**THE SUPREME COURT OF APPEAL OF SOUTH AFRICA**

**JUDGMENT**

Case No: 316/11
Reportable

In the matter between:

**THE MINISTER OF CORRECTIONAL SERVICES** **Appellant**

and

**DUDLEY LEE** **Respondent**

**Neutral citation:** *The Minister of Correctional Services v Lee* (316/11) [2012] ZASCA 23 (23 March 2012)

**Coram:** MPATI P, NAVSA, NUGENT and SNYDERS JJA and NDITA AJA

**Heard:** **23 FEBRUARY 2012**

**Delivered:** **23 MARCH 2012**

**Summary:** Delict – prison authorities failing to take reasonable measures to prevent contagion by tuberculosis – whether state liable – causation – not established that infection would have been avoided but for negligent omission.

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**ORDER**

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On appeal from: Western Cape High Court, Cape Town (De Swardt AJ sitting as court of first instance):

1 The appeal is upheld. The order of the court below is set aside and substituted with an order absolving the defendant from the instance.

2 Each party will pay its own costs both in this court and in the court below.

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**JUDGMENT**

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NUGENT JA (MPATI P, NAVSA and SNYDERS JJA and NDITA AJA CONCURRING)

[1] The respondent in this appeal, Mr Dudley Lee, was arrested in November 1999 on charges of, amongst others, counterfeiting, fraud and money laundering. He was released on bail in February 2000 but arrested again in April 2000. He remained in prison for more than four years, during the course of which he appeared in court about seventy times, before he was acquitted and released in September 2004.

[2] Mr Lee was 54 years old and in reasonable health when he entered prison. After he had been in prison for a little more than three years it was

discovered that he had pulmonary tuberculosis. The condition was treated and he was declared to be cured after about six months.

[3] After his release from prison Mr Lee sued the state, nominally represented by the Minister of Correctional Services, for damages in the Western Cape High Court. Essentially, he alleged that the prison authorities had failed to take adequate precautions to protect him against contracting tuberculosis, that he had contracted the illness in consequence of their omission, and that the omission violated his right to protection of his physical integrity under the common law, the Correctional Services Act 8 of 1959, and the Constitution.

[4] Notwithstanding the form in which the claim was pleaded it was advanced at the trial, and before us, as a delictual claim in the ordinary course. At the trial the monetary amount of the damages alleged to have been suffered was held over for later determination, and the trial proceeded only on the question whether the state was liable for any such damages. The trial court (De Swardt AJ) held that the state was indeed liable and made a declaration to that effect.[1] The Minister now appeals with the leave of that court.

[5] Before turning to the issues that arise in this case it is convenient to provide a brief explanation of pulmonary tuberculosis, and an account of the circumstances in which Mr Lee came to discover that he had contracted it.

[6] The explanation is taken largely from the evidence of Professor Paul van Helden, a research scientist qualified in chemistry, biochemistry

[1] Reported as *Lee v Minister of Correctional Services* 2011 (6) SA 564 (WCC).

and microbiology, who has researched the disease for many years. The relevant part of his evidence is conveniently encapsulated in his expert summary, which was expanded upon orally at the trial, and much of what follows is taken from that document.

[7] Pulmonary tuberculosis is caused by the micro-organism Mycobacterium tuberculosis. Transmission in humans 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.

[8] 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 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.

[9] Active disease develops progressively. As it advances it presents itself in the form of persistent coughing, shortness of breath and chest pain, loss of appetite and loss of weight, general malaise, and night sweats and fever. The common diagnostic tool is a sputum test. A sample of sputum is expelled from the lungs then cultured and examined for the presence of the organism. 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 might

not be representative of the host, which means that a negative result is not confirmation of the absence of the disease.

[10] South Africa has a high incidence of tuberculosis – one of the highest in the world. It has been estimated that more than half the population has been infected by the organism at one time or another; though only in relatively few cases will infection progress to active disease. 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 transmission of the disease.

[11] It comes as no surprise, then, that prisons in this country present a favourable environment for contracting tuberculosis. 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; poorly ventilated cells provide favourable conditions for expelled organisms to hover in the atmosphere for long periods of time; notorious congestion, with prisoners being confined in close contact for as much as 23 hours every day, provides ideal conditions for transmission; open coughing, and spitting of mucus that, in some conditions, is capable of remaining infectious for three months or more, is not uncommon.

