

In this Issue:

Does the new medical parole system give effect to inmates' right to dignity and the public's right to safety?

Does the new medical parole system give effect to inmates' right to dignity and the public's right to safety?

Chesné Albertus¹

'It doesn't mean that if you are HIV positive and the CD4 count is low therefore you would be granted medical parole. It's about sick people, very sick people.' - Correctional Services Minister, Mapisa-Nqakula.²

Introduction

Before 1 March 2012 the early release of inmates on medical grounds was a highly contentious issue in South Africa. The erstwhile law, section 79 of the Correctional Services Act 111 of 1998 (CSA), did not specify who may initiate applications for medical parole.³ It had been assumed that only the Department of Correctional Services (DCS) medical personnel could start the process of applying for medical parole. Unfortunately, the DCS often failed to initiate applications in worthy cases.⁴ Furthermore section 79 only permitted the release of inmates who were in the 'final phase of a terminal illness'. Inmates, suffering from life threatening illnesses, but who were not bedridden or noticeably terminally ill, were considered ineligible for early release on medical grounds. The resultant inroads to inmates' dignity attracted heavy criticism from our courts.⁵

On 1 March 2012 a new section 79 came into operation; the old section 79 had been amended by section 14 of the Correctional Matters Amendment Act 5 of 2011. The amendment of the law was motivated by several factors. One of the main factors which prompted the amendment was that our courts had, in a number of cases, ordered the release of terminally ill inmates whose initial applications had failed because they had not complied with the 'final phase of a terminal illness' requirement.⁶ Prior to the introduction of the new section 79 it was also of concern that the proportion of inmates who had been released on medical grounds over the years had been extremely low compared to the number of inmates who had died of natural causes in prison.⁷ Moreover, the release of Shabir Shaik, former financial adviser to President Zuma, on medical grounds after serving less than three years of his 15 year sentence, triggered public debate and 'put the issue of medical parole under the spotlight'.⁸

In 2009, in response to the continuous controversy surrounding medical parole, Correctional Services Minister, Mapisa-Nqakula, ordered the review of medical parole policy in South Africa. The National Council on Correctional Services, led by Judge Desai, undertook the review (which was finalised in January 2010). The review aimed to address all the shortcomings of the medical parole system.

While the old medical parole system had many flaws some of its major inadequacies related to the

‘final phase of a terminal illness’ requirement.⁹ As a result of this requirement, medical doctors were reluctant to recommend inmates for release on medical grounds as it is ‘difficult to certify’ that an inmate is in the final phase of a terminal illness. The fact that 60 percent of prisoners released on medical parole did not die after placement on parole also highlighted the need to review the law.¹⁰ Seriously ill and/or severely incapacitated inmates were detained in correctional centres despite the fact that DCS did not have the financial and human resources to provide them with proper care.¹¹ The reluctance of medical practitioners to recommend inmates for medical parole also contributed to high numbers of deaths due to natural causes in the correctional centres.¹² It may therefore be inferred that the sole objective of the old section 79, to allow a terminally ill inmate to ‘die a consolatory and dignified death’, had largely not been attained.

In South Africa, a constitutional democracy based on the values of human dignity, equality and freedom,¹³ it is mandatory that the fundamental rights enshrined by the Bill of Rights are respected, protected and promoted.¹⁴ Section 39(2) of the Constitution specifically provides that when interpreting legislation the spirit, purport and objects of the Bill of Rights must be promoted. The legislative framework within which the South African medical parole system operates ought therefore to be understood in the light of the Bill of Rights. Consequently cognisance must be taken of section 10 of the Constitution which provides that everyone has inherent dignity and the right to have their dignity respected and protected. Prisoners are not precluded from the enjoyment of this non-derogable right. The Constitution furthermore provides that all prisoners have a right to be detained in conditions that are consistent with human dignity.¹⁵ This right is supported by section 2 of the Correctional Services Act 111 of 1998 (CSA) which sets out the purpose of the correctional system, stating that the purpose of the correctional system is to contribute to a just, peaceful and safe society by inter alia detaining all inmates in safe custody whilst ensuring their human dignity.¹⁶

