampicin, one of the drugs contained in the standard treatment, colours the urine bright orange and Dr Craven accordingly checked patients' urine to ascertain whether or not they had taken their medication.

[118.] Under cross-examination Dr Craven had to concede that although Rifampicin can be detected in the body by chemical means for up to 24 hours, he could not find any information indicating for what period of time after taking the medication a person's urine would be orange. The colour of the urine would depend upon the particular patient's metabolism, the time when the medication had been taken and the food which had been consumed. The colour of a person's urine was accordingly not necessarily a reliable indicator as to whether or not the medication had been taken. Dr Craven, however, pointed out that his observations of a patient's urine not being orange, had to be seen against the background of a large number of patients whose urine was orange.

[119.] Dr Craven also conceded in cross-examination that not every management failure or 'dereliction of duty' necessarily resulted in harm to a particular prisoner or to the prison population at large. Indeed, in some instances patients who had on occasion ostensibly not received their medication, were eventually cured of TB. An unsatisfactory level of care would, however,

have resulted in inadequate treatment of persons who were ill with TB so that the plaintiff would have inhaled far more bacteria than he would have in the outside world. Dr Craven's opinion in this regard was based on his practice of medicine over 30 years and the period of 16 years during which he had worked at the maximum security prison.

[120.] Dr Craven further conceded that it could not be said that there was no functioning medical system at the maximum security prison during the period 1999 to 2003. There was a system and sometimes it worked, while at other times it did not. He saw it as his ethical duty to get the system improved and that is why he made representations to a variety of people, including the Parliamentary Portfolio Committee.

[121.] Dr Craven agreed that the nurses, despite being understaffed, prioritised chronic illnesses, TB and attending to dressings. He also agreed that some pro-active screening of potential TB patients did take place. Indeed, he was prepared to accept that persons with persistent coughing were offered a TB test by the nurses, when it was put to him that Gertse would testify to this effect. Dr Craven, however, testified that he never saw any 'suspect registers' while he was employed at the maximum security prison and did not know that such registers existed.

[122.] Dr Craven agreed with Dr Theron that certain people are at risk for

becoming ill with TB, notably persons of the lower social orders such as the unemployed, poverty stricken, homeless and vagrants. The reason why these people are more susceptible to TB, is because they are often malnourished and tend to live in overcrowded flats or shanties one on top of the other. Dr Craven also explained that persons of the lower social orders often only see a doctor once they have been ill with TB for some considerable time, because people who live in overcrowded conditions and who smoke, frequently cough and do not regard a cough as pathological. Therefore, they do not seek medical help until such time as further symptoms have presented such as, for example, substantial weight loss, coughing of blood, or night sweats.

[123.] Dr Craven confirmed that most people in South Africa inhale TB bacteria in early life. Those who subsequently become ill with TB either suffer a re-activation of the bacterium which had been inhaled earlier, or become reinfected when a fresh dose of the TB bacterium is inhaled. There is a difference of opinion in medical circles as to whether reinfection is more common than reactivation.

[124.] As far as the plaintiff himself is concerned, Dr Craven confirmed that he saw the plaintiff on the morning after the latter's admission to the maximum security prison, i.e. on 23 November 1999. He was concerned about the plaintiff's ischaemic heart disease, advised him to stop smoking and to lose

weight and ordered that the plaintiff receive half rations. Thereafter, he saw the plaintiff from time to time when the latter had medical complaints and he ordered appropriate treatment.

[125.] On 14 April 2003 the plaintiff complained of TB symptoms and sputum samples were taken which produced a negative result. On 20 May 2003 the plaintiff complained that he had not received his chronic medication for a period of 3 weeks and on 27 May 2003 the plaintiff presented with an inguinal hernia, which was a surgical emergency. Dr Craven ordered his immediate removal to Victoria Hospital. He saw the plaintiff again on 2 June 2003 after his discharge from Victoria Hospital, when it was reported that the plaintiff had pulmonary TB. Dr Craven ordered that sputum samples be taken, that the plaintiff's X-Rays be obtained from Victoria Hospital, that the plaintiff be admitted to the hospital section and be seen again in 8 days' time. On 3 June 2003 Dr Craven saw the X-Ray which had been taken, which showed that the plaintiff had bilateral infiltration and cavities in the lungs, which was indicative of TB.

[126.] On 9 June 2003 Dr Craven received a laboratory report which indicated that both of the plaintiff's sputum samples tested positive for TB. On the strength of the positive sputum tests, Dr Craven ordered that the plaintiff's illness with TB be reported to the Medical Officer of Health, that the plaintiff be started on the standard treatment for TB, Regimen I, and that the

plaintiff be given double rations. The plaintiff started his TB treatment on 10 June 2003 and was sent back to his section, because it was not logistically possible to isolate him, no space for isolation being available. On 18 June 2003 the laboratory reported a positive culture, which confirmed the diagnosis of TB which had been made and on 14 August 2003 a further laboratory report was obtained which showed that the bacteria were sensitive to Regimen I. The last time Dr Craven saw the plaintiff in prison was on 19 September 2003.

[127.] Dr Craven testified that the measures which were required to control the spread of TB at the prison included the following:

[127.1] Separating prisoners who had active TB from the general prison population;

[127.2] Having a sufficient number of properly trained nurses available who had knowledge of the basic management of TB, the testing for TB and the treatment of TB, so that TB cases could be promptly diagnosed and treated, thereby reducing the number of TB bacteria in the environment;

[127.3] Proper application of the DOTS system, that could easily have been achieved by the nurses. Warders could have been asked to assist

in this regard;

[127.4] Reducing the overcrowding of cells;

[127.5] Increasing the number of nurses;

[127.6] Imposing and maintaining discipline.

[128.] In regard to the necessity for discipline, Dr Craven testified that in a disciplined situation prisoners did what they were told, warders and nurses did what they were told and prisoners received their prescribed medication. In a controlled environment such as the prison, if a doctor ordered the isolation of a prisoner, the prisoner would be isolated and if a logistical problem arose in this regard, the problem would be discussed between the warders or governor and the doctor and efforts would be made to resolve it. In fact, during the previous military style of management, this was exactly what happened.

[129.] In Dr Craven's opinion, the failure to manage TB in the maximum security prison in accordance with the guidelines of the DOH would have caused, or contributed to, the plaintiff becoming ill with TB. Such failure would have increased the number of bacteria per cubic metre of air and the plaintiff would accordingly have inhaled more of the TB bacteria than he would have

in the outside world. The increased dose of bacteria, in other words, would have increased his chances of becoming infected with TB if he had not been infected previously and would have increased the risk of any dormant TB bacteria becoming re-activated, thereby leading to the plaintiff becoming ill with the disease.

[130.] Dr Craven was asked to comment on the plaintiff's evidence that he had gone to court on some 70 occasions, whereafter he was usually placed in a communal cell with other prisoners until the following day. Dr Craven testified that in theory when prisoners came back from the courts, newly arrived prisoners, i.e. those who came into the prison for the first time, ought to have been separated from existing inmates. In practice, however, he believed that this had not been done for logistical reasons.

[131.] Dr Craven conceded that while the plaintiff was detained in a single cell his exposure to TB bacteria would have been less than if he had been in a communal cell. However, the plaintiff would still have been exposed to bacteria drifting in the passage on his way to the shower.

[132.] Dr Craven was unable to comment on the day-to-day system which the nurses adopted in seeing patients in the sections and on whether or not a nurse conducted screening of incoming prisoners, because he had no personal knowledge of these events. Dr Craven only heard of a

computerised TB monitoring system at the maximum security prison during the course of the trial, when he was shown an extract from the computerised record. He also saw the TB-wheel, which the nurses used to monitor treatment of TB patients, for the first time when he was in court.

[133.] As was the case with Dr Theron, Dr Craven made many written and verbal recommendations through the appropriate channels to the governor of the maximum security prison, to the Minister, to the Provincial DOH, the Inspecting Judge of Prisons, the Medical Officer of Health, the Medical Association and to the Parliamentary Portfolio Committee. These recommendations related to the employment of additional warders and nurses, the reduction of the number of prisoners and the imposition of better discipline.

[134.] Shortly before he was called to testify, Dr Craven became aware of a letter which the Defendant had written to the Commissioner of Correctional Services dated 4 October 2001 which referred to the report which Dr Craven had provided to the Parliamentary Portfolio Committee and certain correspondence which had been exchanged between various officials in the Department as a consequence thereof (Exhibit H). In his letter, the defendant, inter alia, instructed 'the Acting Provincial Commissioner, Mr Nxele, the Area Manager at Pollsmoor, Mr Engelbrecht and the entire Pollsmoor Management to treat this health problem as a matter of extreme

urgency' and stated 'This horrendous situation as reported must not be allowed to continue any (sic) day further, particularly where the Management has the powers to take immediate remedial steps.'. In a letter dated 9 October 2001 written by the Commissioner of Correctional Services, Mr Mti, to the Acting Provincial Commissioner, Mr Nxele, the former stated 'If the situation as described by Dr Craven, is not addressed, we are heading for an unprecedented catastrophe. I urge you to place the matter at the top of your priorities and (sic) report back to me before the end of October 2001.'

[135.] Despite the serious tenor of the aforesaid letters, Dr Craven testified that no visible improvement was brought about in the health service at the maximum security prison. Although he had made many representations aimed at improving the health care system, nobody liaised with him, or sought his advice in this regard. Instead, he was dismissed by the Provincial DOH and testified that his dismissal had been called for by the DCS. He subsequently took his case to the Labour Court and was reinstated. Pursuant to such reinstatement, he has been working at the Lady Michaelis Hospital.

[136.] Dr Craven could not recall a visit to the Pollsmoor Prison complex by the Director of Health and Physical Care and the Provincial Heads of the Health Care Service during March 2001. He saw the report which had been drawn

subsequent to such visit for the first time while he was in the witness box.

[137.] In dealing with TB statistics at the maximum security prison, Dr Craven was referred to a schedule covering the period 1998 to 2009 which had been prepared by the authorities at the prison. Dr Craven drew attention to the fact that the copy of the actual registers which had been provided, clearly showed the schedule to be incorrect. So, for example, the total number of TB cases for 2001, according to the register, was 177 whereas the schedule referred to only 69 cases. The schedule was also patently incomplete inasmuch as no figures were provided for certain months, such as, for example the months of April to October in 2001.

The Evidence of Mr Gertse

[138.] According to Mr Gertse, the DCS uses three categories of nurses - assistant nurses, staff nurses and professional registered nurses. Each of the 5 prisons at Pollsmoor has its own hospital and each has its own health care personnel consisting of clerks, nurses and a doctor. During the time of the plaintiff's incarceration, a total of 4 doctors were employed on an agency basis and they worked in the mornings up to lunch time. Nurses worked day shifts from 07h00 to 16h00.

[139.] From 2001 to 2003 the head nurse was Mr Slinger. He was in charge at the

maximum security prison and had an office in the hospital. His second in command was Mr Hillier, who worked in the hospital itself, as did Sister Ndzabe. Mr Erasmus was the nurse in E-section, Mr Tiervlei was in D-section and Mr Sibeko, who was a staff nurse, was in charge of C-section. A-section was headed by Mr Aysley and Mr Van Staden used to work in the hospital section, but the latter moved to the medium B prison. Mr Gertse worked at B-section. The nurses were assisted by 4 clerks and approximately 4 nurses from an agency, who were employed on a temporary basis.