[12] Initially Mr Lee was housed in a communal cell but for most of his incarceration he was housed in a cell designed for occupation by one person, but because of congestion, most often he would share the cell with either one or two other prisoners. He was not aware of ever having

shared the cell with a prisoner who had tuberculosis. Nonetheless, isolation from other prisoners at all times, even if one is housed in a single cell, is simply not possible. For example, at times prisoners would be gathered together for exercise, in which case, said Mr Lee, they would be crowded together in a passage for some time, many prisoners coughing and spitting, before being released into the exercise yard, which was itself congested. They would also be collected together in a holding cell prior to being transported for court appearances, then packed 'like sardines' into a police van and transported to the courts, where they would pass the day in congested court cells. On their return they would usually be placed together in a holding cell, overnight, before returning to their allocated cells. One can, without difficulty, envisage other situations in which transmission might easily occur.

[13] Towards the middle of 2003 Mr Lee found himself to be coughing heavily and losing weight. He was conscious of the risk of contracting tuberculosis and he asked for a sputum test to be done. The result was negative. But Mr Lee continued coughing and he asked for a second test. The result of that test was also negative. Meanwhile, he had developed an inguinal hernia, which he attributed to stress induced by heavy coughing.

[14] He was sent to Victoria hospital on 27 May 2003, where the hernia was surgically repaired, and he returned to prison on 30 May 2003. At Victoria hospital, in preparation for the operation, his chest and abdomen were x-rayed, which revealed the presence of tuberculosis.

[15] On his return to prison Mr Lee was admitted to the prison hospital to recuperate from the operation. There he was placed in a communal cell, together with a floating population of about eight or nine other

prisoners. A sputum test was ordered on 2 June 2003. The x-ray plates and a report were received from Victoria hospital on 3 June 2003. The sputum test returned a preliminary positive result on 9 June 2003, which was confirmed on 18 June 2003 once the sample had been cultured. On 10 June 2003 antibiotic treatment was commenced, which continued for about six months.

[16] It was put to Mr Lee repeatedly in cross-examination that he remained in the prison hospital throughout that period. On each occasion Mr Lee repeated that, while his recollection was hazy, he was sure that he had remained in the hospital only until the sutures were removed, which was for a period of about ten days, and he then returned to his section. The cross-examination was misleading – though I do not suggest that that was deliberate – because counsel had misread Mr Lee's written medical record. His medical record reflects that Mr Lee was discharged from the prison hospital and returned to his section on 10 June 2003, the same day that treatment commenced. That accords with Mr Lee's recollection, and with the prison record of his movements from time to time, and with the probabilities. The records reflect that he returned to the prison hospital in September 2003, for an unrelated condition. It might be that he then remained there until January 2004 but that is another matter.

[17] Effective management of tuberculosis is relatively straightforward, according to the evidence, at least in theory. What it calls for is screening and diagnosis to detect the disease, isolation of a carrier for so long as he or she is contagious (generally about two weeks after treatment commences), and antibiotic treatment, generally for about six months. But such a management regime will be effective only if it is adhered to strictly and consistently, which requires adequate support staff.

[18] The authorities at Pollsmoor prison were pertinently aware of the risk to prisoners of contracting tuberculosis. A considerable part of the trial was taken up with evidence advanced on behalf of the Minister purporting to show that adequate systems were in place in the prison to manage the disease. The evidence advanced in that regard was that of Mr Gertse, a qualified professional nurse with further qualifications in primary health care, who had worked at the prison hospital at the relevant time, and that of Professor van Helden.

[19] I do not think independent weight can be attached to the evidence of Professor van Helden on the adequacy of health-care at the prison. The opinions he expressed fell outside his field of expertise; he had never visited the prison; and he had no direct knowledge of the facts, founding his opinions solely on what he had been told by Mr Gertse.

[20] Mr Gertse spoke of procedures that were said to have existed at Pollsmoor prison for screening prisoners, and of facilities that existed for isolation, and of a system that existed for administering medication. Much of that evidence was placed in issue by two medical practitioners called on behalf of Mr Lee, who had worked at the prison over a number of years. Both spoke forcefully of the poor state of health-care at Pollsmoor prison at the relevant time.

