IN THE HIGH COURT OF SOUTH AFRICA
GAUTENG LOCAL DIVISION, JOHANNESBURG

Case No.: 29573/2016

In the application to intervene as *amicus curiae*:

TEDDY BEAR CLINIC	Applicant

In re:

NICOLE LEVENSTEIN	First Applicant
PAUL DIAMOND	Second Applicant
GEORGE ROSENBERG	Third Applicant
KATHERINE ROSENBERG	Fourth Applicant
DANIELA McNALLY	Fifth Applicant
LISA WEGNER	Sixth Applicant
SHANE ROTHQUEL	Seventh Applicant
MARINDA SMITH	Eighth Applicant

and

SIDNEY LEWIS FRANKEL	First Respondent
MINISTER OF JUSTICE AND CORRECTIONAL SERVICES	Second Respondent
DIRECTOR OF PUBLIC PROSECUTIONS, GAUTENG	Third Respondent

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Signed and dated on 25 Januay 2017 at Johannesburg.

CENTRE FOR APPLIED LEGAL STUDIES
Attorneys for the Applicant (in the application to be admitted as amicus curiae)
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Email: Sheena.Swemmer@wits.ac.za

TO: **THE REGISTRAR OF THE ABOVE HONOURABLE COURT**

AND TO: **IAN LEVITT ATTORNEYS**
Attorneys for the Applicant
9th Floor Sandton City Office Towers
West Street, Sandton
2146
Tel: +27 (11) 784 3310
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Reference: I Levitt/A Charalambous/MAT1643

AND TO: **BILLY GUNDELFINGER**
Attorney for the First Respondent
91 Iris Road
C/O Grant Avenue, Norwood
Johannesburg
Tel: 011 728 7571
Fax: 011 728 7597
Reference: Billy Gundelfinger/ew

AND TO: **MINISTER OF JUSTICE AND CORRECTIONAL SERVICES**
Second Respondent
c/o OFFICE OF THE STATE ATTORNEY
12th Floor, North State Building
95 Albertina Sisulu Street (corner of Kruis)
Johannesburg

AND TO: **DIRECTOR OF PUBLIC PROSECUTIONS, GAUTENG LOCAL DIVISION**
Third Respondent
Innes Chambers, corner of Pritchard & Kruis Street
Johannesburg
Reference: 10/2/5/7 2016/245

IN THE HIGH COURT OF SOUTH AFRICA
GAUTENG LOCAL DIVISION, JOHANNESBURG

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GEORGE ROSENBERG — Third Applicant

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DANIELA McNALLY — Fifth Applicant

LISA WEGNER — Sixth Applicant

SHANE ROTHQUEL — Seventh Applicant

MARINDA SMITH — Eighth Applicant

and

SIDNEY LEWIS FRANKEL — First Respondent

MINISTER OF JUSTICE AND CORRECTIONAL SERVICES — Second Respondent

DIRECTOR OF PUBLIC PROSECUTIONS, GAUTENG — Third Respondent

NOTICE OF MOTION

KINDLY TAKE NOTICE that the **TEDDY BEAR CLINIC ("TBC")** hereby applies to the above Honourable Court for an order in the following terms:

1. The non-compliance with the time periods set out in Rule 16A is condoned;

2. The TBC is admitted as an *amicus curiae* in the above proceedings in terms of Rule 16A of the Uniform Rules of Court;

3. The TBC is granted leave to:

   3.1 Submit written argument in the above matter;

   3.2 Present oral argument at the hearing of the above matter; and

   3.3 Adduce the evidence contained in and attached to the founding affidavit as annexure **"TBC 9"**;

4. if any party wished to introduce evidence in response to the evidence contained in the founding affidavit of annexure **"TBC 9"**, it shall files its evidence within fifteen (15) days hereof;

5. Costs against any party that opposes this application;

6. Further and / or alternative relief.

TAKE FURTHER NOTICE that the affidavit of **SHAHEDA OMAR** will be used in support of this application.

TAKE FURTHER NOTICE that the applicant has appointed the **CENTRE FOR APPLIED LEGAL STUDIES** as their attorneys at the address set out below, where they will accept all further notices, documents and other process connected with these proceedings.

SIGNED AND DATED AT JOHANNESBURG ON 15 **OF** November **2016.**

CENTRE FOR APPLIED LEGAL STUDIES
Attorneys for the Applicant (in the application to be admitted as amicus curiae)
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West Campus, University of the Witwatersrand
1 Jan Smuts Avenue
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Email: Sheena.Swemmer@wits.ac.za

TO: **THE REGISTRAR OF THE ABOVE HONOURABLE COURT**

AND TO: **IAN LEVITT ATTORNEYS**
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9th Floor Sandton City Office Towers
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AND TO: **BILLY GUNDELFINGER**

Attorney for the First Respondent

91 Iris Road

C/O Grant Avenue, Norwood

Johannesburg

Tel: 011 728 7571

Fax: 011 728 7597

Reference: Billy Gundelfinger/ew

BILLY GUNDELFINGER
RECEIVED WITHOUT PREJUDICE
16.11.2016
Mekalakala. 13:45

AND TO: **MINISTER OF JUSTICE AND CORRECTIONAL SERVICES**

Second Respondent

c/o OFFICE OF THE STATE ATTORNEY

12th Floor, North State Building

95 Albertina Sisulu Street (corner of Kruis)

Johannesburg

Reference: 5355/16/P45

STATE ATTORNEY
PRIVATE BAG X91, RSB 2000
RECEPTION
2016 -11- 16
Signature
Time

AND TO: **DIRECTOR OF PUBLIC PROSECUTIONS, GAUTENG LOCAL DIVISION**

Third Respondent

Innes Chambers, corner of Pritchard & Kruis Street

Johannesburg

Reference: 10/2/5/7 2016/245

DIREKTEUR VAN OPENBARE VERVOLGING
PRIVAATSAK/PRIVATE BAG X8
2016 -11- 16
APPEALS UNIT
JOHANNESBURG 2000
DIRECTOR OF PUBLIC PROSECUTIONS

IN THE HIGH COURT OF SOUTH AFRICA
GAUTENG LOCAL DIVISION, JOHANNESBURG

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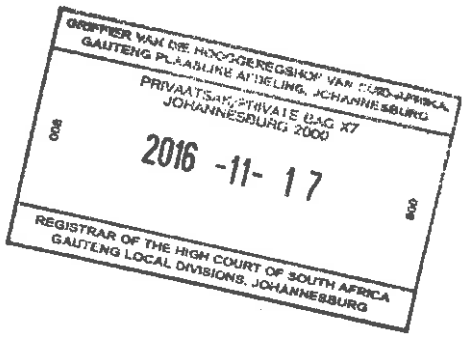

and

SIDNEY LEWIS FRANKEL	First Respondent
MINISTER OF JUSTICE AND CORRECTIONAL SERVICES	Second Respondent
DIRECTOR OF PUBLIC PROSECUTIONS, GAUTENG	Third Respondent

FOUNDING AFFIDAVIT:
APPLICATION TO BE ADMITTED AS AN AMICUS CURIAE
AND TO ADDUCE EVIDENCE

I, the undersigned,

SHAHEDA OMAR

do hereby state under oath that:

1. I am an adult female and the Director of the Teddy Bear Clinic ("TBC") Board and Director of Clinical Services at the TBC. The TBC is situated on the 2nd Floor of the Children's Memorial Institute, 13 Jourbert Street Extension, Parktown, Johannesburg.

2. I am duly authorised to depose to this affidavit and to institute this application on behalf of the TBC. A resolution of the TBC Board is annexed as **"TBC 1"**.

3. The facts contained herein are to the best of my knowledge both true and correct and, unless otherwise stated or indicated by the context, are within my personal knowledge.

OVERVIEW OF THIS APPLICATION

4. This is an application in terms of rule 16A of the Uniform Rules of Court for the admission of the TBC as an *amicus curiae*.

5. The main application raises important issues concerning the constitutional rights to human dignity, equality, privacy, freedom and security of the person, children's rights, access to the courts and fair trial rights.

6. In sum, the purpose of the TBC's application for admission as an *amicus curiae* is:

6.1. to advance legal submissions regarding the constitutionality of section 18 of the Criminal Procedure Act 51 of 1997 ("Criminal Procedure Act") that imposes a prescription period of 20 years in which to prosecute a sexual offence and / or sexual assault, which limit does not apply to rape or compelled rape.

6.2. to adduce relevant evidence, based on expert opinion and publicly-available information, in amplification of this legal argument, pertaining to:

6.2.1. the arbitrary distinction between sexual assault and rape in respect of the nature of the harm;

6.2.2. the State's duty to protect is particularly vital in response to silent communities and failed systems of care;

6.2.3. the nature of disclosure amongst adults.

7. This affidavit is made in support of the TBC's application to be admitted as an *amicus curiae* and to adduce evidence. In what follows, I deal with the following issues:

7.1. Firstly, the interest of the TBC in these proceedings;

7.2. Secondly, the time period for the filing of this application;

7.3. Thirdly, the submissions that the TBC seeks to advance;

7.4. Fourthly, the permissibility of an *amicus curiae* to adduce evidence in court proceedings; and

7.5. Lastly, the evidence that the TBC seeks to adduce.

8. I note at the outset that the applicants have consented to the TBC's admission as an *amicus curiae* in these proceedings. The respondents have not objected to, or opposed, the TBC's application. The TBC accordingly makes this formal application to the Honourable Court to be admitted as an *amicus curiae* in order to make legal submissions and to adduce evidence.

THE INTEREST OF THE TBC IN THESE PROCEEDINGS

9. The TBC is a not-for-profit company that was established in 1986 and specialises in providing holistic services to children who have been abused. Its mission is to minimise the secondary harm to children and their families when they enter into the child protection system. The TBC's vision is to ensure that children will not be abused in the future, yet where children are being abused; it is to promote their healing and stop any further abuse. It does this through a multi-pronged approach including by providing:

9.1. medico-legal examinations at its facility based within the Charlotte Maxeke Academic Hospital in Johannesburg, run by a multi-disciplinary team of paediatricians, doctors, forensic nurses, social workers and volunteers;

9.2. forensic assessments to form the basis of court proceedings concerning violence against children;

9.3. physiological assessments, specifically for children, performed by highly trained and experienced psychologists, for the purpose of providing them with fair access to the criminal justice system. In the context of sexual abuse cases, the assessments in particular assess the impact of the trauma on the victims;

9.4. therapeutic counselling and support where every child who is a victim of abuse is provided with the opportunity to receive therapeutic counselling and support, which focuses on reducing tension and alleviating any fear and anxiety that the child may have, increasing self-acceptance and realising the internal resources that will help the child to cope with the trauma;

9.5. court preparation and support focusing on providing children and parents with skills, emotional support and legal knowledge in preparation for their appearance in court;

9.6. outreach and schools awareness programmes.

10. The TBC has been party to a number of court proceedings in the past dealing with the interests of children, including: *Teddy Bear Clinic for Abused Children*

and Another v Minister of Justice and Constitutional Development and Another,[1] *J v National Director of Public Prosecutions and Another*[2] and *Acting Speaker of the National Assembly v Teddy Bear Clinic for Abused Children and Another.*[3]

11. In addition to the institutional knowledge and experience of the TBC, I have over seventeen years of experience in dealing with children who have been abused and specifically children that have been the victims of sexual abuse, including rape. I have a Doctorate in Social Work with a thesis on young sexual offenders, a Masters in Mental Health, a Bachelor of Arts Honours in Social Work, and a Diploma in Marriage Guidance and Counselling and Forensic Assessment of child victims of abuse. I have co-written a book titled 'Children who sexually abuse other children: a South African perspective' which was published in 2014.[4] I have presented at numerous conferences (national and international) including: the Society for Prevention of Child Abuse and Neglect (SASPCAN), the Southern African Association for Learning and Educational Differences (SAALED), International Association of Treatment of Sexual Offenders (IATSO), SayStop, Sexual Violence Research Initiative (SVRI), the Islamic Medical Association medical convention, and ACOPAB (psychiatry conference).

12. As I shall demonstrate more fully below, the TBC seeks to intervene in this matter in order to bring a clinical perspective stemming from its work with victims,

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[1] 2014 (2) SA 168 (CC). This matter dealt with the constitutionality of section 15, 16 and 56(2) of the Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007.
[2] 2014 (2) SACR 1 (CC). This matter dealt with the constitutional validity of section 50(2) of of the Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007.
[3] 2015 (10) BCLR 1129 (CC). This matter dealt with an extension of period of suspension of declaration of invalidity in terms of *Teddy Bear Clinic for Abused Children and Another v Minister of Justice and Constitutional Development and Another* (see note 1).
[4] My book is accessible at - http://ttbc.org.za/wp-content/uploads/2014/07/Diversion-Handbook.pdf

perpetrators, and concepts of victimization and trauma, and to do so in the public interest and in pursuit of its objectives to highlight the importance of appropriate relief for victims of rape and sexual assault, which it deems a constitutional imperative. The subject-area of the present matter falls squarely within the realm of work that the TBC undertakes. I therefore submit that the TBC is well-placed to make legal submissions and adduce evidence in this matter, and to be of assistance to this Honourable Court in the determination of the important constitutional and public interest issues that are at stake.

THE TIME PERIOD FOR THE FILING OF THIS APPLICATION

13. This application for admission as an *amicus curiae* is filed outside of the time period provided for in Rule 16A of the Uniform Rules of Court. In light of this, I set out below the steps that have been taken by the TBC since learning about this matter to bring this application as expeditiously as possible. To the extent necessary, the TBC seeks condonation from this Honourable Court for the late filing of this application.

14. On 26 August 2016, the applicants filed a notice in terms of Rule 16A notifying interested parties that they raised a constitutional matter in the main application.

15. The TBC became aware of this notice on or about 5 September 2016, and I proceeded to meet with my legal representatives to discuss an intervention in the matter, and to obtain the requisite approval from my board.

16. On 21 September 2016, the TBC's attorneys of record addressed correspondence to the parties seeking their consent to intervene. A copy of this letter is annexed as **"TBC 2".**

17. On 22 September 2016, the third respondent addressed correspondence noting that:

> *'The said application by Nicole Levenstein and Others to gain direct access to the Gauteng Local Division of the High Court to seek constitutional relief relating to the application and provision of section 18 of Act 51 of 1977 is not opposed.*
>
> *Therefore, this Office has no view about your application'*

A copy of this letter is annexed as **"TBC 3".**

18. On 26 September 2016, the first respondent's attorney addressed correspondence dated 23 September 2016 that *"My client neither supports nor opposes your application."* A copy of this letter is annexed as **"TBC 4".**

19. On 4 October 2016 the applicants consented to the TBC's application to intervene in accordance with Rule 16A(2). A copy of this letter is annexed as **"TBC 5".**

20. The Second Respondent has not responded to the TBC's letter seeking consent, and has accordingly neither consented to, nor opposed, the TBC's admission.

21. Due to the importance of the main application to society, as well as the technical and sensitive nature of the subject of child sexual abuse, it has been necessary for me, and the TBC's legal representatives to collate and draw from extensive research in the field in amplification of the TBS's own experience and expertise.

22. The TBC has further sought and obtained assistance from another expert in the field, Nataly Woollett, to speak to the subject. Her expertise is described below.

23. In order to prepare this application, both Ms Woollett and I have liaised extensively with the TBC's legal representatives, in order to provide an holistic account of child sexual abuse, trauma and its manifestations. To do so has also required working around my full-time commitments at the TBC, as well as Ms Woollett's PhD deadlines.

24. Additionally, and against this backdrop, on 19 September 2016, student protests for #FeesMustFall resumed at the University of the Witwatersrand (Wits) where the offices of TBC's attorneys, the Centre for Applied Legal Studies, are situated. These continued with university shut downs until or about the week starting 10 October 2016, when WITS resumed its academic programme, albeit with a few further disruptions that week including up until 14 October 2016 when my attorneys were again advised to vacate their offices. During this period the TBC's legal representatives had limited and intermittent access to their offices, further delaying this application.

25. My attorneys have briefed in-house counsel in this matter in order to alleviate costs. Since or about 17 October 2016 her availability to settle this application

was limited due to appearances in other matters, and attendance at an international conference. The TBC and its legal representatives have not wilfully delayed, and have launched this application as soon as they were reasonably able to do so.

