

IN THE CONSTITUTIONAL COURT OF SOUTH AFRICA

Case No. **CCT 20/12**

SCA Case No. **316/11**

In the matter between

DUDLEY LEE

Applicant

and

THE MINISTER OF CORRECTIONAL SERVICES

Respondent

STATEMENT OF AGREED FACTUAL FINDINGS

The parties agree on the following facts found by the trial court and the Supreme Court of Appeal.

Tuberculosis

1. Tuberculosis (TB) is a formidable infectious disease which is easily spread¹ and is caused by an airborne bacterium, mycobacterium

¹ Annexure G: Trial Court Judgment, para 238

tuberculosis. Transmission in human beings occurs by inhalation of the organism. Once inhaled it will in some cases be destroyed by the host, in other cases it will take hold but be kept in check (in which case it might remain dormant for many years and then be triggered into multiplying and causing active disease), or it will immediately take hold, multiply and manifest in active disease.²

2. A person who has been infected with the organism will not transmit it unless it has progressed to active disease. Organisms might then be transmitted in droplets of sputum that are carried through the air when they are expelled from the lungs, for example by sneezing, coughing or spitting. The carrier will continue to be contagious until the concentration of organisms is reduced sufficiently by medical treatment which generally occurs about a fortnight after treatment begins.³
3. Active disease develops progressively. As it advances it presents itself in the form of persistent shortness of breath and chest pain, loss of appetite and loss of weight, general malaise, and night sweats and fever.⁴

² G: para 8; Annexure DL1: SCA Judgement, para 7

³ DL1: para 8

⁴ DL1: para 9

4. It is a serious public health problem, found worldwide, albeit more common in developing countries⁵ e.g. South Africa, which has one of the highest incidence rates of tuberculosis in the world.⁶
5. Because it is an airborne disease, it spreads more easily in confined environments which are not exposed to adequate sunlight and ventilation.⁷ 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.⁸
6. The indoor environment is more friendly to the tuberculosis bacteria, because these bacteria are vulnerable to sunlight and fresh air.⁹ 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 special anti-bacterial antiseptics in circumstances where there is a lack of sunlight and a good draught of air, it could remain infectious for an extended period of time.¹⁰

⁵ G: para 8

⁶ DL1: para 10

⁷ G: para 239

⁸ G: para 87.1(a)

⁹ G: paras 87.1(c) and 9

¹⁰ G: para 9

7. Dank and poorly ventilated living conditions, close contact with those who have active disease, and an immune system compromised by poor nutrition or other causes, are all conducive to the transmission of the disease.¹¹

8. Not all persons exposed to the tuberculosis bacterium become ill. One of three things may occur:

8.1. The body's immune system may destroy the tuberculosis bacterium;

8.2. The body's immune system could wall off the tuberculosis bacterium in a tiny piece of scar tissue, referred to as a granuloma. In this situation, the tuberculosis bacterium could remain dormant without the person being aware that infection occurred. However, the dormant tuberculosis bacterium could subsequently become active, even many years later, and the infected person would become actively ill;

8.3. The tuberculosis bacterium could take hold and multiply.¹²

9. Three factors have a bearing on whether an exposed person may develop a sub-clinical infection or become actively ill:

¹¹ DL1: para 10

¹² G: para 10; DL1: para 7

- 9.1. The virulence of the tuberculosis bacterium;
 - 9.2. The dose of tuberculosis bacteria inhaled (the larger the number of bacteria inhaled the greater the chance of developing the disease);
 - 9.3. The exposed person's resistance to the bacterium; persons whose immune system has been compromised, or who suffer from another illness that might contribute to the lowering of their immunity (e.g. diabetes mellitus, cancer or HIV) are at greater risk of developing the disease. Smokers also have a high risk of developing tuberculosis.¹³
10. An infectious person will continue to be contagious until the concentration of organisms is reduced sufficiently by medical treatment, which usually occurs a fortnight after treatment begins.¹⁴
 11. Some persons who are ill with tuberculosis shed more bacteria than others and are known as 'super shedders'.¹⁵

