SUBMISSION TO THE PORTFOLIO COMMITTEE ON CORRECTIONAL SERVICES REGARDING DEATHS IN PRISON AND MEDICAL PAROLE

5 Aug '08

Deaths in custody and medical parole

Submission Prepared by Lukas Muntingh, Project Coordinator CSPRI, Community Law Centre, UWC.
Email: lmuntingh@uwc.ac.za Tel: 021-959 2950

Table of Contents

Submission to the Portfolio Committee on Correctional Services regarding deaths in prison and medical parole

INTRODUCTION

Acknowledging the high number of deaths and low number of releases on medical parole poses fundamentally a humanitarian question: why are so many people dying inside prison when the legislation provides an accepted mechanism to enable prisoners to die a dignified and consolatory death? Regardless of the crimes that were committed and the punishment imposed, a humane society has an obligation to act in a manner that recognizes the dignity of every individual, even the vilest criminal.

This submission will deal with a number of issues, being trends in deaths in prisons and release on medical parole; the interpretation of the current legal provisions; recommendations for addressing current problems, and the prevention of deaths in custody.

DEATHS IN CUSTODY

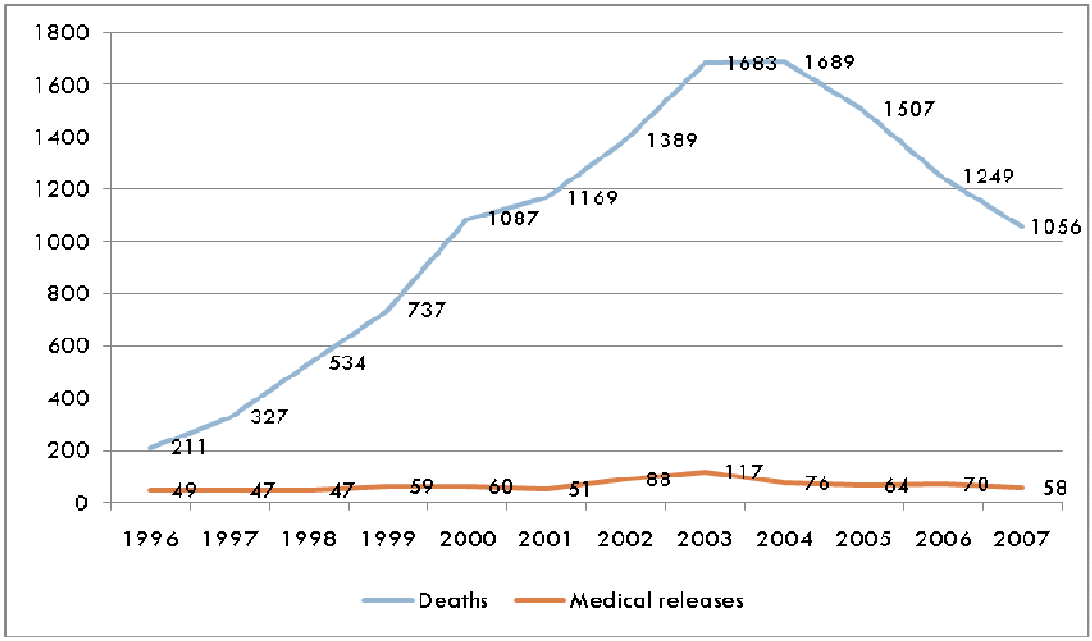
Statistics on deaths in custody and releases on medical parole

The Judicial Inspectorate of Prisons (JIOP) has consistently expressed its concern regarding the high number of deaths due to natural causes in the prison population and, equally important, the low number of releases on medical parole. In the most recent annual report of the JIOP data in this regard, as shown in Figure 1 below, is presented.[1] The mortality rate of prisoners should also, as the JIOP points out, not be seen in isolation and that it is related to the total prison population. In 2006, 8.3 deaths per 1000 prisoners were recorded compared to the 7.0 deaths per 1000 prisoners in 2007. Figure 1 shows that since 2004 there has been a decrease in the total number of deaths and the per 1000 rate confirms that the situation has improved. However, the fact that fewer prisoners are dying in prison does not resolve the moral and legal questions or bringing about certainty and consistency in the administration of medical releases.

It is indeed this vast difference between the number of deaths due to natural causes and the extremely low number of medical releases that gives rise to various questions. Despite the rapid increase in the number of deaths the number of medical releases only went above 100 in one year (2003) during the 12-year period covered in Figure 1. Furthermore, there also does not appear to be any correlation between the number of deaths and the number of prisoners released on medical parole.