[21] Dr Theron is a well-qualified and long experienced medical practitioner. Early in his career he worked for a while at a hospital in KwaZulu-Natal under the guidance of Dr Anthony Barker, who was renowned for his diagnosis, treatment and management of tuberculosis. From 1985 he was a part-time District Surgeon (the title later changed to

Clinical Forensic Practitioner) and his duties included attending at Pollsmoor prison at night. From 1997 he commenced doing three two-hour sessions a week.

[22] He said that from about 1998 he saw a gradual and continuing breakdown of health-care in the prison, including the management of tuberculosis, largely as a result of insufficient qualified health-care personnel. His evidence reflects active campaigning on his part over some years for corrective intervention but to little avail. In 1999, for example, he presented a report to the prison authorities on the poor state of health-care in the prison, and pleaded for intervention. Later he reported his concerns to the Inspecting Judge,[2]and then to a member of the parliamentary portfolio committee, but little came of his exhortations. He said that from time to time there were interventions, but they were perfunctory and short-lived. What he received for his efforts instead was legal proceedings bought against him by the authorities and his association with the prison came to an end.

[23] Dr Craven was a general medical practitioner who worked at the prison for five hours each morning five days a week, from 1988 to September 2003, when he, too, came into conflict with the authorities over the state of health-care. His experience of health-care at Pollsmoor prison was consistent with that of Dr Theron. Campaigning on his part for corrective intervention also came to nought. Mr Muller, a professional nurse who was formerly employed at the prison to co-ordinate health-care, gave evidence to similar effect.

[2]Appointed under s 86 of the Correctional Services Act 111 of 1998.

[24] The court below was impressed by Dr Theron, Dr Craven and Mr Muller, whose evidence she accepted as being honest and reliable. She said that Mr Gertse was not an impressive witness, and she rejected his evidence so far as it was contradicted by others.

[25] I do not find it necessary to go through the evidence of the witnesses in any detail. Any suggestion that an effective programme for managing tuberculosis existed, at least so far as the isolation of contagious prisoners was concerned, is belied by four events that are revealed coincidentally by the evidence.

[26] The first arises from the ordinary practice adopted when prisoners were received from the courts, which would generally be in the late afternoon. Mr Gertse said that upon their arrival the prisoners would be screened, but I think the evidence discloses that the screening was superficial, and then placed overnight in a communal holding cell. The following morning they would be examined by the medical staff to assess their state of health. That information would be recorded and they would then be sent off to their respective cells.

[27] An example of a document recording the procedure was used by Mr Gertse by way of explanation. That document records the examination on 1 October 2003 of 29 prisoners who had been received at the prison. Two prisoners were recorded as having tuberculosis. They were sent off to a cell. Four of the prisoners who were recorded as having no adverse medical conditions were sent to the same cell. (The other prisoners were allocated to other cells).

[28] From that one may deduce that on the evening of 31 September two prisoners with tuberculosis, which must have been active or it would not have been reported, were confined in a cell with at least 27 other prisoners overnight. Perhaps the prison authorities were not then aware that the two prisoners had tuberculosis, but if not, they certainly became aware of that the following day. That notwithstanding, at least four other prisoners were then confined with them in the same cell. Perhaps other prisoners also occupied that cell but that is not disclosed by the evidence.

[29] The other three events concerned Mr Lee himself. I have pointed out that Mr Lee was discovered to have tuberculosis at Victoria hospital prior to his operation, probably on 23 May 2003. By then he had been displaying symptoms of the disease for some time. When he returned to prison the authorities, knowing his condition, placed him in a communal hospital cell with a floating population of about eight or nine other prisoners who did not have the disease.

[30] If there had been any doubt that he had active disease, it was dispelled by 10 June 2003, by which time the preliminary result of the sputum test had been received, and a treatment regimen had commenced. Notwithstanding that he could be expected to remain contagious for a further two weeks, he was returned to his cell in the section, and continued his ordinary life. For at least two weeks one other prisoner, and perhaps two, was confined with him in the cell, for up to 23 hours a day if the ordinary practice was followed.