Whilst prison conditions in South Africa have historically not been described as consistent with prisoners’ human dignity, our courts have as early as 1912 pronounced that with the exception of the right to freedom, prisoners are generally entitled to all their other rights.¹⁷ Innes J held in *Whittaker and Morant v Roos and Bateman* that ‘[inmates] were entitled to all the personal rights and personal dignity not temporarily taken away by law, or necessarily inconsistent with the circumstances in which they had been placed.’¹⁸ Nearly seventy years later Corbett JA, in a minority judgment, confirmed this dictum, which became known as the residuum principle, in *Goldberg and Others v Minister of Prisons and Others*.¹⁹ In *Minister of Justice v Hofmeyr*, reported in 1993, Hoexter JA held that:

"The Innes dictum serves to negate the parsimonious and misconceived notion that upon admission to gaol a prisoner is stripped, as it were, of all his personal rights. . . The Innes dictum is a salutary reminder that in truth the prisoner retains all his personal rights save those abridged or proscribed by law. The root meaning of the Innes dictum is that the extent and the content of prisoner’s rights are to be determined by reference not only to the relevant legislation but also to his inviolable common-law rights."²⁰

In 2008, in *Ehrlich v the Minister of Correctional Services*, Plasket J held that ‘now in the era of democratic constitutionalism . . . the residuum principle has stronger protection than before. There can be no doubt that it is in harmony with the Constitution’s values’.²¹

In the context of medical parole, Van Zyl J in *Stanfield* also confirmed the residuum principle.²² Additionally, the Court articulated how medical parole relates to prisoners’ right to human dignity. The Court held that ‘[t]o insist that [a terminally ill inmate] 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.’²³ Similarly, the Court held that the continued imprisonment of a terminally ill inmate in circumstances where the necessary medical facilities to palliate his condition are lacking, infringes upon an inmate’s right to dignity.²⁴ Likewise, if considerations such as the crime committed by the inmate or the actual time served by an inmate are relied upon to preclude an inmate’s release on medical parole, then the inmate’s dignity is violated.²⁵

It was also held that to detain an inmate until such time as he is no longer physically capable of committing further crimes is inhumane.²⁶ The Stanfield judgment demonstrates that ‘medical parole is a mechanism to protect the dignity of the offender and any other concerns . . . are subservient to this.’²⁷

The old section 79 was criticised for its infringement on inmates’ dignity. According to Correctional Services Minister, Mapisa-Nqakula, however, the new section 79 creates a medical parole system which beckons ‘a complete departure from the previous system’; effect is given to inmates’ right to dignity and due consideration is afforded to public safety.²⁸ Whether the new medical parole system will truly achieve these goals or not, is not self-evident. There is a need to critically analyse the new section 79. To this end an attempt is made here to determine the positive aspects of section 79 as well as to gauge the possible challenges that the law may present to inmates and the public.

Does the amended section 79 adequately protect inmates’ dignity?

From the wording of section 79 it is clear that the legislature had intended to deal with some of the challenges occasioned by the previous medical parole system. The positive (and in some instances seemingly positive) features of section 79 are therefore highlighted here and analysed with a view to gauging its impact on inmates.

Can inmates be assured that their applications will be given due and objective consideration?

Below a brief description of the medical parole application process is provided. The description is followed by a discussion of some of the challenges presented by the application process.

Regulation 29(A)(3) provides that any head of a correctional centre must refer all applications for medical parole to a correctional medical practitioner for evaluation in terms of section 79. The correctional medical practitioner should make a written recommendation as to whether the criteria prescribed by section 79 are present or not to the Medical Parole Advisory Board (MPAB).²⁹ The MPAB’s, which comprises ten medical doctors,³⁰ primary role is to provide an ‘independent medical report to National Commissioner, Correctional Supervision and Parole Board or the Minister, as the case may be.’³¹