[140.] Mr Gertse testified that the health system at the maximum security prison is nurse-driven, with a doctor providing support. In practice, that means that all cases have to be seen by nurses and that only those cases which are not within the nurses' scope of practice are seen by a doctor.

[141.] In the ordinary course, nurses came on duty at 07h00. The nurses would gather in Mr Slinger's office in order to share information relative to the day's programme, whereafter medication would be collected from the store. Each prisoner's prescribed medication would be placed in a separate plastic bag. 'Pill parade' would then be conducted in the sections. There was a sub-clinic for each floor so that sections E1, E2 and E3, for example, would share one clinic on E-floor, such clinic being conducted in a cell reserved for this purpose. For purposes of pill parade, each nurse was provided with a

special trolley, which was divided into compartments into which each prisoner's medication was placed, a ringbinder containing copies of the relevant prescriptions and a medicine administration card for each inmate on which details of the medication administered, had to be recorded. Once the card was full, it would be placed into the person's hospital file. In addition to the prescribed medication, the nurse handed out ordinary over-the-counter type medication such as Panado, cough mixture, foot powder, ointments, bandages and plasters. According to Mr Gertse, all prisoners except those who were in hospital, received their medication in the sections during pill parade. So-called 'ward stock' consisting of Panado, bandages, ointments and the like were kept in the cell where the clinic was conducted.

[142.] Mr Gertse testified that a warder would normally record prisoners' complaints in a complaints book. Inmates who had medical complaints would be sent to the nurse in the section for assessment. The nurse would hand out medication, if appropriate. If the prisoner's complaint fell outside of the scope of the nurse's practice, he would be referred to the doctor in the hospital section. A particular day of the week was reserved for inmates of each section to visit the doctor. If a medical emergency arose, an inmate would, however, be sent through to the hospital immediately.

[143.] During a special course in the management of TB which Mr Gertse completed in 2003, he was taught the signs and symptoms of TB and

received training around the taking of sputum samples which had to be sent to the laboratory for analysis in order to make a diagnosis. Mr Gertse stated that once the doctor had prescribed the applicable TB medication, it was the responsibility of the nurse to manage the treatment. The TB-wheel was used as an aide for the nurse to calculate when follow-up sputum tests had to be conducted and to monitor the nature of the medication that had to be administered. After the first two months, or the intensive phase, of the treatment the patient's medication would be adjusted. The nurse was responsible for handing the medication to the patient and for marking off the applicable box on the patient's treatment card. Mr Gertse said that he did not know that the infectious phase of the disease, according to the doctors, lasted for a period of two weeks after treatment started.

[144.] Mr Gertse testified that the doctors saw patients in the hospital section and that they did not go to the sections where the inmates were housed. The doctors did not know what the tasks were that the nurses had to perform.

[145.] In regard to the screening of prisoners, Mr Gertse testified that offenders coming into prison from the courts would wait in the yard outside the prison building to be counted. The nurse on night duty would ask whether there were any medical complaints and the names of those who said they did, were noted. Prisoners would thereafter be called to enter the building individually in order to be searched, whereafter they would be detained in

a holding cell. Ordinarily prisoners could not be taken back to the sections, because the last vehicles only returned from court at around 18h00 or 18h30 and by that time the cells had been locked down. The night nurse would receive a printout containing the names of persons who had been admitted to the prison and would then go to the holding cells to deal with medical complaints. Minor complaints would be dealt with there and then and prisoners who had more serious complaints would be sent to the hospital so that the doctor could see them the following day. If there was a medical emergency, the prisoner would be sent to Victoria Hospital. The following day, returning prisoners would be taken back to their cells and new arrivals would be screened by the nurses in the court yard at the hospital section.

[146.] Mr Gertse was referred to the forms (Exhibits O and P) which had to be completed during the screening process when persons first entered the maximum security prison. He could not explain why certain prisoners who had ostensibly been allocated to a particular section had apparently not been screened, because their details did not appear on the form. It is also not clear from Mr Gertse's evidence when these forms were completed. In his evidence in chief he testified that prisoners' names were recorded on computer as they came into the system, prison numbers were allocated to them and their medical complaints were noted. The computerised record would be printed as soon as all of the prisoners who had arrived from court

were inside and the list would then be given to the nurse. His answer clearly suggested that the form was completed that evening. Under cross-examination, however, he stated that prisoners' medical details were only filled out on the form when they were screened at the hospital the following day. He then, for the first time, stated that there was a separate book in which the names of persons who had medical complaints would be noted upon admission and that such book would be given to the hospital the following day.

[147.] Mr Gertse testified that the maximum security prison relied on a self-reporting system in terms whereof inmates had to take the initiative and had to report if they were ill or required medical assistance. Such system also applied in instances where inmates suspected that they might have TB. Inmates' complaints would be lodged with a warder, who would make a note in the complaints register. Either the inmate or the warder could then bring the complaint to the attention of a nurse. If TB was suspected, the inmate would be requested to provide a sputum sample in the presence of the nurse and the latter would note such procedure in the suspect register which, according to Mr Gertse, was already being used when he first came to Pollsmoor in 2001. If the sputum test yielded a positive result, such fact would be noted in the suspect register and the report would be forwarded to the doctor. Negative results were similarly noted in the suspect register, but the reports in such cases would not be forwarded to the doctor. The inmate would be informed of the negative rest result and would be advised

to return in 6 months' time for a further sputum test. Only if a prisoner persisted in complaining after a negative result had been obtained, would he be referred to the doctor so that the latter could decide whether or not he needed to be referred for X-Rays.

[148.] When asked why Mr Muller, Dr Theron and Dr Craven appeared to have been unaware of the existence of the suspect register, Mr Gertse testified that Mr Muller was not working inside the maximum security prison, he had an office outside of the admission centre and he only worked in the maximum security prison over week-ends. Drs Craven and Theron did not know about these registers and never asked to see them, but the nurses were told to keep the registers during their training. Although Mr Gertse testified that suspect registers were used during the time when the plaintiff became ill with TB, he stated that he could not find these.

[149.] Mr Gertse testified that once an inmate had tested positive for TB, he would be seen by the doctor, who would issue a prescription for the required medication. The doctor would make a note of the medication required, e.g. Regimen I, on the hospital file, as well as a note that the person had to receive double rations. The nurse would fill out the green patient treatment card as well as the blue hospital card and would immediately start the medication. If the person was very ill, he would be admitted to hospital, but otherwise he would be sent back to one of the single cells reserved for isolation in the sections. After a period of two weeks, when they were no

longer infectious, inmates would go back to the cells which they normally occupied. (Mr Gertse's evidence in this regard clearly implied knowledge of the fact that persons were still infectious during the first two weeks of treatment and contradicted his earlier evidence in this regard.)

[150.] Under cross-examination Mr Gertse was referred to Chapter 7 of the TB guidelines which contains a diagram indicating that broad spectrum antibiotics ought to be prescribed for 7 days and that repeat microscopy was indicated in instances where both sputum tests yielded negative results, but the patient's condition failed to improve. Mr Gertse stated that inmates who continued to complain after negative results had been obtained, would be given cough mixture and would be referred to the doctor the following day. The doctor would then decide what had to be done. However, he subsequently conceded that the prisoner would only be referred to the doctor at some later stage if the cough did not stop once the cough mixture had been used and that the particular prisoner would not be isolated in the interim.

[151.] In cross-examination Mr Gertse was also referred to the provisions of clause 7.1.15 of the standing orders which provides that prisoners who are suspected of having a contagious disease, such as TB, should be kept separately from healthy prisoners until such time as the attending medical officer has certified that they no longer pose a threat to the health of others. Mr Gertse confirmed that persons whose names were included in

the suspect register were not isolated prior to starting treatment.

[152.] According to Mr Gertse, the first three single cells in a section would normally be allocated to isolation. The single cell in which the plaintiff had been detained, was further down the corridor. He conceded that the plaintiff had not been isolated while he was in the hospital section, but said that the nurse in the section was responsible for isolating him. Mr Gertse differed from Mr Muller's evidence that isolation was often not possible because the prison was overflowing. He said that people went in and out all of the time and that he tried his best to isolate people who tested positive for TB.

[153.] Mr Gertse testified that the DOTS system was applied when prisoners had to take their TB medication. The inmate had to take the medication in the presence of the nurse, the nurse would check that the medication had been swallowed and the inmate would in fact be asked to make a special click with his tongue which would ensure that the medication was swallowed. The nurse would then tick off the applicable box on the blue hospital card.

[154.] In cross-examination, Mr Gertse was also confronted with the fact that the plaintiff's TB hospital card reflected that he had been observed taking his medication on days when he had appeared in court and that he could not have been so observed. He then conceded that the nurse would tick off the card even if he/she had not observed the taking of the medication as was

required, in instances where the prisoner was trusted to have done so. He identified the signature at the foot of the hospital card as that of Mr Slinger, the head nurse at the time. He acknowledged, however, that Mr Slinger was not the person who would have administered the plaintiff's medication, it would have been Sister Ndzabe or Mr Erasmus and identified the handwriting on the front of the hospital card as that of Sister Ndzabe. When it was pointed out to him that Sister Ndzabe worked in the hospital and not in the sections, he said that she would check with Mr Erasmus, who performed the pill parade in the section, each day and would then tick off the card. Mr Gertse subsequently changed his evidence in this regard again and stated that Sister Ndzabe and Mr Erasmus both ticked off the card.

[155.] Mr Gertse testified that a computerised record is maintained at the maximum security prison in order to record reportable diseases and that this system had already been in place when he first started working at Pollsmoor. The information recorded on the system includes the inmate's name, prison number, date of birth, diagnosis, date of diagnosis, date when the illness was reported to the DOH, the place and source of infection and the preventative measures taken. He stated that is possible to extract information from this data base in regard to the number of TB cases which were reported at the prison in any given year. A monthly report would in fact be sent off to the Provincial office of the DCS. No extract from such data base was, however, submitted in evidence.

[156.] According to Mr Gertse, there was a good relationship between the warders and nurses and nurses had no difficulty gaining access to the sections. Ordinarily, however, nurses only went into the cells if a prisoner was too ill to walk to the sub-clinic in the section.

[157.] Mr Gertse stated that he did not see Dr Theron in the hospital and that the latter did not work in the sections.

[158.] Mr Gertse contradicted Dr Theron's evidence that the number of nurses at the prison at one stage dropped to only 2. According to Gertse, that was never the case. At the maximum security prison, there were always at least 5 to 6 nurses on a daily basis and the only time when there might have been only one or two nurses on duty would have been if there was a team building session. Team building sessions, however, were held after parades at around 13h00 or 14h00 and, according to Mr Gertse, most of the time offenders were locked up by 14h00. Although he admitted that there was a shortage of nurses to the extent that the actual staff complement was only approximately 50% of the number of approved posts on the staff establishment, he denied that such shortage was severe. He was, however, eventually constrained to admit that there were barely enough nurses to staff the hospital and the sections, that there were days when there were not enough nurses to do the work in the sections and that the warders then had to bring the prisoners to the hospital.

[159.] With reference to the TB registers which Dr Theron alleged had not been properly kept, Gertse testified that the registers were kept and that neither Dr Theron nor Dr Craven ever looked at these. Gertse also denied that the health system in the maximum security prison had broken down, as was alleged by both Dr Theron and Dr Craven. Under cross-examination, Mr Gertse alleged that at some stage a 'TB blitz' was conducted when the nurses went from section to section to take sputum samples from any prisoner who wanted to be tested for TB. (This evidence had not been put to either the plaintiff or any of the witnesses who testified on his behalf.) When plaintiff's counsel referred him to the fact that the TB guidelines prescribed the taking of sputum samples on two consecutive days, Mr Gertse, for the first time, alleged that samples were in fact so obtained.

