

**SUBMISSION ON THE EARLY RELEASE OF
PRISONERS WITH HIV/AIDS
TO THE JALI COMMISSION**

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SUBMISSION TO THE JALI COMMISSION EARLY RELEASE OF PRISONERS WITH HIV/AIDS

Description of the AIDS Law Project

The AIDS Law Project (ALP) is based at the Centre for Applied Legal Studies, University of the Witwatersrand. It is a university based, donor funded institute that specialises in helping people with HIV/AIDS to deal with various legal problems relating to HIV/AIDS. It provides legal advice and assistance to people infected and affected by the epidemic and undertakes high impact public interest litigation to establish legal precedents that protect the rights of these people. It also conducts research on social, legal and human rights issues around HIV/AIDS and uses this research to develop law, policies and "best practice" recommendations.

The ALP has received many queries from prisoners living with HIV/AIDS, especially around the issue of early release on medical grounds. Its experiences are dealing with these complaints is reflected in this submission.

Background to the submission

The ALP and Treatment Action Campaign made a submission to the Jali Commission in March 2004 entitled "HIV/AIDS in Prison: Treatment, Intervention, and Reform". The submission dealt with the origins and causes of HIV infection in prisons, HIV prevalence in prisons, the HIV/AIDS policy of the Department of Correctional Services, including early release, and finally made recommendations, including several on the early release of prisoners with HIV/AIDS.

In that submission, it was argued that the policy on early release for prisoners on medical grounds should be updated to accommodate the increasing number of prisoners who are dying of AIDS while incarcerated. As indicated in the submission, there is little research dealing with the numbers of prisoners infected with HIV, but there are indications that it is a serious problem and that there has been a dramatic increase in the numbers of prisoners dying in prison, which has been attributed to HIV/AIDS. In his report on behalf of the Judicial Inspectorate of Prisons, Judge Fagan made the following observation:

"There has been a rapid escalation in the number of natural deaths in prison. During 1995 the natural death rate among prisoners was 1.65 deaths per 1 000 prisoners, last year it was 7.75 deaths per 1 000 prisoners. The continued escalation in natural deaths at the current rate of 34% per annum will mean that about 15 000 prisoners could die in the next 5 years. The current early release policy for terminally ill prisoners will have to be reconsidered. Although legislation does provide for the early release of terminally ill sentenced prisoners, it excludes unsentenced prisoners. The application of this option of early release on parole has decreased. In 1996 about 20% of terminally ill prisoners were released compared to the only about 6% last year. Last year

*was however considerably better than the year before”.*¹

The Jali Commission has subsequently requested the ALP to make an additional submission in which we address the issue of early release of prisoners with HIV/AIDS in more detail.

HIV disease progression and treatment

There are four stages of HIV infection, the last stage being referred to as AIDS. For the purpose of this submission, it is important to provide a brief summary of each of these stages and its impact on the individual concerned.²

The Acute Stage

This stage is also referred to as “seroconversion disease”. At this stage, the HIV infected individual often experiences a flu-like illness or an illness with a rash, or glandular fever-like illness that is temporary (up to a few weeks’ duration). This illness occurs for approximately four to eight weeks after infection. During this illness, the individual’s immune system is temporarily depressed. However, this is a temporary phase and the immune system then reverts to normal activity, when the individual recovers clinically.

Asymptomatic Immunocompetent Stage

This stage follows after the acute stage. During this stage the individual functions completely normally and is unaware of any symptoms of the infection. The immune function can be tested by various tests. A marker called the *CD4 count* measures the deterioration of immune function. A CD4 count is therefore commonly used as an indicator of immune strength and measures the white blood cells to find out how seriously a person’s immune system has been damaged by the HI virus. A normal CD4 count in people without HIV or people in the early stages of HIV infection is usually between 600 and 2000 cells/ml. But this number steadily drops over time as the disease progresses. This progression varies in individuals and may take a few years or even longer.

