3]Reportable

1]IN THE HIGH COURT OF SOUTH AFRICA

2](CAPE OF GOOD HOPE PROVINCIAL DIVISION)

3] CASE NO 13741/07

4]In the matter between:

5] THE MINISTER OF HEALTH OF THE PROVINCE OF THE WESTERN CAPE
(Respondent in the counter-application)

6]and

7] CEDRIC GOLIATH ***First Respondent (First Applicant)***

~~**FRIEDA GOLIATH** Second Respondent~~

*

~~**CHRISTOPHER ADAMS** Third Respondent~~

*

CORNELL GIDEON Fourth Respondent (*Second Applicant*)

And in the counter-application:

THE MINISTER OF HEALTH Fifth Respondent

THE MINISTER FOR JUSTICE AND CONSTITUTIONAL DEVELOPMENT Sixth Respondent

SOUTH AFRICAN SOCIAL SECURITY AGENCY Seventh Respondent

THE MINISTER OF SOCIAL WELFARE AND DEVELOPMENT Eighth Respondent

8]

9]JUDGMENT DELIVERED: 28 JULY 2008

10]

11]GRIESEL J:

4]* Deceased since the launch of this application.

Introduction

12]The respondents have been diagnosed with highly infectious extensively drug-resistant tuberculosis (*XDR-TB*). The main question for decision is whether their compulsory admission to and continued isolation at the Brooklyn Chest Hospital (*the facility*) is legally justifiable.

13]The present application originally came before me in chambers on 28 September 2007 on the application of the Provincial Minister of Health (herein referred to as *the MEC*), when a rule *nisi* was issued calling upon the respondents to show cause on the return day why an order in the following terms should not be granted:

14]'2.1 Compelling the respondents to be admitted to the Brooklyn Chest Hospital;

15]2.2 Authorising the Sheriff, if necessary, to request members of the South African Police Service to assist him in ensuring that the respondents are admitted to Brooklyn Chest Hospital and remain there until their compliance with paragraph 2.4 below;

16]2.3 …

17]2.4 Compelling the respondents to remain at Brooklyn Chest Hospital until they have fulfilled the criteria for negative sputum culture conversion for XDR tuberculosis for a period of three consecutive months;

18]2.5 Compelling the respondents to adhere to the rules of behaviour for XDR tuberculosis patients at the Brooklyn Chest Hospital.'

19]Further relief aimed at the protection of the identities of the respondents was granted as part of the order. However, the respondents have subsequently of their own accord revealed their identities for purposes of these proceedings, with the result that such relief is no longer necessary.

4]* Deceased since the launch of this application.

20]In terms of the order, the Legal Aid Board was further requested 'to consider providing legal representation for the respondents to answer this application on the return day'. Such legal representation has indeed been provided by the Legal Aid Board and the court is indebted to Adv *H J de Waal* of the Cape Bar and Mr *R Bodart* of the Cape Town Justice Centre for their capable and conscientious assistance to the respondents as well as the court herein.

21]The MEC brings the present application in his official capacity as the Provincial Minister of Health in the Western Cape, who must in that capacity *inter alia* 'provide services for the management, prevention and control of communicable and non-communicable diseases'.[1] He also brings the application in terms of s 38 of the Constitution, in the public interest and in the interests of persons who may be exposed to and contract XDR-TB from the respondents.

22]After the papers were served on the respondents and they were duly re-admitted to the facility, answering affidavits together with a counter-application were delivered on their behalf. (Sadly, two of the four respondents originally cited – the second and third respondents – have succumbed to the disease since the launch of these proceedings.) In their counter-application the respondents joined as fifth to eighth respondents the National Minister of Health, the Minister for Justice and Constitutional Development (incorrectly cited as the 'Minister of Justice'), the South African Social Security Agency (*SASSA*) and the Minister of Social Welfare and Development. In their counter-application, the first and fourth respondents seek an order declaring their detention to be inconsistent with their right to personal freedom as

1 In terms of s 25(2)(*w*) of the National Health Act 61 of 2003 (*the 2003 Act*). Section 1 of the Act defines a '*communicable disease'* to mean 'a disease resulting from an infection due to pathogenic agents or toxins generated by the infection, following the direct or indirect transmission of the agents from the source to the host'.

enshrined in s 12 of the Constitution. They also seek further declaratory relief and a structural interdict, which will be considered in more detail later in this judgment.