[160.] Mr Gertse testified that Dr Craven insisted on absolute silence, because he could not assess patients if it was too noisy. At times when it was too noisy, Dr Craven would leave early. Sometimes Dr Craven would have long talks with some of the patients which resulted in him not having time to attend to all of the prisoners who needed to see him before he knocked off. Mr Gertse did, however, confirm that Dr Craven made notes of things that had not been done and that he would leave a copy of such notes on the desk of Mr Slinger, the nurse in charge of the maximum security hospital.

[161.] As regards the after hours nursing service, Mr Gertse testified that a nurse

had to be on standby at the Pollsmoor premises from 16h00 until 07h00 the following day. If the nurse on standby did not live on the premises, he/she had to come in to be there physically. The after hours shift was divided into first watch, from 16h00 to midnight, and second watch, from midnight to 07h00. During first watch the nurse would have to see all of the new prisoners who came in from the courts and after that the same nurse would be on standby for calls to any of the prisons on the Pollsmoor premises until 07h00 the following day.

[162.] After hours, if a prisoner complained to the warder on duty in his section that he was not feeling well and needed to see the nurse, the warder would inform the person in charge that a nurse was required. The nurse who was on standby would be called to see the inmate concerned. This was the case even if a prisoner complained of a headache. If the prisoner who complained of the headache was in one of the communal cells, the warder on duty in that section would call the warders on duty in the other sections of the prison to assist in taking the particular prisoner out of such cell, because there was only one warder on duty in each section after hours.

[163.] Mr Gertse denied that one of the inmates, Trevor (Blignault), conducted the screening of prisoners on admission, as was alleged by the plaintiff. He testified that Trevor used to assist in writing out the prison card which is handed out to each unsentenced prisoner.

The Evidence of Prof Van Helden

[164.] Prof Van Helden testified that 65% - 80% of adults in South Africa are thought to be infected with TB, which means that they are at risk for developing the disease. However, not all of the people who have been infected with the bacterium become ill. Only approximately 10% of people who have been infected with the TB bacterium, develop infective disease. South Africa, however, has one of the highest incidence rates of TB in the world (600 per 100,000 persons per annum) and in certain areas of the Western Cape the figures are higher. In Khayelitsha, for example, Medicines Sans Frontiers have measured 1600 per 100,000.

[165.] According to Prof Van Helden, the annual risk of infection in South Africa has been measured and estimates of between 3.5 and 4.8% have been made. In his opinion, the true risk is higher. The proportion of people infected in some communities - Ravensmead and Masiphumelele - has been measured using the skin test referred to above and it has been shown that 52.5% of children in the age group between 14 to 17 have been infected. There is accordingly less than a 40% chance that an adult South African has not been exposed to TB infection by age 53 (the age at which the plaintiff came into the prison).

[166.] Under cross-examination, Prof Van Helden stated that the annual risk of infection as aforesaid had been calculated by testing children between the ages of 5 and 7 in Ravensmead and Masiphumelele (Ravensmead is one of

the former so-called 'Coloured Townships', one of the less affluent communities in the Bellville area and Masiphumelele is an informal settlement near Kommetjie). He conceded that one would expect a higher rate of infection and possibly a higher rate of disease in lower socio-economic groups such as those. Children in Constantia, Bishops Court or Plumstead (upper and middle class suburbs in Cape Town) have not been tested and the 3.5% or 4.8% risk of infection would almost certainly not be applicable in those areas. Persons who live in middle and higher socio-economic classes generally have a lower incidence of TB. Prof Van Helden would, however, not concede that persons living in the middle and higher economic classes would be less represented in the overall group of 10% of infected persons who actually became ill with the disease. In this regard, he stated that whether or not a person becomes ill with the disease, depends on genetic factors and inherent susceptibility. His reasoning in this regard is clearly flawed inasmuch as it does not take into account that on his own evidence far less people from the more affluent communities would be included in the pool of persons who had been infected with TB.

[167.] The research which has been done by Prof Van Helden's unit has shown that persons who have had active TB are innately susceptible to the disease and that their risk of developing the disease again is 4 to 7 times higher than that referred to above.

[168.] As regards the difference between reactivation and reinfection, Prof Van

Helden testified that if a person has a recurrent episode of TB, one would not ordinarily know whether it has been caused by reinfection or by reactivation. If a period of more than 2 years has elapsed after the first episode of TB disease, it is usually referred to as a case of reinfection. In the plaintiff's case, it was not possible to state unequivocally whether his TB episode resulted from transmission in prison, or from reactivation of previous infection whilst he lived in open society. One of the studies which was referred to in a publication in which Prof Van Helden participated, however, found that 56% of active disease episodes in that study community could be ascribed to recent transmission.

[169.] Whilst Prof Van Helden was critical of certain portions of the article, Exhibit E, he agreed that in high endemic societies, such as Khayelitsha, most infections causing active TB in adults, represented currently circulating strains of TB that were recently transmitted. He also agreed that in all likelihood, ongoing transmission causes repeated episodes of infection.

[170.] Prof Van Helden pointed out that it was not known whether or not the plaintiff had been infected with the TB bacterium prior to his admission to prison. Inasmuch as there was no evidence that the plaintiff had not been infected prior to entering prison, Prof Van Helden stated that he probably fell into the category of persons who had already been infected, because 80% of adult South Africans have had exposure to the bacterium. Indeed, Prof Van Helden stated that the chances of plaintiff having been exposed

to TB bacteria prior to entering the prison were 'exceptionally high', because South Africa has the dubious distinction of having one of the highest incidences of TB in the world. Under cross-examination, however, it transpired that Prof Van Helden had been unaware of the fact that the plaintiff had been detained in the maximum security prison for approximately 3 years before he developed the disease and that he had accordingly not taken such fact into account in arriving at his conclusions.

[171.] Prof Van Helden stated that the plaintiff's exposure to active TB cases in prison was probably 'very low or non-existent'. His reasons for coming to this conclusion were the following. Mr Gertse had informed Prof Van Helden that the plaintiff had mostly been kept in a single cell, which he shared with persons who had not had active TB at any stage; that inmates in single cells were let out to fetch food twice per day before inmates from communal cells were released and that the plaintiff stayed in the prison hospital for some time. Prof Van Helden accordingly surmised that plaintiff's exposure to other inmates was low in numbers and short in time, so that his exposure to TB cases would probably have been very low. Prof Van Helden had also been informed that inmates who were diagnosed with TB received prompt treatment and knew that when patients received the prescribed treatment, they became less infectious quite rapidly. The aforesaid information and knowledge led him to believe that even if the plaintiff had been exposed to persons regarded as active with TB after they had been on therapy, those persons were probably not infectious.

[172.] Prof Van Helden was of the view that the plaintiff had received the best standard of care that was possible in South Africa. He was immediately placed on appropriate therapy once the positive result of the sputum test was obtained and there was no delay pending the result of the culture. He received the full recommended amount of his medication regularly and for the required period of time. Indeed, Prof Van Helden stated that in his view the standard of care in the prison was better than that in the outside world. He based this conclusion on information provided by Mr Gertse that prisoners who had been diagnosed as being ill with TB were all moved to a separate facility, which removed the risk for others, whereas in the outside world TB patients usually remained at home with their families. He was, however, constrained to concede that inmates could nevertheless become infected through contact with fellow prisoners who had become ill with the disease but had not yet been diagnosed and that the plaintiff could have been infected with TB if he had been in close proximity with actively ill people. Prof Van Helden, however, held to the view that individuals exposed to persons with active TB in open society experienced the same risk. He also conceded that if isolation cells were not sealed off from the main area or section of the prison, it would be undesirable.

[173.] Prof Van Helden was sceptical about Dr Theron's 'TB patient profile' and the latter's statement that the plaintiff did not appear to fall into the category of people who were likely to develop TB. Prof Van Helden stated that Dr

Theron's observations in this regard had not been peer reviewed, that he had not heard of such a profile and that even a top class athlete could develop TB if he/she had the wrong genes. He doubted that one would be able to recognise a candidate for TB at a distance and did not think that one's mental attitude would affect one's susceptibility to the disease. Prof Van Helden, however, agreed with Dr Theron's evidence that stress affects the immune system and that prison presents a stressful environment. He also conceded that he is not a clinician and that he has never diagnosed any person who had active TB.

[174.] Prof Van Helden conceded that in areas with poor ventilation, TB bacteria which had been expelled could drift around and would possibly remain alive for hours. He also conceded that in overcrowded communal cells the chances of somebody being infected with TB bacteria that were coughed up were much higher than it would be in a cell which was not overcrowded. The risk was also present when prisoners lined up in the passage to go out for exercise. In short, if one was in any area with a high concentration of TB bacteria, the risk of becoming infected was higher.

[175.] Prof Van Helden further conceded that he had not visited the prison to familiarise himself with conditions and that he had formulated his opinions on the basis of information given to him by Mr Gertse and others, which he assumed to be true.

Evaluation of the Evidence

[176.] The plaintiff clearly did not always listen carefully to the questions that were put to him, with the result that his answers were not always germane to the issue and questions often had to be repeated. This fact was particularly apparent when he was cross-examined about the duration of his admission to the prison hospital and the corresponding notes in his medical file. At times, he was somewhat long winded and appeared to become confused about events during the period of his incarceration.

[177.] Given that prisoners who were awaiting trial spent approximately 23 hours out of every 24 in their cells, there must clearly have been little to distinguish one day from another. Indeed, the plaintiff himself said that one day was much like the next. The plaintiff spent approximately 4½ years in prison awaiting trial and attended court on approximately 70 occasions during that time. In these circumstances it does not appear to me to be surprising that the plaintiff became confused at times.

[178.] It was readily apparent that the plaintiff feels aggrieved by the fact that he was incarcerated and that his imprisonment resulted from what he regards as trumped up charges. However, he blames his incarceration on the investigating officer and not on the defendant, or the latter's officials/employees. The plaintiff was fair towards the defendant in his testimony and did not appear to be gilding the lily. So, for example, he

readily admitted that warders tried to help him as far as they were able to and that some of them went out of their way to do so. He also made admissions that could count against him, such as, for example, that he had told everybody in prison that he was going to sue as a result of the fact that he had become ill with TB.

[179.] On the whole, the plaintiff came across as a witness who was honestly trying, to the best of his ability, to give an accurate, truthful and reliable account of the time he spent in prison and, in particular, of the circumstances surrounding his illness with TB. I have no hesitation in accepting his evidence.

[180.] Doctors Theron and Craven as well as Mr Muller have been in conflict with the DCS and for this reason their evidence was approached with a measure of circumspection. Their conduct in the witness box was carefully observed and scrutinised, as was the evidence that they proffered.

[181.] Albeit that Dr Theron was critical of the DCS and its management of TB (or lack thereof) in the prison, he was very much aware of the fact that he was called as an expert witness and that he had to be unbiased in the giving of his evidence. He made it clear that he does not have any difficulties or problems with the DCS in his personal capacity, that his concern was for the truth and that he was not taking sides.