¹³ G: para 12

¹⁴ DL1: para 8

¹⁵ G: para 9

12. Tuberculosis is a notifiable disease or communicable disease which must be reported to the Medical Officer of Health, because of the dangers which it poses to society.¹⁶

Diagnosis and Treatment of TB

13. Pulmonary tuberculosis is diagnosed by sputum tests and cultures as well as x-rays of the lungs. X-ray findings on their own are not necessarily conclusive. Normally, a microscopic analysis of a sputum sample is conducted, and a preliminary report on microscopic analysis is provided within two days. If bacteria are present, these are grown in a culture for up to six weeks. If the culture yields a positive result, it is indicative of active TB infection.¹⁷
14. While the presence of organisms confirms the presence of the disease the contrary is not necessarily true. A negative test confirms the absence of organisms from the sample, but the sample may not be representative of the host, which means that a negative test is not confirmation of the absence of the disease.¹⁸
15. It is notionally possible to test persons, via a skin test, to see if they have been infected in the past. However, this is an invasive procedure and

¹⁶ G: paras 16 and 238

¹⁷ G: para 13

¹⁸ G: paras 13 and 257.4; DL1: para 9

persons are not subjected to skin tests. When a person becomes ill with tuberculosis, it is not usually possible to establish definitely whether it is the result of dormant tuberculosis bacteria which has become active (re-activation) or whether it is the result of a fresh infection (re-infection).¹⁹

16. The guidelines for the treatment of TB are based on a Directly Observed Treatment Short-course Strategy (“DOTS”).²⁰ 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.”*

17. The DOTS system of treatment is calculated to ensure that every tuberculosis patient has the support of another person *“to ensure that*

¹⁹ G: para 11

²⁰ G: para 18.

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.²¹

18. In terms of the DOTS system, each person who is diagnosed as being ill with tuberculosis, receives a Patient Treatment Card. This 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.²²
19. The standard treatment for tuberculosis is a combination of four antibiotics, referred to as Regimen I. Multi-drug resistant tuberculosis (MDR TB) is treated with different antibiotics, referred to as Regimen II.²³
20. Effective management of tuberculosis is relatively straightforward, in theory. What is called for, firstly, is screening and diagnosis to detect the disease; secondly, isolation of carriers for so long as they are contagious (generally about two weeks after treatment commences); and thirdly, antibiotic treatment for six months.²⁴

²¹ G: para 19

²² G: para 20

²³ G: para 14

²⁴ DL1: para 17

21. In 2000, the Department of Health published “*The South African Tuberculosis Control Programme Practical Guidelines*” (“*the guidelines*”) for the management of tuberculosis. 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.**”²⁵

Applicant’s medical history and incarceration in Pollsmoor

22. Applicant was arrested during November 1999.²⁶ He was 54 years of age at the time and in reasonable health when he entered prison.²⁷
23. Pollsmoor prison (“Pollsmoor”) is a prison complex consisting of five different prisons: the admissions centre which is also known as the maximum security prison, the woman’s prison, the juvenile prison and the medium security prisons B and C for sentenced prisoners.²⁸ Applicant was detained in the maximum security prison for a period of approximately 4½ years from November 1999 to 27 September 2004.²⁹

²⁵ G: para 17

²⁶ DL1: para 1

²⁷ DL1: para 2

²⁸ G: para 1

²⁹ G: para 2

During the course thereof he appeared in court about seventy times, before he was acquitted and released in September 2004.³⁰

24. Apart from some trouble with his heart and prostate, Applicant was healthy and had never been ill with tuberculosis prior to his incarceration.³¹
25. On his initial arrival at Pollsmoor, Applicant was taken to a holding cell in the administrative section of the maximum security prison. One of the inmates (Trevor Blignault) conducted a basic screening procedure, *inter alia*, by asking persons who had medical conditions to step forward and make themselves known.³²
26. Applicant never saw a nurse conducting screening on any of the occasions that he returned to prison from Court.³³
27. After completion of the necessary administrative processes to register prisoners, Applicant was admitted to the hospital in the maximum security prison because he suffered from a heart condition.³⁴