Asymptomatic Immunosuppression

This stage occurs when there is a progressive increase in the amount of virus in the body and the virus eventually gets the better of the frantic efforts of the body to replenish vast number of CD4 cells. The CD4 cell count then drops below 500 cells per micro-litre. When the count drops below 300 cells per micro-litre, the individual becomes vulnerable to secondary infections and, at that stage, needs to take prophylactic antibiotics and antimicrobials. Although the individual’s immune system is now significantly depressed, he or she may still be completely free of symptoms and be unaware of the progressive disease in his or her body.

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¹ Portfolio Committee On Correctional Services, 16 September 2003, Progress Report With Regard To Overcrowding And The Current Situation In Prisons, <http://www.pmg.org.za/docs/2003/>

² From Hoffmann v South African Airways 2000 (11) BCLR 1211 (CC) at 1216 E-J

During this stage the individual's CD4 cell count is often profoundly depressed and there is a vast volume of virus in the bloodstream. This is the disease phase. Patients whose CD4 count drops below 200 or those with an AIDS defining illness will die unless they take antiretroviral medicines. The risk of multiple opportunistic illnesses also dramatically increases once the CD4 count falls below 200.

It is possible, with the use of antiretroviral medication, to slow down the progression of HIV and thereby keep patients alive and productive. Antiretroviral medicines target either a particular step in the lifecycle of HIV or its interaction with host cells. The correct, timely and appropriate use of antiretroviral treatment will result in the improvement of the clinical condition, quality and quantity of life in the majority of people living with AIDS. It also helps to reduce and/or eliminate opportunistic infections.

Treatment

In August 2003 the South African government agreed to make antiretroviral medicines available to people living with HIV/AIDS. As part of this process, the Department of Health released its "**Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa**" ("Operational Plan") in November 2003. In terms of this plan, it is recognized that antiretroviral treatment should be made available before a patient's CD4 count drops significantly below 200, at which stage there would be a decreased durability of benefit from such treatment. The Department of Health's criteria for a patient to initiate antiretroviral treatment as set out in the Operational Plan, is:

- A CD4 cell count under 200 cells per micro litre and symptomatic, irrespective of disease stage; or
- World Health Organisation (WHO) stage IV AIDS defining illness, irrespective of CD4 count and
- Patient must be prepared and ready to take anti-retroviral medicines (ARVs) regularly.

With regard to the Department of Correctional Services, the Operational Plan remarked that:

"Tight linkages with the public health system will be needed, so that patients requiring evaluation for antiretroviral therapy can be appropriately assessed and started on ARVs by skilled clinicians. The health care team will refer prisoners back to Correctional Services for ongoing primary care follow-up for HIV, with referrals for specialized care in public facilities according to national treatment guidelines. Upon discharge from Correctional Services, clear referral to ongoing care is to be formalized to ensure continuation of therapies and reinforcement of prevention counselling and support" (page 77).

The Operational Plan therefore clearly envisages that prisoners should be able to access antiretroviral medication through public health facilities during their incarceration. The plan further makes provision for a continuation of access to therapy upon their release from prison. Unfortunately, this vision has not yet translated into practice, and it appears from the complaints received by the ALP and

other organizations that antiretroviral treatment is not currently being offered to prisoners by the Department of Correctional Services.

This failure violates section 35(2)(e) of the Constitution that states that all detained persons should have access to medical treatment, appears to ignore the statements contained in the Operational Plan and is contrary to the WHO guidelines on HIV infection and AIDS in prisons that advocates for the principle of equivalence for prisoners:

“All prisoners have the right to receive health care, including preventive measures, equivalence to that available in the community without discrimination, in particular with respect to their legal status or nationality. The general principles adopted by national AIDS programme should apply equally to prisoners and to the community”³

The failure to provide anti-retroviral treatment to prisoners is a critical legal, constitutional and human rights issue and the ALP has written to the Department of Correctional Services, requesting it to provide details of how it intends to implement its obligation to ensure that prisoners have access to treatment. It has also taken up individual cases and will seek to assist those prisoners to enforce their legal rights. However, in the absence of a comprehensive plan to provide antiretroviral treatment in prisons, in the short term, there will continue to be significant numbers of prisoners who will become ill and who should be released from prison.