26. Rule 16A(3) further requires that written consent provided by the parties must be lodged with the registrar within 5 days of receipt thereof. On 15 November 2016, my attorneys followed up with the second respondent to ascertain their position, and resent the TBC's letter seeking consent, a copy of this email is annexed as **"TBC 6"**. At the time of filing this application they had not received a response. The written consent of parties was not filed within 5 days of receipt in terms of this rule. It is filed simultaneously with this application. A confirmatory affidavit from Ms Sheena Swemmer, the TBC's attorney, is annexed as **"TBC 7"**.

27. In the result, the TBC seeks condonation for non-compliance with the time periods set out in Rule 16A. I submit that no prejudice has been caused by the time period within which this application has been filed. No hearing date has as of yet been set. There is therefore still adequate time for the parties to respond to the TBC's submissions should they wish to do so, well in advance of the hearing.

28. I respectfully submit that the TBC has shown good cause for the late filing of its application, and further that no party will be prejudiced should condonation be granted. This is undoubtedly a matter of public importance, and I submit that the submissions and evidence sought to be presented by the TBC are relevant and will be of assistance to this Honourable Court. I therefore request that this

Honourable Court grant condonation to the TBC for the late filing of this application.

THE SUBMISSIONS THAT THE TBC SEEKS TO ADVANCE

29. The TBC seeks to advance legal submissions regarding the constitutionality of section 18 of the Criminal Procedure Act 51 of 1997 that imposes a prescription period of 20 years in which to prosecute a sexual offence and / or sexual assault, which limit does not apply to rape or compelled rape.

30. The evidence which the TBC seeks to introduce describes the nature of the harm of sexual assault, the State's duty to protect in response to silent communities and failed systems of care, and the nature of disclosure by adults who were victims of sexual assault.

The Nature of the Harm

30.1. The Criminal Procedure Act makes an arbitrary distinction between the nature of the trauma and harm caused to the complainant by the perpetration of rape *vis a vis* the perpetration of other sexual offences against her/him:

30.1.1. Sexual assault, particularly of children, causes trauma and emotional scars that can have a negative impact on a child's development and can result in very serious long-term consequences;

30.1.2. Victims' response to sexual abuse and rape is nuanced, and victims respond differently. Long-term sexual abuse and grooming can lead to sustained post traumatic distress and degrees of dissociation, which in some circumstances can be lessor, similar to, or worse than, the incidence of rape;

30.1.3. The current legislative scheme minimizes the recognition of trauma of survivors of sexual offences;

30.1.4. The minimization of trauma of a survivor of a sexual offence can in itself lead to self-destruction, psychological implications and broader adverse consequences on the person's inter-personal relationships and employment.

The State's duty to protect in response to silent communities and failed systems of care

30.2. The potential for harm in failed systems in respect of care facilities, places of safety, and insular communities is rife. This requires the legal system to come to the aid of victims of abuse, at whatever stage, in order to restore trust in systems that are meant to protect them:

30.2.1. In many instances survivors are coerced into silence by the perpetrator and the community or facility may prevent them from speaking due to their dependency thereon. Prescription on prosecution of sexual offences does a disservice to society

where it promotes secondary violation and victimization of the most vulnerable groups by not allowing justice to be seen to be done, where there is a prohibition on prosecution.

30.2.2. The trauma that a victim endures results in displaced aggression which can be particularly relevant in isolated communities, youth centres, care homes and other facilities where they may be abused by the people who ought to protect them, and where children may be the victims of abuse from other survivors of abuse due to the power dynamics in those relationships and systems of support and reliance. It is for this reason that these criminal actions must be sanctioned by the law, at whatever stage the disclosure may be made, in order for such perpetrators to be brought to justice, and removed from re-offending, particularly in such environments.

30.2.3. Trauma is particularly escalated where a victim has no support structures. When a community fails to offer the support needed by the individual, and in some cases actively ostracizes the individual, he/she may experience heightened levels of trauma over and above that of initial the sexual violation. In such scenarios, the state ought to provide the victim with the recourse to the criminal justice system, which was refused by the community, at whatever stage the victim comes forward.

The Nature of Disclosure by Adults

30.3. The applicants highlight the general complexity and contingency of the disclosure process for victims of sexual assault. A number of nuanced factors and specific and intersectional circumstances contribute to disclosure rates and timings, with a general trend indicating that the disclosure of childhood sexual assault is widely delayed until adulthood.

30.3.1. The TBC's evidence regarding disclosure is limited to adult disclosure, in support of its argument that the prescription period imposed by section 18 of the Criminal Procedure Act alienates victims of sexual abuse by failing to afford them adequate and accessible protection of the law.

30.3.2. This may re-traumatize victims due to the unresponsiveness of the law to their abuse and to their attempts to access justice. A prescription period that is not in tandem with nor genuinely accommodating of the length the process of disclosure takes denies victims of sexual assault access to justice, and minimises the harm to them vis-à-vis the harm to victims of rape.

THE PERMISSIBILITY OF AN AMICUS CURIAE TO ADDUCE EVIDENCE

31. Rule 16A(8) of the Uniform Rules of Court provides that "*[t]he court hearing an application to be admitted as an amicus curiae may refuse or grant the application upon such terms and conditions as it may determine*", and rule

16A(9) provides that "*[t]he court may dispense with any of the requirements of this rule if it is in the interests of justice to do so*".

32. The Constitutional Court has settled the position that *amici curiae* are permitted to adduce evidence where this will be of assistance to the court. In *Children's Institute v Presiding Officer of the Children's Court, District of Krugersdorp and Others*, the Constitutional Court pertinently stated that:[5]

> "*Properly interpreted, Rule 16A is in my view permissive and allows for an amicus to adduce evidence. Both a textual and purposive interpretation of the Rule supports this conclusion. In any event, even if Rule 16A does not provide for evidence to be adduced by an amicus, section 173 of the Constitution gives courts the inherent power to regulate their own process and this includes the ability to allow amici to adduce evidence if the interests of justice so demand.*"

33. The Constitutional Court noted in this regard that rule 16A read as a whole provides courts with a great deal of discretion when determining whether to admit *amici curiae*, as well as the terms and conditions under which they may participate in the proceedings, and that the only limitation on a court's discretion to dispense with any of the requirements in rule 16A would be whether it is in the interests of justice to do so.[6] The Constitutional Court went on to hold that the term "*submissions*" contained in rule 16A ought to be

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[5] 2013 (2) SA 620 (CC) at para 17 ("**Children's Institute**").

[6] *Children's Institute* at paras 19-20.

interpreted "*to include written or oral argument, or evidence*",[7] and that properly construed, the phrase "*terms and conditions as it may determine*" in rule 16A(8) empowers a high court to admit any submissions by an *amicus curiae* and to determine, guided by what is in the interests of justice, whether those submissions will include (i) written argument, and if so, to what extent; (ii) oral argument, and if so, the duration thereof; and (iii) the nature and extent of the evidence sought to be led, and if so, under what conditions.[8]

34. As was stated by the Constitutional Court in *In re Certain Amicus Curiae Applications: Minister of Health and Others v Treatment Action Campaign and Others*:[9]

> "*The role of an amicus is to draw the attention of the Court to relevant matters of law and fact to which attention would not otherwise be drawn. In return for the privilege of participating in the proceedings without having to qualify as a party, an amicus has a special duty to the Court. That duty is to provide cogent and helpful submissions that assist the Court.*"

35. It is precisely this that the TBC seeks to do in the present matter. I respectfully submit that the evidence sought to be adduced by the TBC will be of assistance to this Honourable Court, and that the interests of justice favour the TBC being permitted to adduce such evidence.

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[7] *Children's Institute* at para 22 (emphasis added).

[8] *Children's Institute* at para 23.

[9] 2002 (5) SA 713 (CC) at para 5.

THE NATURE AND CONTENT OF THE EVIDENCE THAT THE TBC SEEKS TO ADDUCE

36. The TBC seeks to rely on its experience and expertise in this field to assist the court. The application will also be supported by the expert evidence of Nataly Woollett, a researcher and therapist currently completing her PhD in the School of Clinical Medicine at the University of the Witwatersrand. Ms Woollett has practiced locally and internationally in the field of trauma and traumatic bereavement and has particular expertise in gender based violence and with child witnesses of domestic violence. A copy of Ms Woollett's *curriculum vitae* is annexed as **"TBC 8"**. A supplementary affidavit of Ms Woollett is annexed as **"TBC 9"**.

37. The TBC anticipates that the content of the evidence sought to be adduced will be largely uncontroversial based on my professional experience, and those of the TBC and Ms Woollett. The TBC also relies on reputable sources of publicly available information. Moreover, the TBC does not contemplate the need for any oral evidence to be introduced. It is submitted, therefore, that the TBC should be permitted to adduce this evidence as the interests of justice favour such permission being granted, and the evidence will undoubtedly be of assistance to this Honourable Court in the determination of this matter.

38. The areas which the TBC focuses on below are intersectional by their nature and overlap to a certain extent.

39. The nature and process of disclosure by adults of sexual assault addressed in the main application and by the report of Muller and Hollefy 'The Disclosure Process in cases of Child Sexual Abuse', is inextricably liked to the nature of the harm, and silent communities and failed systems of care.

40. The TBC and Ms Woollett wholly agree with the applicants' report, which primarily focuses on child disclosure and briefly deals with adult patterns of disclosure. Cognisant of the role of an *amicus curiae* not to repeat the arguments of any party, where the TBC makes reference to the disclosure process of sexual abuse (including sexual assault and rape) it is limited to the disclosure process by adults who were child victims, and to the extent that it is inextricably linked to the TBC's argument.

The Nature of the Harm

41. The impact of harm on survivors or rape, including child survivors of rape, is well documented in our criminal jurisprudence,[10] including the social policy rationale for not applying prescription periods to prosecution of the crime of rape. The societal need for the courts to sanction rape in recognition of its prevalence and scourge in our society is also well documented.

42. Protection against child abuse includes sexual assault and rape. It is respectfully submitted that this recognition, from a policy perspective when protecting victims who were raped when they were children, ought similarly to be extended to victims of sexual abuse, for them to have equal protection under the law.

[10] *Bothma v Els and Others* 2010 (2) SA 622 (CC) at para 57.

43. As described by Ms Woollet, "Victims' response to sexual assault and rape is nuanced, and victims respond differently. Long term sexual assault and grooming can lead to sustained post traumatic distress and degrees of dissociation, which in some circumstances can be lessor, similar to, or worse, than the incidence of rape". It is for this reason, and the harm of sexual assault described below, that the TBC submits that the victims of sexual assault ought to have the same protection in law as victims of rape.

44. Sexual violence, has a profound impact on physical and mental health. As well as causing physical injury, it is associated with an increased risk of a range of sexual and reproductive health problems, with both immediate and long-term consequences. Its impact on mental health can be as serious as its physical impact, and may be equally long lasting. Sexual violence can also profoundly affect the social wellbeing of victims.[11]

45. The term sexual abuse in the literature, includes conduct that meets the definitional requires of both rape and sexual assault in the Sexual Offences Act.

46. A history of sexual abuse, can result in depression, sexual dysfunction, and low self-esteem.[12] The TBC is in agreement with the description of sexual abuse conceptualised in the applicants' report into the categories of sexual traumatisation, betrayal, powerlessness and stigmatisation.

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[11] UN World Health Organisation 'World Report on Violence and Health' accessible at: http://www.who.int/violence_injury_prevention/violence/global_campaign/en/chap6.pdf

[12] David Finkellohor, "The Traumatic Impact of Child Sexual Abuse: A Conceptualisation" Trainers Resource Handout

47. The more common symptom in children is known as Post-Traumatic Stress Disorder (PTSD). PSTD manifests in the following ways such as: unmodulated aggression and impulse control, intentional and dissociative problems, and difficulty with various relationships, may it be friends, care-givers, and intimate partners.[13]

48. However, PTSD alone does not capture all the developmental effects of trauma that a child suffers.[14] In this context it is also useful to describe the diagnosis known as the Developmental Trauma Disorder.[15] The developmental effects include behavioural regressions to symptoms such as loss of sleep, appetite and self-care and thereafter to stomach aches and headaches, lack of awareness to danger, self-hatred, blame and ineffectiveness.[16]

49. I have observed these concepts of trauma during my consultations with victims of sexual assault. It is also apparent to me that the harm caused to these victims is similar to those I have observed in victims of rape. I refer to four such cases below of children I have dealt with.

50. 'Child A' disclosed that she was being abused by her biological father. There was no case made against the father and the welfare continued for her to see her father. The foster mother has said that the child does not want to see her father. After the visitation she is depressed and regresses.

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[13] Bessel A Van Der Kolk "Developmental Trauma Disorder" Psychiatric Annals: May 2005 35, 5; Psychology Module pg 405.
[14] Ibid pg 406
[15] Ibid.
[16] Ibid.

51. Some of the symptoms of the abuse is that she wipes faeces on the bathroom floor, keeps food in the room and under her bed, wakes up at night and enters her parents' room threatening to kill her father, she physically attacks her foster parents and class mates.

52. Child B was abused and eventually raped by her mother's boyfriend. The child upon disclosing the incident attended at TBC for therapy. The child's symptoms included lack of appetite, nightmares, clinginess and preoccupation.

53. Child C is a boy. He was abused by a 16 year old child. The perpetrator exposed his penis to the child and asked that he touched it. Post-disclosure, the child is angry and hurt. He hurts his sister.

54. Child D is young girl who was abused by her grandfather. The child came home and start crying while urinating. While there was no 'penetration', the doctor confirmed sexual stimulation to her vagina. The child is aggressive, cries and eats a lot.

55. These cases highlight the harm of sexual abuse where there has been sexual assault and in respect of one victim, also rape. In each case, the child reacted differently. However the commonality of these cases is that developmental disorders have occurred.

56. As noted by Ms Woollet, a child could endure complex trauma which affects their moods, instils anxiety and aggression, results in depression and affects their

relationships with others. The cases above confirm that the children who fell victim to sexual abuse have undergone personality and behavioural changes.

57. Through my experience, it is apparent that the harm caused by the sexual abuse or sexual assault, has comparably harmful impacts as the sexual abuse or rape in children. Children and adults who attend at the TBC amply demonstrate that sexual assault results in PTSD, stigmatisation, sexual traumatisation, betrayal and powerlessness. In respect of both victims of sexual assault and rape, it is pertinent that the harm of the symptoms of the PTSD continue into adulthood.

58. I respectfully submit that the harm recognised by the law in respect of trauma as a consequence or rape, ought equally to apply to that of sexual assault.

Communities, Failed Systems of Care, and the Act of Silencing

59. There are two main subsections which will be discussed below that relate to the act of communities silencing survivors of sexual abuse and the reluctance to report abusers to authorities, they are: acquaintance molestation and youth organisations' silence around sexual abuse, with the example of Ohel in the United States (US), and the prevalence of community silencing around sexual abuse with examples from Asian communities in the United Kingdom (UK), communities in Windhoek, Namibia and Mpumalanga and communities in Transkei.

Acquaintance Molestation

60. It is generally recognised that there are three groups of sexual offenders in relation to children, these are: the family members of the child, acquaintances of the child and strangers.[17]

61. In the case of the acquaintance molester he requires frequent visits with the child to cultivate a relationship.[18] The acquaintance molester controls the child primarily through grooming and by exploiting the immaturity and developmental stages of the child.[19] This mode is chosen over violence which may provoke the child to disclose what is occurring.[20]

62. While definitions of grooming may differ, it can be described '[t]he process by which a child is befriended by a would-be abuser in an attempt to gain the child's confidence and trust, enabling them to get the child to acquiesce to abusive activity. It is frequently a pre-requisite for an abuser to gain access to a child'.[21] Grooming is partially dependent on the developmental stages, needs, and vulnerabilities of the targeted child victims.[22] All children may be vulnerable to grooming and children that are at high risk to the grooming techniques include children that crave affection and those that have previously suffered from sexual abuse.[23]

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[17] K V Lanning et al 'Acquaintance Molestation and Youth Serving Organizations' (2014) Journal of Interpersonal Violence 1, 2.
[18] Ibid pg 2.
[19] Note 17 at 2.
[20] Note 17 at 3.
[21] A A Gillipsie Cybercrime: Key Issues and Debates (2016) 271.
[22] Note 17 at 11.
[23] Note 17 at 11.