³⁰ DL1: para 1

³¹ G: para 37

³² G: para 39

³³ G: para 39

³⁴ G: paras 39 and 40

28. On the following morning, 23 November 1999,³⁵ Dr Craven examined Applicant and booked him into the hospital where he stayed until he was released on bail in February 2000.³⁶ Dr Craven treated Applicant for his ischaemic heart disease, advised him to stop smoking, lose weight and ordered that Applicant should receive half rations.³⁷
29. Applicant was arrested again in April 2000³⁸ and was detained in Pollsmoor Maximum Security Prison until his acquittal.
30. On the 70 occasions Applicant attended court, 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 that they were to attend, before being loaded onto trucks or vans which took them through to court. Prisoners going to Cape Town 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.³⁹

³⁵ G: para 124

³⁶ DL1: para 1

³⁷ G: para 124

³⁸ DL1: para 1

³⁹ G: para 50

31. On his return, Applicant, with the other prisoners, would be counted and searched before being let into the reception and the communal cells where they had waited to go to court in the morning. New prisoners were registered and existing inmates were taken to the overnight cells. On some occasions when he was not feeling well, warders made a plan to get Applicant back to his cell.⁴⁰
32. Initially, after his second arrest, Applicant was housed in a communal cell, but for most of his incarceration he was housed in a single cell with one or two other persons.⁴¹
33. For most of his incarceration, Applicant was housed in E-Section of the maximum security prison, in a cell designed for occupation by one person. He shared this cell with one or two other prisoners.⁴² At one stage, the whole of Applicant's section was moved to the Medium B prison "B" where Applicant was detained in a communal cell with about 25 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 again*".⁴³

⁴⁰ G: para 51

⁴¹ DL1: para 12

⁴² G: para 51; DL1: para 12

⁴³ G: para 51.

34. Applicant was not aware of sharing a cell with someone who had tuberculosis.⁴⁴
35. Prisoners, such as Applicant, who were incarcerated while on trial spent up to 23 hours a day in their cells. Weather permitting they would be taken out and into a concrete yard for exercise for 30 to 60 minutes. The yard was packed with prisoners. When they lined up to go there they were confined in close proximity to each other in a passage leading to the yard.⁴⁵
36. Lock down occurred at around 16h00 or 16h30, when a barred gate and solid metal door to the cell would be shut and remain so until morning.⁴⁶
37. Applicant regularly had sputum tests performed. The results of all these tests were negative until 2003.⁴⁷
38. Applicant became ill with TB after spending some three years in the maximum security prison.⁴⁸

⁴⁴ DL1: para 12

⁴⁵ G: para 53

⁴⁶ G: para 54

⁴⁷ G: para 42

⁴⁸ G: para 232

39. On 14 April 2003, Applicant complained of tuberculosis symptoms, whereupon sputum samples were taken which produced a negative result.⁴⁹
40. On 27 May 2003, Dr Craven diagnosed Applicant as having an inguinal hernia⁵⁰ and ordered his immediate transfer to Victoria Hospital⁵¹ where the hernia was surgically repaired.⁵²
41. On Applicant's return to the maximum security prison, on 30 May 2003, he was admitted to the prison hospital. There he was placed in a communal cell with a floating population of either eight or nine other prisoners⁵³ and remained there albeit that the prison authorities learned of his infectious condition during that time.⁵⁴
42. When Dr Craven saw Applicant on 2 June 2003, after his discharge, it was reported to him that Applicant had pulmonary TB. Dr Craven ordered that sputum samples be taken, that Applicant's X-Rays be obtained from Victoria Hospital, that Applicant be admitted to the prison hospital section and that he should see the Applicant in eight days.⁵⁵