In specific the MPAB must assess whether an inmate suffers from one of the conditions listed in regulation 29A (5)(a) and (b) or any other condition not listed in these regulations provided it complies with the principles of section 79. From the regulations it appears that the written recommendation of the correctional medical practitioner will be the subject of the assessment. In terms of Regulation 29B(8)(a) a member of the MPAB may also examine any sentenced offender applying for medical parole.³² Presumably the examination referred to is a physical examination of the prisoner; the regulation itself does not expressly state the nature of the examination. The circumstances in which such an examination may occur are not stipulated in the regulations. It is also not clear why MPAB members may as ‘far as possible’ only examine inmates ‘within the region wherein they are appointed.’³³ Moreover it seems curious that these regulations appear under the heading ‘Appointment and composition of the Medical Parole Advisory Board’. At this juncture it must be noted that these regulations are confusing and that their purpose is not clear. Finally, Regulation 29A(7) provides that if the MPAB’s recommendation is positive, the National Commissioner, Correctional Supervision and Parole Board or the Minister, must consider whether the inmate indeed poses a low risk of reoffending and whether appropriate arrangements for his supervision, care and treatment had been made.

There are two obstacles which may compromise inmates’ and the public’s confidence in the MPAB’s recommendations. The first obstacle is that the MPAB’s recommendations will largely be based on the assessment of the written recommendations of a correctional medical practitioner. Not all inmates will be examined by all MPAB members. This does not create the mechanism necessary to eradicate subjectivity or errors in the medical parole system. Mistakes or inaccuracies (whether made

intentionally or not) by a correctional medical practitioner may thus contribute to or lay the basis for the MPAB's recommendation to the final decision-makers in an application.

The second obstacle arises due to the composition of the MPAB when reviewing applications and the limitation with regards to the examination of inmates. It is required that the Chairperson, deputy chairperson and at least three other MPAB members must be present when reviewing an application.³⁴ The latter may examine an inmate whose medical parole application is under consideration.³⁵ However, MPAB members should 'as far as possible' examine only inmates from the region for which he/she (the board member) had been appointed. Practically this means that if none of the board members present during the review process had been appointed for the region within which an inmate finds himself then, the inmate will not necessarily be examined. The assurance that fairness and objectivity will prevail is thus diminished.

In summation the MPAB has the potential to instil confidence in the new medical parole system. Within the parameters of the new section 79 that potential remains untapped, however. This is due to the limitation on the MPAB with regards to the examination of inmates and because the MPAB will generally be restricted to the written reports of correctional medical practitioners. It is of concern that the new legislation does not make it clear whether the report of a treating physician will be considered by the MPAB.

Apart from the inherent challenges presented by the new law, there are also practical considerations which may negatively impact on the goals of ensuring a medical parole system characterised by objectivity and efficiency. As an example it may be considered that in 2009/2010 some 900 prisoners died due to natural causes.³⁶ From earlier reports by Judicial Inspectorate for Correctional Services we know that 85% were under medical treatment and thus potential cases for medical parole – thus 765 cases in a year, which means that the MPAB will need to deal with 64 cases per meeting if they meet once per month. Even if they spend only half an hour per case, their meeting will nonetheless last 32 hours or four working days per month. That is assuming that all the information is available. At such a work rate it will be little more than rubber stamping.

How far beyond the old section 79 criterion of 'in the final phase of a terminal illness' does the new section 79 really extend?

Section 79(1)(a) provides that an inmate may be considered for placement on medical parole if he is '... suffering from a terminal disease or condition or if [he] is rendered physically incapacitated as a result of injury, disease or illness so as to severely limit daily activity or inmate self-care.' On the face of it section 79(1)(a) extends the possibility of being considered for medical parole beyond inmates who are terminally ill and bedridden. Presumably the law permits inmates to apply for medical parole before they reach the stage where they are awaiting their death. Put differently, it may thus seem that the new law is a major improvement on the old law as it is no longer required that an inmate's death should be imminent.³⁷

The omission of the phrase "in the final stage of a terminal condition" from the new section 79 definitely broadened the scope of who may apply for medical parole. It, however, also raises the question of whether any prisoner diagnosed with a terminal condition may be granted medical parole regardless of his physical state. Some may argue that the diagnosis of a terminal medical condition in itself should not make a prisoner eligible for medical parole as it may 'open the floodgates to ... applications'.³⁸ The question should, however, be answered with reference to the genuine purpose of medical parole, i.e. to protect the dignity of terminally ill prisoners.³⁹ The perennial question in every application should thus be whether the terminally ill prisoner's dignity will be best served inside or outside the walls of prison.