63. Respected studies have found that acquaintance molesters pursue careers or seek paid or voluntary work at organisations where they are likely to meet children.[24] Many offenders may seek out careers or voluntary work for benevolent purposes initially, yet discover their sexual interest in children or in a particular child only after having chosen [the] work'.[25]

64. The lack of reporting sexual abuse committed against children in youth facilities is made up of both inadvertent and intentional reasons for why these organisations do not respond adequately when responding to abuse.[26] The inadvertent reasons include: ignorance, incompetence, denial, the philosophy of forgiveness, 'good old boy' networks or elitism.[27] The reasons that account for intentional lack of adequate response include: expense, fear of being sued by the accused, cover-ups and complicity.[28] It is highly unlikely that both these lists are closed lists on the reasons for ill-response. There are usually both components (inadvertent and intentional) involved when decisions are made by the decision-makers, for example: ignorance and then damage control.[29] It is important to note that children can be victimised in organisations whether or not that organisations is legally negligent or even the degree of that negligence.[30]

65. There are four commonly misunderstood phenomena around acquaintance molestation. These are: the diversity of sexual activity, 'nice-guy offenders', 'compliant' child victims and the grooming/seduction process.

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[24] Note 17 at 3.
[25] Note 17 at 3.
[26] Note 17 at 5.
[27] Note 17 at 5.
[28] Note 17 at 5.
[29] Note 17 at 5.
[30] Note 17 at 5.

65.1. The diversity of sexual activity – the number of different forms of sexual activity creates difficulty in defining the different sexual acts.[31] In the case of children, acts that can be seen as harmless can be sexual acts.[32] These include acts like: touching, rubbing, hugging, horseplay, biting, foot-rubs or contact with shoes or clothing.[33] The best way to see the diversity of sexual acts is by having a broad conceptualisation and to regard sexual misconduct as any action motivated by sexual desire or any sexual act towards a child.[34]

65.2. 'Nice-guy offenders' – acquaintance offenders are often described as 'nice guys' and 'pillars of the community', they may seem to love and be loved by children.[35] Many people cannot believe that a man who is respected by the community, spiritual, generous or seems to legitimately care about children could be an abuser.[36] People may rally and support the abuser and shame or blame the victim.[37]

65.3. 'Compliant' child victims – this is a term that is used to explain the children who partially or fully cooperate in their own sexual abuse without the threat of violence.[38] As a result of the grooming or education process or other basic human needs the child might be compliant with her abuse.[39] Some confusing behaviour that can occur and make evaluation of the situation

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[31] Note 17 at 8.
[32] Note 17 at 8.
[33] Note 17 at 8.
[34] Note 17 at 8.
[35] Note 17 at 9.
[36] Note 17 at 9.
[37] Note 17 at 9.
[38] Note 17 at 10.
[39] Note 17 at 10.

difficult are: trading sex for attention, confusion over sexuality and feelings, embarrassment and guilt over sexual activity, denying or exaggerating victimisation.[40] None of these factors change the fact that the child is a victim.[41]

65.4. Grooming or seduction process – for offenders who prefer younger children they often groom or seduce the parents or care-givers of the child.[42] This is done to ensure the trust and confidence of the parents or care-givers. The abuser may then engage with games with the child to manipulate them into sexual activity.[43] The child may also then be physically separated from the parents or care-takers by attending the youth organisation. The more trust the abuser has cultivated the better the chances of success in grooming and assuring that the child does not disclose.[44] The parents or care-givers may even encourage that the child spend longer periods with the abuser as they believe he is 'good' for the child.[45]

66. Where there is separation from parents or care-givers inherent to the structure of the organisation such as: camping, scouting, choirs or sports teams, special precautions are needed to protect the child.[46] Without these protections, the organisation may inadvertently provide the abuser with almost everything necessary to groom and seduce children.[47] These organisations must be aware

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[40] Note 17 at 10.
[41] Note 17 at 10.
[42] Note 17 at 11.
[43] Note 17 at 11.
[44] Note 17 at 12.
[45] Note 17 at 12.
[46] Note 17 at 12.
[47] Note 17 at 12.

of the subtle differences between mentoring done for the benefit of the child and grooming done for the benefit of the offender.[48]

Ohel Children's Home and Family Services ("Ohel"), Brooklyn, New York

67. Ohel is but one example of the prevalence of sexual abuse in youth organisations as well as the silence of staff and the greater community around child sexual abuse. It must be noted that the failure of youth organisations to report sexual abuse is in no way isolated to Jewish organisations or Jewish communities.

68. Ohel is one of the American Orthodox Jewish communities' most prominent welfare organisations and to this day performs foster care, adoption and counselling.[49] In 2009 in an exposé by Hella Winston of *Jewish Week* she found that Ohel had failed to report child sexual abuse as required by New York statutes.[50] This was despite a special programme introduced by the organisation called 'Kol Tzedek', the purpose of which was to 'encourage the highly insular Orthodox Jewish community in Brooklyn to recognize the seriousness of child sex abuse'.[51] Ohel has been described as being part of the Orthodox Jewish community frequently subordinating the right of children who have been sexually abused to preserve the community's good name.[52]

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[48] Note 17 at 12.
[49] A Neustein and M Lesher 'What Went Wrong at Ohel Children's Home - and What Can Be Done About Its Failure to Protect Jewish Children from Abuse?' In Ersi Abacı Kalfoğlu and Rehat Faikoglu (Eds.), *Sexual Abuse - Breaking the Silence* (InTech [open access], March 2012), Chapter 12, p 183-200, 183.
[50] Ibid pg 183.
[51] Note 49 at 183.
[52] Note 49 at 184 – 185.

69. In her 2007 article Hella Winston discusses the case of Stefan Colmer. Colmer was charged with sodomising two young boys on numerous occasions in the Brooklyn area. Years prior to his arrest Colmer was treated at Ohel in a sexual-offenders program and voluntarily opted-out before completion thereof, Ohel chose not to report Colmer citing doctor-patient confidentiality.[53] When arrested in 2007 Colmer had no criminal record as no one (the victims, the victims families, the community nor Ohel) had reported him to the police.[54] In 2006 a rabbi was approached by the children who told him of the sexual abuse by Colmer. Although the rabbi was advised to contact the police he chose not to and merely advised Colmer to stay away from the school that the children attended.[55] Also, in 2007 blog posts arose that informed the Brooklyn community of Colmer's sexual abuse of children, yet there was still a failure of the community to report the incidents.

Asian Communities in Bradford, United Kingdom

70. In a study of Asian communities in Britain (specifically Bradford), Gilligan and Akhtar found that there was an underreporting of child sexual abuse.[56] In consultation with women from the group it was apparent that there was unanimity that child sexual abuse must be responded to.[57] Yet, in consultation numerous factors were suggested that hampered the response to child sexual abuse. These

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[53] Winston H 'A Suspected Pedophile Eludes the System' (2011) *The Jewish Week*, May 6 2009.
[54] Ibid
[55] Note 53.
[56] P Gilligan and S Akhtar 'Cultural Barriers to the Disclosure of Child Sexual Abuse in Asian Communities: Listening to What Women Say' (2006) British Journal of Social Work 1361. Gilligan and Akhtar only refer to the study community as being 'Asian' it must be noted that 'Asian' appears to refer to individuals from countries such as India, Pakistan and Bangladesh and are predominantly Muslim in faith (see p1363).
[57] Note 56 at 1367.

include: lack of basic knowledge about child sexual abuse, lack of awareness of the existence and nature of the services available to respond to it, fear of public exposure, if child sexual abuse is disclosed, fear of meeting culturally insensitive responses from professionals and cultural factors, which appeared to impede individuals' and families' willingness to disclose child sexual abuse.[58]

71. Women interviewed in the study also cited cultural imperatives that, for them, made reporting difficult.[59] This included the notions of *izzat* (honour/respect), *haya* (modesty) and *sharam* (shame/embarrassment), which have been found to be crucial determinants of behaviour when reporting sexual abuse.[60] It must be noted that these imperatives did heighten the barriers of reporting abuse, yet they also contain potential means to overcome this.[61]

72. Some examples of women's responses to reporting sexual abuse recorded in the study include:

72.1. 'It's difficult to go to someone outside including services for help as this would show that family in a bad light and it could also get out in the community bringing shame to the family.'[62]

72.2. 'It won't be easy to talk to people about this kind of thing, only with certain members of the family, i.e. those from the same generation and in certain

[58] Note 56 at 1367.
[59] Note 56 at 1367.
[60] Note 56 at 1367.
[61] Note 56 at 1367.
[62] Note 56 at 1368.

contexts such as when it actually takes place. [...] It'd be difficult to talk to the elder generation about this.'[63]

72.3. 'Her mother is feeling helpless too because of her izzat and her family's izzat, who's going to believe her daughter. Mother believes her, but who else would believe them or support them? This could cause major family feuds, and instead of dealing with Alia's issues it would create other problems.'[64]

73. Besides the cultural imperatives of *izzat, haya and sharam* there are other barriers to reporting in the Asian community. The issue of migration has also been found to be an obstruction to reporting, as families often felt that they needed to be seen to be 'doing well' in the eyes of family members back in Pakistan.[65]

74. Furthermore, Chew-Graham cited sexual activity as being prescribed within moral limits as a contributing factor to lack of reporting.[66] Discussing sexual activity also requires *haya* (modesty) and can make it difficult for women to discuss abuse within their own family.[67]

Communities in Windhoek, Namibia and Mpumalanga

75. In a study conducted by the Medical Research Council of South Africa ("MRC"), of communities in Windhoek, Namibia and Mpumalanga, the MRC found that in

[63] Note 56 at 1368.
[64] Note 56 at 1368.
[65] Note 56 at 1370.
[66] Note 56 at 1370.
[67] Note 56 at 1370.

Namibian respondents of the interview there was a strong view that reporting child rape to the police was inappropriate.[68] Generally, it was found that there were three common responses to child rape: (1) report to the police or alternatively to the Chief for a traditional court case, (2) do nothing, or (3) accept material goods (livestock or money) as compensation [69] In Namibia the community distinguished between child rape of a five year old child versus rape of a fifteen year old girl.[70] Action against rapists is focused on perpetrators of the rape of young children whereas if a young teenager is raped the opinion is that 'she asked for it', these ideas were even expressed by mothers' whose children were raped.[71]

76. In interviews in South African communities it was found that there is a hierarchy of social problems which are viewed as being more serious than rape.[72] According to respondents 'when faced with prospects of disrupting the family, losing face, greater poverty and losing the home, child rape would be overlooked.'[73] There is also the view that sustaining a gender hierarchy is more important than taking action against a rapist. Recorded examples of this include: 'the woman whose child was raped by her husband over the Easter weekend, was told by some in the community to stay with him. Another woman from the community explained that in rural areas, if a wife suspects her husband, and confronts him, and her mother-in-law comes to hear of it, she will argue with the

[68] Jewkes R et al '"If they rape me, I can't blame them": Reflections on gender in the social context of child rape in South Africa and Namibia' Social Science & Medicine 61 (2005) 1809–1820 at 1816. Although the term sexual abuse has been used throughout this affidavit, the MRC's study specifically refers to rape.
[69] Above at 1816.
[70] Note 68 at 1816.
[71] Note 68 at 1816.
[72] Note 68 at 1817.
[73] Note 68 at 1817.

wife saying: "how can you ask a man that kind of question, a man is head of his house, he can do what he likes". The mother- in-law would call the man for a secret meeting to reprimand him, but would not let the wife know.'[74]

Communities in the Transkei

77. In a study concerning children with disabilities in the Eastern Cape, mothers were asked what would happen if their child with a disability was hurt or abused.[75] In response one participant stated '[i]t happens amongst female children but it's very rare. It once happened in my village where certain man abused a Child [sic] with a disability but the police were not involved in the matter. It was dealt with by the community'.[76] A second participant stated '[i]t also happened in my village. A certain female child was abused sexually and the boy was also not arrested. The community dealt with it'.[77]

78. A third participant spoke to what she perceived as parents lack of care for their children with disabilities when it came to sexual abuse. She stated '[s]uch things usually happen to CWD (children with disabilities) whose parents do not really pay attention to the fact that their children have disabilities and do not take special care of their children. In my village the girl that was raped even fell pregnant and didn't know who the father of the child was'.[78]

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[74] Note 68 at 1817.
[75] Eastern Cape FGD- Zithulele Hospital- March 2014- English translation at 13
[76] Ibid at 13.
[77] Note 76 at 13.
[78] Note 76 at 13.

79. In *Bothma* the Constitutional Court recognised in respect of rape that "child rape is an especially egregious form of personal violence. As law reports from other jurisdictions show, it is sadly found in all social classes in all parts of the world. It is widespread, if under-reported, in South Africa. By its nature it is frequently characterised by secrecy and denial. There is accordingly a special public interest in taking action to discourage ad prevent the rape of children. Because it often takes place behind closed doors and is committed by a person in a position of authority over the child, the result is the silencing of the victim, coupled with difficulty in obtaining eye-witness corroboration. Complainants should be encouraged rather than deterred when, breaking through feelings of fear and shame, the seek to bring to light the past abuses against them."[79]

80. The non-disclosure of abuse by communities is an extension of the idea of the acquaintance molester and the failure of youth organisations to report sexual abuse. This extends to entire communities who fail to disclose known sexual abuse committed against a child or children due to the community's inadvertent or intentional reasons. This further points to the need of the state to come the aid of victims at whatever point disclosure is made.

81. The criminal justice system, through the office of the National Prosecuting Authority, as an organ of state, is enjoined to promote, protect uphold the Constitution. In matters such as these, the rights to dignity, freedom and security of the person, equality, access to justice, and equal protection before the law are paramount. The TBC submits that the same encouragement to victims or rape

[79] *Bothma* at para 46 (internal references excluded.)

bring to light past abuses against them, ought to be applied to victims of sexual assault.

The Nature and Process of Adult Disclosure of Sexual Assault

82. The process of sexual assault disclosure is a complex and lengthy process.[80] This has been recognised in our jurisprudence in the context of sexual assault and rape which "abounds with reference to the special consideration that needs to be given to the manner in which sexual abuse of children, especially if prolonged, can provoke delay in their later lodging complaints as adults about such abuse."[81]

83. The memory of sexual assault can manifest after a period of time and is triggered in various ways, which includes: reluctance or fear during sexual interpersonal relationships, the fear of being a bad parent, self-harming behaviours and continuous feelings of anger, shame and guilt.

84. The child victim may develop dissociation with herself during the commission of a sexual offence, or as an adult when a memory relating to or re-enactment of such an act is triggered. At the time of a traumatic incident the person responds in three ways, that is, freeze, flight or fight. In most cases of sexual offences, the person responds by freezing and fails to register his/her surroundings. In

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[80] S.G. Smith 'The process and meaning of sexual assault and disclosure' Unpublished dissertation: Georgia State University (2005) 4 available at: http://scholarworks.gsu.edu/psych_diss/7; M. Ciarlante 'Disclosing Sexual Victimization' (2007) 14(2) The Prevention Researcher, 11.

[81] *Bothma v Els* 2010 (2) SA (CC) at para 22 quoting *Van Zijl v Hoogenhout* 2005 (2) SA 93 (SCA) at paras 1 to 14; *S v Cornick and Another* 2007 (2) SACR 115 (SCA) at para 35. See also *Bothma* at paras 49 to 60.

essence, this means that the mind no longer controls the body. This in-turn further contributes to a complainant having no or a fragmented memory of the event.

85. The post-traumatic stress disorder that a victim suffers as a result of a sexual offence causes fragmented memory of the event/act. As a result, disclosure of the event and thereafter dealing with it often occurs in phases over a long period of time.

86. Before disclosure can take place by a victim of sexual assault, the victim importantly must first internally acknowledge an act of sexual abuse occurred, and secondly that it was wrongful and harmful - this then motivates or necessities the need for disclosure.