[31] To the knowledge of the authorities, Mr Lee could have been expected to be contagious until at least about 24 June 2003. According to the prison record of his movements that was produced in evidence on

behalf of the Minister, Mr Lee was nonetheless sent off by the prison authorities to attend court on 19 June 2003, which would ordinarily have entailed being closely confined with other prisoners in a police van, then spending a day with other prisoners in a court cell, and then being returned in the van, possibly with prisoners who were being taken to prison for the first time. There is nothing to suggest that the excursion on that occasion did not take its usual course.

[32] There is no reason to think that these were isolated lapses. If they happened on those occasions how often, one might ask, did they happen before and after? They provide strong corroboration for the evidence of Dr Theron, Dr Craven and Mr Muller, and that of Mr Lee himself, that any management system that might once have existed was in disarray. Indeed, in a moment of disarming candour, Mr Gertse conceded that what he had described was the theory, but that was not how things had actually worked.

[33] The three elements of a delictual claim that is founded on negligence are well established – a legal duty in the circumstances to conform to the standard of the reasonable person, conduct that falls short of that standard, and loss consequent upon that conduct.[3]

[34] Turning to the first element, negligent conduct will attract liability only if it is wrongful – by which is meant that considerations of public and legal policy require that the negligent act or omission should be held actionable for damages.[4] In *Pilkington Brothers*[5] this court cautioned that

[3]See the line of cases cited in *First National Bank of South Africa Ltd v Duvenhage* 2006 (5) SA 319 (SCA) amongst others.
[4]*Trustees, Two Oceans Aquarium Trust v Kantey & Templer (Pty) Ltd* 2006 (3) SA 138 (SCA) paras 11-13 and cases cited.
*Trustees, Two Oceans Aquarium Trust v Kantey & Templer*, para 12.
[5]*Lillicrap, Wassenaar and Partners v Pilkington Brothers (SA) (Pty) Ltd* 1985 (1) SA 475 (A).

'[o]ur law adopts a conservative approach to the extension of remedies under the *lex Aquilia*'.[6] While that remains true today, the question whether the law should recognise an action must 'necessarily now be informed by the norms and values of our society as they have been embodied in the 1996 Constitution.'[7]

[35] The learned judge in the court below held that negligent failure on the part of the authorities to have reasonably adequate precautions against contagion, which was the foundation of the claim, ought indeed to be categorised as wrongful, and I agree.

[36] A person who is imprisoned is delivered into the absolute power of the state and loses his or her autonomy. A civilised and humane society demands that when the state takes away the autonomy of an individual by imprisonment it must assume the obligation to see to the physical welfare of its prisoner. We are such a society and we recognise that obligation in various legal instruments. One is s 12(1) of the Correctional Services Act 111 of 1998, which obliges the prison authorities to 'provide, within its available resources, adequate health care services, based on the principles of primary care, in order to allow every inmate [of a prison] to lead a healthy life'. The obligation is also inherent in the right given to all prisoners by s 35(2)(e) of the Constitution to 'conditions of detention that are consistent with human dignity'.

[37] Three reasons were advanced on behalf of the Minister why those public duties should not translate into a private action for damages when they are not fulfilled. The first was that to do so would impose an inordinate burden on the state. Secondly, it was submitted that to

[6] At 500D.
[7] *Minister of Safety and Security v Van Duivenboden* 2002 (6) SA 431 (SCA) para 17.

recognise a claim for damages will expose the state to indeterminate liability. Thirdly, it was submitted that there are means other than a claim for damages that enable prisoners to vindicate their rights. In my view none of those bear scrutiny.

[38] The state already bears a statutory and constitutional duty to see to the physical welfare of prisoners so far as that is reasonably possible. To recognise a private action for damages adds nothing to that burden: it merely recognises a particular consequence if the obligation is not fulfilled. It ought not to be overlooked that recognition of a delictual remedy will not impose obligations on the state that will be too onerous to fulfil. What is required is no more than reasonable conduct on its part.