Section 79(2)(b) requires that every application for medical parole be accompanied by a written

medical report recommending placement on medical parole. Section 79(2)(c) stipulates that the medical report ‘must include’:

- a) complete diagnosis and prognosis of the terminal illness or physical incapacity from which the prisoner suffers;
- b) a statement by the medical practitioner indicating whether the offender is so physically incapacitated as to limit daily activity or inmate self-care; and
- c) reasons as to why the placement on medical parole should be considered.

On closer scrutiny of the provision it seems that in addition to the prognosis and diagnosis of the terminal illness or physical incapacity, a medical practitioner must state in writing that the prisoner is incapacitated to the extent that his daily activities or self-care are limited. It furthermore seems that an application for medical parole will not be considered unless the latter statement is included in the medical practitioner’s written report. If this reading of section 79(2)(c) is accurate then the new section 79 like its predecessor makes a grave inroad into inmates’ right to dignity. It also renders the phrase “terminally ill” redundant. It may also then limit applications for medical parole to inmates who are already suffering the indignity of being dependent on others for their daily self-care. To avoid the latter interpretation the legislature should have made it more explicit that section 79(2)(b)(ii) is not a requirement which applies to all applicants for medical parole and that it specifically applies to applicants who wish to be released due to their physical incapacitation.

Does section 79 reasonably ensure that inmates will lead a dignified life after their release?

If it is accepted that the purpose of section 79 is to protect the dignity of inmates, it would be pointless to release them unless adequate provision for their care and necessary medical treatment had been made. Section 79(1)(c) appears to address this need. It requires that ‘appropriate arrangements for the inmate’s supervision, care and treatment within the community to which the inmate is to be released’ be made in order for an application for medical parole to be considered. This requirement is laudable, but the CSA itself does not provide any guidance as to what constitutes ‘appropriate arrangements’. The new regulations which amend the 2004 Correctional Services Regulations are also silent on this issue.⁴⁰ It does not provide details on who ought to make the arrangements or what constitutes ‘appropriate arrangements’. In terms of section 79(1), the National Commissioner,⁴¹ the Correctional Supervision and Parole Board⁴² or the Minister of Correctional Services,⁴³ are the final decision-makers in a parole application.⁴⁴ Arguably one of the latter will have the final say as to the appropriateness of arrangements. This does, however, not assist persons who wish to prepare applications for medical parole. They will have to learn what is deemed appropriate through trial and error.

Furthermore the question of what should happen to inmates who do not have any family or other support networks outside of the correctional environment cannot be overlooked. If sufficient state or private care institutions are not available to accommodate such inmates outside of the prison environment they will not meet the requirement in terms of section 79(1)(c). Medical parole can then not be granted. This may be a violation of the right to be equal before the law.

It should be borne in mind though that the state’s primary duty is towards the protection and promotion of inmates’ dignity and well-being. The question should therefore always be how may an inmate’s dignity best be given effect to. If an inmate’s dignity can best be served in prison (whether in a prison hospital or other health care facility) then the prisoner ought not to be released. The prisoner should then be afforded the benefit of available resources in the correctional environment.

Is the new medical parole system ‘accessible’ to all inmates?

Section 79(2)(a)(i) and (ii) respectively provide that an application for medical parole may be lodged by ‘a medical practitioner’ or ‘a sentenced offender or a person acting on his or her behalf.’ This is a major improvement on the old system as anyone can lodge an application for medical parole. It

affords an avenue for possible relief to inmates who are capable of navigating the medical parole application process or who have friends and/or family who are willing to lodge applications on their behalf. However, there are inmates who are not literate and are thus incapable of lodging an application. Additionally, many inmates can also not rely on friends and family to apply for medical parole on their behalf because they have lost contact with them.