87. Disclosure of sexual assault is generally recognised as a continuous process rather than a once-off event.[82] Disclosure can be described as occurring along a continuum that is characterized by various personal, indirect and direct forms of disclosure that reveal varying amounts of detail.[83]

88. Disclosures by victims may range from tentative disclosure that includes prayer, journaling, hinting as to the abuse suffered or relaying hypothetical scenarios of abuse that contain elements of the actual abuse so as to test the response of

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[82] S.G. Smith (n80 above), 10; Ciarlante (n80 above) 11; C. Esposito 'Child sexual abuse and disclosure: what does the research tell us?' Office of the Senior Researcher, New South Wales: Family and Community Services, 11 available at https://www.facs.nsw.gov.au/__data/assets/file/0003/306426/LiteratureReviewHowChildrenDiscloseSexualAb use.pdf

[83] Smith (n80 above), 10.

people. More active disclosures may also occur through intermittent relaying of abuse to friends, family, authority or healthcare professionals.

89. An area which has not yet been sufficiently explored as a definitional facet of disclosure is whether disclosure progresses in a linear fashion from tentative to active disclosure or whether the process vacillates between the victim revealing events of sexual abuse and then concealing further details or recanting previous statements.[84]

90. A victim's decision to disclose can be accidental (particularly in the case of disclosure of sexual abuse by young children)[85] or purposeful. During purposeful disclosure the victim considers reasons for disclosing the abuse or avoiding disclosure as well as the outcome of such disclosure.[86] The need to self-acknowledge the incident through disclosing it to a friend/professional in order to work through the incident and further the need to express the feelings and thoughts, such as anger, shame and guilt heralded by the abuse are some of the reasons for disclosing such abuse.[87]

91. As with child disclosure, in adult disclosure, victims may also calculate the outcome of the abuse; uncertainty as to whether they were abused, the possibility of victim-blaming, the probability of success in and stressfulness of criminal and legal process and unwanted attention and re-traumatization often deter

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[84] Smith (n80 above), 11.
[85] Espositi (n82 above), 8.
[86] Smith (n80 above), 4.
[87] Smith (n80 above), 7.

disclosure. Victims also consider who to disclose abuse to, whether they will be believed and how much detail to provide during disclosure.[88]

92. The applicants' report deals with considerations for disclosure amongst children.

93. An additional factor in the timing of adult disclosure is the nature of the harm experienced. Victims of sexual abuse commonly suffer from complex trauma and Post-Traumatic Stress Disorder (PTSD) as a result of the harm suffered during sexual abuse. Such trauma manifests as depression, poor mental health, self-injury and feelings of anger, shame and guilt.[89] These emotional and cognitive aspects of trauma may themselves hamper early or eventual disclosure as the victim does not feel safe and wishes to dissociate themselves from the abuse in order to forget or cope with the incident.

94. Woollett notes that dissociation from sexual abuse suffered is a very common reaction to trauma suffered as a result of childhood sexual abuse.[90] Dissociation describes the psychological effect of sexual abuse and a coping strategy used by victims of sexual abuse. Psychologically, victims may experience mild detachment from immediate surroundings or more severe detachment from physical and emotional experience as a result of or during the commission of sexual abuse or subsequent sexual engagement by the victim. Dissociation may also be used as a coping strategy where a victim aims to actively 'forget' the abuse and resultant feelings through self-harming behaviours such as substance abuse for the purposes of numbing. Dissociation thus leads to victims repressing

[88] Esposito (n82 above), 1.
[89] Woollett affidavit at paras 6-20
[90] Woollett affidavit at paras 23-25

memories of the abuse, this impacts disclosure into adulthood as it results in the victim having a fragmented, non-sequential and incomplete memory of the event which is often only voiced when the memory has been triggered, often years later, or voiced over time.

95. Cultural and religious norms relating to the topic and practice of sex and sexual acts, virginity and family honour, gendered views on bodily autonomy may impact disclosures. Religions and cultures in which sex is taboo and virginity is revered may make it more difficult for victims to disclose experiences of sexual abuse, particularly when the victim is uncertain as to whether the act constituted sexual abuse and the perpetrator is well known.[91] Again, it must be emphasised that these experiences are not dispositive and are often interlinked with and contingent upon a number of other factors.

96. Some authors propose that children abused by family members or prominent social figures delay reporting sexual abuse as they are uncertain as to whether the event constitutes abuse and are embroiled with confusion caused by conflicting of feelings of guilt and loyalty towards the perpetrator.[92] Children are also concerned that they will not be believed and that it will result in family violence and fragmentation. This can continue well into adulthood.

97. Generally, disclosure is primarily made to parents and care-givers by children while adolescents and adults confide in peers.[93] Strikingly, disclosures are very rarely made to authorities (such as police officers) and health professionals;

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[91] Esposito (n82 above), 23; Smith (n80 above), 50.
[92] Esposito (n82 above), 26.
[93] Esposito (n82 above), 15.

frequency reports to authorities are generally in the range of 5 – 20%.[94] The shock, violence and stigma attached to the crime deter victims from reporting the abuse to authorities. In addition, fear of not being believed, secondary victimization as well as limited faith in the criminal justice system contribute to the low official reporting statistics.[95]

98. The above paragraphs highlight the general complexity and contingency of the disclosure process for victims of sexual assault. A number of nuanced factors and specific and intersectional circumstances contribute to disclosure rates and timings, with a general trend indicating that the disclosure of childhood sexual assault is widely delayed until adulthood.

99. The prescription period of 20 years imposed by section 18 of the Criminal Procedure Act is insufficiently cognisant of the nature and process of sexual assault disclosure. It does not take cognizance of the fact that disclosure of sexual abuse is not a single event, and that it is a dynamic process that occurs in stages over a lengthy period of time and impacted by numerous factors, thereby denying complainants the right to access to justice.

100. The prescription period alienates victim of sexual abuse by failing to afford them adequate and accessible protection of the law, thereby often re-traumatizing victims due to the unresponsiveness of the law to their abuse and to their attempts to access justice. A prescription period that is not in tandem with nor genuinely accommodating of the length the process of disclosure takes

[94] Esposito (n82 above), 17.
[95] Ciarlante (n80 above), 13.

denies victims of sexual assault their constitutional rights to access to justice, dignity and equality.

CONCLUSION

101. In light of the above, the TBC submits that its submissions are both relevant and novel, and that it would be in the interests of justice for the TBC to be admitted as *amicus curiae* in order to advance legal argument and to adduce evidence. Accordingly, the TBC prays for an order in terms of the notice of motion to which this affidavit is attached.

SHAHEDA OMAR

SIGNED and SWORN to BEFORE ME at JOHANNESBURG this 15th day of November 2016, the deponent having acknowledged that she knows and understands the contents of this affidavit, that she has no objection to taking the prescribed oath and that she considers the said oath to be binding on her conscience.

COMMISSIONER OF OATHS

Anjuli Leila Mcisty
Attorney
South African Human Rights
Commission
Floor 2, Braampark Forum 3

45
I

From: **Sheena** sheena.swemmer@wits.ac.za
Subject: Nicole Levenstein and Others v Sidney Lewis Frankel and Others (Case no. 29573/2016)
Date: 16 November 2016 at 10:33
To: **Ian Levitt** ian@ianlevitt.co.za, **Ian Levitt** angelike@ianlevitt.co.za, info@ianlevitt.co.za
Cc: gina.snyman@wits.ac.za, **khuraisha Patel** khuraisha786@gmail.com, **Zeenat Sujee** Zeenat.Sujee@wits.ac.za

Dear Ian

The Centre for Applied Legal Studies acts on behalf of the Teddy Bear Clinic in the above matter. As per our agreement with you for electronic service, kindly find attached the Teddy Bear Clinic's application to intervene as an amicus curiae in the matter of Nicole Levenstein and Others v Sidney Lewis Frankel and Others (Case no. 29573/2016) consisting of:

1. The Notice of Motion and Founding Affidavit with annexures; and
2. The Filing Notice and correspondence in terms of Rule 16A (3)

Kindly acknowledge receipt.

Best

Sheena

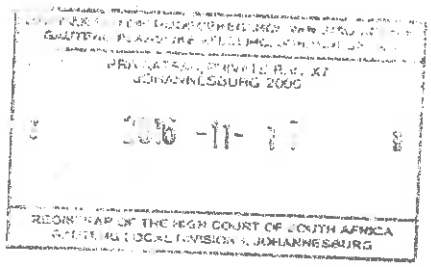
Sheena Swemmer
rney
re For Applied Legal Studies
ersity of The Witwatersrand
7 (0) 11 717 8609
7 (0) 82 491 6646
te Bag 3 | Wits 2050 | South Africa

CALS
Centre for Applied Legal Studies

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Filing Notice ito Rule 16A(3)

Notice of Motion and Founding Affidavit (A)



TEDDY BEAR CLINIC
FOR ABUSED CHILDREN

Head Office
The Memorial Institute for Child Health and Development
13 Joubert Street Ext.
Parktown

Postnet Suite 320
Private Bag X30500
Houghton 2041

www.ttbc.org.za

Branches
Head Office and Johannesburg:
Tel: (011) 484-4554/4539
Cel: 083 392 8100
Fax: (011) 484-4551
Krugersdorp:
Tel: (011) 660-3077
Cel: 071 736 3989
Soweto:
Tel: (011) 980-8160/8873
Cel: 060 865 2097
Diversion programme:
Cel: 079 374 4401

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RESOLUTIONS ADOPTED BY THE WRITTEN CONSENT

OF THE TEDDY BEAR CLINIC FOR ABUSED CHILDREN (REGISTRATION NUMBER 2003/000306/08) ("the Company")

We, the persons whose names appear below and who have signed this document, are the directors of the Company and we have received notice of the matters below to be decided. The memorandum of incorporation of the Company allows the adoption in writing of the following resolutions in terms of section 74 of the Companies Act No 71 of 2008 ("the Act"). Accordingly we hereby adopt by written consent of all the directors given in person or by electronic communication, the following resolutions in terms of section 74 of the Act.

IT WAS RECORDED THAT:

1. The Company notes hereby resolves to intervene as amicus curiae in litigation regarding the constitutional challenge to the law of prescription, in respect of sexual assault, and specifically in the matter of NICOLE LEVENSTEIN AND OTHERS // SIDNEY LEWIS FRANKEL AND OTHERS (CASE N°: 29573/16), and including possible appeals.

   1.1. The Teddy Bear Clinic For Abused Children

2. The Company has decided that Shaheda Bibi Omar, the Director, is authorised to depose to all affidavits in this matter.

   2.1. Shaheda Bibi Omar

3. The Company instructs CALS to act as it's legal representatives

   3.1. CALS

DIREKTEUR VAN DIE HOOGGeregshof VAN SUID-AFRIKA
GAUTENG PLAASLIKE AFDELING, JOHANNESBURG
PRIVAATSAK/PRIVATE BAG X7
JOHANNESBURG 2000
2016 -11- 17
REGISTRAR OF THE HIGH COURT OF SOUTH AFRICA
GAUTENG LOCAL DIVISION, JOHANNESBURG

The following resolutions were then passed and are subsequently numbered in the order that they were passed:

RESOLUTIONS:

1. **RESOLVED THAT** The Company notes hereby resolves to intervene as amicus curiae in litigation regarding the constitutional challenge to the law of prescription, in respect of sexual assault, and specifically in the matter of NICOLE LEVENSTEIN AND OTHERS // SIDNEY LEWIS FRANKEL AND OTHERS (CASE N°: 29573/16), and including possible appeals.

   1.1. The Teddy Bear Clinic For Abused Children

2. **RESOLVED THAT** Shaheda Bibi Omar, the Director, is authorised to depose to all affidavits in this matter.

   2.1. Shaheda Bibi Omar

3. **RESOLVED THAT** the Company accepts, CALS to act as it's legal representatives

   3.1. CALS

TEDDY BEAR CLINIC
FOR ABUSED CHILDREN

The Memorial Institute for Child Health and Development
13 Joubert Street Ext.
Parktown

Postnet Suite 320
Private Bag X30500
Houghton 2041

www.ttbc.org.za

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Cel: 083 392 8100
Fax: (011) 484-4551
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Tel: (011) 660-3077
Cel: 071 736 3989
Soweto:
Tel: (011) 980-8160/8873
Cel: 060 865 2097
Diversion programme:
Cel: 079 374 4401

48

Clive Peter van Niekerk
Director
Date: 28/09/2016

Michael SolomonTeke
Director
Date: 28/09/2016

James Clucas
Director
Date: 28/09/2016

Shaheda Bibi Omar
Director
Date: 28/09/2016

Lorna Jacklin
Director
Date: 28/09/2016

Penelope Mpho Moumakwa
Director
Date: 28/09/2016

Candice Christina Pillay
Director
Date: 28/09/2016

Nonhlanhla Peggy-Sue Khumalo
Director
Date: 28/09/2016

Patrick O Flaherty
Director
Date: 28/09/2016

TBC 2

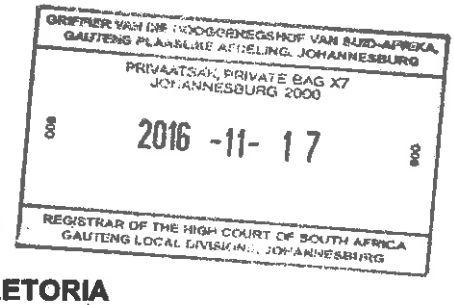
CALS

Centre for Applied Legal Studies

DJ Du Plessis Building West Campus Wits Braamfontein
Private Bag 3 Wits University 2050 South Africa
Tel + 27 11 717-8600 Fax + 27 11 717 1702
www.law.wits.ac.za/cals

Tel: 011 717 8607 (direct)
Ref: S Swemmer

TO: IAN LEVITT ATTORNEYS
Attorneys for the Applicants
Per Email: ian@ianlevitt.co.za
angelike@ianlevitt.co.za



TO: GUNDELFINGER ATTORNEYS
Attorneys for the First Respondent
Email: billy@gundelfinger.com

TO: OFFICE OF THE STATE ATTORNEY, PRETORIA
Attorneys for the Second Respondent
By fax: 012 309 1649

TO: Adv A Chauke
Director of Public Prosecutions, South Gauteng
Third Respondent
Email: AChauke@npa.gov.za

21 September 2016

Dear Sirs / Madam

NICOLE LEVENSTEIN AND OTHERS // SIDNEY LEWIS FRANKEL AND OTHERS (CASE NO. 29573/16)

1. We refer to the above matter. We act on behalf of the Teddy Bear Clinic ("TBC"). TBC wishes to participate as *amicus curiae* in the above application in terms of Rule 16A of the Uniform Rules of Court.

2. The Teddy Bear Clinic was established in 1986 and has specialised in providing holistic services to children who have been abused. Its mission is to minimize the secondary harm to children and their families when they enter the child protection system. Its vision is to ensure that children will not be abused anymore, but where they are being abused, to promote their healing and stop any further abuse, and to minimize any secondary harm to children and their families upon their entering the child protection system. It does this through a multipronged approach including providing:

2.1 medico-legal examinations at its facility based within the Charlotte Maxexe Academic Hospital, run by a multi-disciplinary team of pediatricians, doctors, forensic nurses, social workers and volunteers;

2.2 forensic assessments to form the basis of court proceedings concerning violence against children;

2.3 psychological assessments (including mental age) specifically for children with special needs by highly trained and experienced psychologists, for the purpose of providing them with fair access to the criminal justice system. In the context of sexual abuse cases, the assessments in particular assess the impact of the trauma on the victims;

2.4 therapeutic counseling and support where every child who is a victim of abuse is provided with the opportunity to receive therapeutic counseling and support, which focuses on reducing tension and alleviating any fear and anxiety that the child may have, increasing self-acceptance and releasing the internal resources that will help the child to cope with the trauma;

2.5 court preparation and support focuses on providing children and parents with skills relating to testifying in court such as narrating the incident that happened rather than coaching them on what to say as well as emotional support and legal knowledge in preparation for their appearance in court;

2.6 outreach and schools awareness programmes.

3. TBC is able to bring a clinical perspective in this matter stemming from its work with victims, perpetrators, concepts of victimization and trauma. TBC seeks to file limited evidence by way of affidavit and to make written and oral submissions as described below.

4. The TBC will argue that the prescription period of 20 years in which to prosecute a sexual offence and/or assault, in terms of section 18 of the Criminal Procedure Act 51 of 1997, except for rape or compelled rape, is invalid and unconstitutional on the following bases:

5.1 The nature of the harm

The Criminal Procedure Act makes an arbitrary distinction between the nature of the trauma and harm caused to the complainant by the perpetration of rape *vis a vis* the perpetration of other sexual offences against her/him:

5.1.1 Sexual assault, particularly of children, and particularly when repeated over time and through early development, causes trauma and emotional scars that can have a negative impact on a child's developmental trajectory and result in very serious long-term consequences.