[39] Limitless or indeterminate liability raises its head in relation to claims for pure economic loss, in which it is not possible to determine where the consequences of the negligent act might end. An example of that, taken from English cases, is found in *Caparo Industries Plc v Dickman*.[8] The question in that case was whether an auditor owed a duty of care (in the English law sense, which incorporates what in our law is the element of wrongfulness) to an investor who had relied upon the audited accounts of a company that were alleged to be misleading. One of the factors relied upon for holding that the auditor did not owe such a duty was the potential for indeterminate liability. Lord Oliver of Aylmerton said the following:[9]

'As I have already mentioned, it is almost always foreseeable that someone, somewhere and in some circumstances, may choose to alter his position upon the faith of the accuracy of a statement or report which comes to his attention and it is always foreseeable that a report – even a confidential report – may come to be communicated

[8] *Caparo Industries Plc v Dickman* 1990 (2) AC 605 (HL).
[9] At 643C-D.

to persons other than the original or intended recipient. To apply as a test of liability only the foreseeability of possible damage without some further control would be to create a liability wholly indefinite in area, duration and amount and would open up a limitless vista of uninsurable risk for the professional man.'

[40] We are dealing with a claim for physical injury, which does not have the same potential. That the negligent conduct might give rise to claims from a significant number of persons who are injured in the same way is not the same as indeterminate liability. Indeed, what is often called 'product' or 'manufacturers' liability exposes the manufacturer of mass-produced items to potential liability at the hands of a large number of consumers, but this court nonetheless recognised such a claim in *Ciba-Geigy (Pty) Ltd v Lushof Farms (Pty) Ltd.*[10]

[41] As for the submission that other means are available to prisoners to vindicate their rights I think that is cynical. The prospect of political support being mobilised by prisoners to vindicate their rights, or of proceedings being brought by prisoners for a mandamus, which were the means suggested, is remote.

[42] Prisoners are amongst the most vulnerable in our society to the failure of the state to meet its constitutional and statutory obligations. It seems to me that there is every reason why the law should recognise a claim for damages to vindicate their rights. To find otherwise would altogether negate those rights.

[43] Turning to the question of negligence the classic test was articulated by Holmes JA in *Kruger v Coetzee*,[11] and has since been

[10] *Ciba-Geigy (Pty) Ltd v Lushof Farms (Pty) Ltd* 2002 (2) SA 447 (SCA).
[11] *Kruger v Coetzee* 1966 (2) SA 428 (A) at 430E-F.

consistently followed. In short, a person is negligent if he or she fails to take reasonable steps to guard against harm occurring if the harm is reasonably foreseeable and a reasonable person in his or her position would have taken those steps.

[44] The prison authorities were well aware that prisoners might contract tuberculosis if reasonable steps were not taken to prevent it. I think I have made it clear earlier in this judgment that the evidence establishes convincingly that to the extent that any system existed at all for the proper management of the disease its application in practice was at best sporadic and in at least some respects effectively non-existent. I return to the matter later in this judgment but for the moment I need only say that I agree with the court below that the prison authorities failed to maintain an adequate system for management of the disease and in that respect they were negligent.

[45] That leaves the matter of causation, which is more problematic.

[46] To succeed in an action for damages a plaintiff must establish that it is probable that the negligent conduct caused the harm. It was said by this court in *Minister of Police v Skosana*[12] that the test in that regard is 'whether but for the negligent act or omission of the defendant the event giving rise to the harm in question would have occurred'.

[47] Where the negligent conduct is a positive act the application of that test is relatively straightforward. Generally one would mentally eliminate the negligent act and assess whether the harm would then have occurred. But the application of the test is more problematic where the conduct

[12] *Minister of Police v Skosana* 1977 (1) SA 31 (A) at 35C-D.

takes the form of an omission. In that case the defendant, by definition, was obliged to initiate reasonable action, and the question then is what would have happened if that had occurred?