Description and analysis of current policy

Placement on parole for medical reasons is regulated by section 69 of the **Correctional Services Act 8 of 1959**:

“A prisoner serving any sentence in prison:
a) *who suffers from dangerous infectious or contagious disease or*
b) *whose placement on parole is expedient on the grounds of his physical condition or, in the case of a woman, her advanced pregnancy, may at any time on the recommendation of the medical officer be placed on parole by the commissioner, provided that the prisoner sentenced to imprisonment for life shall not be placed on parole without the consent of the Minister”.*

Since the act was passed, there have been further developments and it is clear from various amendments that the trend is to permit the Department of Correctional Services to also take into account whether the illness is terminal (Section 11 of the Parole and Correctional Supervision Amendment Act 87 of 1997, which has been assented to) and the right of prisoners to dignity in death (section 79 of the Correctional Services Act 111 of 1998, which is not fully operational). The wording of section 69 is however sufficiently broad to accommodate various situations, including those in the amendments.

In terms of the **prison standing orders**, various factors should be “seriously kept in mind when considering a prisoner for placement/release on medical grounds” including “(v) in all cases where there is no doubt as to the nature of the illness and

³ WHO 1993: 1

the life expectancy it is advisable that the placement/release on medical grounds be considered on a conditional basis” Another guideline states that injudicious placement or release on parole may foil the real objectives of the sentencing authority.⁴

The Department of Correctional Services’ policy document entitled **Management strategy: HIV/AIDS in prisons**, in article 6.16 provides for the following:

- *“Terminally ill prisoners should be considered for placement on medical grounds (compassionate release).*
- *Monthly medical reports must be submitted for all offenders under consideration for early release or placement on medical grounds to assist the parole board’s decisions.*
- *Thorough medical examination should be conducted to assist decisions by parole boards.*
- *Two independent medical doctors shall examine the prisoner who is to be considered for early release.*
- *Social work reports should also be submitted to indicate the availability of after care and care providers.*
- *In all cases of referrals to other care providers, the offender shall give an informed consent.*
- *Early identification of the relatives and other service providers for HIV/AIDS infected prisoners is important to facilitate placement after release. This can be achieved through partnership with other services providers including the families.*
- *Each prison must identify community structures to assist with placement after release. Such services should include hospice care, social workers and others to assist in training relatives.”*

In summary, the Department of Correctional Services has the power to release prisoners where it is considered to be expedient to do so on the grounds of his or her health status. The Department’s policy on HIV/AIDS specifically makes provision for the early release of terminally ill AIDS prisoners and creates a framework within which such a release should take place. In the next section, we try to highlight some of the problems with the current legislative and policy framework.

Problems in current policy

In practice however, early release on medical grounds is a bureaucratic and often lengthy process and many prisoners’ conditions worsen and some die before their release is approved. Many factors contribute to the delays: ⁵

⁴ This standing order was supplemented in 2001 in the Western Cape, to identify an area manager with minimum rank of director, as delegated official to decide matters concerning parole on medical grounds. Such persons “must be satisfied that the prisoner is terminally ill”.

⁵ From Presentation by KM Mabena “Situational analysis prison health care” presentation by KM Mabena, 14 November 2003 and AIDS Law Project / Treatment Action Campaign submission - Interview #4: Social Worker X

- There is an increase in the number of HIV positive and TB cases and ultimately terminally ill prisoners who die within prisons. Co-infection of TB and HIV/AIDS also affect disease progression.
- There is sometimes a reluctance by family members to receive the released person back especially if terminally ill and this may be worse if HIV status is known and officials fail to make adequate arrangements for other placements for such prisoners.
- Where the Department of Correctional Services health staff believe that a prisoner should be released, the prisoner must be seen by the district surgeon, specialist, social worker and the parole board, which can take several weeks and can even stretch out for months.
- Parole Board members may not be skilled in assessing complex medical circumstances. Applications are often rejected based upon an incorrect consideration of current and/previous criminal records and other irrelevant factors, without due consideration of the prisoner's medical needs.