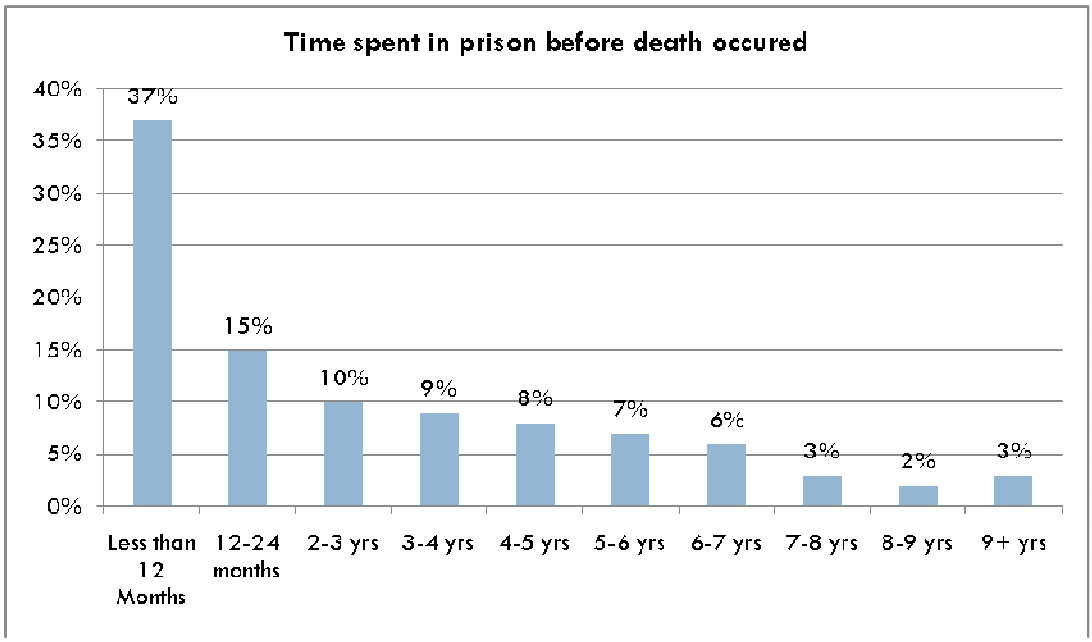
[1] Office of the Inspecting Judge (2007) *Judicial Inspectorate of Prisons Annual Report 2006/7*, Cape Town, p.26

FIGURE 1



The statistics presented in Figure 1 require further investigation in order to understand mortality trends better. Data analysed by the Judicial Inspectorate reveal that prisoners who die in custody, die within a relatively short period after being imprisoned, as shown in Figure 2.[2]

FIGURE 2



[2] Office of the Inspecting Judge (2007) *Judicial Inspectorate of Prisons Annual Report 2006/7*, Cape Town, p. 44

Figure 2 shows that 37% of deaths occur after a period of less than 12 months in custody and that 62% of deaths occur within three years of imprisonment. There is little doubt that imprisonment itself can have a severe consequence on a person's health. If conditions are not conducive to healthy living and an individual's health is already compromised prior to admission (for example by poor diet and/or a chronic health condition), the consequences can be severe. Individuals may also have contracted certain diseases such as TB and HIV/Aids or developed cancer prior to imprisonment and the deterioration of their condition is then accelerated by inadequate medical services and poor conditions of imprisonment. What is particularly worrying of this trend is that perfectly manageable conditions such as diabetes or asthma have now become life-threatening conditions. In managing and preventing deaths in prisons, the period immediately following admission is therefore critical to ensure that health and medical problems are identified in time.

A further factor that needs to be borne in mind is that the prison population is not stable even though there may be an annual average in custody. For example, in 2006 the average number of prisoners in custody was approximately158 000, but a total of 368 150 people circulated through the prison system. The overwhelming majority of these prisoners were unsentenced and who may have spent any period from a few days to several months, if not years, in prison. Doing proper health status examinations, as is required by section 6(5)(b) of the Correctional Services Act, then becomes a virtual impossibility when the Department is experiencing staff shortages in respect of health care professionals.