[182.] Dr Theron was taken to task in regard to his evidence that he doubted the statistics relating to the number of nurses employed at the prison, which had been provided by the Defendant during the course of the trial. In the event, however, his evidence regarding the shortage of nurses was supported by Mr Muller and the letters which the latter forwarded to the authorities at the time. Even Mr Gertse had to concede that there was a drastic nursing shortage. Moreover, none of the source documents which had been used to compile the statistics were made available so that the figures could be verified. In such circumstances, Dr Theron's reservations about the veracity and reliability of the defendant's statistics does not strike me as untoward, or unfair, nor does it detract from the value of his evidence.

[183.] Dr Theron's evidence relating to his development of a TB patient profile was the subject of much scrutiny under cross-examination. It became clear from the evidence, however, that such profile consisted of certain clinical observations and objectively ascertainable criteria which he applied in his practice of medicine, such as, for example, an under nourished appearance, and clinical signs of depression, which tended to undermine a patient's immune system. In the final analysis, the various elements of the TB patient profile which he developed consisted of various symptoms and behaviour which he would consider in arriving at a differentiated diagnosis, just as he would do if he had to determine whether or not a patient suffered from, for example, heart disease. His medical training and clinical

experience caused him to take account of the various factors which made up the TB patient profile in making a diagnosis of his patient's condition.

[184.] On an overall conspectus of the evidence of Dr Theron and of his demeanour in the witness box, I am satisfied that he was an honest and objective witness who gave a reliable account of the health system in the prison and of the impact which it had on the management and spread of TB. His main concern during the period of his employment at Pollsmoor was clearly the welfare of his patients and it was his concern for his patients that brought him into conflict with the DCS. I have no hesitation in accepting his evidence.

[185.] It was readily evident that Dr Craven is somewhat of a martinet. He is clearly a strict disciplinarian who sets high standards of performance for himself and others. He obviously believes that if a job is worth doing, it is worth doing well. It appears that at times he may have been somewhat inflexible in his approach to matters, such as, for example, his insistence on absolute silence when he had to see patients at the prison. He did, however, have a valid reason for doing so, inasmuch as he could not perform his job adequately if he could not hear a patient's lung, heart and blood sounds sufficiently clearly.

[186.] Dr Craven, like Dr Theron, appeared to have been genuinely concerned about the disintegration of the health system in the maximum security

prison, because this had a direct, negative impact on the welfare of his patients. His frustration with the DCS and the manner in which the health system in the prison was approached, was readily evident. He clearly took the responsibility which vested in him by the nature of his position at the prison very seriously and was, for this reason, very critical of the DCS. He testified in a calm and forthright manner and did not pull any punches.

[187.] Under cross-examination Dr Craven was referred to a number of patients' hospital files which had been selected at random, in order to determine the reliability and accuracy of his list of derelictions of duty. It was sometimes difficult to reconcile the derelictions which Dr Craven had listed with the contents of the individual hospital file. For this reason, Mr Jamie submitted that Dr Craven's evidence was unreliable.

[188.] Dr Craven's notes about the various derelictions of duty were rather cryptic and he conceded that these had to be interpreted in context. He was, however, at somewhat of a disadvantage when he was confronted with the various hospital files in the witness box, without having had a prior opportunity of refreshing his memory from such files. He conceded that he could not in all instances tie in the notes he had made with the contents of the files.

[189.] In my view, the fact that it was not possible to reconcile Dr Craven's notes with the relevant hospital files fully, does not serve to detract from the

overall value of his evidence. I accept that he may well have been fairly stringent in his requirements on some occasions, because he clearly expected a very high standard of performance and became extremely frustrated by the circumstances under which he had to perform his work at the prison. At no stage, however, did I get the impression that Dr Craven was anything less than open and frank with the Court, or that he was being deliberately unfair or biased against the defendant. The high standards of performance which he set for himself and others may nowadays appear to be somewhat old fashioned and may be irritating to persons who tend to have a more relaxed attitude, but such fact does not detract from the honesty, veracity or reliability of his evidence. His evidence is accordingly accepted.

[190.] Mr Muller was also a good witness. Albeit that he is still in conflict with the DCS, he testified in a calm and balanced manner and there was no indication that he was partisan. He did not volunteer to support the plaintiff's case, he came to Court to testify under a witness subpoena. His evidence in regard to the critical nursing shortage and the impact which this had on the health system at the prison, was borne out by the letters which he had written at the time. There was no indication that he was biased against the defendant, or that he was deliberately painting a bleaker picture than was necessary. I am satisfied that he gave an honest account of the situation at the prison and that his evidence is both credible and reliable. His evidence is accordingly also accepted.

[191.] There is no reason to doubt the veracity or credibility of the evidence given by Ms Caldwell. Her evidence, however, did not substantially contribute to the determination of the issues herein.

[192.] Mr Gertse was a poor witness. He obviously had much to lose if he gave evidence which did not favour the defendant's case and it was obvious that he tried to put the DCS in the best possible light. If his evidence were to be believed, the defendant had a health system in place which functioned perfectly, despite the fact that the prison was not only extremely over crowded, but also suffered from a critical shortage of nurses. Moreover, despite the massive overcrowding, he would have the Court believe that all TB patients who were in the infectious stage of the disease, were isolated. In addition, he was obviously prepared to draw conclusions favourable to the defendant's case even though he had no personal knowledge of events. His evidence relating to the completion of the plaintiff's TB hospital card offers a prime example of this fact.

[193.] Mr Gertse also frequently contradicted himself. Some of these contradictions have already been alluded to herein above. The record will reveal many more. Moreover, it was patently obvious that he tailored his evidence to suit the case. His evidence, referred to above, relating to the completion of the plaintiff's TB hospital card, the TB blitz which had allegedly been conducted and the taking of sputum samples on consecutive days, clearly demonstrates his penchant for modifying the truth.

[194.] On the whole, Mr Gertse was clearly not an unbiased witness and his evidence is tainted by many defects. I am not satisfied that he was truthful, nor am I satisfied that his evidence was reliable. In so far as his evidence is contradicted by the witnesses who testified for the plaintiff, his evidence is accordingly rejected.

[195.] Prof Van Helden suffered the misfortune of having been briefed by Mr Gertse. In the result, many of the facts which underpinned his opinions are suspect, incorrect and unreliable. So, for example, Prof Van Helden was told that persons who were diagnosed as having active TB were all isolated so that the risk to other inmates was reduced, that the DOTS system was consistently followed and that the plaintiff had been kept in a single cell and had not been exposed to infection by other prisoners. On the basis of such information, all of which was factually incorrect, Prof Van Helden concluded that the care of TB patients in prison was better than in the outside world. The evidence of the plaintiff as well as that of Dr Theron and Dr Craven is clear that due to overcrowding by no means all TB cases were isolated. Indeed, the plaintiff himself was not isolated.

[196.] Prof Van Helden also appeared to fall into the trap of losing his objectivity. So, for example, he used statistical evidence which was obtained in lower socio-economic areas such as Ravensmead and Masiphumelele to justify his opinion that the plaintiff, who came from a middle class environment, had probably been infected with TB prior to coming into the prison, in

circumstances where he himself had admitted that those statistics would not be applicable in middle and higher socio-economic areas. Indeed, Prof Van Helden went so far as to say that the plaintiff's chances of having been infected with TB prior to entering prison were 'exceptionally high'.

[197.] There is no doubt that Prof Van Helden is an expert is his field, but he is not a medical doctor and has had no experience in the diagnosis and treatment of TB. His experience relates to research. On the whole, Prof Van Helden's evidence was tainted with bias and misinformation. As a consequence, his evidence is, in my view, in many instances unreliable and inaccurate.

[198.] Both Dr Theron and Dr Craven have had much experience in the diagnosis and treatment of TB during the years that they have practised medicine and their expertise in this regard is beyond question. By virtue of their expertise and the fact that they were directly involved in the health system at the prison, they were in a unique position to provide an insight into the circumstances at the prison which impacted upon the management of TB during the plaintiff's incarceration. Whenever the evidence of Prof Van Helden is in conflict with that of Drs Theron and Craven, I unhesitatingly accept the latter versions.

The Legal Position

[199.] In order to establish a claim in delict, a plaintiff has to prove that the

defendant negligently committed an act which was unlawful and that the act so complained of was causally related to the harm which ensued.

[200.] In the instant case, it was not disputed that the acts of omission which had been alleged by the plaintiff in his particulars of claim, if established, would constitute acts for the purposes of liability in delict. The defendant has, however, taken issue with the plaintiff in regard to the elements of unlawfulness, fault and causation.

[201.] Negligent omissions are unlawful only if these occur in circumstances that the law regards as sufficient to give rise to a legal duty to avoid negligently causing harm (Minister of Safety and Security v Van Duivenboden 2002 (6) SA 431 (SCA) at 441E-F). As was stated in Minister of Polisie v Ewels 1975 (3) SA 590 (A) at 597A-B, negligent omissions will only be regarded as constituting unlawful conduct if the circumstances of the case are such that the omission not only evokes moral indignation, but the 'legal convictions of the community' require that it be regarded as unlawful. The enquiry is a broad one in which all of the relevant circumstances must be taken into account (Minister of Safety and Security v Van Duivenboden, supra, at 442B-E para [13] and cases there cited).

[202.] As the Constitutional Court has pointed out in Carmichele v Minister of Safety and Security 2001 (4) SA 938 (CC) at 961F the Constitution, which is the supreme law, embodies an objective, normative value system which

pervades all areas of the law. Moreover, section 39(2) of the Constitution expressly provides that '(W)hen interpreting any legislation, and when developing the common law or customary law, every court, tribunal or forum must promote the spirit, purport and objects of the Bill of Rights.' In applying the test laid down in the case of Ewels referred to above, a court must accordingly have regard to the fact that the 'legal convictions of the community' must now be informed and guided by the norms and values which have been enshrined in the Bill of Rights, because norms or values which are inconsistent with the Constitution, have no validity (Minister of Safety and Security v Van Duivenboden, supra, at 444E-H, para [17]).

[203.] As Nugent JA pointed out in Van Duivenboden's case[1] the general reluctance to impose liability for omissions, which is underpinned by the concept that individuals are free to 'mind their own business', may have been strengthened by the Bill of Rights in so far as individuals are concerned. Public officials, however, appear to find themselves in a less advantageous position.

> 'The protection that is afforded by the Bill of Rights to equality and to personal freedom and to privacy might now bolster that inhibition against imposing legal duties on private citizens. However, those barriers are less formidable where the conduct of a public authority or a public functionary is in issue, for it is usually the very business of a public authority or functionary to serve the interests of others and its duty to do so will differentiate it from others who similarly fail to act to avert harm. The imposition of legal duties on public authorities and functionaries is inhibited instead by the perceived utility of permitting them the freedom to provide public services without the chilling effect of the threat of litigation if they happen to act negligently and the spectre of limitless liability. That last consideration ought not to be unduly exaggerated, however,

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1 AR 445B-F, PARA [19]

> bearing in mind that the requirements for establishing negligence and a legally causative link provide considerable practical scope for harnessing liability within acceptable bounds.'

[204.] The Constitution itself recognises that the State has a duty to act in order to promote and to protect the rights which are the subject of the Bill of Rights. Section 7(2) of the Constitution, read with section 2 thereof, expressly provides that the State 'must respect, protect, promote and fulfil the rights in the Bill of Rights' and that the obligations imposed by the Constitution 'must be fulfilled'. Section 8(1) of the Constitution provides that the 'Bill of Rights applies to all law, and binds the legislature, the executive, the judiciary and all organs of state'.