5.1.2 Victims' response to sexual abuse and rape is nuanced, and victims respond differently. Long term sexual abuse and grooming can lead to sustained complex trauma and post-traumatic stress disorder with degrees of dissociation and mental ill-health which in some circumstances can be lessor, similar to, or worse, than the incidence of rape.

5.1.3 The current legislative scheme minimizes a victim of sexual offences' trauma and experience of long-term mental health difficulties.

5.1.4 The minimization of trauma suffered by a victim of a sexual offence can in itself lead to self-destruction, continued feelings of anger, shame and guilt, psychological implications and broader adverse consequences on the person' inter-personal relationships, physical health and future employment.

5.2 *Disclosure of sexual abuse is not a single event*

The prescription period of 20 years does not take cognizance of the fact that disclosure of sexual abuse is not a single event but occurs in stages over a lengthy period of time, thereby denying complainants the right to access to justice:

5.2.1 The complex trauma and post-traumatic stress disorder that a victim suffers as a result of a sexual offence (as defined in the Criminal Law (Sexual Offences and Related Matters) Amendment Act 2007), typically causes dissociation and fragmented memory of the event/act. The term dissociation describes a wide array of experiences ranging from mild detachment from immediate surroundings to more severe detachment from physical and emotional experience during the commission of a sexual offence or subsequent sexual engagement by the victim. Dissociation leads to active 'forgetting' through, amongst others, self-harming behaviours that numb, such as alcohol and substance abuse, in order to repress memories for those highly traumatized. Dissociation and fragmented memory have consequences for disclosure of childhood sexual abuse, contributing to the disclosure process occurring over time and only typically when the victim feels safe (which is sometimes later in life).

5.2.2 The memory of sexual assault manifests after a period of time and is triggered in various ways, generally through the senses and in particular inter-personal experiences e.g. during sexual activities.

These often tend to occur after the initial traumatic experience and often many years later.

5.3 *The State's duty to protect in response to silent communities and failed systems of care*

The potential for harm in failed systems of care facilities, places of safety, and insular communities (more specifically, particular religious, cultural and ethnic communities) is vast. This requires the legal system to come to the aid of victims of abuse, at whatever stage, not least in order to restore trust in systems that are meant to protect them:

5.3.1 In many instances survivors are coerced in silence by the perpetrator and the community or facility may prevent them from speaking due to their dependency and reliance on someone typically regarded as powerful and regularly as trustworthy. Prescription on prosecution of sexual offences does a disservice to society where it promotes secondary violation and victimization of the most vulnerable groups by not allowing justice to be seen to be done, where there is a prohibition on prosecution.

5.3.2 The trauma that a victim endures often results in displaced aggression. Displaced aggression describes the situation where a victim of sexual offence behaves aggressively towards another individual who generally occupies a lower position of power than the victim and who was not involved in the initial conflict as a result of the victim being unable to aggress towards the initial source of assault or incitement. The victim's failure to accost the original aggressor can itself be attributed to power structures within that relationship. Displaced aggression becomes particularly relevant in isolated communities, youth centres, care homes and other facilities where children may be the victims of abuse from other victims of abuse due to the power dynamics in those relationships and systems of support and reliance.

5.3.3 Trauma is chiefly escalated where a victim has no support structures, or when those who are reasonably expected to protect, actively victimize. When a community fails to offer the support needed by the individual (e.g. where the victim is not believed), and in some cases actively ostracizes the individual, he/she may experience heightened levels of trauma over and above that of the initial sexual violation. This is known as secondary victimization.

6. The Teddy Bear Clinic will rely on its experience and expertise in this field to assist the court. The application will also be supported by the expert evidence of Nataly Woollett, who has training and qualifications in psychology, art therapy and play therapy, and is currently a PhD candidate in the School of Clinical Medicine at the University of the Witwatersrand. Ms Woollett has practiced locally and internationally in the field of trauma and traumatic bereavement and has particular expertise in gender based violence and child/adolescent experience of interpersonal violence (domestic violence, child abuse, etc.)

7. We hereby request your clients' consent that our client be admitted as *amicus curiae* to adduce limited evidence, make written submissions and to present oral argument.

8. Kindly advise whether you consent to the Teddy Bear Clinic intervening as *amicus curiae* by close of business on **Monday, 26 September 2016.**

9. We look forward to your positive response.

Yours faithfully,

Sheena Swemmer
Attorney: Centre for Applied Legal Studies
Email: Sheena.Swemmer@wits.ac.za

Fax Send Confirmation

Date/Time	: 22-SEP-2016 11:31 THU
Model Name	: SL-M4070FR
Machine Serial Number	: ZECHBJEG10004BH
Host Name	: SEC30CDA795FDD5

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CALS
Centre for Applied Legal Studies

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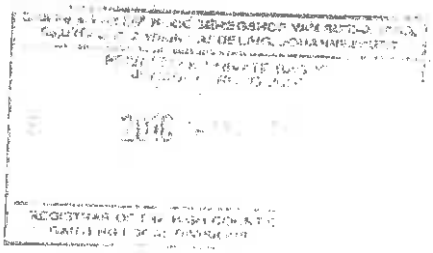
Tel: 011 717 8607 (direct)
Ref: S Swemmer

TO: **IAN LEVITT ATTORNEYS**
Attorneys for the Applicants
Per Email: ian@ianlevitt.co.za
angelike@ianlevitt.co.za

TO: **GUNDELFINGER ATTORNEYS**
Attorneys for the First Respondent
Email: billy@gundelfinger.com

TO: **OFFICE OF THE STATE ATTORNEY, PRETORIA**
Attorneys for the Second Respondent
By fax: 012 308 1649

TO: **Adv A Chauke**
Director of Public Prosecutions, South Gauteng
Third Respondent
Email: AChauke@npa.gov.za



21 September 2016

Dear Sirs / Madam

NICOLE LEVENSTEIN AND OTHERS // SIDNEY LEWIS FRANKEL AND OTHERS
(CASE NO. 29873/16)

1. We refer to the above matter. We act on behalf of the Teddy Bear Clinic ("TBC"). TBC wishes to participate as *amicus curiae* in the above application in terms of Rule 16A of the Uniform Rules of Court.

Faculty of Commerce, Law and Management
University of the Witwatersrand

1063

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Director of Public Prosecutions
Gauteng Local Division

NATIONAL PROSECUTING AUTHORITY
South Africa

Reference Number: 10/2/5/7 2016/245
10/2/4/1 2015/60
Cr
Enquiries: Ms S Greef
Telephone Number: (011) 220-4186

22 September 2016

Ms Seena Swemmer
Center for Applied Legal Studies
Private Bag 3
WITS UNIVERSITY
2050

FOR ATTENTION: MS SEENA SWEMMER
FAX NUMBER: 011 717 1702
E-MAIL ADDRESS: Sheena.Swemmer2wits.ac.za

DPP Gauteng Local Division
Regional Office

Tel: +27 11 220 4000
Fax: +27 11 220 4057

Innes Chambers
Cnr Pritchard &
Kruis Street
Johannesburg
2000

Private Bag X8
Johannesburg
2000

www.npa.gov.za

Dear Madam,

NICOLE LEVENSTEIN AND EIGHT OTHERS versus THE MINISTER OF JUSTICE AND CORRECTIONAL SERVICES AND THE DIRECTOR OF PUBLIC PROSECUTIONS, GAUTENG

Receipt of your e-mail dated 21 September 2016 is hereby acknowledged.

It is hereby confirmed that a Notice of Motion in re the above noted action has been served to this Office.

The said application by Nicole Levenstein and Others to gain direct access to the Gauteng Local Division of the High Court in order to seek Constitutional relief relating to the application and provisions of section 18 of Act 51 of 1977 is not opposed.

Therefore, this Office has no view about your application.

Yours sincerely

M A CLARKE
DIRECTOR OF PUBLIC PROSECUTIONS
GAUTENG LOCAL DIVISION, JOHANNESBURG

... people can live in freedom and security

BILLY GUNDELFINGER
ATTORNEY-AT-LAW

TBC4 57

91 Iris Road
Cor. Grant Avenue, Norwood
Johannesburg 2192
P.O. Box 95165, Grant Park 2051
Telephone: 011-728-7571
Telefax: 011-728-7597
E-Mail: Billy@Gundelfinger.com

E-MAIL TRANSMISSION

23rd September 2016

Our Ref: Billy Gundelfinger/ew
Your Ref: S. Swemmer

CENTRE FOR APPLIED LEGAL STUDIES
Per E-Mail: Sheena.Swemmer@wits.ac.za
c.c. Ian Levitt Attorneys - angelike@ianlevitt.co.za
Office of The State Attorney Pretoria - Fax No. 012-309-1649
Advocate A Chauke - Achauke@npa.gov.za

Dear Sirs,

RE: NICOLE LEVENSTEIN and OTHERS // SIDNEY FRANKEL

1. I acknowledge receipt of your e-mail of the 21st instant.

2. My client neither supports nor opposes your application.

Sincerely,

BILLY GUNDELFINGER

TBC5 58

Ian Levitt
ATTORNEYS

DATE: 4 OCTOBER 2016

YOUR REF: S SWEMMER
OUR REF: I LEVITT/A CHARALAMBOUS/MAT1643

CENTRE FOR APPLIED LEGAL STUDIES

PER EMAIL: SHEENA.SWEMMER@WITS.AC.ZA

Dear Sirs,

RE: NICOLE LEVENSTEIN & OTHERS // SIDNEY LEWIS FRANKEL

1. The above matter as well as your letter dated 21 September 2016 refers.

2. We confirm that we consent to the Teddy Bear Clinic intervening as *amicus curiae* in this matter.

3. We trust you find the above in order.

Yours faithfully

IAN LEVITT ATTORNEYS
PER: ANGELIKE CHARALAMBOUS

Sent electronically and therefore unsigned

19th Floor, Office Towers, Sandton Shopping Centre, cnr Rivonia & 5th Street, SANDTON
P.O.BOX 783244, SANDTON, 2146
Docex No. DX 54 SANDTON SQUARE
Tel: (011) 784-3310 Cell: 082-445-1586 Fax (011) 784-3309
Website: www.ianlevitt.co.za
Ian Levitt B.Com., LLB (Wits), HDip Tax Law (Wits)
E-mail: ian@ianlevitt.co.za
Assisted by: **Michael Strauss** BA Law (Stellenbosch) LLB (RAU)
E-mail: michael@ianlevitt.co.za
Assisted by **Jeanne Bosman Strauss** LLB,LLM, Cert in Medicine & Law (Cum Laude)
E-mail: jeannebosman@iburst.co.za
Assisted by **Pieter De Weerdt** B.Com., LLB (Stellenbosch)
E-mail: pieter@ianlevitt.co.za
Assisted by **Sadiyah Samrod** B.Com., LLB (UJ)
E-mail : sadiyah@ianlevitt.co.za
Assisted by **Angelike Charalambous** B.Com., LLB (UJ)
E-MAIL : angelike@ianlevitt.co.za

-JOC 6 59

From: **Sheena** sheena.swemmer@wits.ac.za
Subject: Letter to request consent to be admitted as amicus - Nicole Levenshtein // Sidney Lewis Frankel (29573/2016)
Date: 15 November 2016 at 09:52
To: yselesho@justice.gov.za
Cc: **Tafadzwa Mahubaba** tafadzwamahubaba@ymail.com, **Zeenat Sujee** Zeenat.Sujee@wits.ac.za, **Gina Snyman** gina.snyman@wits.ac.za, **Khuraisha Patel** khuraisha.patel@wits.ac.za

Dear Ms Selesho

As per your conversation with Tafadzwa from our offices. I have attached our letter requesting consent to be admitted as an amicus in the above matter.

Best

Sheena

Frankel_Letter of Consent 21... FINAL.pdf

Sheena Swemmer
ney
re For Applied Legal Studies
ersity of The Witwatersrand
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F (0) 82 49 : 6646
ite Bag 3 | Wits 2050 | South Africa

CALS Centre for Applied Legal Studies | UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

IN THE HIGH COURT OF SOUTH AFRICA
GAUTENG LOCAL DIVISION, JOHANNESBURG

Case No.: 29573/2016

In the application to intervene as *amicus curiae*:

TEDDY BEAR CLINIC	Applicant

In re:

NICOLE LEVENSTEIN	First Applicant
PAUL DIAMOND	Second Applicant
GEORGE ROSENBERG	Third Applicant
KATHERINE ROSENBERG	Fourth Applicant
DANIELA McNALLY	Fifth Applicant
LISA WEGNER	Sixth Applicant
SHANE ROTHQUEL	Seventh Applicant
MARINDA SMITH	Eighth Applicant

and

SIDNEY LEWIS FRANKEL	First Respondent
MINISTER OF JUSTICE AND CORRECTIONAL SERVICES	Second Respondent
DIRECTOR OF PUBLIC PROSECUTIONS, GAUTENG	Third Respondent

CONFIRMATORY AFFIDAVIT: APPLICATION TO BE ADMITTED AS AN AMICUS CURIAE AND TO ADDUCE EVIDENCE

I, the undersigned,

SHEENA JUSTINE SWEMMER

do hereby state under oath that:

1. I am an adult female, admitted attorney practicing at the Centre for Applied Legal Studies ("CALS"), situated at 1 Jan Smuts Avenue, Braamfontein.

2. The facts in this affidavit are to the best of my knowledge true and correct and, unless stated to the contrary or the contrary appears from the context hereof, falls within my personal knowledge.

3. I have read the affidavit of **SHAHEDA OMAR** and I confirm the contents thereof insofar and to the extent as it refers to myself.

SHEENA JUSTINE SWEMMER

SIGNED and SWORN to BEFORE ME at JOHANNESBURG this 15 day of NOV 2016, the deponent having acknowledged that she knows and understands the contents of this affidavit, that she has no objection to taking the prescribed oath and that she considers the said oath to be binding on her conscience.

STATION COMMANDER
2016 -11- 15
BEVELVOERDER: SPEURDIENS
FAIRLAND
SOUTH AFRICAN POLICE SERVICE

118460
CST

COMMISSIONER OF OATHS

TBC8

62

Nataly Woollett, M.A. (PhD candidate)
43A Link Road, Atholl, 2196, South Africa
+27 766380564
woollettn@gmail.com

EDUCATION

2012 PhD — PhD (candidate) in School of Clinical Medicine, University of the Witwatersrand. *Title: A description of the mental health outcomes of HIV positive adolescents accessing care in Johannesburg*

2002 Dual MA — Lesley University, Boston USA (Clinical Psychology & Art Therapy)

1997 BA (Hons) — University of South Africa (Clinical Psychology)

1995 South African Sign Language Qualification, Witwatersrand Sign Language School (3 year qualification)

1994 BA — University of the Witwatersrand (Psychology, Art History, Zulu)

LICENSURE/REGISTRATION

- HPCSA registration AT0001023, South African license
- Licensed Mental Health Counselor (LMHC), State of New York, USA
- Licensed Creative Arts Therapist (LCAT), State of New York, USA
- Registered Art Therapist (ATR) with the American Art Therapy Association
- Registered Play Therapist-Supervisor (RPT-S) with the American Association for Play Therapy
- EMDR training level I and II (trauma intervention)

PROFESSIONAL EXPERIENCE

Lawyers Against Abuse (LvA), JHB, South Africa *May 2011-present*
Co-founder and board member

- NGO dealing with gender based violence (GBV) by providing direct, immediate representation to victims utilizing an integrated approach; recognising the psychosocial drivers of GBV and how trauma is manifested in victims, systems and service providers.