Based on DCS statistics it appears that the mortality profile of prisoners roughly reflects the overall profile of the prison population in respect of sentence status and gender. Roughly a quarter (24%) of prisoners who died in 2006/7 was unsentenced and 2.2% were female.[3]

What is, however, less clear are the exact causes of death when this is due to natural causes. Statistics in this regard have not been made available by the JIOP or the DCS. The rapid increase in deaths due to natural causes from 1996 onwards has been ascribed to HIV/Aids by the Office of the Inspecting Judge and other commentators, but this has not been verified by independent research. The cause of death has implications for the current debate on medical parole as different illnesses and the prognosis for recovery may require different responses from the DCS in respect of medical parole. For example, an Aids patient who has not had access to anti-retroviral therapy (ART) may need to be considered in a different light than the cancer patient with no prospect of recovery, as was the case in *Stanfield v Minister of Correctional Services*. Accurate information on the cause of death will firstly establish if the DCS is indeed providing proper care to prisoners suffering from treatable, manageable or curable conditions. Secondly, it is furthermore necessary to establish the mortality profile and cause of death, if applicable, of prisoners who have been released on medical parole. It is important that policy and decisions are based on reliable information and not on isolated incidents proffered as policy anchors.

LEGISLATIVE PROVISIONS AND CASE LAW

Section 79

Chapter 7 of the Correctional Services Act deals with releases from prison and placement on day parole, parole and correctional supervision. The provisions in the Act are detailed and somewhat complicated as a result of the different types of prison sentences that may be imposed. It is not within the scope of this submission to describe these, but suffice to say that even parole boards have found the application of the

[3] Office of the Inspecting Judge (2007) *Judicial Inspectorate of Prisons Annual Report 2006/7*, Cape Town, p. 43

provisions complex and apparently confusing.[4] Of particular relevance is the provision for placement under correctional supervision or release on parole on medical grounds in Section 79:

Any person serving any sentence in a prison and who, based on the written evidence of the medical practitioner treating that person, is diagnosed as being in the final phase of any terminal disease or condition may be considered for placement under correctional supervision or on parole, by the Commissioner, Correctional Supervision and Parole Board or the court, as the case may be, to die a consolatory and dignified death.

It is notable that unsentenced prisoners are excluded as there is no sentence to be converted to parole or correctional supervision. The fact that a very substantial number of prisoners spend months, if not years awaiting trial clearly presents a problem in this regard if the person cannot be released on bail.[5] Section 62(f) of the Criminal Procedure Act does, however, make provision for the placement of an accused under the supervision of a probation officer or correctional official and this provision can be used to this effect. Section 79 also makes a blanket provision for any sentenced prisoner to benefit from this provision and sentence length, offence or type of offender has no bearing on the decision to be made by either the court, Correctional Supervision and Parole Board (CSPB), Minister or Commissioner on the advice of a medical practitioner. Release on medical grounds is also singular in purpose, namely to allow the prisoner to die a consolatory and dignified death. Parole and medical parole, as they stand now, are not there to address the shortcomings of the prison system. The purpose of medical parole is not to enable the prisoner to receive treatment, recover and lead a normal life. Unless the purposes of medical parole are changed by an amendment to the Act, there does not appear to be justifiable grounds for using it to access any treatment, such as ART.[6]

What appears to be more problematic is the interpretation of the phrase in section 79 'in the final phase of any terminal disease or condition'. One may indeed ask: How final is final? Section 79 sets two requirements in respect of the medical practitioner's assessment. Firstly, the diagnosis must indicate that the disease or condition is terminal and that there is thus no chance of recovery; it is inevitable that the patient will die from the diagnosed disease. Secondly, the medical practitioner's prognosis finds that the patient's condition is of such a nature that his/her demise is imminent; it will happen soon. This became a core issue in the case of *Stanfield v Minister of Correctional Services*.

The case of Stanfield

Stanfield v Minister of Correctional Services and Others was placed before the Cape High Court in 2003.[7] The matter was, incidentally, heard by the current Inspecting Judge of Prisons, Judge D Van Zyl. Mr. Stanfield was serving a six-year prison sentence for tax evasion and was during his imprisonment diagnosed with an aggressive and terminal form of lung cancer. He had already commenced with chemotherapy and according to two medical experts had no chance of recovery and the effect of the chemotherapy would only be palliative. In view of this, he applied to the DCS to be released on medical parole, a request denied by the DCS and thus the application to the Cape High Court. A driving, but as it would turn out irrelevant, set of factors in the Parole Board's decision-making was that Mr. Stanfield was not visibly ill, although hospitalised, and that he continued to smoke.[8] It also appears that many of the