[205.] In determining whether or not there is a legal duty to act on the part of a public official, the relevant factors must now accordingly be weighed in the context of the spirit, purport and objects of the Bill of Rights which recognises a Constitutional State founded on dignity, equality and freedom, in which the government has positive duties to promote and uphold such values. Given the provisions of the Constitution which have been referred to in the immediately preceding paragraph, the Constitutional Court has found that there is a duty imposed on the State and all of its organs not to perform any act that infringes the Bill of Rights. Indeed, in some circumstances the State and its organs would be obliged to provide appropriate protection to everyone through laws and structures which have been designed to afford protection against infringement of the rights

contained in the Bill of Rights (see Carmichele v Minister of Safety and Security, supra, at 957B-D and F).

[206.] Section 41(1)© of the Constitution, moreover, provides that '(A)ll spheres of government and all organs of state ... must ... provide effective, transparent, accountable and coherent government for the Republic as a whole' . As was pointed out by the Supreme Court of Appeal in Olitzki Property Holdings v State Tender Board and Another 2001 (3) SA 1247 (SCA) at 1263E:

> 'T)he principle of public accountability is central to our new constitutional culture, and there can be no doubt that the accord of civil remedies securing its observance will often play a central part in realising our constitutional vision of open, uncorrupt and responsive government.'

[207.] The principle of accountability, however, does not necessarily translate into a civil remedy in the form of an action for damages. Other appropriate remedies, whether judicial or non-judicial, might be available[2]. As was said by Nugent JA in Van Duivenboden [3],

> 'However, where the State's failure occurs in circumstances that offer no effective remedy other than an action for damages the norm of accountability will, ... ordinarily demand the recognition of a legal duty unless there are other considerations affecting the public interest that outweigh that norm. For as pointed out by Ackermann J in Fose v Minister of Safety and Security ...
>
> > without effective remedies for breach ... the values underlying and the right entrenched in the Constitution cannot properly be upheld or enhanced. Particularly in a country where so few have the means to enforce their rights through the

[2] Minister of Safety and Security v Van Duivenboden, supra, at 446G-H

[3] At 447B-E

> courts, it is essential that on those occasions when the legal process does establish that an infringement of an entrenched right has occurred, it be effectively vindicated. The courts have a particular responsibility in this regard and are obliged to 'forge new tools' and shape innovate remedies, if needs be, to achieve that goal.'

[208.] In determining whether or not the breach of a statutory duty is to be regarded as unlawful so that it would give rise to a private law claim for damages, Cameron JA stated the position as follows in the Olitzki Property Holdings case[4]:

> 'Where the legal duty the plaintiff invokes derives from breach of a statutory provision, the jurisprudence of this Court has developed a supple test. The focal question remains one of statutory interpretation, since the statute may on a proper construction by implication itself confer a right of action, or alternatively provide the basis for inferring that a legal duty exists at common law. The process in either case requires a consideration of the statute as a whole, its objects and provisions, the circumstances in which it was enacted, and the kind of mischief it was designed to prevent. But where a common-law duty is at issue, the answer now depends less on the application of formulaic approaches to statutory construction than on a broad assessment by the court whether it is "just and reasonable" that a civil claim for damages should be accorded. The conduct is wrongful, not because of the breach of the statutory duty per se, but because it is reasonable in the circumstances to compensate the plaintiff for the infringement of his legal right. The determination of reasonableness here in turn depends on whether affording the plaintiff a remedy is congruent with the court's appreciation of the sense of justice of the community. This appreciation must unavoidably include the application of broad considerations of public policy determined also in the light of the Constitution and the impact upon them that the grant or refusal of the remedy the plaintiff seeks will entail.' (Footnotes omitted)

[209.] Cameron JA added that, in instances where the court has to determine whether or not a delictual claim arises from the breach of a statutory provision, the fact that the provision is embodied in the Constitution may, depending on the nature of the provision, attract a duty more readily than if it had been in an ordinary statute.[5]

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[4] At 125B-F para [12]

[5] At 1258E-F, para [14]

[210.] Even if the law recognises the existence of a legal duty to act and even if such duty has been breached, with the result that the conduct complained of is unlawful, the element of fault must still be satisfied before liability will attach to the defendant. In order for fault or culpability to attach to an omission, the test referred to in Kruger v Coetzee [6] is applied, which means that liability arises if a reasonable person in the position of the defendant would have foreseen that his conduct would reasonably possibly cause harm to another and would have taken reasonable steps to avert it, but the defendant failed to do so (Minister of Safety and Security v Van Duivenboden, supra, at 441G-442). The test is an objective one which does not depend on the subjective intent or mind set of the defendant, but rather on the particular circumstances of each case.

[211.] Last but not least, there must be a causal connection between the unlawful and negligent conduct complained of, and the harm which is alleged to have ensued. The element of causation involves two distinct enquiries. Firstly, in regard to the issue of factual causation, it must be determined whether or not the postulated cause can be identified as the sine qua non of the loss in question. This has become known as the 'but-for' test. In applying such a test, one makes a hypothetical enquiry as to what would probably have happened, but for the wrongful act of the defendant. If the plaintiff's loss would still have ensued absent the defendant's conduct, factual causation

[6] 1966(2) SA 428 (A) at 430E-F

is lacking and that is the end of the matter. Secondly, if factual causation has been established, it must be determined whether the wrongful act is linked sufficiently closely to the loss concerned for liability to ensue. If the damage is too remote, no liability will accrue.[7]

Issues to be Decided

[212.] In order to determine whether or not the defendant is liable to the plaintiff in the instant case, it appears to me that the following underlying issues need to be decided:

(1) Whether or not the prevailing conditions in the maximum security prison at Pollsmoor, during the period November 1999 to June 2003, were such that the spread of TB was facilitated thereby; If the answer to this issue is in the affirmative,

(2) Whether it is more probable than not, that the plaintiff's illness with TB was occasioned by, or resulted from, the prevailing conditions in the maximum security prison at Pollsmoor during his incarceration. If so,

(3) Whether a reasonable person, in the position of the defendant, would

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[7] mCubed International (Pty) Ltd & Another v Singer & Others 2009 (4) SA 471 (SCA) at 479F-J and cases there cited

have foreseen that the prevailing conditions in the maximum security prison would reasonably possibly spread TB amongst the inmates in the said prison and cause inmates, such as the plaintiff, who had not previously been ill with TB, to succumb to the disease. If so,

(4) Whether or not a reasonable person in the position of the defendant would have taken steps to guard against the spreading of TB as aforesaid? If the latter question is answered affirmatively,

(5) Whether or not the defendant took reasonable steps to guard against the spread of TB in the maximum security prison to inmates, such as the plaintiff, who had not been ill with TB and, if not

(6) whether or not the defendant's failure to take such steps was unlawful, thereby giving rise to a private law claim for damages.

Did the prevailing conditions in the maximum security prison facilitate the spread of TB?

[213.] When the plaintiff first came into the maximum security prison at Pollsmoor in November 1999, TB was already prevalent in the prison. The evidence of Dr Theron is clear in this regard. Indeed, throughout the time of the plaintiff's incarceration, TB remained a problem in the prison. This much is clear from the evidence of both Dr Theron and Dr Craven.

[214.] Dr Theron and Dr Craven were agreed that control over TB in the prison environment was dependant upon the effective screening of incoming prisoners, the isolation of infectious patients and the proper administration of the necessary medication over the prescribed period of time. All of these measures were heavily dependant upon a sufficient number of suitably qualified nursing staff being available. The provision of adequate nutrition and ventilation also played an important role.

[215.] As has been referred to above, clause 4.1(a) of Chapter 3 of the standing orders provided that all persons admitted to prison, should been seen on admission by a registered nurse for, inter alia, medical problems, whether acute or chronic. Such provision is reiterated in clause 4.4(a) which stated that '(A)ll admissions must be screened by a registered nurse on admission using the screening form.' Clause 6.1 of the said standing orders stated that '(F)ollowing screening at the reception, all admissions must be taken to the prison health facility by the unit manager or reception manager within 24 hours, for a medical examination by the registered nurse or medical officer/practitioner as prescribed.' Clause 6.2 provided that at prisons where there are primary health care clinics at the housing units, the medical examination may be performed at such clinics. The intention of the standing orders appears to me to be clear and unambiguous. Every incoming prisoner must be screened by a registered nurse on admission and every such prisoner must be medically examined within 24 hours of admission. The reasons why such a strict obligation was imposed are, in

my view, self-evident. Firstly, prisoners who were ill or injured had to receive medical attention. Secondly, prisoners who posed, or could reasonably pose, a health risk to others had to be identified in order that the necessary steps might be taken to prevent other inmates from becoming ill. Indeed, clauses 14 and 15 of the said Chapter of the standing orders contained, inter alia, the following provisions in regard to communicable and contagious diseases:

> 14.6.1 Whenever there is a suspicion that a prisoner ... could be suffering from a communicable, or contagious disease. The case must immediately be brought to the attention of the Supervisor: Nursing and the attending medical officer/ practitioner.
>
> 14.6.3 If the registered nurse or attending medical officer/ practitioner deems it necessary to isolate/segregate the prisoner ... suspected to be suffering from a communicable, or contagious disease, the recommendations or prescriptions must always be adhered to.
>
> 15.1 All prisoners with communicable conditions must be isolated in strict accordance with the medical officer's/ practitioner's and registered nurse's orders issued in each case.
>
> 15.3 Each prison must have written orders on infection control which must be monitored and reviewed annually.'

[216.] Mr Gertse initially testified that incoming prisoners were screened by the nurse who was on night duty. He subsequently changed his evidence in this regard and said that the night nurse conducted a pre-screening and that incoming prisoners who volunteered that they had medical problems were screened at the hospital the following day. The plaintiff's evidence was that on admission to the prison one of the inmates, Trevor Blignault, would ask persons who were ill to come forward. Mr Muller testified that there was only one nurse on duty at Pollsmoor after 16h00 and that nurse

was responsible for all 5 of the prisons. The screening of prisoners who came from the courts in the afternoons could accordingly not be performed by the night nurse and did not form part of the duties which such nurse was expected to perform. Mr Muller knew this to have been the case, because he was in charge of nursing services at Pollsmoor and prepared the duty roster. Dr Craven's working hours did not extend to the afternoon and there was accordingly no doctor on duty at the time when prisoners were brought back from the courts. It is accordingly clear from the evidence which has been accepted, that during the period of the plaintiff's incarceration, prisoners were not screened by a registered nurse or medical practitioner, whether for TB or any other disease, upon their arrival at the prison.

[217.] Mr Muller testified that the nurses ensured that incoming prisoners were screened on the morning after their admission and that those with medical complaints were then referred to the doctor. Under cross-examination Mr Gertse stated that the screening forms, such as Exhibits O and P, containing the details of the incoming prisoners were printed out on completion of the admission process. The nurse would then fill out the medical details on such form the following day when incoming prisoners were screened. As is evident from the aforesaid Exhibits, the forms contain only the most basic information in regard to prisoners' health status - their body mass and whether or not they had any medical complaints. It appears that the nurses who conducted the screening process did not physically examine any of the

incoming prisoners. They merely noted whether a prisoner provided a positive or negative answer to the question as to whether he had any medical complaints. Only those prisoners who stated that they had medical complaints were referred to the doctor for examination.