Although it cannot be reasonably expected that section 79 should make provision for all eventualities, it would be prudent if the law had created a mechanism to ensure that inmates who are illiterate and/or who have no support outside of the correctional centres are not precluded from the possibility of applying for medical parole. A possible mechanism to ensure that inmates are not unfairly prevented from accessing the medical parole system may be to expressly confer a primary duty on the DCS, as custodian of all prisoners, to initiate applications for medical parole. At the same time prisoners or anyone acting on their behalf should not be prevented from initiating applications.

Regulation 29A(1)⁴⁵ provides that if during a health status examination it is discovered that an inmate is suffering from a condition listed in regulation 29A(5), the conditions which may make an inmate eligible for medical parole, 'such facts must be recorded in the prescribed register'. The register could have been useful in holding the DCS accountable for informing inmates about their possible eligibility for medical parole and for the initiation of medical parole applications on prisoners' behalf. Unfortunately, the new section 79 does not confer these obligations on the DCS.

Does the amended section 79 adequately protect the public against repeat re-offending by inmates who are released?

In South Africa many offenders commit crime during their incarceration and after they are released from prison. The need to attenuate the impact of repeat offending on the public safety is consequently evident. Section 79 arguably includes at least two safeguards aimed at preventing re-offending. The first is the requirement that an inmate must pose a 'low risk' of re-offending and the second safeguard lies in the possibility that medical parole can be revoked in certain circumstances. These two safeguards are discussed below.

How effective is the 'low risk of re-offending' requirement in preventing the commission of crime by a medical parolee?

The notion that it is "not inconceivable that [terminally ill inmates] would be even less inhibited from committing further crimes should they be released prematurely,"⁴⁶ although rejected in Stanfield appears to underlie the section 79 low risk of re-offending criterion. This may be due to the estimated high rate of repeat offending in South Africa, but it should be added immediately that there exists no reliable and scientific findings in this regard. The question that looms, however, is whether it is possible to establish, with reasonable certainty, whether an inmate poses a 'low risk' of reoffending.

Medical parole decision-makers may choose to rely on section 79(5) as it contains factors which may be considered when determining an inmate's risk of reoffending. These factors include: (a) whether at the time of sentencing, the court was aware of the inmate's medical condition for which he is seeking medical parole; (b) a presiding officer's sentencing remarks; (c) the type of offence for which the inmate had been convicted and the length of the sentence still to be served; (d) the previous criminal record of the inmate; or any of the factors listed in section 42(2)(d). Section 42(2)(d) permits medical parole decision makers to consider the crime for which an inmate had been convicted, the length of his sentence and remarks of the sentencing judge. Furthermore, an inmate's previous criminal record, conduct, disciplinary record, training, aptitude, physical and mental state as well as the likelihood of a relapse into crime, the risk posed to the community and the manner in which this risk can be reduced may be considered.

The factors in section 42(2)(d) are in many respects the same as those in section 79(5). Both provisions, however, fail to offer guidance that will significantly assist in making reasonably accurate risk assessments. To determine an inmate's risk of reoffending arguably calls for the skills and experience of experts. Currently ' . . . there is very little South African based sociological and psychological research documenting the predictive factors associated with re-offenders'.⁴⁷ In the absence of relevant expertise, the consideration of the factors listed in sections 79(5) and 42(2)(d) may give rise to speculation regarding an inmate's risk of committing further crimes. It may therefore be arbitrary, biased, subjective and ultimately unconstitutional.

Cancellation of medical parole

Section 79(7) permits the cancellation of medical parole. Inmates who contravene their parole conditions or who commit further crimes while on parole can therefore be compelled to serve the balance of their prison sentence in a correctional centre. This arguably inhibits the commission of further crime by parolees and thus contributes to public safety. Section 79(7) has been criticised as it expressly precludes the cancellation of medical parole on account of the improved health of an inmate.⁴⁸ This aspect of section 79(7) may indeed appear to be peculiar as it justifies medical parole in circumstances where the primary condition, severe illness and incapacity, for such parole ceases to exist.