⁴⁹ G: para 125; DL1: para 13

⁵⁰ G: para 125

⁵¹ G: para 125

⁵² DL1: para 14

⁵³ DL1: para 15

⁵⁴ DL1 : paras 29 &30

⁵⁵ G: para 125; DL1: paras 14 and 15

43. On 3 June 2003 Dr Craven saw the X-Ray which indicated that Applicant had bilateral infiltration and cavities in the lungs which was indicative of tuberculosis.⁵⁶
44. On 9 June 2003 Dr Craven received the laboratory report which indicated that Applicant's sputum samples tested positive for tuberculosis. Dr Craven ordered that Applicant's illness be reported and that Applicant was to start on Regimen I treatment.⁵⁷
45. Notwithstanding that he could be expected to remain contagious for a further two weeks, Applicant was returned to his cell where he was confined for up to 23 hours a day with at least one other prisoner.⁵⁸
46. After spending approximately 10 days in the hospital section, Applicant went back to the single cell he shared with two other prisoners.⁵⁹
47. Applicant completed the full course of treatment and was cured of tuberculosis.⁶⁰
48. Applicant had been warned that he could be reinfected and could develop drug resistant TB if he failed to take the medication as

⁵⁶ G: para 125; DL1: paras 14 and 15

⁵⁷ G: para 126; DL1: paras 14 and 15

⁵⁸ DL1: para 30

⁵⁹ G: para 44

⁶⁰ G: para 237

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 tuberculosis medication in the cell with him.⁶¹

49. Applicant was a smoker, which made him more susceptible to tuberculosis.⁶²

Prison environment and control of TB

50. Prisons in this country present a favourable environment for contracting tuberculosis⁶³ (for the following reasons):

- 50.1. many prisoners will have entered prison from socio-economic conditions in which there is a high incidence of the disease; many will not have had ready access to medical treatment and be contagious: many will lack the acumen to detect the presence of the disease and take steps to have it treated;

⁶¹ G: para 48

⁶² G: para 230

⁶³ DL1: para 11

50.2. poorly ventilated cells provide favourable conditions for expelled organisms to live in the atmosphere for long periods of time;

50.3. there is “notorious congestion”, the prisoners being confined to close contact for as much as 23 hours every day, which provides ideal conditions for transmission;

50.4. open coughing, and spitting of mucus that, in some conditions, is capable of remaining infectious for three months or more, is not uncommon.⁶⁴

51. There were cases of both MDR-TB and XDR-TB in the maximum security prison.⁶⁵

52. The authorities at Pollsmoor prison were pertinently aware of the risk to prisoners of contracting tuberculosis.⁶⁶

53. The approved accommodation at the maximum security prison was 1619 inmates. The lock up total on occasion was as much as 3052.⁶⁷ Single cells regularly housed three inmates and communal cells were filled with double and sometimes triple bunks.⁶⁸

⁶⁴ DL1: para 11

⁶⁵ G: para 227

⁶⁶ DL1: para 18

⁶⁷ G: para 223

⁶⁸ G: para 223

54. There was a lack of free-flowing air in the communal cells of the maximum security prison. The air was thick with smoke from cigarettes and “*hondjies*”. The communal 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.⁶⁹
55. Control of tuberculosis at Pollsmoor depended upon effective screening of incoming prisoners, the isolation of infectious patients and the proper administration of the necessary medication over the prescribed period of time.⁷⁰
56. Clause 4.1(a) of Chapter 3 of the Standing Correctional Orders provides that all persons admitted to prison, should be seen on admission by a registered nurse for, inter alia, medical problems, whether acute or chronic.⁷¹

⁶⁹ G: para 224

⁷⁰ G: para 214

⁷¹ G: para 215

57. Such provision was 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”*.⁷²

58. Clause 6.1 of the said Standing Correctional 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.”*⁷³

59. 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.⁷⁴

60. Clauses 14 and 15 of Chapter 3 of the Correctional Standing Orders made the following provisions for 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.

⁷² G: para 215

⁷³ G: para 215

⁷⁴ G: para 215

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.*⁷⁵

61. The maximum security prison had only 50% of the nurses who were required. Not all of the employed nurses were at work.⁷⁶

62. During the period of Applicant's incarceration, prisoners were not screened by a registered nurse or medical practitioner for TB or any other disease, upon their arrival at the prison.⁷⁷ No doctor was on duty when prisoners were brought back from court. There was only one nurse on duty at Pollsmoor after 16h00 and that nurse was responsible for all five of the prisons. Prisoners who came from the courts in the afternoon

⁷⁵ G: para 215

⁷⁶ G: para 60

⁷⁷ G: para 216

could not be screened by the night nurse, and screening did not form part of that nurse's duties.⁷⁸