[4] For a more detailed description of problems experienced in one particular case (Motsemme H v Min of Correctional Services), see CSPRI Newsletter No. 14, http://www.easimail.co.za/BackIssues/cspri/0912_Issue639.html
[5] At the end of August 2005 there were nearly 21 000 awaiting trial prisoners who had been in custody for longer than three months. Of this group 1528 had been in custody for longer than two years. (Information supplied by the Office of the Inspecting Judge)
[6] Muntingh L 'Medical Parole for Prisoners: prisoners' means to access anti-retroviral treatment?' *ALQ Newsletter*, March 2006
[7] 2003 JDR 0871 (C)
[8] Para 12 and 79

motivating factors in the Department's decision-making in this case were indeed perceptions without factual base and opinions without legal merit. Some of the reasons forwarded for denying his application for medical parole were:

- he does not appear to be ill;
- he is able to dress and feed himself;
- his life expectancy is between 6 and 12 months;
- he is a high profile prisoner;
- the objectives of punishment had not been brought home and he had not yet served one third of his sentence, and
- he was still smoking.[9]

An important matter that emerged from the case was the ability of the DCS to provide the care that Mr. Stanfield required. In its response the DCS attempted to persuade the Court that the Department had the capacity to provide the Applicant with adequate care. However, based on expert evidence the Court rejected this and found:

> The third respondent's failure to recognise and accept the obvious inadequacy of the medical facilities at the Drakenstein prison or, for that matter, at any other prison under the jurisdiction of the Department, is a second instance of his failure to respect the applicant's inherent right of dignity. Although such facilities may be adequate for the treatment of ordinary, run-of-the-mill illnesses and medical problems, it is abundantly clear that they are totally inadequate for the treatment of terminally ill patients such as the applicant. To insist that he remain incarcerated while being housed in the said facilities constitutes a blatant denial of his most basic right to be treated with dignity and respect, regardless of the crime he has committed and the period of his sentence that he has actually served. [10]

The Court also made reference to life expectancy and was not pleased with the views of the Department's official when motivating the denial of the application:

> The suggestion by the third respondent that the applicant's life expectancy was "not so short" that further incarceration would not serve a purpose and that there was no assurance that he would abstain from committing a crime cannot, in my view, constitute a requirement in terms of section 69 of the Act. There is no indication of what a "short", as opposed to a "not so short", life expectancy may be. Nor can it be determined when a prisoner is so ill that it would be physically impossible for him to commit a crime. I should imagine that the commission of further crimes would be the last thing on the mind of any prisoner released on parole for medical reasons, particularly when he knows that he has only a few months to live.[11]

In the course of the judgment, Van Zyl J repeatedly returns to the Constitutional requirement of respecting the dignity of Mr. Stanfield and regarded the reluctance of the Department to allow the application for release on medical parole as an attack on his dignity:

---

[9] "Hy geniet tans goeie gesondheid, op die oog af lyk hy nie siek nie. Hy help homself deur self te eet, aan te trek en te was. Sy lewensverwagting is tans 6 maande tot 1 jaar en kan daar gekyk word na, of die behandeling waarop hy tans is, enige uitwerking het. Die gevangene is 'n hoë profiel geval en het hy nog nie eers 1/3 van sy vonnis gedoen nie. Die strafoogmerke moet tuisgebring word en as 'n voorbeeld vir ander misdadigers dien. Die minimum vereistes, soos gestel deur Dr. Eedes, kan deur die departement nagekom word en is dit onnodig dat hy op eie koste in 'n hospitaal (privaat) moet bly. Hy sal heel menswaardig in 'n gevangenis aangehou kan word. Wat my die ergste van die aansoek ontstel, is dat al die dokters mediese ontslag aanbeveel en bekommerd is oor kieme in die gevangenis, maar nie een praat enigsins van die feit dat Stanfield nog rook nie. Hy sal eers drasties iets moet doen aan sy rookgewoontes." Para 12

[10] Para 125

[11] Para 110

> To insist that he remain incarcerated until he has become visibly debilitated and bedridden can by no stretch of the imagination be regarded as humane treatment in accordance with his inherent dignity. On the contrary, the overriding impression gained from the third respondent's attitude in this regard is that the applicant must lose his dignity before it is recognised and respected.[12]

From the above it is concluded that the test for what is 'final' rests on the promotion and protection of the prisoner's dignity. Under the circumstances of a poor prognosis and imminent death, concerns regarding the administration of criminal justice and punishment become subservient to the right to dignity. The duty to promote and protect the right to dignity should, however, be assessed on a case-by-case-basis looking at the factors directly relevant to this.