Wits Reproductive Health and HIV Institute (formerly ECHO and RHRU), University of Witwatersrand, JHB, South Africa *Oct 2010-July 2016*
Technical Head: Psychosocial/ Researcher

- Principal Investigator of randomized control trial of nurse-led intervention for intimate partner violence (IPV) in pregnancy (collaborating with WHO): *Addressing violence against women in antenatal care: testing an intervention in South Africa.* Managed implementation of study: submitted ethics; developed protocol; designed intervention content; trained nurses; oversaw clinical quality; managed recruitment and retention (n=1300 participants); managed 4 antenatal clinic sites in Johannesburg; ensured data quality and regulatory compliance.
- Head of technical team dealing with psychosocial programming with a focus on mental health and HIV, adolescent health, and gender based violence.
- Manage multidisciplinary staff that provides technical advice and mentoring to Department of Health (DoH) and Social Development (DSD) colleagues in North West Province, Ekurhuleni, Mpumalanga and Region F of City of Johannesburg.
- Capacitate DoH and DSD colleagues (10 day training run 3 times per year for 4 years) who work in Thuthuzela Care Centers (for sexual assault/rape) and Medico-Legal Clinics in Johannesburg on how to manage trauma, the special needs of children and adolescent victims, how to curb burnout etc.
- Created intervention and training DVD for lay counsellors in healthcare settings to identify and treat trauma and traumatic bereavement in children, adolescents and their caregivers.
- Member of The Eastern and Southern Africa Regional Interagency Task Team on Children and AIDS (RIATT-ESA).
- Member of working groups to create National Draft Psychosocial Support Strategy (2015), National Draft Adolescent Sexual and Reproductive Health and Rights Framework Strategy (2015), National HIV

Disclosure Guidelines for Children and Adolescents (2014), National Adolescent Treatment Guidelines (2014), National Adolescent Youth Policy (2012) with NDoH, NDSD, NDoE and collaborating NGOs.
- Member of reference group 'Breaking the cycle: intervention for child witnesses of domestic violence'. Group consists of senior leaders of Childline, Teddy Bear Clinic, RAPCAN, TVEP, and MRC.

Wits ECHO (Enhancing Children's HIV Outcomes), Wits Health Consortium, JHB, South Africa *Nov 2009-Oct 2010*

Psychosocial Programme Manager

- Part of multidisciplinary team working in variety of government clinics and hospitals in Gauteng and North West Province serving the needs of HIV infected children, adolescents and their families.
- Manage, train and supervise team of psychologists, social workers and counsellors who provide psychosocial support to all children, adolescents and caregivers within all clinics/hospitals served.
- Manage donors and provide reporting for USAID, PEPFAR, UNICEF, and Irvin Stern Foundation.

Healthy Connections, Lutheran Medical Center, Brooklyn, NY, USA *Aug 2002-Feb 2009*

Senior Mental Health Counsellor, Creative Arts Therapist, Play Therapist

Outpatient mental health community based clinic of major hospital specializing in trauma and traumatic bereavement

- Provide individual, group and family psychotherapy using art, play and verbal therapy to clients (2 - 75 yrs) with variety diagnoses. Emphasis on treatment of children and families. Trauma and traumatic bereavement include: terror attacks of 09/11, domestic and gang related violence, immigration and trafficking, sudden chronic medical illness, various forms of abuse and neglect, loss of parent to death, incarceration, deportation, foster care, abandonment, HIV/AIDS etc.
- Co-facilitated group of World Trade Centre evacuees and conducted crisis debriefing post 09/11.
- Work as part of multidisciplinary team serving largely immigrant population of Spanish, Arabic, Polish, Russian and Chinese descent. Collateral work with parents, school officials, religious leaders,immigration lawyers, law guardians, foster care agencies, Administration of Children's Services (ACS), advocacy agencies, etc.
- Active participant in planning, monitoring, implementing and evaluating policy and programme protocol, continually seeking to be one of the city's most comprehensive and ethical child focussed trauma treatment centres.
- As senior therapist, supervised junior therapists and graduate social work interns from Columbia University, Fordham University and New York University.
- Active contributor in writing successful grants for program (Robin Hood Foundation, Van Amerigen Foundation, Avon, Dove).

CONSULTING EXPERIENCE

International consultations

November 2012
Invited as Technical Advisor to WHO for researchers conducting intervention research in antenatal care settings to reduce intimate partner violence in low-income settings, Geneva, Switzerland.

May 2010
Invited to Global Consultation on Service Provision for Adolescent Living with HIV in Kampala, Uganda, organized by UNICEF, WHO, FHI, GNP+, MUJHU CARE Research Collaboration and Uganda Paediatric Association

January 2009
Invited by United Nations Relief and Works Agency for Palestinian Refugees in the Near East (UNRWA) to train social workers, psychologists, teachers and lawyers in Amman and Aqaba, Jordan in *Playful Ways to Engage and Stimulate Young Children in Refugee Camps,* funded by UNICEF and *Understanding and Managing Children's Reactions During Acrimonious Divorce,* funded by Legal Aid Jordan.

Gender and Media Southern Africa (GEMSA), JHB, SA *Jun/Jul 2009*

- Contracted as research writer and editor for the 'Making Care Work Count' policy baseline study. Study conducted in Botswana, Democratic Republic of Congo (DRC), Lesotho, Malawi, Mauritius, Mozambique, Namibia, Swaziland, Tanzania, Zimbabwe and Zambia. Audited policies on community care work in the area of HIV/AIDS. Edited 12 country reports and created final regional report launched at the Heads of State Summit in the DRC in September 2009. Funded by UK Department for International Development (DFID).

Woz'bona of Sekhukhune Educare Project (CBO), Jane Furse, SA *May/Aug 2009*

- Conducted 2x4 day trainings for 30 community care workers in the Orphans and Vulnerable Children (OVC) programme entitled *How to Use Art and Play Across the Developmental Spectrum to Reach and Recognise Children Who Are Traumatized and Grieving.* Emphasis is also placed on self care of care workers. Funded by USAID and PEPFAR.

Bethany House, Bertrams, JHB, SA *Apr-Jun 2009*

- Conducted 16 week group therapy for children in domestic violence shelter (aged 6-13yrs) who present with severe behavioural and emotional difficulties resultant of trauma histories.
- Principal investigator of research study at shelter validating protocol of manualized treatment for children/adolescents (unpublished document).

A Caring Hand Bereavement Center, Manhattan, NY, USA *Sept 2008-Dec 2008*

- Co-facilitate weekly groups for preschool (4-6yrs) and school aged children (7-12yrs) at bereavement centre where children have recently lost a parent or primary caretaker (many as a result of 09/11). Children present with host of Post Traumatic Stress Disorder (PTSD), complex trauma, depressive and adjustment disorder symptoms.
- Participate in managing and implementing group protocol for bereaved children developed by Dr. Robin Goodman, PhD.

Center Against Domestic Violence, Brooklyn, NY, USA *May 2004-Dec 2008*

- Co-facilitate weekly groups for preschool (2-5yrs) and school aged children (6-12yrs) in tier 1 emergency domestic violence shelter who present with severe behavioural and emotional difficulties resultant of trauma histories.
- Lead psychoeducation groups with mothers to educate on the symptoms of childhood trauma and facilitate more effective parenting.
- Co-authored manual with Reem Abukishk (unpublished document) that details facilitating 12-week therapy group with school aged children in the shelter system to address PTSD and depressive disorder.
- Principal investigator on study at shelter validating protocol of manualized treatment (unpublished document)

Children's Aid Society, City Challenge Collaboration, Brooklyn, NY, USA *Sep 2007-Dec 2008*

Alternative high school for juvenile offenders returning from Youth Leadership Academy, OCFS mandate

- Provide weekly group therapy in juvenile justice facility for adolescent boys (14-18yrs) recently released from their sentence and are still the wards of state.
- Group therapy focuses on psychoeducation regarding trauma and managing its symptoms, managing dual diagnosis of substance and alcohol abuse, reintegrating into life after incarceration.
- Provide support to staff regarding managing 'cadets' and understanding trauma symptom presentation.
- Provide training to all staff within Office of Child and Family Services (OCFS – New York State Regulated Government Office) and Children's Aid Society within Brooklyn location and upstate 'bootcamp'/leadership training facility.

TEACHING/SUPERVISOR EXPERIENCE

- Honourary joint appointment with School of Public Health, Faculty of Health Sciences, University of Witwatersrand, Senior Lecturer Position – September 2016
- Invited lecturer at University of Johannesburg to teach on short course entitled '*Art Therapy and Social Action*' through Faculty of Art, Design and Architecture (FADA) – July 2016
- Invited lecturer at University of Johannesburg to teach Honours Social Work students (class on *'Trauma and Traumatic Bereavement'*) and Master Social Work students (class on *'Mental Health and HIV Prevention'*) through Social Work Department – January 2016/2015/2014/2013
- Invited lecturer at University of Witwatersrand to teach MPH and MSc students (class on '*Sexual Reproductive Health Needs of Adolescents in Context of HIV'*) – March 2013
- Invited lecturer at University of Witwatersrand to teach Drama For Life MA Drama Therapy students (class on *'Trauma and Traumatic Bereavement in the South African Context: Nonverbal Therapies and their Power to Transform'*) – Aug 2013/ Oct 2014/ June 2015
- Supervisor to Shanaaz Kapery Randeria, University of Liverpool, MPH, 2013 *Thesis: Exploring the perceptions of adults interacting with adolescents on adolescent sexual reproductive health information and education needs in Johannesburg, South Africa*

EXAMINER EXPERIENCE

- External examiner for Drama for Life Department of University of Witwatersrand School of Arts – oral and research report final examination for masters degree in drama therapy (MA) – July 2016
- Internal examiner for University of Witwatersrand Medical School – research report submitted for masters in medicine (MMed) – May 2016
- External examiner for University of Pretoria Music Therapy Unit – oral examination for masters degree in music therapy (MA) – May 2016
- External examiner for HPCSA – conversion exam (written and oral) for masters level art therapists qualified overseas – April 2016

PEER REVIEWING

- Abstract review committee member for Africa for 28th Annual Meeting of ISTSS (International Society for Traumatic Stress Studies) in Los Angeles, USA (2012).
- Reviewer of grant applications for the Robert Carr Civil Society Networks Fund (RCNF) for Aids Fonds (international HIV/AIDS donor), Amsterdam, Netherlands
- Journal reviewer for *International Journal of Family Medicine; African Journal of Primary Health Care & Family Medicine; Child Abuse Review; Journal of Traumatic Stress Studies; Journal of Women's Health; Psychology of Women Quarterly; Southern African Journal of HIV Medicine; BMJ Open; Current HIV Research*

PEER-REVIEWED JOURNAL PUBLICATIONS

Woollett, N. & Hatcher, A.M. (2016). Mental health, intimate partner violence and HIV. *S African Medical Journal (in press).*

Woollett, N. & Thomson, K. (2016). Understanding the intergenerational transmission of violence. *S African Medical Journal (in press).*

Woollett, N., Black, V., Cluver, L. & Brahmbhatt, H. (2016). Bereavement and incomplete disclosure's impact on understanding vertical transmission: implications for treatment with perinatally infected adolescents in Johannesburg. *African Journal AIDS Research (in press)*

Hatcher, A. M., Stöckl, H., Christofides, N., **Woollett, N.**, Pallitto, C. C., Garcia-Moreno, C., & Turan, J. M. (2016). Mechanisms linking intimate partner violence and prevention of mother-to-child transmission of HIV: A qualitative study in South Africa. *Social Science & Medicine, 168, 130-139.*

Hatcher, A. M., **Woollett, N.**, Pallitto, C. C., Mokoatle, K., Stöckl, H., & Garcia-Moreno, C. (2016). Willing but not able patient and provider receptiveness to addressing intimate partner violence in Johannesburg antenatal clinics. *Journal of Interpersonal Violence, 1-26.*

Sprague, C., **Woollett, N.**, Parpart, J., Hatcher, A., Sommers, T., Brown, S. & Black, V. (2015) When nurses are also patients: IPV and the health system as an enabler of women's health and agency in Johannesburg. *Global Public Health, 11(1), 1-17*

Sprague, C., Hatcher, A., **Woollett, N.** & Black, V. (2015) How nurses in Johannesburg address intimate partner violence in female patients: Understanding IPV responses in low and middle-income country health systems. *Journal of Interpersonal Violence, 1-29*

Sprague, C., Hatcher, A., **Woollett, N.** & Black, V. (2015). 'They can't report abuse, they can't move out. They are at the mercy of these men': exploring connections between intimate partner violence, gender and HIV in South African clinical settings. *Culture, Health & Sexuality, 1-15*

Hatcher, A.H, **Woollett, N.**, Pallitto, C., Mokoatle, K., Stockl, H., MacPhail, C., Delay-Moretlwe, S. & Garcia-Moreno, C. (2014). Bidirectional links between HIV and intimate partner violence in pregnancy: Implications for prevention of mother-to-child transmission. *Journal of the International AIDS Society, 17(1), 1-9*

G Jonsson (Chair), N Davies, C Freeman, J Joska, S Pahad, R Thom, K Thompson, **N Woollett** (Panel Members), J Furin, G Meintjes (Reviewers) (2013). Management of mental health disorders in HIV positive patients – Guidelines from the South African HIV Clinicians Society. *SA J HIV Med, 14 (4), 155-165*

OTHER PUBLICATIONS

Woollett, N. (2016). Adolescents living with HIV: emerging issues in public health in South Africa. Book Chapter in *Children, Young People and HIV/AIDS: A Cross-Cultural Perspective,* Liamputtong, P (Ed.) Springer: Switzerland.

AIDSTAR-One (2016). *The clinical management of children and adolescents who have experienced sexual violence: Technical considerations for PEPFAR programs.* USAID, PEPFAR (contributor to document)

NACOSA (2015). *Guidelines and recommended standards for the provision of support to rape survivors in the acute stage of trauma* (contributor to document)

Wits Reproductive Health and HIV Institute (2015). *Support for victims of sexual assault pamphlets: victims; parents and caregivers and healthcare providers* (contributor to document)

Wits Reproductive Health and HIV Institute (2014). *Working with adolescents living with HIV: A toolkit for healthcare providers.* Wits RHI/Southern African HIV Clinicians Society (contributor to document).

Hartmann, M. & Krishnan, S. (2014) *Ethical and Safety Recommendations for Intervention Research on Violence Against Women.* RTI International Global Gender Center (contributor to document)

Woollett, N. (2013). The psychosocial challenges of HIV positive youth: the silent epidemic. *HIV Nursing Matters, 4 (1), 22-25*

Woollett, N. (2012). Managing Gender Based Violence in Healthcare Settings. *HIV Nursing Matters, 3 (3), 10-13.*

Woollett, N. (2011). *Recognising and treating trauma and traumatic bereavement in children and adolescents: a counsellor guide.* Wits Reproductive Health and HIV Institute (WRHI).

Woollett, N. (2010). *Children's Peace Building Programme,* Caritas International & Damietta Peace Initiative.

Woollett, N. (2010). *Adolescent Peace Building Programme,* Caritas International & Damietta Peace Initiative.

Woollett, N., Lowe-Morna, C., Rama, K. & Muzenda, G. (2009) *Regional Report: Making Care Work Count. A Policy Analysis.* Gender and Media South Africa (GEMSA).