23]I shall refer to the first and fourth respondents in the main application collectively as 'the respondents' and to the other respondents in the counter-application by their official designations.

XDR-TB

24]Tuberculosis is an air-borne disease caused by the micro-organism *Mycobacterium tuberculosis.* The disease is a communicable one and, where it affects the lungs – which happens in about 75% of cases – then the disease may be transmitted through infectious droplets which are produced whenever the infected person coughs, sneezes, spits or sings. Categories of persons particularly susceptible to contracting tuberculosis include children younger than 5 years; patients who are HIV positive; as well as patients with a range of other conditions which affect the immune system and result in higher susceptibility to tuberculosis infection, such as, *inter alia*, diabetics, alcoholics, patients on steroids, etc.

25]Tuberculosis can be divided into drug sensitive tuberculosis and drug-resistant tuberculosis. Multi-drug Resistant tuberculosis (MDR-TB) is resistant to what is known as the first line drugs, whereas XDR-TB is an extension of MDR-TB and is resistant, in addition, to certain further drugs. The principles of treatment for MDR-TB and for XDR-TB are the same, the main difference being that XDR-TB is associated with a much higher mortality rate than MDR-TB because of a reduced number of effective treatment options.

4]* Deceased since the launch of this application.

26]On the undisputed medical evidence before us it is clear that XDR-TB is a highly infectious and dangerous disease. Indeed, it has been described as 'a serious global health threat'.2 Prevention and deterrence, rather than treatment after the fact, is therefore of prime importance.

27]At present there is no proven regimen for the treatment of XDR-TB and no reliable data – local or otherwise – on the possibility of a cure for XDR-TB. of drug-resistant TB in South Africa is addressed through detailed 'Policy Guidelines', issued in July 2007 by the Director: Tuberculosis Control in the National Department of Health. This policy, which draws heavily from the World Health Organisation (WHO) Guidelines, is currently implemented by the Province and at the facility. With regard to treatment of patients with XDR-TB, the Guidelines *inter alia*state as follows:

28]'XDR-TB patients have a much reduced chance for cure and a very high risk of premature death; therefore, management of these cases should be prioritised using the same basic principles as those for MDR-TB. XDR-TB patients **must** be hospitalized, preferably at the MDR-TB referral centres, where additional infection control measures such as isolation facilities should be provided.'3

29]The facility in question is at present the only dedicated public health facility in Cape Town that treats XDR-TB patients. It specialises in the treatment of tuberculosis and is staffed by specialist medical practitioners skilled in the treatment of XDR-TB. The treatment lasts for between 18 and 24 months, consisting of the administration of a minimum of five drugs at a total cost (in respect of the required drugs) of approximately R63 000 per patient.

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2 Singh JA, Upshur R, Padayatchi N () '*XDR-TB in South Africa: No Time for Denial or Complacency'*, published on 23 January 2007in the Public Library of Science (*PLoS Med* **4** (1)), accessible at http://medicine.plosjournals.org (accessed 24 July 2008).

3 Policy Guidelines para 8.1, Record p 257.

4]* Deceased since the launch of this application.

30]Sputum conversion from positive to negative in XDR-TB patients is regarded as an indication of successful treatment. Once sputum culture conversion has occurred for three consecutive cultures, taken at monthly intervals, the patient is at minimal risk of transporting the disease and the disease can be managed on an outpatient basis. (It is this minimum requirement which is postulated in para 2.4 of the order quoted above as a necessary pre-condition for the discharge of the respondents.)