The proposed amendment to section 79

The Correctional Services Amendment Bill (32 of 2007) proposed a substantive amendment to section 79 which was not accepted, but it is nonetheless useful to reflect briefly on this for the purposes of highlighting some of its flaws in order to further the debate on medical parole. Clause 63 of the Bill proposed the following amendment (insertions underlined and deletions in brackets):

> 'Any person serving any sentence in a [prison] correctional centre and who, based on the written evidence of the medical practitioner treating that person, is diagnosed as being in the final phase of any terminal disease or condition, and is considered by the Correctional Supervision and Parole Board or, in the case of a person serving a life sentence, by the Minister, as not being capable of committing a crime in future, may be considered for placement under correctional supervision or on parole, by the National Commissioner, Correctional Supervision and Parole Board or the [court] Minister, as the case may be, to die a consolatory and dignified death."

The amendment proposed a further requirement in addition to the medical diagnosis, namely that the CSPB or the Minister (in case of life sentences) must be of the opinion that the person is '*not being capable of committing a crime in future*'. It appears that this requirement would then reflect on factors in addition to those covered by a medical practitioner, but the Bill did not set out what these factors should be. However, as the section deals with medical parole it is not clear what other factors can be considered if they are not of a medical nature. With such wide discretion the possibility for unfair discrimination is opened up. Moreover, the amendment suggested that the CSPB or the Minister, as the case may be, would be able to make an assessment on the future criminal intentions, or not, of the prisoner. If such a skill did in fact exist in the Department it should indeed be applied to all parole applicants and not only to those who are applying to be released on medical parole.

The proposed amendment attempted to address the fear that if medical parole is used to facilitate access to anti-retroviral therapy (ART), that dangerous offenders suffering from Aids related illnesses could be released and as a result of the therapy, their recovery may be so significant that they would be able to continue their criminal activities and re-victimize society. The DCS did not provide any evidence that this fear is based on a substantial pattern.

The purpose of the correctional system is firstly to enforce the sentences of the courts and secondly, to detain all prisoners in safe custody and whilst ensuring their human dignity.[13] In this sense then the DCS has a total responsibility; it is alone responsible for prisoners and cannot release them because it cannot care for them adequately. On the other hand, it also cannot deny qualifying prisoners access to ART and also deny them medical parole when they are in the final stages of Aids. The duty of care then remains with the DCS and it must therefore establish the means to provide adequate care. If current capacity is lacking with regard to ART, then the DCS has a duty to develop such capacity and provide total care. Prisoners

[12] Para 124

[13] Correctional Services Act S 2(a)-(b)

who qualify for ART must receive this treatment inside the prison system and therefore avoid the situation referred to above.

ACHIEVING CONSISTENCY

The current procedure

The current procedure for releases on medical parole is set out in the B-Orders and is summarised below.[14] It is noted that the Correctional Services Amendment Bill (32 of 2007) brought about some changes to the delegation of authority, as described further below. The currents steps in the procedure are:

- The "Medical Report on Prisoner" is completed by the medical doctor and submitted to the Head of Centre for comment and recommendation for further submission of the recommendation/ request to the Case Management Committee (CMC).
- The CMC evaluates the recommendation/request for release on medical grounds and advise the Correctional Supervision and Parole Board (CSPB)/Area Manager on the following: the most suitable institution/ hospital for after-care and accommodation (which may also be the family) is provided for by a written undertaking.
- The CMC sends the recommended/request per "Medical Report on Prisoner" to the Area Manager/Court/CSPB for assessment and a decision.
- The authority to release a prisoner on medical grounds is delegated as follows:
    - Prisoners serving a sentence of less than 12 months - Area Manager (Changed to 24 months in Amendment Bill; 'Area manager' replaced by 'National Commissioner' in the Bill)
    - Prisoners serving a sentence of longer than 12 months' imprisonment including habitual criminals – CSPB (Changed to 24 months in Amendment Bill)
    - Life Imprisonment - Minister (prior to implementation of new Act, 1 Oct 2004) (see Correctional Services Amendment Bill s 79; reverted to the Minister)
    - Life imprisonment - Court *a quo* (after implementation of new Act) (see Correctional Services Amendment Bill s 79; reverted to the Minister)
    - Persons declared as dangerous criminals in terms of s 286A of the Criminal Procedure Act - Court *a quo* (not affected by the amendment)

The B-Orders also list a number of factors that 'should also be seriously kept in mind when considering a prisoner for placement/release on medical grounds'. It is assumed that this refers to the CMC, National Commisisoner and CSPB, and not to the court *a quo* or the Minister. The substantive factors (excluding those of an administrative nature) are:

- The consequences of inadequate after-care for the Department of Correctional Services. As far as possible prisoners should be placed/released into the care of an institution (hospital/clinic/or other medical institution).