[218.] In the context of the aforesaid screening process, it is important to bear in mind Dr Craven's testimony that persons from the lower economic classes who smoked and lived in crowded conditions, frequently coughed and did not regard a cough as pathological. They only went to the doctor when additional symptoms manifested. The aforesaid evidence is clearly based on Dr Craven's experience and accords with the probabilities. It is accordingly unlikely that incoming prisoners who were already ill with TB, but who had not yet experienced marked symptoms other than coughing, would have volunteered that they were ill. Had these prisoners been properly screened, a simple chest examination would have revealed that there was an underlying pathology and they could have been separated out from the general prison population. The evidence of Drs Craven and Theron are clear in this respect. As a result of the manner in which the nurses implemented the screening process, which amounted to no more than asking whether or not an incoming prisoner had any medical complaints, the vast majority of such prisoners were accordingly not medically screened, inasmuch as no physical examination was conducted unless a prisoner was referred to the attending doctor.

[219.] The aforesaid screening process, such as it was, appears to have constituted the only screening that was conducted. Drs Theron and Craven testified that mass screening of prisoners had been conducted in the past when the old, military style of management was in place, but not during the time of the plaintiff's incarceration when the more relaxed management style had been adopted. Dr Theron, however, testified that it would have been possible for a doctor to conduct the screening of all of the inmates from time to time on a cell by cell basis, although such screening had not taken place.

[220.] Instead of screening prisoners for infectious diseases, such as TB, from time to time after their admission, the authorities at the maximum security prison relied on a self-reporting system in terms whereof prisoners had to make it known if they were ill or required medical attention. With regard to TB in particular, the authorities, according to Mr Gertse, maintained a 'suspect register'. If an inmate was suspected of having TB, whether because he reported it or whether a nurse was of the opinion that a prisoner might be suffering from TB, a sputum test would be conducted and the inmate's name would be recorded in the such register. Although Mr Muller testified that all test results ought to have been referred to the doctor for further attention, Mr Gertse's evidence was that only the cases which yielded positive results would be referred to the doctor. If test results were negative for TB, the nurse would merely counsel the inmate and, if necessary, treat the cough. It is by no means clear that the suspect

register was used during the period prior to the plaintiff becoming ill. Mr Gertse's evidence was extremely unreliable, for the reasons already adverted to. Mr Muller could not recall whether the suspect register was used during 2002 and 2003. Neither Dr Craven nor Dr Theron had knowledge of such a register during their period of employment at Pollsmoor and the plaintiff also did not know of its existence. Dr Craven only had knowledge of a suspect register which had been maintained after he had left the prison. Even if a suspect register had been maintained, however, it is by no means clear what purpose it was intended to serve. There is no evidence that persons whose names had been entered into the register and whose sputum tests produced negative results were followed up on any regular basis or at all. In the absence of appropriate monitoring of prisoners who were suspected of having TB, but who tested negative, the keeping of such a register appears to have been a wholly useless exercise.

[221.] The prison authorities' failure to screen incoming prisoners adequately appears to me to have constituted a contravention of clause 4 of Chapter 3 of the standing orders. Such failure obviously permitted persons who were ill with an infectious disease, such as TB, to mingle with other prisoners, at the very least while they were held in the overnight cell. If they did not volunteer that they were ill with TB, or that they were suffering from symptoms which were indicative of TB, upon their arrival at the maximum security prison, they would remain in the general prison population until such time as they did request medical assistance, or until

such time as they were so ill that one of the warders or nurses noticed it and caused them to be medically examined. In the mean time, those who were ill with TB would be expelling TB bacteria into their overcrowded cells every time they sneezed, coughed or spat.

[222.] It is also clear on the evidence of Dr Theron and Dr Craven that various further factors played a role in the transmission of TB in the maximum security prison - overcrowding, a lack of free flowing air, lack of isolation facilities, inadequate application of the DOTS system in the administration of the necessary TB medication and a severe shortage of nurses.

[223.] The evidence of Drs Theron and Craven in regard to overcrowding was confirmed by Mr Muller and by the official correspondence at the time. Although the approved accommodation at the maximum security prison was 1619 inmates, the lock-up total on occasion was as much as 3052, which constituted 189% occupation (Exhibit A p 58). Single cells regularly housed 3 inmates and communal cells were filled with double and sometimes triple bunks. Given that TB bacteria are air borne, these circumstances must clearly have facilitated the transmission of the disease. Indeed, the evidence of Drs Craven and Theron, as well as of Prof Van Helden, was to the effect that TB spreads more easily in crowded conditions, especially in a closed environment. (In the light of such evidence, Prof Van Helden's refusal to acknowledge the necessity of isolation in the prison environment, was particularly unconvincing.)

[224.] In addition to the overcrowding, the evidence was clear that there was a lack of free flowing air in the cells of the maximum security prison. Dr Theron described the atmosphere in communal cells as one of dinginess and squalor. The air was thick with smoke from cigarettes and 'hondjies'. The cells had windows along one of the cell walls with a doorway on the opposite side. Once lock down had occurred at approximately 16h00, there was no cross-ventilation at all until the next morning at approximately 07h00 when the steel door to the cell would be opened. Dr Craven confirmed that during such time prisoners would be coughing, sneezing and spitting over each other. Prisoners were confined to their cells for 23 hours a day - unless they went to court - and were only let out for exercise for an hour.

[225.] It is also clear from the evidence that isolation of infective TB patients was not routinely practised. Dr Craven and Mr Muller testified that isolation of infectious TB patients was not practically possible, due to the overcrowding of the maximum security prison and the concomitant lack of suitable accommodation. Moreover, although so-called isolation cells were available in the hospital section of the maximum security prison, Dr Theron testified that these in fact did not provide isolation in the true sense. The evidence was that the solid metal doors to such cells were seldom closed, because the prisoners detained in such cells would then be cut off from contact with others and would have inadequate ventilation. Mr Gertse would have the Court believe that all prisoners who were infective were isolated, whether

in the hospital section or in some of the single cells in the sections which had been reserved for this purpose. His evidence in this regard was, however, contradicted by Mr Muller and Dr Craven, does not accord with the probabilities if regard is had to the measure of overcrowding and does not fit in with the plaintiff's treatment.

[226.] The plaintiff was not isolated at any stage after he had been diagnosed as suffering from TB. During the period of approximately 4½ years while he was awaiting trial, the plaintiff was detained in the E-section of the maximum security prison at Pollsmoor, save for a few months when he was held in the Medium B prison. Albeit that he spent some time in communal cells, he was incarcerated in a single cell for most of the time. He was, however, always in contact with other prisoners. He shared his single cell with two other inmates. On the approximately 70 occasions when he went to court, he was confined with other inmates in a holding cell at Pollsmoor, in the truck that conveyed him to court and in the court cells. On occasions when he was hospitalised in the prison, he was in a communal ward. When prisoners were let out for exercise, they congregated in the passage before being let out in the exercise yard. Indeed, even when the plaintiff was diagnosed as suffering from TB, he was not isolated from other prisoners, but returned to his cell.

[227.] It is clear from the plaintiff's evidence as well as that of Mr Gertse that the DOTS system of treatment was not adhered to in the maximum security

prison. As was explained by Dr Craven, the DOTS system is particularly important in the treatment of TB, because patients are frequently not inclined to take their medication on account of the side effects. Patients are also frequently poorly motivated to continue taking their medication once they feel better. Unless the entire period of treatment is completed, however, the patient may develop MDR-TB or even XTR-TB. Dr Theron held the same view. Indeed, Dr Theron testified that the fact that there were cases of both MDR-TB and XTR-TB in the maximum security prison was indicative of the fact that patients had not completed the entire course of medication. The evidence of the plaintiff and of Mr Gertse established that patients were not always seen to take their medication. The plaintiff testified that he was sometimes given as much as a week's medication in advance. Mr Gertse's evidence established not only that the patient treatment cards were sometimes filled out in advance of medication being taken, or subsequent thereto, but that such cards might be marked off by a person who had no direct knowledge of the administration of the medication.

[228.] There was a substantial nursing shortage at all of the prisons which form part of the Pollsmoor prison complex. The maximum security prison, in particular, had approximately 50% of the nurses which were required. The letters written by Mr Muller in this regard provide graphic detail of such fact. Dr Theron testified as to such shortage, as did Dr Craven. As a direct result of the fact that the number of available nurses was insufficient , clinics were

not held in the sections on a daily basis and patients had difficulty in obtaining their TB medication. Dr Craven testified that it was logistically impossible for the nurses to do what was required of them. The shortage of nurses was exacerbated by a shortage of warders and as a result, inmates who were ill and who required medical attention sometimes could not get to see the doctor. Dr Theron testified that inmates had sometimes been ill with TB for months before being brought to the doctor.

[229.] Given the nature of the disease and the manner in which it is transmitted, each of the factors adverted to above, on its own, was capable of facilitating the spread of TB in the maximum security prison. When these are regarded cumulatively, as they must, because none of these factors operated in isolation, the conclusion is inescapable that the spread of TB was indeed facilitated by the prevailing conditions in the said prison.

Is it more probable than not that the plaintiff's illness with TB was occasioned by, or resulted from, the prevailing conditions in the maximum security prison?

[230.] The plaintiff was 53 years old when he was first admitted to the maximum security prison. His evidence that he had not ever been ill with TB prior to such admission, was not challenged. Upon his admission, he was fit and well, save for some heart and prostate problems and he appeared to be well nourished. Dr Craven regarded him as obese and ordered that he receive

half rations. Although the plaintiff smoked, a factor which would make him more susceptible to TB, his evidence that he was fit and well and had always looked after his physical health, was also uncontested. Even when he was in prison, he kept an eye on his health by requesting regular sputum tests.

[231.] When the plaintiff is measured against the typical TB patient profile which Dr Theron referred to, the latter was of the opinion that the plaintiff had not been a typical candidate for the development of TB. Per contra, the plaintiff appeared to have been robust and well nourished. There was no evidence that he displayed any of the clinical signs and symptoms which were, in Dr Theron's experience as a clinician, indicative of TB or of susceptibility thereto.

[232.] The plaintiff became ill with TB after spending some 3 years in the maximum security prison. Given the plaintiff's medical history, coupled with the prevailing conditions in the maximum security prison, Dr Theron concluded that the prison situation caused him to become vulnerable to TB, because his immune system had broken down as a result of the stressful environment. Dr Craven testified that the plaintiff would have inhaled far more of the TB bacteria in prison than he would have in the outside world and that the increased dose of bacteria would, in turn, have increased the plaintiff's chances of becoming ill with the disease. Dr Craven also came to the conclusion that the plaintiff became ill with TB as a result of his

imprisonment.

[233.] Prof Van Helden took issue with the views of Dr Craven and Dr Theron, but his evidence in this regard was wholly unreliable. Not only did he attempt to apply inappropriate statistics to the plaintiff's case, but his opinion that the plaintiff had in all likelihood been infected with TB prior to being admitted to the prison, did not take into account the fact that the plaintiff had been incarcerated for a period of approximately 3 years before he succumbed to the disease.

[234.] During the course of the trial, much time was spent on the re-activation of TB as opposed to re-infection. It appears to me that such debate between Drs Theron and Craven on the one hand and Prof Van Helden on the other, is of academic importance only. Fact of the matter is that the plaintiff had been tested for TB when he was a child and lived in Edenvale. He had never been ill with TB throughout his entire life. He did not fit the patient profile for persons who would be vulnerable to TB. He came into a prison which had an unacceptably high incidence of TB and 3 years later he was diagnosed with the disease. When regard is had to these factors and to the manner in which the disease is spread, the conclusion is, in my view, inescapable that but for his incarceration in the maximum security prison, the plaintiff would probably not have become ill with TB.