31]As appears from the policy guidelines quoted above, it is preferable that all patients with XDR-TB should have their treatment initiated in hospital because of the toxicity of the drugs, the monitoring and management of side effects, and protection from indiscriminate prescribing to avoid further and even more resistant strains of tuberculosis. However, the majority of XDR-TB patients – including the present respondents – have a history of irresponsible compliance with TB treatment. This gives rise to the dilemma as to how the objectives of the policy guidelines are to be achieved where the patients are not willing to submit to voluntary isolation and treatment.

Position of the respondents

32]It is common cause that the respondents have been diagnosed with XDR-TB and are presently infectious. Furthermore, it appears to be beyond dispute that the respondents' contact with their families and other members of the public creates a severe public health risk of infecting others with XDR-TB. In these circumstances, the MEC feels justified in seeking an order permitting their continued isolation at the facility until they are no longer infectious.

33]The respondents' attitude regarding the relief claimed is somewhat ambivalent. They do not dispute the medical evidence nor the risk posed by them as infectious XDR-TB patients to others. Recognising the risks and in an

4]* Deceased since the launch of this application.

effort to obtain appropriate treatment, all the respondents were initially voluntarily admitted to the facility. However, subsequent to commencing their treatment, some of the respondents refused to be isolated or treated for XDR-TB, and regularly absconded from the facility. On the evidence before us, it is thus clear that the respondents are not willing *voluntarily* to isolate themselves and to prevent them spreading infection to others. The conduct of the first respondent, in particular, has been described as 'disruptive, violent and dis-respectful'. In addition,

34]'(h)e uses abusive language to fellow patients and to the staff of the facility. He is violent towards the security guards. …He admits to using cannabis and "tik" and often comes "high" to the ward, behaving strangely and smelling of cannabis.'

35]The fourth respondent, while generally being more compliant than the first respondent, has also on occasions absconded from the facility and interrupted his treatment. The likely consequence of this behaviour is not only treatment failure, but also infection of others.

36]The respondents purport to justify their conduct on the basis of conditions at the hospital, as well as their financial and family responsibilities. Nonetheless, they appear to realise that they cannot ask for the rule *nisi* simply to be discharged, as 'that would be irresponsible'. At the same time, however, the respondents contend that their detention at the facility is inconsistent with s 12(1) of the Constitution,[4] with the result, according to them, that the rule *nisi* cannot be confirmed either.

Discussion

37]It is undisputed that the compulsory isolation of the respondents at the

4 '*Everyone has the right to freedom and security of the person, which includes the right – (a) not to be deprived of freedom arbitrarily or without just cause…*'

4]* Deceased since the launch of this application.

facility amounts to a deprivation of freedom. The first question for decision is whether such deprivation is 'arbitrary' or 'without just cause'. In my view, the answer must clearly be no: isolation of patients with infectious diseases is universally recognised in open and democratic societies as a measure that is justifiable in the protection and preservation of the health of citizens, even though it necessarily involves some intrusion upon the individual liberty of the patients concerned. Thus –

•Article 12 of the UN International Covenant on Civil and Political Rights (ICCPR) permits the limitation of the right to liberty of movement by restrictions provided by law which are necessary, *inter alia*, to protect public health.

•Article 25 of the Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights,[5] similarly provides that '(p)ublic health may be invoked as a ground for limiting certain rights in order to allow a state to take measures dealing with a serious threat to the health of the population or individual members of the population'. Such measures, however, 'must be specifically aimed at preventing disease or injury or providing care for the sick and injured.'