[14] B-Order, Order 1, Chapter 25 para 5.0

- Confirmation of a suitable after-care institution in the absence of family may be problematic because of the lack of community resources, and therefore the CMC, through involvement (religious workers, social workers, etc.), [should] try to identify a "suitable" aftercare institution.
- The fact that an injudicious placement/ release may result in the foiling of the objectives punishment of the sentencing court.
- The costs involved in the health care of the prisoner need not be directly conclusive when considering a prisoner's placement/release on medical grounds.
- In all cases where there is no doubt as to the terminal nature of the illness and the life expectancy is short, it is advisable that the placement/release on medical grounds be considered on a conditional basis.
- In the cases of placement on parole, pertinent and clear conditions must be set with regard to after-care, care and medical treatment.

Following the proposed amendments to the Correctional Services Act, the authority to release a prisoner on medical parole will rest with the National Commissioner in respect of prisoners serving a sentence of less than 24 months; the CSPB in respect of prisoners serving sentences of longer than 24 months and habitual criminals; the Minister in respect of prisoners serving life imprisonment, and the court *a quo* in respect of prisoners declared as dangerous criminals. It must also be assumed that the National Commissioner will delegate his/her authority in respect of prisoners serving sentences of less than 24 months.

Despite the attempt to simplify the procedure in the Correctional Services Amendment Bill, the fact remains that four distinct institutions have authority over medical parole and that this authority is essentially derived from the sentence that was imposed on the offender and has little to do with the essence of the issue being decided, namely the medical condition of the prisoner and his or her prognosis. There is indeed the need to simplify this and bring about not only consistency but also prompt decision-making.

In respect of the CSPBs it is known that there exist substantial backlogs in respect of parole applications in general.[15] It is, however, not known if these delays also extend to medical parole applications and it is therefore submitted that the Committee enquires from the DCS in this regard.

Recommendations for consistency and prompt decision-making

Despite the Bill of Rights and the obligation to protect and promote the dignity of all persons, including prisoners, this appears to have been undermined by the Department's overriding concern with security and thus the extremely low number of prisoners being released on medical parole. The position of the Correctional Services Act is clear in describing the purpose of medical parole, namely to ensure that the prisoner who is diagnosed in the final stages of a terminal illness or condition be released to die a dignified and consolatory death. The Act does not subject such releases conditional to security concerns or questions about whether the purposes of punishment have been achieved. The central duty placed on the Department is to ensure the dignity of the prisoner in the final stages of his or her life. **In view of this it is recommended that the Department critically examines and revises, where necessary, its policies and procedures to give effect to this obligation. It is furthermore recommended that the staff of the Department and CSPB chairpersons be trained accordingly to give effect to this duty.**

The statistics on medical parole made available by the JIOP (see Figure 1) are helpful but it only provides a limited and quantitative picture. Moreover, it only refers to prisoners that have in fact been released on medical parole and there is no data available on prisoners who have applied for medical and have not

[15] The JIOP found backlogs in cases at 22 of the 93 prisons inspected in 2007/8. [Office of the Inspecting Judge (2007) *Judicial Inspectorate of Prisons Annual Report 2007/8*, Cape Town, p. 18]

been released or died prior to the adjudication of their applications. It is also unknown what reasons CSPBs employ when they grant or deny applications for medical parole. In short, a lot more information is required in order to understand the problem thoroughly and develop policy accordingly. **It is therefore submitted that the Committee requests the DCS to provide it with the necessary quantitative and qualitative information pertaining to trends in deaths of prisoners and medical parole.** This should at least cover the following:

- The exact cause of death of prisoners categorised as 'natural causes'
- The life span of prisoners released on medical parole
- The number of prisoners granted medical parole but who died prior to being released
- The quantum of parole violations and/or criminal activities of prisoners released on medical parole
- Trends in the reasons for granting and denying medical parole
- The distribution of successful and unsuccessful applications for medical parole across the 52 CSPBs and management areas
- Opinions of the courts in respect of medical parole