Woollett, N & Ortega, N. (2007) *Preschool Shelter Group Therapy Treatment Manual.* Lutheran Medical Center, NYC

Woollett, N & Abukishk, R. (2005) *Children's Shelter Group Therapy Treatment Manual.* Lutheran Medical Center, NYC

CONFERENCE PROCEEDINGS

2016

Woollett, N. (2016). *Missed opportunities in managing violence and addressing mental health in HIV positive adolescents retained in care in Johannesburg.* Oral presentation at 1st SA Violence Conference, Johannesburg, SA

Van Eck, L.A., **Woollett, N.**, Pallitto, C., Garcia-Moreno, C. & Hatcher, A.M. (2016). *'I stuck it out as a woman': why women tolerate, accept and normalize abuse.* Oral presentation at 1st SA Violence Conference, Johannesburg, SA

Mphahlele, S., **Woollett, N.**, Pallitto, C., Garcia-Moreno, C. & Hatcher, A.M. (2016). *Unplanned pregnancy as a driver of IPV among HIV positive women.* Oral presentation at 1st SA Violence Conference, Johannesburg, SA

Thomson, K., Pleaner, M., **Woollett, N.** & Perlman, H. (2016). *Responding to the needs of adolescent victims of rape and sexual assault.* Poster presentation at 1st SA Violence Conference, Johannesburg, SA

Hatcher, A.M, Stockl, H., Christofides, N., **Woollett, N.**, Pallitto, C., Garcia-Moreno, C. & Turan, J.M. (2016). *Intimate partner violence and vertical HIV transmission: causal pathways and protective factors for PMTCT adherence.* 1st SA Violence Conference, Johannesburg, SA

Woollett, N. (2016). *Complexities in research with adolescents <18yrs and adolescent experience of Gender Based Violence (GBV).* Invited panel presentation at Southern African HIV Clinician's Society 3rd Biennial Conference, Johannesburg, SA

Woollett, N. (2016). *Exploring HIV positive adolescent adherence issues in public health systems.* Invited panel presentation at Southern African HIV Clinician's Society 3rd Biennial Conference, Johannesburg, SA

Pahad, S & **Woollett, N.** (2016). *'I often wish I could be like other children': Neurocognitive and psychological features of HIV positive children and adolescents.* Oral presentation at 31st International Congress of Psychology (ICP), Yokohama, Japan

Pahad, S, **Woollett, N.** & Thomson, K. (2016). *The young and the resilient: exploring the construct of resilience among HIV positive adolescents from the perspective of adolescent HIV healthcare providers and experts.* Oral presentation at 31st International Congress of Psychology (ICP), Yokohama, Japan

2015

Sprague, C., Hatcher, A., **Woollett, N.** & Black, V. (2015). *How Nurses in Johannesburg address intimate partner violence in female patients: Understanding IPV responses in low and middle-income country health systems.* Poster presentation at Sexual Violence Research Initiative (SVRI) Forum, Cape Town, SA

Hatcher, A.M., Porter, O., **Woollett, N.**, & Garcia-Moreno, C. (2015). *Adaptation of nurse-led empowerment counselling for South African antenatal clinics: lessons for clinical training and mentorship.* Poster presentation at Nursing Network on Violence Against Women International (NNAWI), Atlanta, US

2014

Pahad, S., Thomson, K. & **Woollett, N.** (2014). *The young and the resilient: healthcare provider reflections on resilience in HIV positive adolescents.* Poster presentation at South African HIV Clinician's Society Conference, Durban, SA

2013

Woollett, N.C. (2013). *Children and adolescents born with the HIV virus.* Invited plenary speaker SA National Conference on Orphans, Children and Youth made Vulnerable by HIV/AIDS, Durban, SA.

Pahad, S & **Woollett, N.** (2013). *Psychological testing of HIV-positive OVCY with reported learning difficulties and challenges in adherence to ART.* Oral presentation SA National Conference on Orphans, Children and Youth made Vulnerable by HIV/AIDS, Durban, SA

Woollett, N. (2013). *Curbing the intergenerational transmission of trauma: outcomes of an intervention for child witnesses of domestic violence and their mothers.* Presentation at Sexual Violence Research Initiative (SVRI) Forum, Bangkok, Thailand.

Hatcher, A, **Woollett, N**, Pallitto, C.C, Goolam, A, Delany-Moretlwe, S, MacPhail, C, Stockl, H & Garcia-Moreno, C. (2013). *"Willing but not able": high acceptability of addressing intimate partner violence in antenatal care is hindered by persistent gaps in policy and resources.* Poster presentation at Sexual Violence Research Initiative (SVRI) Forum, Bangkok, Thailand.

Woollett, N. (2013). *Fragmentation and disconnection: linking HIV, gender based violence (GBV) and health in the South African context.* Invited presentation Corporealities of Violence in Southern Africa Workshop, Edinburgh University, UK.

Woollett, N. (2013). *The body keeps the score: reflections of formative research regarding intimate partner violence during pregnancy and antenatal clinic visits.* Invited presentation for Driving Challenges in HIV/AIDS Colloquium, University of Johannesburg, SA.

Woollett, N. (2013). *The body keeps the score: reflections of formative research regarding intimate partner violence during pregnancy and antenatal clinic visits.* Presentation for Medical Humanities Research Group at the Wits Institute for Social and Economic Research (WiSER), University of the Witwatersrand, SA

Hatcher, A, **Woollett, N,** Goolam, A, Pallitto, C.C, Delany-Moretlwe, S, MacPhail, C, Stockl, H & Garcia-Moreno, C. (2013). *Patient and provider perspectives on addressing intimate partner violence in Johannesburg antenatal clinics.* Poster presentation at International Conference on AIDS and STI's in Africa (ICASA) conference, Cape Town, SA.

Hatcher, A., Mokoatle, K., Ngoma, B., Stockl, H., MacPhail, C., Delany-Moretlwe, S., Pallitto, C., Garcia-Moreno, C. & **Woollett, N.** (2013). *Types and impact of intimate partner violence among pregnant women: patient and provider perspectives from two Johannesburg antenatal clinics.* Johannesburg Health District Research Conference, Johannesburg, SA

Hatcher, A., **Woollett, N.**, Pallitto, C., Goolam, A., Delany-Moretlwe, S., MacPhail, C., Stockl, H., & Garcia-Moreno, C. (2013). *Bidirectional links between HIV and intimate partner violence in pregnancy: implications for prevention of mother-to-child transmission.* Presentation at 3rd Structural Drivers of HIV Conference, Cape Town, SA.

Woollett, N. (2013). *Understanding trauma and traumatic bereavement in the South African context: nonverbal therapies and their power to transform.* Invited keynote speaker for Creative Expressive Arts Therapy Symposium hosted by Department of Educational Psychology, University of Johannesburg, SA.

2012

Woollett, N. (2012). *Lay counselor training in trauma and traumatic bereavement: how to identify symptoms and address them in children and adolescents.* Invited presentation Orphans and Vulnerable Children (OVC) conference, Gallagher Estate, Midrand, SA.

Woollett, N. (2012). *The effects of Gender Based Violence (GBV) and Domestic Violence (DV) on children and adolescents.* Invited presentation Gender Conference, University of Johannesburg, Faculty of Humanities, SA.

2011

Woollett, N. (2011). *Child witnesses of domestic violence: the overlooked victims.* Poster presentation at Public Health Association of SA (PHASA) Conference, Sandton, SA.

Woollett, N. (2011). *Lay counsellor training in trauma and traumatic bereavement: how to do it.* Workshop presented at World Congress of the World Federation for Mental Health, Cape Town, SA.

Woollett, N. (2011). *Child witnesses of domestic violence: the overlooked victims.* Poster presentation at World Congress of the World Federation for Mental Health, Cape Town, SA.

Woollett, N. (2011). *Lay counsellor training in trauma and traumatic bereavement: interventions that promote psychosocial change and strengthen healthcare systems.* Plenary presentation at Sexual Violence Research Initiative (SVRI) Forum, Cape Town, SA.

Woollett, N. (2011). *Child witnesses of domestic violence: research outcomes from group treatment in SA and USA.* Presentation at Sexual Violence Research Initiative (SVRI) Forum, Cape Town, SA.

Woollett, N. (2011). *Enforcing the Domestic Violence Act in healthcare settings: mental health care and legal responsiveness for victims in the public healthcare arena.* Invited panel presentation for 'Women's Month Dialogue'

organised by Gauteng Provincial Department of Health and Social Development in collaboration with the Gauteng Victim Empowerment Shelter Network, Turffontein, SA.

Woollett, N., Ketlhapile M. & Meyers, T. (2011). *Identifying barriers and challenges in the provision of and access to care of HIV infected women and children - results from focus group discussions with PHC nurses in Gauteng.* Poster presentation at South African AIDS Conference, Durban, SA.

2010

Woollett, N., auf der Heyde, T. & Abukishk, R. (2010). *Navigating the verbal/non-verbal continuum: the value of creative arts therapies (CAT) in transforming trauma.* Poster presentation at International Society for Traumatic Stress Studies (ISTSS) 26th Annual Meeting, Montreal, Canada

Woollett, N. (2010). *Child witnesses of domestic violence: the overlooked victims.* Plenary presentation at Orphans and Vulnerable Children (OVC) Conference, Sandton, SA

Woollett, N. (2010). *Community based intervention for children and adolescents: peace building and non-violence.* Poster presentation at Orphans and Vulnerable Children (OVC) Conference, Sandton, SA

Woollett, N. (2010). *Why does trauma feel like a boomerang? Understanding re-enactment and the social context of trauma/PTSD.* Invited keynote speaker to Mali Martin Polokeng Center (Domestic Violence Center) AGM, Bronkhorstspruit, SA.

Woollett, N. (2010). *Lessons learned from ECHOs adolescent psychosocial support services program.* Invited presentation at 'Coordinating the response to adolescent HIV prevention and treatment in South Africa' inaugural meeting, Soweto, SA

Woollett, N. (2010). *Child witnesses of domestic violence: the overlooked victims.* Invited workshop for Drama for Life Conference, University of Witwatersrand, Johannesburg, SA

Woollett, N., Berman, H., Booth, M., Dlamini, Z., Rakabe, M. & Pule, P. (2010). *The use of creative arts therapy training and intervention in the promotion of psychological change.* Panel presentation for Drama for Life Conference, University of Witwatersrand, Johannesburg, SA

2009

Woollett, N. (2009). *TF-CBT & play/art based children's group therapy in domestic violence shelters in Brooklyn, NY, USA and Bertams, JHB, SA.* Invited presentation for the South African Institute for Traumatic Stress (SAITS), Johannesburg, SA

2008

Woollett, N. (2008). *Immigrants and Domestic Violence (DV): adjusting the clinical lens.* Presentation at International Society for Traumatic Stress Studies (ISTSS) 24th Annual Meeting, Chicago, IL, USA

Woollett, N. & Ortega, N. (2008) *Trauma and domestic violence: are immigrants different?* Invited presentation given at Global Social Work Student Conference, Fordham University, Manhattan, NY, USA

Woollett, N. & Ortega, N. (2008) *Trauma and domestic violence: are immigrants different?* Workshop presented at 2008 International Counseling Psychology Conference, Chicago, IL, USA

2007/2006

Woollett, N., Ortega, N. & Kan, M. (2007) *Complex adaptation to trauma as it relates to immigrants particularly those faced with Domestic Violence (DV).* Poster presented at the 18th Annual International Trauma Conference, Boston, MA, USA

Woollett, N., Smith, R. & Weintraub, S. (2006) *Spiritual counseling and mental health trauma recovery since 9/11: conflict and collaboration.* Invited panel presentation at the Annual Conference of NYDIS (New York Disaster Interfaith Service), Manhattan, NY, USA

TBC 9 70

IN THE HIGH COURT OF SOUTH AFRICA
GAUTENG LOCAL DIVISION, JOHANNESBURG

Case No.: 29573/2016

In the application to intervene as *amicus curiae*:

TEDDY BEAR CLINIC	Applicant

In re:

NICOLE LEVENSTEIN	First Applicant
PAUL DIAMOND	Second Applicant
GEORGE ROSENBERG	Third Applicant
KATHERINE ROSENBERG	Fourth Applicant
DANIELA McNALLY	Fifth Applicant
LISA WEGNER	Sixth Applicant
SHANE ROTHQUEL	Seventh Applicant
MARINDA SMITH	Eighth Applicant

and

SIDNEY LEWIS FRANKEL	First Respondent
MINISTER OF JUSTICE AND CORRECTIONAL SERVICES	Second Respondent
DIRECTOR OF PUBLIC PROSECUTIONS, GAUTENG	Third Respondent

SUPPORTING AFFIDAVIT:
APPLICATION TO BE ADMITTED AS AN AMICUS CURIAE
AND TO ADDUCE EVIDENCE

I, the undersigned,

NATALY WOOLLETT

do hereby state under oath that:

1. I am an adult female researcher and therapist with training and qualifications in psychology, art therapy and play therapy. I have practiced both locally and internationally in the field of trauma and traumatic bereavement and have particular expertise in gender-based violence and with child witnesses of domestic violence. I am currently completing my doctorate at the University of the Witwatersrand in the School of Clinical Medicine on mental health outcomes of HIV-positive adolescents. A copy of my *curriculum vitae* is annexed as **"TBC 7"**.

2. The facts contained herein are to the best of my knowledge both true and correct and, unless otherwise stated or indicated by the context, are within my personal knowledge.

3. I have been approached by the Centre for Applied Legal Studies ("CALS") to provide an opinion related to my area of expertise in the experience of trauma and trauma bereavement in the case of children who have been sexually violated, with specific focus on sexual assault, and the impact on their adult life.

4. I have read the main application and the report of Muller and Hollefy 'The Disclosure Process in cases of Child Sexual Abuse'.

5. I have also read the affidavit of Ms Shaheda Omar on behalf of the Teddy Bear Clinic and confirm the contents of that affidavit in so far as they relate to me. I further confirm that the substance of the evidence and conclusions in the TBC's affidavit and application accord with my professional experience.

Trauma in children

6. From a psychological perspective, trauma occurs when a child experiences an intense event that threatens or causes harm to his or her emotional and physical well-being. Trauma can be the result of exposure to a natural disaster such as a hurricane or flood or to events such as war and terrorism. Witnessing or being the victim of violence, serious injury, or physical or sexual abuse can be traumatic for a child.

7. There are many different definitions of child abuse. This argument follows the definition within the South African Children's Act 38 (2005) which defines child abuse as "any form of harm or ill-treatment deliberately inflicted on a child and includes assaulting a child or inflicting any other form of deliberate injury to a child [...] exposing or subjecting a child to behavior that may harm the child psychologically or emotionally."

8. Both sexual assault and rape can thus be defined as child abuse and both can lead to significant psychological harm, including complex trauma and post traumatic stress disorder (PTSD).

9. When children have a traumatic experience, they react in both physiological and psychological ways. Their heart rate may increase, and they may begin to sweat, to feel agitated and hyperalert, to feel "butterflies" in their stomach, and to become emotionally upset (these are autonomic nervous system responses typically referred to as 'fight, flight or freeze'). These reactions are distressing, but normal — they are the body's way of protecting us and preparing us to confront danger. However, some children who have experienced a traumatic event will have longer lasting reactions that can interfere with their physical and emotional health.

10. Children who suffer from child traumatic stress are those who have been exposed to one or more traumas over the course of their lives and develop reactions that persist and affect their daily lives after the traumatic events have ended. Traumatic reactions can include a variety of responses, including: intense and ongoing emotional upset, depressive symptoms, anxiety, behavioral changes, difficulties with attention, academic difficulties, nightmares, physical symptoms such as difficulty sleeping and eating, and aches and pains, among others. Children who suffer from traumatic stress often have these types of symptoms when reminded in some way of the traumatic event.

11. Some of these children may develop ongoing symptoms that are diagnosed as PTSD. Child traumatic stress is the stress of any child who has had a traumatic experience and is having difficulties moving forward with his or her life.

12. PTSD is a disorder defined by the Diagnostic and Statistical Manual (DSM)[1] as having specific symptoms: the child continues to re-experience the event through nightmares, flashbacks, or other symptoms for more than a month after the original experience; the child has avoidance or numbing symptoms—he or she will not think about the event, has memory lapses, or may feel numb in connection with the events—and the child has feelings of arousal, such as increased irritability, difficulty sleeping, or others. Every child diagnosed with PTSD is experiencing child traumatic stress, but not every child experiencing child traumatic stress has all the symptoms for a PTSD diagnosis.

13. Not every child who experiences a traumatic event will develop symptoms of child traumatic stress. This depends on a range of factors including his or her history of previous trauma exposure, because children who have experienced prior traumas are more likely to develop symptoms after a recent event. Also those who are consistently exposed to traumatic events are more likely to be symptomatic. They also include an individual child's mental and emotional strengths and weaknesses and what kind of support he or she has at home and elsewhere. Where there is little protection from those expected to protect, such as parents and caregivers, or when those who are expected to protect put children in harm's way, there is typically increased risk of being symptomatic.

14. For children who do experience traumatic stress, there are a wide variety of potential consequences, many of which will continue throughout development and into adulthood if they remain unaddressed.

[1] The DSM is the source of diagnoses that are utilised by health sector insurers and medical aids.

Complex trauma

15. The clinical term PTSD has some limitations in its application. Post Traumatic Stress Disorder became a diagnostic category after the Vietnam War to describe otherwise healthy individuals before the war coming back from war with a host of psychological difficulties. As the name implies, there was a clear traumatic experience, namely war, and after this experience (post) there was the occurrence of disorder. Although some people who have experienced past traumatic events may reside in an objectively safe current environment, this is not the case in contexts of enduring child abuse. In these circumstances, ongoing threat and danger is a predictable and expected part of growing up and is typically at the hands of someone known to the victim.