•Article 5 §1 (*e*) of the European Convention on Human Rights (1950) provides for an exception to the right to liberty and security of the person, *inter alia* in respect of 'the lawful detention of persons for the prevention of the spreading of infectious diseases.'[6]

•Moreover, national legislation in other open and democratic societies also permits the isolation of patients with infectious communicable disease. By

5 Issued by the UN Economic and Social Council.

6 See also *Enhorn v Sweden* 56519/00 [2005] EHCHR 34 (25 January 2005) para 33.

way of example, we were referred to the Ontario Health Protection and Promotion Act,[7] which gives broad authority to medical health officers to order a person who is or may be infected with a communicable disease to 'isolate himself or herself and remain in isolation from other persons'; otherwise 'conduct himself or herself in such a manner as not to expose another person to infection'; undergo medical examination and submit to necessary treatments. Section 22(2) thereof provides that a medical health officer may issue such an order if she/he has reason and probable grounds to be believe, *inter alia* 'that a communicable disease exists or may exist or that there is an immediate risk of outbreak of a communicable disease'; that such communicable disease presents a risk to the health of persons; and the requirements specified in the order are 'necessary in order to decrease or eliminate the risk to health presented by the communicable disease'.[8]

•Likewise, s 14(1) of the 1992 Constitution of Ghana provides for an express limitation to the right to liberty *inter alia* 'in the case of a person suffering from an infectious or contagious disease, a person of unsound mind, a person addicted to drugs or alcohol or a vagrant, for the purpose of his care or treatment or the protection of the community'.

•Also significant in this context are the provisions of Article 6 of the African Charter on Human and Peoples' Rights (1981/1986):

38]Every individual shall have the right to liberty and to the security of his person. No one may be deprived of his freedom except for reasons and conditions previously laid down by law. In particular, no one may be arbitrarily arrested or detained.

39]In the article by Singh *et al*, referred to above,[9] the authors refer to the fact

7 R.S.O 1990.

8 See also *Toronto (City Medical Officer of Health) v Deakin* [2002] O.J. No. 2777 (Ont. Crt. Just).

9 Footnote above.

4]* Deceased since the launch of this application.

that the 'WHO recommends that persons with MDR-TB voluntarily refrain from mixing with the general public and from those susceptible to infection'. They proceed, however, by stating:

40]'The emergence of XDR-TB indicates that the WHO strategy of allowing the patient to assume responsibility for mixing with the general public may be too permissive and more attention to strategies of infection control in the community is required. In general, from both an ethical and legal perspective, measures that rely on voluntary cooperation and are the least restrictive in terms of interfering with human rights are preferred. However, if such measures prove to be ineffective, then more restrictive measures may need to be contemplated. …

41]The use of involuntary detention may legitimately be countenanced as a means to assure isolation and prevent infected individuals possibly spreading infection to others. However, South African officials have raised human rights concerns in dealing with the country's XDR-TB and MDR-TB outbreaks, although they have conceded that forcible treatment may be a viable option in tackling the outbreak. Health workers and human rights advocates in South Africa and elsewhere must be reminded that although a country's Bill of Rights may bestow a range of human rights on individuals, these rights can usually be restricted if doing so is reasonable and justifiable. They should be made aware of any national laws and municipal by-laws that permit the provision of involuntary treatment and isolation measures in the interests of public health.' (emphasis added)

42]In the light of the authorities referred to above, it is abundantly clear that, *in principle*, the limitation on the freedom of movement of patients with infectious diseases is reasonable and justifiable in 'an open and democratic society based on human dignity, equality and freedom', as contemplated by s 36(1) of the Constitution.[10] The views of the authors expressed in the preceding paragraph thus enjoy ample support in the international field. It is accordingly clear to me that in the circumstances of this case the limitation on the freedom of movement of the respondents as a result of the court's order

10 '*The rights in the Bill of Rights may be limited only in terms of law of general application to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, taking into account all relevant factors…*'

4]* Deceased since the launch of this application.

cannot be described as either 'arbitrary' or 'without just cause'.