In the above it was noted that four distinct institutions have authority over the granting of medical parole. This description oversimplifies the situation somewhat as there are indeed 52 CSPBs. This structure is too large and complicated, and creates too many variables to ensure consistency in decision-making in general but more specifically, in respect of medical parole. Despite the good intentions to devolve this decision-making process and bring in civilian involvement, it must present the DCS with tremendous administrative, management and legal problems. These problems cannot be overlooked as the Commissioner of Correctional Services remains ultimately responsible and accountable for the decisions of a CSPB. **It is therefore recommended that the Committee enquires from the DCS as to the possible restructuring of the CSPB system in order to create a structure that would alleviate the current problems.**

It also appears that there are considerable delays in the decision-making process in granting or denying applications for medical parole; an issue noted by the JIOP in its 2007/8 annual report.[16] These delays reportedly have the unfortunate result that prisoners who have applied for release on medical parole die before their applications have been finalised. There is reason to believe that an important reason for the delay in decision-making is the late identification of prisoners who should be considered for medical parole by the medical staff of the Department. The early identification of prisoners who may be eligible for medical parole would enable the Department's other officials to collect the necessary information and undertake preparations to submit the case for consideration to the CMC and subsequently to the HOC, CSPB, Minister or court as the case may be. **It is therefore recommended that the Committee requests specific proposals from the DCS on how the current procedure can be streamlined and decision-making expedited.**

Section 76 of the Correctional Services Act establishes the Correctional Supervision and Parole Review Board (CSPRB) and section 75 stipulates that the decision of a CSPB is final unless the Minister or Commissioner, or the Inspecting Judge of Prisons (following the Amendment Bill) places the decision before the CSPRB for reconsideration. It should be noted that the CSPRB is a structure that generally meets four times per year and is made up of individual members of the National Council for Correctional Services (NCCS) who fulfil this function *ex officio* or as unpaid members of the public. In view of this, it was clearly not the intention of the legislature, when approving the Correctional Services Act that the CSPRB would function as an appeals chamber for the CSPBs. It does not have the capacity nor the allocated time to

[16] Office of the Inspecting Judge (2007) *Judicial Inspectorate of Prisons Annual Report 2007/8*, Cape Town, p. 27.

fulfil such a function. It is more likely that the CSPRB was conceptualised as a body that would develop guidelines for the CSPBs based on actual cases that are referred to it. Such cases would presumably be selected because they are representative of the cases the CSPBs deal with regularly, or are selected in order to develop precedent on particular issues. In respect of medical parole and bringing about consistency, there is thus an important role for the CSPRB to play in developing guidelines. **In view of the above it is recommended that the CSPRB assumes this function assertively and provide the necessary guidance on medical parole.**

The Correctional Services Amendment Bill empowers the Inspecting Judge to refer parole matters to the CSPRB.[17] This is regarded as a valuable mechanism to bring selected cases to the attention of the CSPRB and in particular medical parole cases with the view that the CSPRB will utilise the opportunity to develop guidelines. **It is therefore submitted that the Office of the Inspecting be requested to actively seek out cases involving medical parole and submit these to the CSPRB for consideration.**

The Correctional Services Amendment Bill also created the 'incarceration framework'; a mechanism designed reportedly to simplify the administration of placement on parole and correctional supervision. The point has been made thoroughly that the current parole regime is overcomplicated and confusing by Prof Sloth-Nielsen in her submission on the Correctional Services Amendment Bill: 'Three points emerge from the above: (1) administrative officials and parole boards are required by law to apply different systems of calculation, depending on when a prisoner was admitted to serve his or her sentence; (2) the previous system will remain applicable for a considerable time for prisoners given lengthy prison sentences before 1 October 2004 and (3) there is ample indication at grassroots level (confirmed by DCS officials) that the old system is not being applied by many parole boards, who are applying the new system to all prisoners regardless of when they were admitted to service their sentence. This lies at the root of some of the litigation that is taking place.'[18] Although her submission did not directly deal with medical parole, the central message of a need for simplification is clear. **It is therefore submitted that the Committee in its deliberations on the incarceration framework, when it is submitted by the DCS to Parliament, be mindful of the dire need for simplification and also reflect on issues pertaining to medical parole**.