Analysis of relevant case law

The decision to refuse early release on medical grounds has been successfully challenged in two recent, unreported cases: WC Du Plooy v Minister of Correctional Services (6399/04, TPD) and Colin Stanfield v Minister of Correctional Services and others (5075/03, CPD). Whilst the two cases did not deal with HIV/AIDS, the judgments provide useful guidelines in interpreting current legislation on early release on medical grounds.

WC Du Plooy v Minister of Correctional Services (6399/04, TPD, judgment delivered by Patel J on 15 March 2004)

In this case, the Applicant had committed armed robbery and was sentenced in September 2003 to 15 years imprisonment. He was admitted to the prison hospital at an early stage of his imprisonment. The Applicant had leukemia with a life expectancy of one to two years. At the time of the application for parole on medical grounds, this life expectancy had dropped to one to three months. The Parole Board refused the application for parole and the decision was approved by the Head of the Prison. The Applicant made an application to review of the decision to refuse his release.

The court set aside the initial decision and ruled that the Applicant be placed on parole subject to the following conditions:

1. That he be monitored by the Department of Community Corrections in accordance with the statutes and regulations pertaining to Correctional Services;
2. That he continued to be under the supervision of his doctor at the local hospital;
3. In the event of him being discharged from the hospital, that he be placed under the care of his wife at their home;
4. That he be under house arrest except for being allowed to undergo any medical treatment at any hospital, clinic, doctors consulting rooms or hospice.

In his reasons for judgment, the judge commented that there is a tension between the necessity of imprisonment and the need to be compassionate towards someone suffering from a terminal illness.

The Applicant's treating doctor noted that prison conditions were not conducive to the treatment of the Applicant:

- It was difficult to administer medication;
- The Applicant was exposed to opportunistic infections from other sick prisoners;
- There are no doctors skilled in the administration of palliative care in the employ of the Department of Correctional Services;
- Prison officials did not provide the Applicant with the specific food prescribed for his condition, ostensibly due to budget constraints;
- The Applicant's state of health further required daily palliative care and regular hospice intervention.

Significantly, the judge equated the refusal to place the Applicant on medical parole with an infringement of his inherent right to dignity. The judge held that the refusal further violated the Applicant's rights under section 12(1)(e) of the Constitution not to be treated or punished in a cruel, inhuman or degrading way, section 27(1)(a) to have access to health care services, section 35(2)(e) to be detained in conditions consistent with human dignity, including nutrition and medical treatment, section 32(1)(a) and (b) to access to information and section 33(1) and (2) to just administrative action.

Colin Stanfield v Minister of Correctional Services, The Commissioner of Correctional Services, the Parole Board (Helderstroom Prison) and another (5075/03, CPD, judgment delivered by Van Zyl J on 12 September 2003)

The Applicant was 48 years old and was convicted of fraud and sentenced in March 2001 to 6 years imprisonment, a sentence which he started to serve in February 2002. In May 2003 the Applicant was diagnosed as suffering from incurable and inoperable lung cancer. The only therapy available was chemotherapy at a hospital outside prison. This required that the Applicant be treated as an in-patient for 3 consecutive days every 21 days for about 5 months. During the treatment the Applicant could suffer from possible side-effects such as nausea, vomiting, weakness, diarrhea, hair loss and weight loss and his immune system would be affected, with a high risk of infection and bleeding. He would need easy access to medical care in the case of complications. His doctor recommended that he not be exposed to crowded conditions in prison that would place him at risk of infection. The life expectancy of the Applicant was estimated at 6 to 8 months with treatment. In addition the Applicant suffered from advanced coronary disease for which it was recommended that he be brought closer to adequate medical facilities, given the high risk of an acute event occurring. The side effect of treatment is that the Applicant is highly susceptible to chest infections such as TB, which would dramatically shorten his life. The doctor concluded that there was no Department of Correctional Services medical facility which could adequately care for the Applicant. This statement was disputed by the Department who argued that there were facilities at the prison where the Applicant could be accommodated. The Applicant

had applied to be released on medical parole and the Department of Correctional Services had rejected the application. The Applicant took the decision on review.