43]I did not understand the respondents to take issue with the basic approach outlined above. Instead, their argument tended to focus on the question whether the limitation sought to be imposed on the respondents' right to freedom of movement is permitted 'in terms of a law of general application', as required by the first leg of the limitation clause in s 36 of the Constitution. In this regard, the respondents submitted that in the present state of the law in South Africa, there is 'no constitutionally valid statutory basis for the arrest and the detention of persons such as the respondents'. I proceed to consider the basis for that argument.

Legal framework

44]In the applicant's founding affidavit, the MEC relied mainly on the provisions of s 7 of the 2003 Act as justification for the present application. The relevant provisions read as follows:

45]'**7. Consent of user** – (1) Subject to section 8, a health service may not be provided to a user without the user's informed consent, unless –

46](a) …

47](b) …

48](c) provision of a health service without informed consent is authorised in terms of any law or a court order;

49](d) failure to treat the user, or group of people which includes the user, will result in a serious risk to public health…'

50]The respondents argue that the provisions of s 7 do not apply to the present scenario. The issue, so they say, is not the provision of a 'health service' without informed consent, but the 'arrest and detention' of a person against

4]* Deceased since the launch of this application.

that person's will. The Act currently does not provide for a power to 'arrest' and 'detain'. It is envisaged in the Act that this question will eventually be dealt with by way of regulations, to be adopted in terms of s 90 of the Act relating to 'Communicable Diseases'. However, such regulations have not yet been promulgated and currently only exist in draft form.[11]

51]Moreover, the 'Regulations relating to Communicable diseases and the Notification of Notifiable medical conditions' published in terms of sections 32, 33 and 34 of the previous Health Act ('*the 1987 regulations'*)[12] do indeed provide for the compulsory medical examination, hospitalisation or treatment of persons suffering from a communicable disease referred to in Annexure I thereof, including tuberculosis. However, so it was argued, these regulations have become 'practically unworkable' due to the repeal of large parts of the previous Health Act.

52]Although the respondents' argument is not without some merit, I do not agree with the basic premise on which it is based. 'Health services' is defined in s 1 of the 2003 Act as –

53]'(a) health care services, including reproductive health care and emergency medical treatment, contemplated in section 27 of the Constitution;

54](b) basic nutrition and basic health care services contemplated in section 28(1)(*c*) of the Constitution;

55](c) medical treatment contemplated in section 35(2)(*e*) of the Constitution; and

56](d) municipal health services.'

57]Applying a purposive approach to the provisions of s 7, read with s 1 of the

11 GN R.27, published in Government Gazette No 30681, dated 25 January 2008.

12 Published under Government Notice No. R2438 of 30 October 1987.

* Deceased since the launch of this application.

2003 Act, the concept of 'health service' is wide enough, in my view, to encompass the involuntary isolation of patients with infectious diseases at a State-funded healthcare facility, such as the facility in question. In the result, the respondents' argument in this regard cannot be accepted.

58]Having said that, it is undoubtedly preferable that the full statutory and regulatory framework be put into place and implemented as soon as practically possible by promulgating the draft regulations that have been published for comment as long ago as January this year. This does not mean, however, that until such time as the regulatory framework is in place, the MEC is powerless to give effect to his statutory duty to 'provide services for the management, prevention and control of communicable and non-communicable diseases'.[13] In my view, the MEC is clearly entitled to approach the court for the necessary authorisation as contemplated by s 7 of the 2003 Act, as he has done in the present instance. If there can be any criticism levelled against the Provincial health authorities, it is for the fact that their security arrangements in isolating the respondents and other patients in similar positions have on numerous occasions been proved to be inadequate and ineffectual.