As parole is generally the objective of most inmates,⁴⁹ some may argue that attempts to manipulate their (inmates') health condition in an effort to be granted medical parole may not be too far-fetched. The knowledge that their freedom is guaranteed even if they recover after release may serve as further motivation to meet the initial requirements for medical parole. It may further be contended that while the ' . . . commission of further crimes would be the last thing on the mind of any prisoner released on parole for medical reasons . . .',⁵⁰ a prisoner who has recovered may be less inclined to desist from committing crime. Public safety is consequently compromised by the absence of mechanisms to send medical parolees back to prison if they recover. Against this argument it may be asserted that the possibility of revoking medical parole will always exist in circumstances where a parolee violates parole conditions. What is more, the White Paper on Corrections itself states that '[b]y its very nature, incarceration can have a damaging effect on both the physical and mental well-being of inmates.' Release may therefore of itself be beneficial to the sick prisoner.

Conclusion

The issues raised in respect of each of the two primary questions posed here denote that the new medical parole system will not operate without challenges. Some of the recurring questions with regards to the early release of inmates on medical grounds have not been effectively addressed by the new section 79. For example, though our courts have rejected the requirement that inmates must be bedridden and severely debilitated in order to be granted medical parole, it seems that in effect section 79 has not moved away from it completely. The very requirements aimed at reasonably ensuring that inmates who are released are assured of a dignified life, may have a discriminatory effect on vulnerable and indigent inmates. Inmates without resources, support or the skills to attempt an application on their own may be precluded from accessing the medical parole system. Additionally, the MPAB is constrained by the largely 'deskbound' nature of its tasks. Inmates and the public alike should be assured that the MPAB's role will not be confined to reviewing correctional medical practitioners' written recommendations and the occasional request to examine an inmate.

Furthermore, though public safety is not the primary concern when considering an application for medical parole, due consideration should be given to it. The 'low risk of re-offending' requirement, in the absence of sociological and psychological expertise, amounts to mere speculation regarding an inmate's future criminality. This does not reasonably contribute to public safety and may violate

prisoners' right to dignity. It may ultimately be concluded that more is needed to inspire confidence in the system.

Footnotes:

1. The author is a lecturer in the LLB Foundation Programme at the University of the Western Cape (UWC) and holds an LLB (cum laude) and LLM (Constitutional Litigation), (UWC). I am grateful to Mr Lukas Muntingh of Civil Society Prison Reform Initiative (CSPRI) for his comments on the earlier drafts of this newsletter.
2. Lindeque, M New Medical Parole Advisory Board won't "open floodgates" 19 February 2012 <http://www.jacarandafm.com/kagiso/content/en/jacaranda/jacaranda-news?oid=1542187&sn=Detail&New-Medical-Parole-Advisory-Board-won> [Accessed 23 February 2012].
3. See for example the Speech by Hon NN Mapisa-Nqakula at the Parole Board Working Session held at Pretoria Management area on 26 March 2012 <http://www.dcs.gov.za/UploadedFiles/Parole%20Board%20Work%20Session%20Speech.pdf> at p11 [Accessed 25 April 2012]; Minister announces the Medical Parole Advisory Board <http://www.dcs.gov.za/UploadedFiles/medical%20paroleboard.pdf> [Accessed 25 April 2012].
4. Judicial Inspectorate of Prisons Annual Report 2008/ 2009 at p 25 <http://judicialinsp.pwv.gov.za/Annualreports/Annual%20Report%202008%20-%202009.pdf> [Accessed 24 May 2012].
5. Stanfield v Minister of Correctional Services 2003 (4) ALL SA 282 (C) at para 124.
6. See for example Mazibuko v Minister of Correctional Services and another [2007] JOL 18957 (T); Du Plooy v Minister of Correctional Services and others [2004] JOL 12850 (T); Stanfield supra.
7. Mujuzi, J. Releasing terminally ill prisoners on medical parole in South Africa South African Journal on Bioethics and Law December 2009 (2) at p 60.
8. Mujuzi supra at p59.
9. Reviewing medical parole: Brief notes on the proposed amendments to section 79 of Correctional Services Act 1998 <http://www.pmg.org.za/report/20101110-department-correctional-services-matters-related-enhanced-parole-syst> [Accessed 27 May 2012].
10. Ibid.
11. Ibid.
12. Ibid.
13. Section 7(1) Constitution of South Africa, 1996.
14. Section 7(2) Constitution of South Africa, 1996.
15. Section 35(2)(e) of the Constitution, 1996.
16. Section 2(b).
17. Whittaker and Morant v Roos and Bateman 1912 AD at 122–123.
18. Ibid.
19. 1979(1) SA 14(A) at 39 C–E.
20. 1993(3) SA 131(A) at 141 C–E.
21. Case No. 6113/2007 at para 7.
22. Stanfield supra at para 90.
23. Stanfield supra at para 124.
24. Stanfield supra at para 125.
25. Ibid.
26. Stanfield supra at para 126.
27. Muntingh, L. and Ballard, C. (2011) Correctional Matters Amendment Bill (41 of 2010), CSPRI Newsletter, No. 38, June.
28. Speech by Hon NN Mapisa-Nqakula at the Parole Board Working Session supra at p 11.
29. Section 79(3)(a) introduced the establishment of the MPAB.
30. Minister announces new Medical Parole Advisory Board, 23 February 2012 , <http://www.info.gov.za/speech/DynamicAction?pageid=461&sid=25537&tid=58789>
31. Section 13 of the Correctional Matters Amendment Act 5 of 2011 provides that the Correctional Supervision and Parole Boards may place sentenced offenders under medical parole and make recommendations to the court on the granting of medical parole to inmates who had been declared dangerous criminals in terms of section 286A of the Criminal Procedure Act 51 of 1977. The Board may also make recommendations to the Minister in respect of the granting of medical parole to inmates sentenced to life imprisonment. Section 13(7)(a) empowers the National Commissioner to grant medical parole to a prisoner serving a sentence of 24 months or less
32. Regulation 29B(8)(a).
33. Regulation 29B(8)(c).
34. Regulation 29B(5).
35. Regulation 29B(8).
36. Judicial Inspectorate for Correctional Services Annual Report 2010/ 2011 at p 25.
37. Mujuzi supra at 59.
38. Bauer, N. Correctional Services widens the criteria for medical parole Mail and Guardian 23 February 2012 <http://mg.co.za/article/2012-02-23-correctional-services-widens-criteria-for-medical-parole> [Accessed 23 March 2012].
39. Ibid.

40. Regulations Gazette 27/2/2012 No. 35032.
 41. In respect of prisoners sentenced to 24 months or a shorter term of imprisonment.
 42. In respect of prisoner serving definite sentences of imprisonment of more than 24 months.
 43. In respect of prisoners sentenced to life imprisonment.
 44. A court must decide whether or not to release prisoners who had been declared dangerous criminals in terms of section 286A of the Criminal Procedure Act 51 of 1977. See section 13 of the of the Correctional Matters Amendment Act 5 of 2011.
 45. Regulations Gazette 27/2/2012 No. 35032.
 46. Stanfield supra para 34.
 47. See Muntingh, L. and Ballard, C. supra.
 48. Bateman, C. 'Tighter medical parole – Shaik, rattle and roll' South African Medical Journal (2012) 102 at p210 -212.
 49. Moses, J. ' Is it a right or a privilege?' (2003) 19 SAJR at 264.
 50. Stanfield supra para 10.
 51. White Paper on Corrections 2005 at para 10.5.3.
-



CSPRI welcomes your suggestions or comments for future topics on the email newsletter.

Tel: (27) 021-9592950

<http://www.cspri.org.za>

If this email was forwarded to you and you would like to receive these newsletters in the future, please click [here](#) to subscribe.