[235.] The fact that the plaintiff had been aware that TB was prevalent in the

prison where he was detained and that he smoked, does not take the matter any further. The plaintiff was unaware as to the identity of the inmates were who were ill with TB, because the majority of the inmates smoked and coughed. However, even if he had known the identity of the prisoners who were ill with TB, he could not necessarily have avoided them. Although he spent most of his time in a single cell, which he shared with 2 other inmates, he was incarcerated in communal cells for some time during his incarceration and, in particular, when he had to attend court on 70 separate occasions. He also came into contact with other prisoners when they congregated in the passage leading to the court yard where they exercised. Just as smoke drifted down the corridor during the day, a fact which was not disputed, Dr Craven expected the TB bacteria to come drifting down the corridor. The fact that the plaintiff smoked might have caused him to be more susceptible to TB, but even if he had not smoked, he could not have avoided coming into contact with smoke.

[236.] On the totality of the evidence, I am accordingly satisfied that it is more probable than not that the plaintiff contracted TB as a result of his incarceration in the maximum security prison at Pollsmoor.

[237.] Once the plaintiff had been diagnosed as suffering from TB, he was promptly treated by means of the required prescription drugs. He completed the full course of treatment and was cured of TB. In these circumstances, the allegations made in paragraphs 15.2 and 15.3 of the

plaintiff's Particulars of Claim, to the effect that the responsible authorities failed to provide the plaintiff with adequate medical treatment, are without foundation.

Would a reasonable person, in the position of the defendant, have foreseen that the prevailing conditions in the maximum security prison would reasonably possibly spread TB amongst the inmates and cause inmates, such as the plaintiff, to succumb to the disease?

[238.] As has been alluded to above, TB is a formidable infectious disease which is easily spread. It is also a notifiable or communicable disease which must be reported to the Medical Officer of Health, because of the danger which it poses to society. It is, moreover, a disease which is difficult to treat, because patients are frequently not compliant once the symptoms have lessened. Incomplete treatment may result in infectious patients with chronic TB and in the development of resistant strains of TB such as MDR-TB and XTR-TB which are more difficult to treat.

[239.] It is well acknowledged that TB, because it is an airborne disease, spreads more easily in confined environments which are not exposed to adequate sunlight and ventilation. The cells which housed prisoners at the maximum security prison are not properly ventilated for a great part of the day and there is inadequate sunlight. Notably, cross-ventilation is absent after lock down and the free flow of air and light in the communal cells are further

restricted by blankets and the like which are put up to provide privacy, thereby causing such cells to be dark and dingy. Prisoners are confined to such cells for 23 hours per day in severely overcrowded conditions. Whereas the TB guidelines do not stipulate that persons in the outside world who are ill with the disease must be isolated from their families, Dr Theron and Dr Craven were agreed that isolation was extremely important in the closed prison environment. Their evidence in this regard is logical and, in my view, any person with a modicum of common sense would appreciate that in the prison context, or for example in an army camp, or any other place where people are confined in close quarters, TB patients have to be separated out lest they spread the disease.

[240.] Given the prevalence of TB in the maximum security prison, it appears to me that any reasonable person in the position of the defendant would also have realised and appreciated that the measure of overcrowding would facilitate the spread of the disease, especially in circumstances where there was inadequate screening of incoming prisoners, inadequate treatment of those who were ill with TB and inadequate numbers of nursing staff, in addition to overcrowding and the lack of isolation facilities. Once again, it is a matter of logic and common sense, having regard to the nature of the disease and the manner in which it is transmitted.

[241.] The evidence of Drs Theron and Craven established that the greater the pool of bacteria, the greater the chances are of becoming infected with the

disease. Persons who had previously had TB were also, according to Prof Van Helden, more susceptible to a recurrence. Even persons who had not previously been ill, but whose immune system had become compromised, were at risk for developing the disease. A reasonable person in the defendant's position, who was responsible for the health and welfare of prisoners, would no doubt have ensured that he/she had been informed of the risk factors and would accordingly have appreciated these facts. Defendant's attention had been drawn to the problems posed by overcrowding, nursing shortages and the spread of TB, as is evidenced by the letters written by Mr Muller and the alarms raised by Dr Theron and Dr Craven which culminated in the approach to the parliamentary portfolio committee.

[242.] In the result, I am satisfied that a reasonable person in the position of the defendant would have foreseen that the prevailing conditions in the maximum security prison at Pollsmoor would reasonably possibly spread TB amongst inmates and cause inmates, such as the plaintiff, who had not previously been ill with TB, to succumb to the disease.

Would a reasonable person, in the position of the defendant, have taken steps to guard against the spread of TB?

[243.] Given the serious nature of the disease, the ease with which it is transmitted and the risk which the disease posed to the health of the

general prison population, warders and nurses included, a reasonable person in the position of the defendant would, in my view, have taken steps to guard against the spread of the disease, if it was at all feasible to do so. It has to be determined, however, what steps could reasonably have been taken.

[244.] It is readily evident that the lack of proper ventilation and sunlight in the cells of the maximum security prison was due to the manner in which the building had been designed and constructed. Incarceration under such circumstances is clearly undesirable and may constitute a breach of the plaintiff's right in terms of clause 12 of the Constitution not to be treated or punished in a cruel, inhuman or degrading way. There is no doubt that the lack of proper ventilation and sunlight in the prison cells materially contributed to the spread of TB in the prison. The plaintiff, however, proffered no evidence that such design flaw is practically capable of remediation and it is not the task of this Court to speculate on measures that could or could not have been instituted to remedy such defect.

[245.] Overcrowding of the prison was clearly a major problem and certainly contributed to the spread of TB in the prison. It is, however, by no means clear what steps could have been taken to alleviate the situation. Reference was made to the fact that some prisoners were let out on early parole in order to reduce the number of inmates and that other prisons, such as Goodwood, did not suffer from overcrowding, but the maximum security

prison remained overcrowded. Whilst it is true that the defendant did not offer any reasonable explanation as to why the overcrowding was permitted to continue, other than for Mr Gertse's evidence that the courts sent prisoners there and that the authorities at Pollsmoor had no choice in the matter, the plaintiff failed to tender any evidence as to reasonable steps that could have been taken to reduce the overcrowding. Once again, the Court is not entitled to speculate about the steps that could or could not reasonably have been taken to do so.

[246.] The evidence tendered by Dr Theron does, however, establish that the spread of TB can be curtailed by introducing some relatively simple, cost effective, measures as had been demonstrated during his experience at the low cost, community hospital, ran by Dr Barker in Kwazulu Natal during the period 1971 to 1973. What is required, is early identification of persons who are deteriorating and who may accordingly become vulnerable to TB, early diagnosis of the disease, effective treatment and proper nutrition.

[247.] It appears to me that in the context of the maximum security prison at Pollsmoor, the aforesaid measures would translate into the proper screening of incoming prisoners, inclusive of a physical chest examination; separating out those who had, or were suspected of having TB, or who were obviously under nourished and vulnerable to TB; the provision of adequate nutrition to those who were undernourished and otherwise vulnerable to TB; regular and effective screening of the prisoner population, inclusive of examinations

by means of X-Rays and/or physical chest examinations by means of a stethoscope, to identify possible TB infection; isolation of infectious inmates and effective implementation of the DOTS system over the prescribed period of time.

[248.] The measures referred to in the immediately preceding paragraph, other than isolation, are all obviously dependant on sufficient numbers of nursing staff and doctors to perform the various tasks. The shortage of nursing staff had been a major problem at Pollsmoor in general and, at the maximum security prison in particular, for a considerable period of time. The correspondence by Mr Muller and Mr Engelbrecht which form part of Exhibit A referred expressly to the under staffing of the health care service in the prison and the effect thereof on the standard of care. The report by Ms Magoro, the Director Health and Physical Care dated March 2001 (Exhibit A p 53 et seq) similarly drew attention to these matters. However, as is apparent from subsequent correspondence, posts remained vacant. By facsimile dated 21 January 2002 forwarded to the Commissioner of Correctional Services, the Area Manager, Mr Engelbrecht, drew attention to the fact that 10 posts for professional nurses were vacant and that a memorandum regarding the appointment of additional nurses which had been sent in October 2001, had not been answered (Exhibit A, p 29 -30). Facsimiles sent by Mr Muller to the aforesaid Commissioner on 28 November 2001 and 16 January 2002, drew attention to the fact that vacant posts for registered nurses had been advertised in August 2001,

interviews had been conducted from 29 October to 2 November 2001, but appointments had not been made (Exhibit A p 32 - 34).

[249.] According to the evidence given at the trial of the matter, staff shortages remained a problem throughout the time of the plaintiff's incarceration. In my view, a reasonable person in the defendant's position would have realised that adequate staffing was the key to the prevention and control of TB and would have taken steps to ameliorate the staff shortage as a matter of some urgency.

[250.] The overcrowding of the maximum security prison obviously made it difficult, if not impossible, to isolate all of the persons who were in the infectious stage of TB in the prison hospital. The evidence of Dr Theron and Dr Craven made it clear that isolation was an important element in the prevention of the spread of TB in a closed environment, such as the prison and logic dictates that infectious prisoners ought to have been separated from the general prison population if the spread of TB was to be curtailed.

[251.] Whilst the evidence has established that some so-called isolation facilities were available in the hospital section, it was apparent from Dr Theron's evidence that the design of the so-called isolation cells was such that isolation was not capable of practical implementation. There is no evidence that such problem was capable of remediation, given the physical constraints of the prison building. Mr Gertse, however, testified that some

of the single cells in the sections were also used as isolation facilities. If it is accepted that some of the single cells were set apart for isolation purposes, it tends to indicate that with a measure of re-organisation, more cells could have been used for such purpose. However, no evidence as to whether or not it would have been feasible to do so, was presented.

[252.] In conclusion, a reasonable person in the defendant's position would, in my view, have taken steps to guard against the spread of TB in the maximum security prison, because it is such a formidable disease which is easily spread. More particularly, a reasonable person would have ensured that sufficient numbers of nursing staff were employed to perform the various tasks involved in the control and prevention of TB in the said prison.

Did the defendant take reasonable steps to guard against the spread of TB?

[253.] On the evidence before the Court, one could not reasonably have expected the defendant to re-design the prison, or to remedy the design defects. The evidence tendered is also insufficient to determine whether or not the defendant could reasonably have gained control over the overcrowding.

[254.] The failure to isolate infectious TB patients may well have breached the defendant's obligations in terms of clause 15 of Chapter 3 of the standing orders which provides that prisoners with communicable conditions must be

isolated. Given the constraints imposed by inadequate accommodation and overcrowding I am, however, not satisfied that it has been established that it would have been reasonably possible to provide isolation for all of the infectious prisoners.

[255.] The evidence has, however, established that if sufficient members of nursing staff had been available, proper and effective screening could have been conducted, which was one of the key elements in gaining control over the spread of TB in the prison. In addition, nurses would have been able to conduct clinics in the various sections on a daily basis, which means that it would have been possible to identify potential TB patients more expeditiously and to implement the DOTS system effectively. In short, the evidence has established that sufficient numbers of nursing staff were essential in combatting and controlling TB in the prison. Put differently, the serious shortage of trained nursing staff was one of the main factors which resulted in the loss of control over TB in the maximum security prison.

[256.] The defendant, obviously had the power and authority to appoint additional staff, but failed to do so. The reasons why vacant positions were not filled, are obviously within the exclusive knowledge of the defendant, but the defendant tendered no evidence to show that it was impossible, inappropriate, or unreasonable, to fill vacant posts on the nursing staff establishment, or that there were alternative means of curtailing the spread

of TB in the maximum security prison. The high water mark of the defendant's case was that a self-reporting system was in place in the prison, that it was up to inmates to report if they were ill and that sputum tests were conducted for prisoners who requested these.