59]It is instructive, in this context, to compare the situation pertaining in Canada, as it appears from the facts in *Toronto (City Medical Officer of Health) v Deakin* referred to above.[14] The respondent, a TB patient, brought a challenge in terms of the Canadian Charter of Rights and Freedoms to the extension of his treatment order by the medical officer of health, under a regulatory scheme. He had consented to a four month detention and treatment order and this was extended for a further four months in order to control his TB. The patient argued that his continued detention violated his constitutional

13 See footnote above.

14 Footnote above.

liberty rights. The court accepted that his Charter Rights were violated, but concluded that the infringement was justified to protect public health and prevent the spread of TB. It appeared from the evidence, *inter alia,* that the patient was being detained at the facility in question

60]'in a magnetically locked room, which has a special ventilation system to deal with potentially contagious airborne bacteria. …Two security guards take turns outside his door. When he is escorted outside, on the seven daily "smoke breaks" he is physically restrained to prevent his escape. … (He) was placed in the locked room after two incidents where he absconded from the Centre and scaled a wall … in one case to go and buy a case of beer, arguably putting community members at risk of contracting tuberculosis. He has also been shackled to the bed on several occasions when he purportedly became violent and hurled items around his room.'[15]

61]Against this background, the court had no hesitation in granting an order for his further detention, concluding as follows:

62]'(The patient's) rights under s 7 of the Charter [equivalent to s 12(1) of our Constitution] have indeed been violated. But those breaches were justified. The most egregious, the shackling, were timed to deal with outbreaks of violence. The facts show that the shackling was never vindictively or arbitrarily applied. …The transcript and the evidence show that the doctors and staff … are handling a most difficult and challenging situation with wisdom and sensitivity. They deserve praise. I find the occasional use of restraints was necessary and limited. It was motivated by the need to protect the patient and the staff at the facility.'[16]

63]In the circumstances of the present case, I am satisfied that the MEC has made out a sufficient case for the granting of a final order herein. In the light of this conclusion, it is not necessary to consider the MEC's alternative arguments based on the common law doctrine of necessity or the duty of the State in terms of s 7(2) of the Constitution to 'respect, promote and fulfil the

15 Paras 19 and 21 of the judgment.

16 Para 31.

4]* Deceased since the launch of this application.

rights in the Bill of Rights'.

4]* Deceased since the launch of this application.

64]The counter-application

65]In their counter-application, the respondents originally claimed wide-ranging relief in the following terms:

66]'2.1 Declaring the arrest and detention of the First, [~~Third~~] and Fourth Respondents to be inconsistent with s 12 of the Constitution;

67]2.2 Declaring that Seventh Respondent may not terminate or interrupt the payment of any grant under the Social Assistance Act 13 of 2004 in respect of a person compulsorily detained in a medical facility for the treatment of XDR Tuberculosis, if the dependants of such a person are unable to support themselves;

68]2.3 Declaring the failure of the Applicant to promptly inform the First, ~~Third~~ and Fourth Respondents of the right to choose, and to consult with, a legal practitioner, to be inconsistent with s 35(2)(b) of the Constitution;

69]2.4 Declaring the failure of the Applicant to promptly inform the First, ~~Third~~ and Fourth Respondents of the right to have a legal practitioner assigned to a detained person by the state and at state expense, if substantial injustice would otherwise result, and the failure by Sixth Respondent to provide for such a legal practitioner to be assigned to persons such as the Respondents, if a substantial injustice would result, to be inconsistent with s 35(2)(c) of the Constitution;

70]2.5 Declaring the failure of the Applicant to provide First, ~~Third~~ and Fourth Respondents with conditions of detention that are consistent with human dignity, including at least exercise and the provision, at state expense, of adequate accommodation, nutrition and reading material, to be inconsistent with s 35(2)(e) of the Constitution;

71]2.6 Declaring the failure of the Applicant to provide for facilities in which the First, ~~Third~~ and Fourth Respondents can communicate with, and be visited by, their spouses or partners, next of kin and chosen religious counsellor and legal representatives, to be inconsistent with s 35(2)(f) of the Constitution;

72]2.7 Directing the Applicant and Fifth to Seventh Respondents to present to

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this Court, within a time period to be determined by this Court, a plan ("the plan") on how they intend to rectify the failure to comply with their constitutional obligations set out above and directing that the First, ~~Third~~ and Fourth Respondents may submit comments on such a plan in a manner to be determined by this Court.'