The Act in section 79 makes provision for the 'placement under correctional supervision or on parole'. It does not specifically state that such a release must be conditional or unconditional. The G337 form 'Medical Report on Prisoner', gives effect to this by specifying that a release may by conditional or unconditional. There is therefore nothing preventing the Department to impose any of the conditions listed under section 52 of the Correctional Services Act, with a few exceptions as provided for in law, when releasing prisoners on medical parole. **It is therefore recommended that the Department, where the case warrants it, make placement under correctional supervision and on parole for medical reasons conditional to the provisions in section 52 of the Correctional Services Act.**

PREVENTION

A submission on deaths and medical parole needs to address prevention. The increase in the total number of deaths, as shown in Figure 1 attests to the serious problem that the DCS is facing. More concerning is the trend presented in Figure 2 that the majority of prisoners (62%) who die in prison, die within the first three years of admission. In view of these trends, a number of issues are emphasised.

[17] Clause 51 of the Bill
[18] Sloth-Nielsen J (2007) Submission to the Portfolio Committee on Correctional Services regarding the Correctional Services Amendment Bill 32 of 2007, para 5

There is little doubt that **prison overcrowding** has a severely detrimental effect on prisoners' health. Overcrowding has been a long standing problem for the DCS and its causes has been described by several researchers and commentators, including the Judicial Inspectorate. What is of particular concern is that the number of awaiting trial prisoners has shown a steady increase from 2006 when it was at its lowest level since 1998 (approximately 44 000) to 53 400 in January 2008. Since January 2008 the figure dropped slightly to 49 421 in June 2008. This remains well above the 1996 level of just below 30 000 unsentenced prisoners. The prisons listed in Table 1 are all above 200% full as at the end of the June 2008.[19] Overcrowding at this level is not acceptable and holds severe consequences for both prisoners and staff of the DCS. **All efforts need to be made to ensure that prison overcrowding is reduced and that the prison population remains within the capacity of the DCS's infrastructure.**

TABLE 1

Correctional Centres	Capacity	Unsentenced	Sentenced	In Custody	% Occupation
Zonderwater Med. A	877	0	1759	1759	200.57%
George	514	349	712	1061	206.42%
Pretoria Local	2171	4522	104	4626	213.08%
Thohoyandou Female	134	10	283	293	218.66%
Caledon	215	400	75	475	220.93%
Thohoyandou Med. B	219	468	21	489	223.29%
East London Med. B	543	1197	17	1214	223.57%
Johannesburg Med. B	1300	0	2920	2920	224.62%
Umtata Max.	720	8	1622	1630	226.39%
Pollsmoor Max.	1872	3624	645	4269	228.04%
Johannesburg Med. A	2630	6230	145	6375	242.40%
King Williams Town	301	629	112	741	246.18%
Durban Med. B	1853	0	4621	4621	249.38%
Mount Frere	42	0	110	110	261.90%
Odendaalsrus	350	974	27	1001	286.00%
Bizana	57	108	70	178	312.28%
Umtata Med.	580	1161	831	1992	343.45%
TOTAL	14378	19680	14074	33754	

Thorough medical screenings and health status examinations of admissions must be done as is required by the Correctional Services Act. Particular attention must be paid to existing medical conditions and prisoners that are on chronic medication. Ensuring that prisoners who are on chronic medication have access to their medication will reduce the number of deaths in custody and also reduce the demand for medical parole.

The problems that the Department is experiencing in respect of health care services have been noted by the Portfolio Committee previously as well as the JIOP. Despite these challenges, **all efforts must be made to ensure that prisoners have access to adequate health care that is based on the principles of primary health care, being promotive, preventive, curative and rehabilitative health care services.**

It is not known at this stage what proportion of prisoners who qualify for ART are indeed receiving this therapy. However, it is imperative that **prisoners who do qualify for ART should receive it.**

[19] Statistics supplied by the JIOP.

CONCLUSION

It is CSPRI's position that the central objective of medical parole is to ensure the dignity of the prisoner in the final stages of his or her life. The Correctional Services Act enables the Department and its structures to achieve this result. The challenge therefore is to firstly ensure that as many deaths as possible are indeed prevented. Secondly, to remove or amend the administrative and procedural obstacles hindering the efficient and effective management of medical parole. Thirdly, as intangible as they may be, attitudes towards prisoners, especially those who are terminally ill, need to be addressed to ensure that their right to dignity is upheld.