[257.] The authorities' reliance upon a self-reporting system, in terms whereof prisoners had to come forward if they were ill, appears to me to have been ill-advised, inappropriate and wholly insufficient in the fight against TB in the prison environment for, inter alia, the following reasons:

[257.1] According to the evidence, most of the inmates smoked, cells were filled with smoke and drifted down the corridor and most of the inmates coughed. Mere coughing was accordingly unlikely to precipitate any action on the part of an affected inmate. Indeed, Dr Craven's evidence was that people who usually cough do not regard a cough as pathological and only go to the doctor once additional symptoms have manifested. Such evidence also accords with common sense and with the probabilities. In instances where people have become ill with TB, they accordingly cough up bacteria until such time as they have manifested additional symptoms which make them realise that they are ill. In the closed prison environment which is characterised by poor ventilation and a lack of sunlight, this means that the bacteria remain active for some

time. Moreover, with each person who has become ill with TB, but has not been diagnosed, the pool of TB bacteria increases. Fellow inmates who are not ill with TB are, however, exposed to the TB bacteria which may be present in a cell for 23 hours each day;

[257.2] According to the evidence, prison gangs had their own 'doctors' or 'inyangi', who exercised control over inmates and who dictated when inmates could see the prison doctor. Inmates who were ill with TB could accordingly be prevented from seeking timeous medical assistance, thereby increasing the pool of bacteria in the prison environment;

[257.3] the number of nurses employed at the maximum security prison were wholly insufficient to cater for the needs of inmates. As Mr Muller testified, it was accordingly not possible for a nurse to visit each of the sections on a daily basis so as to attend to inmates' complaints. It was also practically difficult for inmates to get to the hospital to see the doctor, as was testified to by Dr Theron and the plaintiff. The number of warders was insufficient and there were many gates and check points to traverse. Dr Theron testified that there had been several cases in the maximum security prison where prisoners with active TB had been incarcerated for 3 or 4 months without having been referred to the hospital, because of

difficulties with access;

[257.4] There was insufficient monitoring of suspected TB cases. Nurses did not get to see inmates in the sections on a daily basis, due to the staff shortage. Although Mr Gertse tended to suggest that the 'suspect register' was already being used at the time of the plaintiff's incarceration, it is by no means clear that this was the case. Mr Gertse's evidence was tainted by unreliability on account of his bias in favour of defendant's case and the fact that he did not appear to have much respect for the truth. However, even if one were to accept that the register was being maintained, Mr Gertse testified that in instances where sputum tests produced negative results, such results were not brought to the attention of the doctor. Sputum tests do not always produce positive results in instances where a patient is already ill with TB. This was illustrated in the plaintiff's own case. If prisoners whose sputum tests produced negative results were referred to the doctor, the latter would, at least, have been able to perform a proper chest examination in order to determine whether there was evidence of any underlying pathology which required further investigation and/or treatment. Given the failures in the system alluded to above there was, however, no proper follow-up of suspected TB cases.

[258.] In light of the circumstances adverted to above, the crisp answer to the question as to whether the defendant took reasonable steps to guard against the spread of TB, or to curb its spread in the maximum security prison, is no. There is no evidence that the defendant, or members of the DCS took any steps whatsoever to guard against the spread of TB in the maximum security prison. It follows that the defendant's omission(s) referred to above, constituted negligence.

Allegations of Negligence Found to Have been Proved

[259.] On the totality of the evidence, at appears to me that the Plaintiff has proved the following elements of his claim on preponderance of probabilities:

[259.1] That it was common for inmates, including the plaintiff, to be congregated in close proximity to one another and to be housed in mass cells;

[259.2] That a considerable proportion of prisoners were ill with TB and were infectious, but that they were not isolated from the general prison population;

[259.3] That it was reasonable to expect that persons who were in the

infectious stage of the disease, would expel TB bacteria by coughing, sneezing or spitting and that such bacteria would infect fellow inmates who were in close proximity to them;

[259.4] That it was reasonable to expect that some of the inmates who were infected with TB bacteria as aforesaid, would themselves become ill with the disease;

[259.5] That the plaintiff was infected with TB bacteria during his imprisonment and became ill with the disease;

[259.6] That the responsible authorities could have prevented, or curtailed, the spread of TB in the maximum security prison by providing sufficient numbers of adequately trained nursing staff to properly screen incoming prisoners for TB, to screen inmates regularly for TB, to effectively counsel those inmates who had been in close contact with freshly diagnosed TB patients and to apply the DOTS system effectively;

[259.7] That the responsible authorities failed to prevent or curtail the spread of TB as aforesaid and failed to provide adequate numbers of nursing staff to perform the aforesaid tasks;

Was the defendant's failure to take reasonable steps as aforesaid unlawful?

[260.] As appears from the extract of the Plaintiff's Particulars of Claim which has been referred to in paragraph [6] above, the plaintiff has alleged that the conduct of the responsible authorities was unlawful in that the plaintiff's rights at common law, under the Correctional Services Act 1959 and under the Constitution, were violated.

[261.] If it is found that an omission is culpable, because a reasonable person in the position of the defendant would not only have foreseen the harm, but would also have acted to avert it, that is not the end of the matter. Negligent conduct consisting of an omission is only visited with liability in circumstances that the law regards as sufficient to give rise to a legal duty to avoid negligently causing harm. Whether or not such a legal duty is to be imposed, must be determined by the courts upon a consideration of public and legal policy which is consistent with constitutional norms[8].

[262.] As was pointed out in Van Duivenboden [9] the reluctance to impose liability for omissions is often founded on the concept that individuals are free to mind their own business and the protection which is afforded by the Bill of Rights to equality, personal freedom and privacy may further militate

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[8] Minister of Safety and Security v Van Duivenboden, supra, paras [12] - [17] at 441E-444G. See also Mcintosh v Premier Kwa Zulu Natal [2008] 4 All SA 72 (SCA) at 77d-f

[9] Supra, paras [19] - [20] at 445B-446E

against imposing legal duties on private citizens. Different considerations, however, apply in instances where the conduct of a public authority or functionary is in issue. Public functionaries are, after all, usually charged with serving the interests of the community so that their failure to act cannot be dealt with on the same footing as an omission on the part of private individuals. In the interests of effective government, public functionaries must be afforded the freedom to arrange their affairs and to provide public services without the constant threat of litigation if they were to act negligently. The position of public functionaries is, however, different from that of private individuals in a most important respect. The Constitution expressly imposes certain obligations upon the State. So, for example, section 7 of the Constitution requires the State to protect, promote and to fulfil the rights embodied in the Bill of Rights. Section 2 of the Constitution demands that the obligations imposed by the Constitution be fulfilled and section 41(1) expressly provides that all spheres of government and all organs of State within such spheres must provide government that is accountable, in addition to being effective, transparent and coherent.

[263.] The defendant is ultimately responsible for the safety, health and well-being of prisoners. In fulfilling that responsibility the defendant, in accordance with his obligations in terms of the 1958-Act and the Constitution, must clearly take such steps and do such things as may be necessary to ensure

that the right of a prisoner to treatment which is not inhuman or degrading, is preserved, as well as his right to dignity.

[264.] In the instant case, it appears to me that the plaintiff's rights as aforesaid have been violated. The evidence clearly shows that the plaintiff was detained in extremely overcrowded and poorly ventilated cells. Although the plaintiff received adequate medical treatment once he had been diagnosed with TB, the severe shortage of qualified nurses caused health services in the prison to break down. As a consequence, persons who were ill with TB were not routinely provided with adequate treatment and TB, inclusive of MDR-TB and XTR-TB became prevalent in the prison. In addition, the defendant and/or his officials at the maximum security prison failed to act in accordance with the provisions of section 23 of the 1959-Act and the standing orders, inasmuch prisoners with infectious diseases, such as TB, were not routinely separated from the remainder of the prison population, thereby facilitating the spread of the disease, given that the inmates found themselves in a closed, poorly ventilated environment. Instead of adopting measures to curtail the spread of TB in the maximum security prison, such as adequate screening, the authorities relied on a wholly inappropriate self-reporting system which permitted persons with TB to remain in the general prison population. The authorities had been warned in graphic terms that the situation at Pollsmoor, inclusive of the maximum security prison, was grave cause for concern and that conditions

at the prison were conducive to the risk of spreading TB, bur failed to address the problems in any meaningful manner.

[265.] The conditions under which the plaintiff was detained show considerable similarity with those in the case of Kalashnikov v Russia, an application decided by the European Court of Human Rights under the Convention for the Protection of Human Rights and Fundamental Freedoms. Kalashnikov had been detained in a pre-trial prison which was particularly overcrowded. His cell was so overcrowded that inmates had to take turns to sleep. There was an absence of adequate ventilation, but despite such situation prisoners smoked in the cell. He was allowed outside for exercise for 1 or 2 hours per day, but spent the rest of the time in the cell with limited space for himself and in a stuffy atmosphere. The cell was infested with pests and he contracted various skin diseases and fungal infections throughout his detention. On occasion he was detained with persons suffering from TB and syphilis.

[266.] Albeit that the European Court of Human Rights found that the Russian government had not had the direct or positive intention of humiliating or debasing the applicant, it found that the conditions of detention, in particular the severely overcrowded an insanitary environment and its detrimental effect on the applicant's health and well-being, combined with the length of his detention (from June 1995 to October 1999, i.e. a period

of approximately 4 years) amounted to degrading treatment.

[267.] The circumstances under which Kalashnikov was incarcerated, appear to have been somewhat worse than those which prevailed at the maximum security prison where the plaintiff had been detained. However, whereas there was evidence before the European Court that the Russian government were doing their best to improve conditions of detention in Russia, the defendant has not proffered any such evidence. Although Mr Jamie mentioned in argument that the defendant was subject to certain financial constraints, there was in fact no evidence to that effect.

[268.] Prison inmates live in an environment which is closed and which puts them at the mercy of defendant and his officials. It was the duty of the defendant and his officials, in terms of the 1958-Act and the Constitution, to provide prisoners with treatment which is neither inhumane nor degrading and to preserve prisoners' right to dignity. The failure of the defendant and his officials to do so is, in my view, not justifiable, whether in terms of section 36 of the Constitution or otherwise. These considerations must weigh heavily in favour of a finding that the defendant's conduct, and that of his officials, was unlawful. A further factor which must be borne in mind is that the plaintiff would have no means of redress if the defendant's conduct - and that of his officials - was held to be lawful. The result would be that the responsible authorities could ignore

their duties to prisoners with impunity. In my view, neither public nor legal policy, nor the provisions of the Constitution, could have intended such a wholly inequitable and unjustifiable result.

[269.] It follows that, in my view, the conduct of the defendant and his officials in omitting to take steps to guard against the spread of TB in the maximum security prison as aforesaid, was unlawful.

[270.] In the result, the following order is hereby made:

1. The defendant is declared to be liable to the plaintiff in delict pursuant to the plaintiff having become ill with TB whilst he was incarcerated in the maximum security prison at Pollsmoor;

2. The registrar is requested to set the matter down for hearing, in consultation with the Judge President, in order for the parties to lead evidence pertaining to the quantum of the plaintiff's damages in respect of his illness with TB as aforesaid and the sequelae thereof;

3. Defendant is to pay the plaintiff's costs of suit as between party and party.

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A M DE SWARDT, A J