73]In oral argument before us, the relief as originally claimed underwent somewhat of a metamorphosis:

•First, the relief claimed under para 2.1 was abandoned in favour of a prayer seeking an order declaring the 1987 regulations to be unconstitutional, but suspending the order of invalidity for a period of three months. In my view, the abandonment of the original prayer 2.1 was entirely justified in the light of the reasons set out above. With regard to their amended claim, I am not persuaded that the respondents require a declaration of constitutional invalidity as the MEC has not sought to invoke the provisions of the 1987 regulations in order to justify the respondents' isolation.

•The relief claimed under paras 2.3 and 2.4 was likewise abandoned and rightly so: as a fact, the respondents have been provided with legal representation at state expense for purposes of opposing these proceedings.

•Third, with regard to the relief claimed in terms of paras 2.2 and 2.5–2.7, counsel asked that the application for such relief be postponed for hearing on the semi-urgent roll. In my view, this request can be accommodated by the order that I propose to grant herein.

•Fourth, certain additional declaratory orders were sought, declaring that –

'4.1 "adequate medical treatment" in s 35(2)(*e*) of the Constitution includes a right for the respondents "to receive counselling regarding their medical conditions and its consequences for themselves and others";

4.2 the term "adequate reading material" in s 35(2)(*e*) includes a

4]* Deceased since the launch of this application.

right for them to receive "appropriate reading material" and an "adequate reading and recreational facility";

4.3 section 35(2)(*f*) includes a right to an "adequate facility in which [they] can communicate with and be visited by their spouses or partners, next of kin and chosen religious counsellor, and consult with a legal practitioner".'

74]With regard to the declaratory relief quoted in the preceding paragraph, I shall accept (without deciding) that the respondents do indeed fall within the category of 'everyone who is detained' as contemplated by s 35(2) of the Constitution. The MEC did not take issue with this approach, nor did he dispute that the respondents are entitled to conditions of isolation 'that are consistent with human dignity, including at least exercise and the provision at state expense, of adequate accommodation, nutrition, reading material and medical treatment', as contemplated by s 35(2)(*e*) of the Constitution. The MEC points out that, prior the launching of the present application, steps had already been taken to improve the conditions of isolation at the facility for XDR-TB patients. Since then a number of further improvements have been implemented, including:

•the implementation of a psycho-social rehabilitation programme;

•the appointment of further counsellors;

•implementing a further system in terms of which patients receive further written instructions in addition to the written consent forms signed at the time of initiating treatment;

•the provision of newspapers and television, including satellite television.

75]With regard to counselling as part of their medical treatment (para 4.1 of

4]* Deceased since the launch of this application.

the counter-application), the MEC's response is that the facility does indeed provide counselling for persons in the position of the respondents. Although the new psycho-social rehabilitation programme has only been implemented properly in the male ward, it will also be implemented in the female XDR ward. The programme is not implemented by nurses, but by social workers, occupational therapists and adherence counsellors. The suggestion by the respondents that the nurses required to implement the programme have not been appointed, is accordingly plainly wrong, according to the MEC.

76]As for 'adequate reading material' and an 'adequate reading and recreational facility' (para 4.2), copies of newspapers as well as other reading material are available in the library at the facility. The MEC submits, however, that the right to reading material does not extend to tabloids, such as *Die Son*, being provided at state expense.

77]Regarding the right to facilities in which the respondents can communicate with and be visited by their spouses or partners, next of kin and chosen religious counsellor and legal practitioners (para 4.3), this, again, is not disputed on behalf of the MEC. Specifications for the construction of a visitation room have been issued and the first meeting in respect thereof was planned for 27 May 2008. The tender process for the modular rooms is under way. Contrary to the suggestion by the respondents, the plan for the modular recreation rooms has not been abandoned. A further measure to improve visitation and consultation is the ten sets of benches and tables with a thatch covering, to be placed outside the wards for visitation purposes.