[48] That was explained by Corbett JA in *Siman & Co (Pty) Ltd v Barclays National Bank Ltd:*[13]

'In order to apply [the test for factual causation] one must make a hypothetical enquiry as to what probably would have happened but for the unlawful act or omission of the defendant. In some instances this enquiry may be satisfactorily conducted merely by mentally eliminating the unlawful conduct of the defendant and asking whether, the remaining circumstances being the same, the event causing harm to plaintiff would have occurred or not. If it would, then the unlawful conduct of the defendant was not a cause in fact of this event; but if it would not have so occurred, then it may be taken that the defendant's unlawful act was such a cause. This process of mental elimination may be applied with complete logic to a straightforward positive act which is wholly unlawful. So, to take a very simple example, where A has unlawfully shot and killed B, the test may be applied by simply asking whether in the event of A not having fired the unlawful shot (ie by a process of elimination) B would have died. In many instances, however, the enquiry requires the substitution of a hypothetical course of lawful conduct for the unlawful conduct of the defendant and the posing of the question as to whether in such case the event causing harm to the plaintiff would have occurred or not; a positive answer to this question establishing that the defendant's unlawful conduct was not a factual cause and a negative one that it was a factual cause. This is so in particular where the unlawful conduct of the defendant takes the form of a negligent omission. In *The Law of South Africa* (*ibid* para 48) it is suggested that the elimination process must be applied in the case of a positive act and the substitution process in the case of an omission. This should not be regarded as an inflexible rule. It is not always easy to draw the line between a positive act and an omission, but in any event there are cases involving a positive act where the application of the but-for rule requires the hypothetical substitution of a lawful course of conduct (cf Prof A M Honoré in 11 *International Encyclopaedia of Comparative Law* c 7 at 74-6). A straightforward example of this would be where the

[13] *Siman & Co (Pty) Ltd v Barclays National Bank Ltd* 1984 (2) SA 888 (A) at 915B-H.

driver of a vehicle is alleged to have negligently driven at an excessive speed and thereby caused a collision. In order to determine whether there was factually a causal connection between the driving of the vehicle at an excessive speed and the collision it would be necessary to ask the question whether the collision would have been avoided if the driver had been driving at a speed which was reasonable in the circumstances. In other words, in order to apply the but-for test one would have to substitute a hypothetical positive course of conduct for the actual positive course of conduct.'

[49] That was said in a minority judgment but it expresses no more than the logical application of *Skosana* and not a principle of law. In any event it was repeated by the same learned judge, in abbreviated form, and on that occasion writing for an unanimous court, in *International Shipping Co (Pty) Ltd v Bentley.*[14] There the learned judge said that in determining the question of factual causation

'… one must make a hypothetical enquiry as to what probably would have happened but for the wrongful conduct of the defendant. This enquiry may involve the mental elimination of the wrongful conduct and the substitution of a hypothetical course of lawful conduct and the posing of the question as to whether upon such an hypothesis plaintiff's loss would have ensued or not. If it would in any event have ensued, then the wrongful conduct was not a cause of the plaintiff's loss; *aliter,* if it would not so have ensued. If the wrongful act is shown in this way not to be a *causa sine qua non* of the loss suffered, then no legal liability can arise.'[15]

[50] In considering the question of causation the learned judge in the court below turned her attention to whether Mr Lee had been infected during the time he was in prison, which the Minister had disputed. In support of that denial the Minister placed store upon the opinion of Professor van Helden that Mr Lee was probably infected even before he was incarcerated, and that the dormant organism had then activated in

[14] *International Shipping Co (Pty) Ltd v Bentley* 1990 (1) SA 680 (A).
[15] At 700F-H.

prison, leading to active disease. Much of his evidence was taken up with defending that opinion, which is unfortunate because in my view its foundation is fallacious.

[51] The opinion expressed by Professor van Helden was founded on no more than the prevalence of tuberculosis, the suggestion being that because a majority of people who include Mr Lee have been infected with the organism at some time, it is probable that Mr Lee had been infected before he went to prison.

[52] That a majority of people within a particular group have been infected is no doubt of keen interest to epidemiologists and public health authorities but it tells nothing of who the infected individuals are. The question in this case is whether Mr Lee was within the majority or within the minority, not as a matter of statistical probability, but as a matter of probable fact. The court below was not misled by that fallacious line of reasoning and found, as a probable fact, that Mr Lee contracted tuberculosis while he was in prison.

[53] Before us counsel for the Minister did not pursue that line of fallacious reasoning and correctly conceded that Mr Lee was probably infected while he was incarcerated, but he submitted that the matter does not end there. He submitted that the evidence does not exclude the possibility that Mr Lee was infected in a police van while being taken to court, or in the court cells, in which case, so it was submitted, the prison authorities were not responsible.