In this matter the judge also set aside the decision to refuse the Applicant's application to be placed on parole on medical grounds in terms of section 69 of the Correctional Services Act 8 of 1959. The judge ordered that the Applicant be placed on medical parole on the following conditions:

- That the Applicant remain under the medical supervision of his doctor at the local hospital;
- That, on discharge from the hospital, he be placed under the care of his wife or sister or housekeeper at his home.

The Respondents' rationale for refusing parole on medical grounds was based on the view that the Applicant's life expectancy was not so short that further imprisonment would not serve a purpose and they have an obligation to ensure that the sentence imposed by the court be served as far as possible. They further felt that since the prisoner's health condition was of such a nature that he was still able to do most things for himself, he was also still able to commit further crimes if released. The Respondents further claimed that the decision to grant medical parole was based on a wide discretion. The court held that however wide the discretion might be, it was not unfettered, and a proper consideration and assessment of all relevant facts and circumstances was required.

The judge held that section 69 of the Correctional Services Act 8 of 1959 meant that the Respondent has discretion **at any time** to place on parole a prisoner serving **any sentence** in a prison, provided his placement is **expedient** on the ground of his **physical condition** and further provided it is preceded by the recommendation of the medical officer. It was therefore irrelevant what period of imprisonment the Applicant has actually served. "Expedient" was interpreted to mean useful, beneficial, advantageous, suitable, convenient, or appropriate. Unlike section 79 of the Correctional Services Act of 1998, terminal illness or requirements relating to life expectancy, state of being bedridden or imminent death have never formed part of section 69. The law does also not suggest that the prisoner should be (physically or otherwise) unable to commit any crime should he be released on parole for medical reasons. It was further held that the Respondent's reference to the word "physically" appeared to allude to the Applicant's external or outward appearance as opposed to his internal or "medical" condition. Such an interpretation was not in accordance with the ordinary meaning of the words in section 69 and did not respect the Applicant's inherent right to human dignity:

"By restricting his understanding of such condition to the applicant's external or outward appearance, which is clearly only temporary and will undoubtedly undergo a radical change in the near future the third respondent chose to ignore, or downplay, the fact that he is suffering from an inoperable and incurable disease that will inevitably cause his death within a few months" [par 124].

The ALP argues that the two cases referred to above provide useful guidelines that assist in a proper understanding of the relevant statutory provisions. Both

judgements emphasize the need to strike a balance between the obligation of the Department of Correctional Services to ensure that convicted prisoners serve their sentences, and the needs of prisoners with serious illnesses to be treated with compassion and dignity. The cases point to the factors that should be taken into account when assessing applications for medical parole.

Conclusion and recommendations

Compassionate release

The ALP recommends that Department of Correctional Services bring their policy in line with the **World Health Organisation Guidelines on HIV infection and AIDS in Prisons** which provides for early release as follows:

“51. If compatible with considerations of security and judicial procedures, prisoners with advanced AIDS should be granted compassionate early release, as far as possible, in order to facilitate contact with their families and friends and to allow them to face death with dignity and in freedom.

52. Prison medical services should provide full information on such prisoners’ health status, treatment needs and prognosis, if requested by the prisoner, to the authorities competent to decide upon early release. The needs of those prisoners without resources in the community should be taken into account in any early release decision”.

This approach is supported by current case law.

The Department’s HIV/AIDS policy should be amended to state that where appropriate, namely where the prisoner’s state of health indicates that it is necessary, prisoners with AIDS **will** be released on medical parole. Furthermore the policy must emphasize the obligation on the part of the Department to act expeditiously and that there should be no unnecessary delays in initiating and processing these applications. The Department must seek to actively identify those prisoners whose state of health would qualify them for early release. It should be noted that, due to their state of health, prisoners are not always in a position to initiate applications for early release. When prisoners become eligible for this option, they should be informed of the possibility of early release and assisted in such applications, where they unable to do so themselves. The policy should be brought to the attention of all prisoners.