78]In short, the MEC contends that the conditions of isolation of the respondents at the facility not only comply with, but exceed the requirements of s 35(2)(*e*). There has been significant improvement in the conditions at the

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facility. In the circumstances, the MEC contends that there is no need for the relief sought by the respondents in respect of communication, visitation or recreation.

79]With regard to the declaratory orders sought as part of the counter-application, it must be borne in mind that the court's power to grant declaratory relief is derived from the provisions of s 19(1)(*a*)(iii) of the Supreme Court Act, 59 of 1959, which is substantially a re-enactment of its forerunner, s 102 of the General Law Amendment Act 40 of 1935.[17] It is a discretionary remedy, which will not ordinarily be granted where there is no existing dispute between the parties regarding the right in contention, although the existence of a dispute is not a prerequisite for the exercise of the power conferred on the High Court by the subsection.[18]

80]As pointed out above, the rights asserted by the respondents in paras 4.1–4.3 of the amended counter-application are neither disputed nor denied by the MEC. A declarator in the terms sought would therefore serve no purpose.

81]In any event, before declaratory relief will be granted, the interested persons against whom or in whose favour the declaration will operate must be identifiable and must have had an opportunity of being heard in the matter.[19] This is not the position in the present case. Without attempting to identify or limit the persons of classes of persons in respect of whom the declaratory relief may apply, it is clear that – at the very least – other patients being treated in the isolation ward of the facility would also have a real and substantial interest in the relief claimed. The present respondents do not purport to

17 Erasmus *Superior Court Practice* (1994 with loose-leaf updates, Service 29) at A1-33. See also *Family Benefit Friendly Society v CIR* 1995 (4) SA 120 (T) at 124D–126E.

18 *Ex parte Nell* 1963 (1) SA 754 (A) at 760B. See also *Cordiant Trading CC v Daimler Chrysler Financial Services* 2005 (6) SA (SCA) para 16 and the authorities referred to in that paragraph.

19 *Family Benefit Friendly Society* case at 125J.

4]* Deceased since the launch of this application.

bring a 'class action' on behalf of those patients, or indeed on behalf of any other interested parties. It follows, in my view, that declaratory relief of the kind sought by the respondents cannot be granted on the present papers.

82]Costs

83]With regard to costs, it appears that the fees of counsel for the respondents will not be covered by Legal Aid to the full extent of his services herein. However, counsel for the MEC as well as the National Minister gave an assurance from the Bar that their clients would undertake liability for the shortfall. It is sufficient, for purposes of this judgment, simply to record such undertaking, without the need to make a formal order to that effect.

84]Conclusion

85]In the circumstances, the following order is granted:

1. A final order is issued –

86](a) Compelling the respondents to be admitted to the Brooklyn Chest Hospital;

87](b) Authorising the Sheriff, if necessary, to request members of the South African Police Service to assist him in ensuring that the respondents are admitted to Brooklyn Chest Hospital and remain there until their compliance with paragraph (c) below;

88](c) Compelling the respondents to remain at Brooklyn Chest Hospital until they have fulfilled the criteria for negative sputum culture conversion for XDR tuberculosis for a period of three consecutive months;

89](d) Compelling the respondents to adhere to the rules of behaviour for XDR-TB patients at the Brooklyn Chest Hospital.

90]2. No order is made with regard to the counter-application, but leave is granted to the respondents, if so advised, to renew the counter-application, duly amplified insofar

4]* Deceased since the launch of this application.

as may be necessary, upon notice to the other parties and interested persons.

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92]

93]**B M Griesel**
Judge of the High Court

Yekiso J: I agree.

94]_____

95]**N J Yekiso**
Judge of the High Court

4]* Deceased since the launch of this application.