[54] If the prison authorities send a prisoner off to court in a crowded police van, to pass the day in a crowded court cell, when they know, or

ought reasonably to know, that the prisoner is contagious, I cannot see why they would not bear responsibility for the consequences. But, countered counsel, contagion might emanate from a prisoner who was not sent from the prison, but who is being taken to prison for the first time by the returning van, which is true, but for reasons that will become apparent I need not deal with that possibility. I will assume in favour of Mr Lee that he was probably infected by a prisoner who had active tuberculosis while under the control of the prison authorities.

[55] Once having found that Mr Lee was probably infected in prison the learned judge seems to have considered that the causation enquiry had been exhausted, because she said nothing further on the issue. In that I think she fell into error. The question was not whether the incarceration caused the harm, but whether it was caused by the negligent omission. Whether or not he was infected while incarcerated was a necessary but not an exhaustive step in that enquiry. If he was not infected while incarcerated then that would obviously end the enquiry. But if he was indeed infected while incarcerated the question still remains whether he would have been infected if there had been reasonable management of the disease. Proof alone that reasonable precautions were not taken to avoid foreseeable harm, and that the harm occurred, does not establish that the former caused the latter.

[56] Whether harm would have occurred if reasonable action had been taken to avoid it entails a two-stage enquiry of fact. First, what would a reasonable person in the position of the defendant have done to avoid the occurrence of the harm? The second stage of the enquiry, which is capable of being decided only once the first has been answered, is whether the harm would have been avoided had that been done? The law

does not demand that a defendant must guarantee that foreseeable harm does not occur – only that he or she must take reasonable steps to avoid it. Life has many hazards that will not be avoided even when reasonable steps are taken to do so.

[57] The question what ought reasonably to have been done will usually be answered in the course of determining whether the defendant was negligent – because his or her culpability cannot be evaluated without a standard first being determined against which to evaluate it – but that need not always be so. In this case, for example, it cannot be gainsaid that a consistent system of some kind at least was required to screen prisoners, isolate any that were found to be contagious, and administer treatment. I have already found that if any system existed at all its application in practice was at best sporadic and in at least some respects non-existent. On any standard that falls short of what ought reasonably to have been done. But while that failure on any standard is sufficient to find that the prison authorities were negligent it is not sufficient for determining whether the harm was caused by the omission. What needs to be established in addition is what the prison authorities ought to have done: only from there can one proceed to the enquiry whether that would have prevented Mr Lee being infected.

[58] In the course of her reasoning on the issue of negligence the learned judge in the court below expressed what ought to have been done in generalised terms. She said the following:

‘It appears to me that in the context of the maximum security prison at Pollsmoor [reasonable 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.

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.'

[59] All that is true but in each case it begs the question what would have been reasonable. So, for example, while proper screening procedures for incoming prisoners are no doubt required, that begs the question what procedures might reasonably be expected in a large and congested prison. And while regular and effective screening of inmates will clearly reduce the risk of contagion, what is reasonably regular and effective when applied to some 4 000 prisoners? It might be tempting to answer those questions by saying that what ought to have been done was everything that would have avoided tuberculosis being transmitted but that would be fallacious. I have already indicated that the prison authorities are not required to guarantee that transmission will not occur: only to take reasonable steps to prevent it.

[60] Many factors would need to be balanced against one another in determining what might reasonably be expected in a large prison, quite apart from what constitutes medical best-practice: the security demands of the prison; the financial resources that are available to the prison authorities; generally accepted practice amongst prison authorities; the

extent to which trained personnel are available; the space available for isolation; the incidence of the disease; and other factors besides. What the enquiry would amount to is a substantial and complex systemic enquiry. The scant evidence in this case goes nowhere towards conducting that enquiry.

[61] But whatever enquiry might be conducted in that regard it seems to me that Mr Lee confronts at least one insuperable hurdle. From the evidence before us it is apparent that whatever management strategies might be put into place there will always be a risk of contagion if only because diagnosis is necessarily a precursor to intervention, and the disease might often be diagnosed only well after the prisoner has become contagious. I do not think the prison authorities can reasonably be expected to examine some 4 000 prisoners with such regularity and thoroughness that tuberculosis will always be detected before the prisoner becomes contagious. Self-reporting will necessarily be the only means for its detection in many cases. Once more, Mr Lee himself is an example of the time that can elapse before the risk of contagion is detected.