The social worker assigned to contact the family and to ensure that appropriate care is available upon release, should be notified when the patient is treated for an AIDS-related illness, rather than waiting until the prisoner is near death to begin this process, which also delays the consideration of the application. In this way, the social worker will have more time to make the necessary arrangements and can also provide assurances to the prisoner that may encourage him to hang onto life a little longer so that he may be rejoined with his family before dying.

The decision for early release should involve the input of the nurses who care for the prisoner on a day-to-day basis, confirmed by a medical practitioner. Separate medical examinations by two medical practitioners should not be a requirement as it frequently delays the application. Only where it is deemed necessary for a proper consideration for the application, should a specialist be required to conduct an examination. The application should be sent to one correctional services official who is tasked with making sure that the prisoner in the application is the same one as the prisoner in the hospital.

In addition, members of the Parole Board and all other officials in charge of determining early release on medical grounds should receive adequate education about HIV/AIDS and its treatment. The Parole Board and any other person or structure responsible for determining these applications must fast-track urgent applications.

Antiretroviral roll-out

The South African government has committed itself to providing antiretrovirals in the public sector. In the Operational Plan, the following is noted:

“People living with HIV infection should be provided with a continuum of care and support services that respond to their changing needs over the course of their infection. Components of this continuum of care include: prevention-related interventions; voluntary counselling and HIV testing (VCT); medical care and treatment by a dedicated, trained medical team; psychosocial support; nutritional assistance; social supports; and as needed community-based services and home-based care. At the stage where ARVs are required to maintain health, medication should be made available and accessible through coordinated programmes”....⁶

As indicated elsewhere in this submission, the Operational Plan does make provision for the needs of prisoners. It is our view that there are no convincing legal arguments that would preclude the prison population from receiving the same standard of care as the general population. It is however unclear from the Operational Plan or from Department of Correctional Services' policy how the roll-out of anti-retroviral medication will take place in the prison setting and these medications are currently unavailable to prisoners. In line with the provisions of the constitution, the Operational Plan and the equivalence principle, it is of the utmost importance that a plan is developed to ensure that ARVs are made accessible and available to all prisoners who need them.⁷

⁶ Operational Plan op cit, p. 54.

⁷ The equivalence principle was tested in the case of LX v Union of India & Others (High Court of Delhi, 2000) where an arrested person had HIV and was placed on antiretroviral medication by the prison authorities. When he was granted bail, he was informed that he would not continue receiving the medication after his release. He applied to court for an order that the prison authorities continue provision of medication. The interim order was granted. In January 2004, based on the Government of India's decision to provide free antiretrovirals in the public health sector, the Court ordered that the petitioner must present himself for a medical exam and his medicines at one of designated hospitals for antiretroviral roll out in Delhi. At the hospital he was told that he does not qualify for criteria for receiving medicines under the roll out plan and that the combination of drugs he was using was not

In the absence of the immediate development and implementation of such a plan, many prisoners with AIDS will die premature and preventable deaths. It is our view that the provisions of section 69, insofar as it states that early release should be made where it is expedient to do so based on considerations of the physical health of the prisoner, allow for an application for early release based on the failure to provide anti-retrovirals to a prisoner who meets the criteria set out in the Operational Plan and who is serving a sentence in a prison within the catchment area of an accredited site that provides anti-retrovirals to patients in the public sector.

It is our view therefore that until such time as the Department of Correctional Services is able to ensure that all prisoners with HIV who meet the clinical criteria for starting treatment, have access to anti-retroviral medication, the Department will run a considerable risk in that large numbers of prisoners may successfully apply for early release in order to access anti—retroviral treatment outside of prison.

prescribed under the scheme. Court in turn instructed government to enroll him for treatment and to switch medicines to those under the scheme on condition that the drug combination under the roll out plan should provide the same benefits to the petitioner as the medicines he has already been taking.