63. Incoming prisoners were screened on the morning after their admission and those with medical complaints were then referred to the doctor.⁷⁹

64. Persons who were ill with TB were allowed to mingle - at least overnight. If they did not volunteer that they were ill with tuberculosis, or that they were suffering from symptoms which were indicative of tuberculosis, 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 meantime, those who were ill with tuberculosis would be expelling tuberculosis bacteria into their overcrowded cells every time they sneezed, coughed or spat.⁸⁰

65. Screening forms (such as exhibits O and P) containing details of incoming prisoners were printed out on completion of the admission process. They contained only the most basic information in regard to the prisoner's health status – body mass and whether they had any medical complaints. Nurses who conducted the “*screening*” process did not

⁷⁸ G: paras 60 and 216

⁷⁹ G: para 216

⁸⁰ G: para 221

physically examine any of the prisoners. They merely noted whether a prisoner provided a positive or negative answer to the question as to whether he had any medical complaints; and only prisoners who answered affirmatively received medical attention.⁸¹

66. 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.⁸²

67. Persons from lower economic classes, who smoked and lived in overcrowded conditions, frequently coughed and did not regard the cough as pathological, and only went to the doctor when additional symptoms manifested. Therefore, it was unlikely that incoming prisoners who were already ill with tuberculosis, who had not experienced marked symptoms, other than coughing, would have volunteered that they were ill.⁸³

68. 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 a suspect register.⁸⁴ Only the cases which yielded positive results would be referred to the doctor. If test results were

⁸¹ G: para 217

⁸² G: para 219

⁸³ G: para 218; DL1: para 11

⁸⁴ G: para 220

negative for TB, the nurse would merely counsel the inmate and, if necessary, treat the cough.⁸⁵

69. Isolation of infected tuberculosis patients was not routinely practised.⁸⁶

Some of the single cells were used as isolation facilities. With a measure of organisation more cells could have been used for this purpose. However, no evidence as to whether or not it would have been feasible to do so, was presented.⁸⁷

70. It was not possible to separate prisoners who were in the infectious stages of tuberculosis from other prisoners because there was insufficient accommodation available.⁸⁸ The isolation cells in the hospital section of the maximum security prison did not provide "isolation" because the solid metal doors were seldom closed.⁸⁹

71. As a result of the insufficiency of nurses, clinics were not held in the sections on a daily basis⁹⁰ and patients did not receive medication. Patients had difficulty in obtaining their TB medication. It was logistically impossible for the nurses to do what was required of them.⁹¹

⁸⁵ G: para 220

⁸⁶ G: para 225

⁸⁷ G: para 251

⁸⁸ G: para 225

⁸⁹ G: para 225

⁹⁰ G: para 228

⁹¹ G: para 228

72. 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. Correspondence by Mr Frans Muller (the person responsible for coordinating health care between the five prisons at Pollsmoor) and Mr Engelbrecht (the Area Manager) expressly referred to the understaffing of the health care service in the prison and the effect thereof on the standard care.⁹²

72.1. The correspondence by Mr Muller and Mr Engelbrecht which forms part of exhibit “A” referred expressly to the understaffing of the health-care service in the prison and the effect thereof on the standard of care.

72.2. 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.

72.3. In a facsimile dated, 21 January 2002, that was forwarded to the Commissioner of Correctional Services, Mr Engelbrecht drew attention to the fact that 10 posts for professional nurses were vacant and that a memorandum regarding the appointment of

⁹² G: para 248

additional nurses, which had been sent in October 2001, had not been answered (exhibit “A” pp 22-30).