[62] Mr Lee was alive to the risk of contracting tuberculosis and sensitive to the need for early diagnosis. That notwithstanding, he had been coughing heavily, and had begun to lose weight, symptoms of progression of the disease, before he asked for a sputum test. It would have been at least a week or two before the result was returned and then it was negative. Some time went by before he asked for a second test and once more at least a week or two must have passed before another negative result was returned. It was only coincidentally that the presence of the disease was then diagnosed. I would be hard-pressed to find that the prison authorities ought reasonably to have isolated him from other

prisoners immediately he reported his symptoms, and then kept him isolated even though the first test was negative, and continued to do so even when the second test was negative, and continued to do so until coincidentally the disease was diagnosed. All that time there was a real risk that Mr Lee was contagious, but yet he was in close contact with at least the prisoner with whom he shared a cell, and probably others at times. If the prisoner with whom he had shared his cell had contracted the disease from Mr Lee it is difficult to see on what basis it could be attributed to fault on the part of the prison authorities.

[63] If that much time elapsed before Mr Lee was diagnosed, so much more might it be expected to occur, even when sputum tests are immediately positive, where the prisoner concerned is less well-informed, and perhaps even indifferent to taking prompt action to avoid transmission, which I think can be expected of at least some among the prison population. It is just as likely as not that Mr Lee was infected by a prisoner who the prison authorities could not reasonably have known was contagious. I cannot see that it is possible in those circumstances to find it having been proved that the negligent omission caused the infection.

[64] The difficulty that is faced by Mr Lee is that he does not know the source of his infection. Had he known its source it is possible that he might have established a causal link between his infection and specific negligent conduct on the part of the prison authorities. Instead he has found himself cast back upon systemic omission. But in the absence of proof that reasonable systemic adequacy would have altogether eliminated the risk of contagion, which would be a hard row to hoe, it cannot be found that but for the systemic omission he probably would not

have contracted the disease. On that ground I think that the claim ought to have failed.

[65] There remains the question of where the costs should fall, which lies within the discretion of a court. Ordinarily the costs of litigation will follow the result but the nature of the case and the conduct of the litigation are considerations that might call for a different order.

[66] Mr Lee has certainly had a hard time of it. For four years he was imprisoned while the state mustered its case against him and then the state failed. Meanwhile Mr Lee knew that he was at risk of contracting tuberculosis in a prison where the health-care regime was breaking down. When it occurred he had to manipulate and cajole at times to ensure that he consistently received medication, conscious that he would suffer adverse consequences if he failed to do so. He had good reason to feel aggrieved when he left prison but his troubles were not yet at an end.

[67] When he vented his grievance by suing the state he was met with a defence on every leg of his claim. The state contested that Mr Lee had been infected in prison with no substantial grounds for doing so. It contested the allegations of an inadequate health-care regime when it must have known that it was defending the indefensible. The failing regime had been repeatedly reported by its medical doctors at high level, various reports on the situation had been circulated, newspapers had reported the position, a report of an inspector from the office of the Inspecting Judge that had been prepared some four years before the matter came to trial disclosed that tuberculosis management was virtually non-existent, and so on. Yet the state persisted in contending that all had been well at Pollsmoor and acknowledged no responsibility towards Mr

Lee at any time. By adopting that approach the state forced Mr Lee into a trial that endured for about three weeks, in which he was compelled to take up the time of professional men to prove what was incontestable.

[68] Mr Lee set out to vindicate an important statutory and constitutional right and has done so substantially. It is true that his claim has failed but only on a narrow factual point. The state has important responsibilities to its citizens. It might not always be able to fulfill them but then it ought properly to recognise where it has failed.

[69] I think it would be most unjust if, in view of the nature of the rights that are in issue, and the manner in which the litigation was conducted by the state, Mr Lee were to be called upon to pay the state's costs, and I intend to order accordingly.

[70] 1. The appeal is upheld. The order of the court below is set aside and substituted with an order absolving the defendant from the instance.

2 Each party will pay its own costs both in this court and in the court below.

R W NUGENT
JUDGE OF APPEAL

APPEARANCES:

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|---|---|
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