72.4. 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” PP 32-34).⁹³

Medication

73. The DOTS system of treatment was not routinely adhered to in the maximum security prison. 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.⁹⁴ Unless the entire period of treatment is completed, however, the patient may develop MDR-TB or even XTR-TB.⁹⁵ Patient treatment cards were sometimes filled out in advance of medication being taken, or subsequent thereto, but such cards might be marked off

⁹³ G: para 248

⁹⁴ G: para 228

⁹⁵ G: para 227

by a person who had no direct knowledge of the administration of the medication.⁹⁶

74. Nurses could not always reach the sections. 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 a doctor.⁹⁷

75. Gang influence was strong in the maximum security prison, and if they decided that any particular person would not be permitted to undergo a sputum test, that was the end of the matter.⁹⁸

76. Prisoners who were diagnosed with tuberculosis tended to keep quiet about it because there was a stigma attached to the condition.⁹⁹

Omissions of fact

77. 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. Applicant did not offer evidence that the

⁹⁶ G: para 227

⁹⁷ G: **para 228**

⁹⁸ G: para 45

⁹⁹ G: para 45

design flaw of the maximum security prison was practically capable of remediation.¹⁰⁰

78. Although overcrowding of the prison was clearly a major problem, Applicant did not offer evidence showing that overcrowding in prison could be alleviated.¹⁰¹

79. It was established that while there were so called “isolation facilities” in the hospital section, the design of the cells were such that isolation was not capable of practical implementation. Applicant did not offer evidence showing that isolation in prison could be practically implemented.¹⁰²

80. It is apparent that whatever management strategies are put in place there will always be a risk of infection if only because diagnosis is a precursor to intervention, and the disease might often be diagnosed well after the prisoner has become contagious.¹⁰³

81. The prison authorities could not reasonably be expected to examine 4000 prisoners with such regularity and thoroughness that tuberculosis would always be detected before the prisoner becomes contagious. Self-

¹⁰⁰ G: para 244

¹⁰¹ G: para 245

¹⁰² G: para 251

¹⁰³ DL1: para 61

reporting will necessarily be the only means of its detection in many cases.¹⁰⁴

82. Applicant is an example of the time that can lapse before the risk of contagion is detected.¹⁰⁵

83. Applicant was alive to the risk of contracting tuberculosis and sensitive to the need for early diagnosis. Applicant asked for a sputum test after he displayed symptoms showing progression of the disease, i.e. coughing heavily and losing weight. The sputum test yielded a negative result. The prison authorities could not reasonably be expected to have kept him isolated from the time he reported his symptoms until the disease was diagnosed.¹⁰⁶

Conclusions of fact

84. In all the time, from showing symptoms to being diagnosed, there was a real risk that Applicant was contagious and could have infected other persons whom he came into contact with.¹⁰⁷

85. If that much time elapsed before Applicant was diagnosed, so much more might this be expected (even when sputum tests are immediately

¹⁰⁴ DL1: para 61

¹⁰⁵ DL1: para 61

¹⁰⁶ DL1: para 62

¹⁰⁷ DL1: para 62

positive) where the prisoner is less informed, and perhaps indifferent to taking prompt action to avoid transmission, which can be expected of at least some among the prison population.¹⁰⁸

86. Applicant could have been infected by a prisoner who the prison authorities could not reasonably have known was contagious.¹⁰⁹

87. Applicant does not know the source of his infection, and had he known he might have established a causal link between the infection and specific negligent conduct on the part of the authorities.¹¹⁰

88. To the extent that any system existed at all for the management of the disease its application in practise was at best sporadic and in at least some respects effectively non-existent.¹¹¹

89. The spread of TB was facilitated by the prevailing conditions in the prison.¹¹²

90. It is more probable than not that Applicant contracted TB as a result of his incarceration in the maximum security prison at Pollsmoor.¹¹³

¹⁰⁸ DL1: para 63

¹⁰⁹ DL1: para 63

¹¹⁰ DL1: para 64

¹¹¹ DL1: para 44

¹¹² G: para 213 - 229

¹¹³ G: para 236; DL1 para 53

Disputed conclusions of the Trial Court

91. TB was prevalent in the maximum security prison when Plaintiff was detained there in November 1999, and remained a problem throughout his detention.¹¹⁴ Respondent disputes this finding and in support thereof Respondent will refer to parts of the Record.

Dated at **CAPE TOWN** on this 21st day of **JUNE 2012**.

STATE ATTORNEY

Per: _____

CJ BENKENSTEIN

Respondent's Attorney

JONATHAN COHEN & ASSOCIATES

Per: _____

JONATHAN COHEN

Applicant's Attorney

¹¹⁴ G: para 213