16. Complex trauma is a term that helps understand the manifestation of traumatic stress, particularly in children and adolescents who experience continuing threat. The term complex trauma describes children's exposure to multiple traumatic events that occur repeatedly, are often of an invasive, interpersonal nature, and have wide-ranging, long-term impacts. [2]

17. These events are severe and pervasive, with repeated incidence over an extended period of time (i.e. months or years) that includes emotional abuse, physical abuse, sexual abuse, or profound neglect. They usually begin early in life and can disrupt many aspects of the child's development and the very formation of a self. Since they often occur in the context of the child's relationship

[2] Cook, A., Spinazzola, J., Ford, J., Lanktree, C., Blaustein, M., Cloitre, M., & Van der Kolk, B. (2005). Complex trauma. *Psychiatric annals*, *35*(5), 390-398.

with a caregiver, they interfere with the child's ability to form a secure attachment bond. Many aspects of a child's healthy physical and mental development rely on this primary source of safety and stability.

18. Complex trauma can have devastating effects on a child's physiology, emotions, ability to think, learn, and concentrate, impulse control, self-image, and relationships with others.

19. Across the life span and into adulthood, complex trauma is linked to a wide range of problems, including: addiction, chronic physical conditions, depression and anxiety, self-harming behaviors, and other psychiatric disorders. Individuals experience lifelong difficulties related to self-regulation, relationships, psychological symptoms, alterations in attention and consciousness, self-injury, identity, and cognitive distortions.

20. Beyond the consequences for the child and family, these problems carry high costs for the victim into adulthood, and for society. For example, a child who cannot learn may grow up to be an adult who cannot hold a job. A child with chronic physical problems may grow up to be a chronically ill adult. A child who grows up learning to hate himself/herself may become an adult with an eating disorder or substance addiction.

21. Children whose families and homes do not provide consistent safety, comfort, and protection may develop ways of coping that allow them to survive and function from day-to-day. For instance, they may be overly sensitive to the moods

of others, always watching to figure out what the adults around them are feeling and how they will behave. They may withhold their own emotions from others, never letting them see when they are afraid, sad, or angry. These kinds of learned adaptations make sense when physical and/or emotional threats are ever-present and survival is at stake. As a child enters into adolescence and adulthood and encounters situations and relationships that are safe, these adaptations are no longer helpful, and may in fact be counterproductive and interfere with the capacity to live, love, and be loved which may persist throughout their adult life.

Consequences of childhood sexual abuse

22. Prior child sexual abuse has been associated with a range of outcomes in adulthood, including: poorer psychological well-being, pervasive feelings of shame and self-stigma, teenage pregnancy and early sexual debut, conflicted parenting behaviors, and adjustment problems in the victim's later offspring.[3] The primary outcome of child sexual abuse in children and adults is poor mental health for all genders,[4] including increased depression, anxiety[5] PTSD or

[3] Coffey, P., Leitenberg, H., Henning, K., Turner, T., & Bennett, R. T. (1996). Mediators of the long-term impact of child sexual abuse: Perceived stigma, betrayal, powerlessness, and self-blame. *Child abuse & neglect*, *20*(5), 447-455.

[4] Hill, T. D., Kaplan, L. M., French, M. T., & Johnson, R. J. (2010). Victimization in Early Life and Mental Health in Adulthood An Examination of the Mediating and Moderating Influences of Psychosocial Resources. *Journal of Health and Social Behavior*, *51*(1), 48-63.

[5] Li, M., D'Arcy, C., & Meng, X. (2016). Maltreatment in childhood substantially increases the risk of adult depression and anxiety in prospective cohort studies: systematic review, meta-analysis, and proportional attributable fractions. *Psychological medicine*, *46*(04), 717-730.

complex trauma[6] and suicidality[7] - particularly during adolescence where suicide is the second leading cause of death for this population.[8]

23. Dissociation is a common reaction subsequent to childhood sexual abuse and has been identified as a risk factor for child, adolescent and adult psychopathology.[9] The term dissociation describes a wide array of experiences from mild detachment from immediate surroundings to more severe detachment from physical and emotional experience.[10] The major characteristic of all dissociative phenomena involves a detachment from reality, rather than a loss of reality as in psychosis.[11] Dissociation is commonly displayed on a continuum. In mild cases, dissociation can be regarded as a coping mechanism or defense mechanisms in seeking to master, minimise or tolerate stress – including boredom or conflict. At the non-pathological end of the continuum, dissociation describes common events such as daydreaming while driving a vehicle. Further along the continuum are non-pathological altered states of consciousness.[12]

---

[6] Lawson, D. M., Davis, D., & Brandon, S. (2013). Treating complex trauma: Critical interventions with adults who experienced ongoing trauma in childhood. *Psychotherapy*, *50*(3), 331.

[7] Devries, K. M., Mak, J. Y., Child, J. C., Falder, G., Bacchus, L. J., Astbury, J., & Watts, C. H. (2014). Childhood sexual abuse and suicidal behavior: a meta-analysis. *Pediatrics*, peds-2013.

[8] Stewart, J. G., Kim, J. C., Esposito, E. C., Gold, J., Nock, M. K., & Auerbach, R. P. (2015). Predicting suicide attempts in depressed adolescents: Clarifying the role of disinhibition and childhood sexual abuse. *Journal of affective disorders*, *187*, 27-34.

[9] Ensink, K., Bégin, M., Normandin, L., Godbout, N., & Fonagy, P. (2016). Mentalization and dissociation in the context of trauma: Implications for child psychopathology. *Journal of Trauma & Dissociation*, (just-accepted).

[10] Dell, P. F., & O'Neil, J. A. (Eds.). (2010). *Dissociation and the dissociative disorders: DSM-V and beyond*. Routledge.

[11] As above.

[12] Above, note 9.

24. Dissociation leads to active 'forgetting' and can aid in repressing memories for those highly traumatised.[13] Trauma most typically leads to fragmented memory with disorganised characteristics of the trauma experience recall; which exacerbates symptom complexity and treatment.[14]

25. Dissociation and fragmented memory have consequences for disclosure of childhood sexual abuse, contributing to the disclosure process occurring over time and only typically when the victim feels safe (which is sometimes later in life).

26. Memory is often triggered through the body and senses in later experiences (touch, sound, taste, smell, sight), leading to memory recall and often confusion on the part of the victim.[15]

27. Often, in an attempt to repress the memory that might have been remembered, and to manage emotional dysregulation that results, victims can engage in self harming behaviours that aid in numbing, i.e. cutting behavior, alcohol and substance use, eating disordered behavior, and more.[16]

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[13] Brewin, C. R. (2007). Autobiographical memory for trauma: Update on four controversies. *Memory*, *15*(3), 227-248.

[14] McKinnon, A., Brewer, N., Meiser-Stedman, R., & Nixon, R. D. V. (2017). Trauma memory characteristics and the development of acute stress disorder and post-traumatic stress disorder in youth. *Journal of behavior therapy and experimental psychiatry*, *54*, 112-119.

[15] Van der Kolk, B. A. (1994). The body keeps the score: Memory and the evolving psychobiology of posttraumatic stress. *Harvard review of psychiatry*, *1*(5), 253-265.

[16] Mandavia, A., Robinson, G. G., Bradley, B., Ressler, K. J., & Powers, A. (2016). Exposure to Childhood Abuse and Later Substance Use: Indirect Effects of Emotion Dysregulation and Exposure to Trauma. *Journal of Traumatic Stress*.

28. Victims' response to sexual assault and rape is nuanced, and victims respond differently. Long term sexual assault and grooming can lead to sustained post traumatic distress and degrees of dissociation, which in some circumstances can be lessor, similar to, or worse, than the incidence of rape. All of this conduct is classified as sexual abuse.

29. In addition, research indicates an association of child sexual abuse with physical ill health in adulthood.[17] The amount of childhood victimisation experienced is a significant predictor of health problems in adulthood, controlling for the significant negative effects of health risk behaviors and mental health problems on physical health. Physical assaults and sexual abuse have been associated with a range of health problems (including pain, sleep problems, eating problems, cortisol dysregulation, and weight fluctuations).

30. Experience of childhood sexual abuse also has detrimental effects on later adult intimate relationships.[18] This relationship insecurity is based on fundamental distrust and difficulties with intimacy, leading to problems in sexual development and functioning,[19] and disruptions in familial and other adult relationships.[20] This insecure attachment style has implications for intimate partnerships but also with

[17] Coles, J., Lee, A., Taft, A., Mazza, D., & Loxton, D. (2015). Childhood Sexual Abuse and Its Association With Adult Physical and Mental Health Results From a National Cohort of Young Australian Women. *Journal of interpersonal violence*, *30*(11), 1929-1944.

[18] Tardif-Williams, C. Y., Tanaka, M., Boyle, M. H., & MacMillan, H. L. (2015). The impact of childhood abuse and current mental health on young adult intimate relationship functioning. *Journal of interpersonal violence*, 0886260515599655.

[19] Noll, J. G., Trickett, P. K., & Putnam, F. W. (2003). A prospective investigation of the impact of childhood sexual abuse on the development of sexuality. *Journal of consulting and clinical psychology*, *71*(3), 575.

[20] Rumstein-McKean, O., & Hunsley, J. (2001). Interpersonal and family functioning of female survivors of childhood sexual abuse. *Clinical psychology review*, *21*(3), 471-490.

parenting the next generation.[21] Recent research has shown that victims' children may also be negatively affected.[22]

31. The current legislative scheme minimizes a survivor of sexual offences' trauma. This minimization of trauma of a survivor as a sexual offence can in itself lead to self-destruction, psychological implications and broader adverse consequences on the person's inter-personal relationships and employment.

32. I am available to assist the court with any further analysis if required.

NATALY WOOLLETT

SIGNED and SWORN to BEFORE ME at JOHANNESBURG this 15 day of 11 2016, the deponent having acknowledged that she knows and understands the contents of this affidavit, that she has no objection to taking the prescribed oath and that she considers the said oath to be binding on her conscience.

SOUTH AFRICAN POLICE SERVICE
CLIENT SERVICE CENTRE
2016 -11- 15
CSC
ROSEBANK
SUID-AFRIKAANSE POLISIEDIENS

COMMISSIONER OF OATHS

[21] Kwako, L. E., Noll, J. G., Putnam, F. W., & Trickett, P. K. (2010). Childhood sexual abuse and attachment: An intergenerational perspective. *Clinical Child Psychology and Psychiatry*, *15*(3), 407-422.

[22] Dixon, L., Browne, K., & Hamilton-Giachritsis, C. (2005). Risk factors of parents abused as children: a meditational analysis of the intergenerational continuity of child maltreatment (Part I). *Journal of Child Psychology and Psychiatry*, *46*(1), 47-57.

IN THE HIGH COURT OF SOUTH AFRICA
GAUTENG LOCAL DIVISION, JOHANNESBURG

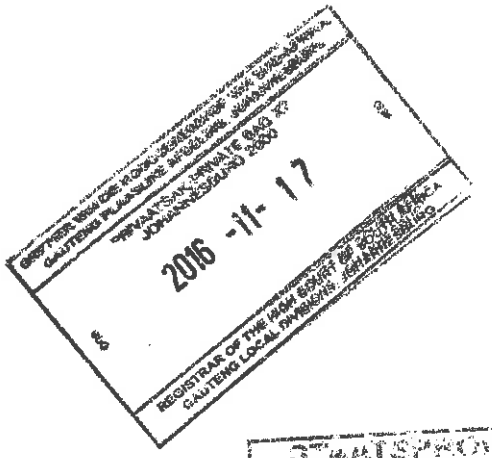
Case No.: 29573/2016

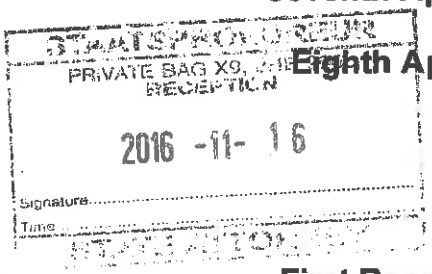
In the application to intervene as *amicus curiae*:

TEDDY BEAR CLINIC	**Applicant**

In re:

NICOLE LEVENSTEIN	**First Applicant**
PAUL DIAMOND	**Second Applicant**
GEORGE ROSENBERG	**Third Applicant**
KATHERINE ROSENBERG	**Fourth Applicant**
DANIELA McNALLY	**Fifth Applicant**
LISA WEGNER	**Sixth Applicant**
SHANE ROTHQUEL	**Seventh Applicant**
MARINDA SMITH	**Eighth Applicant**





and

SIDNEY LEWIS FRANKEL	**First Respondent**
MINISTER OF JUSTICE AND CORRECTIONAL SERVICES	**Second Respondent**
DIRECTOR OF PUBLIC PROSECUTIONS, GAUTENG	**Third Respondent**

FILING NOTICE: LODGING OF CONSENT IN TERMS OF UNIFORM RULE 16A(3)

KINDLY TAKE NOTICE that the following document are presented for filing:

1. Letter of consent from the 1st – 8th Applicant in the main application to be admitted as an amicus curiae;
2. Letter from the 1st Respondent neither supporting nor opposing admission as an amicus curiae; and
3. Letter from the 3rd Respondent not opposing the main application in this matter.

Dated at **JOHANNESBURG** on the 16th day of November 2016.

CENTRE FOR APPLIED LEGAL STUDIES
Attorneys for the Applicant (in the application to be admitted as amicus curiae)
1st floor, DJ du Plessis Building
West Campus, University of the Witwatersrand
1 Jan Smuts Avenue
Johannesburg
Tel: 011 717 8600
Fax: 011 717 1702
Email: Sheena.Swemmer@wits.ac.za

TO: THE REGISTRAR OF THE ABOVE HONOURABLE COURT

AND TO: IAN LEVITT ATTORNEY

AND TO: IAN LEVITT ATTORNEY

Attorney for the applicants
19th Floor, Office Towers
Sandton City Office Towers
Cnr Rivonia & 5th Street
Ref:

AND TO: BILLY GUNDELFINGER

Attorney for the First Respondent
91 Iris Road
Norwood, Sandton
Tel: 011 728 7571
Ref: Billy Gundelfinger/ew

BILLY GUNDELFINGER
RECEIVED WITHOUT PREJUDICE
16.11.2016
15:45

AND TO: THE MINISTER IF JUSTICE AND CORRECTIONAL SERVICES

Office of the State Attorney
North State Building
Cnr Albertina Sisulu & Kruis Street
Johannesburg
Ref: 5355/16/P45 (Van Schalkwyk)

PRIVATE BAG X9, JHB 2000
RECEPTION
2016 -11- 16

DIREKTEUR VAN OPENBARE VE...
PRIVAATSAK/PRIVATE BAG X9
14:50
2016 -11- 16
APPEALS UNIT
JOHANNESBURG 2000
DIRECTOR OF PUBLIC P... AUTO...

AND TO: THE DIRECTOR OF PUBLIC PROSECUTIONS

South Gauteng
Cnr Von Brandis and Pritchard Street
Johannesburg
Ref: 10/2/5/7 2016/205

From: **Sheena** sheena.swemmer@wits.ac.za
Subject: Nicole Levenstein and Others v Sidney Lewis Frankel and Others (Case no. 29573/2016)
Date: 16 November 2016 at 10:33
To: **Ian Levitt** ian@ianlevitt.co.za, **Ian Levitt** angelike@ianlevitt.co.za, info@ianlevitt.co.za
Cc: gina.snyman@wits.ac.za, **khuraisha Patel** khuraisha786@gmail.com, **Zeenat Sujee** Zeenat.Sujee@wits.ac.za

Dear Ian

The Centre for Applied Legal Studies acts on behalf of the Teddy Bear Clinic in the above matter. As per our agreement with you for electronic service, kindly find attached the Teddy Bear Clinic's application to intervene as an amicus curiae in the matter of Nicole Levenstein and Others v Sidney Lewis Frankel and Others (Case no. 29573/2016) consisting of:

1. The Notice of Motion and Founding Affidavit with annexures; and
2. The Filing Notice and correspondence in terms of Rule 16A (3)

Kindly acknowledge receipt.

Best

Sheena

Sheena Swemmer
ney
re For Applied Legal Studies
ersity of The Witwatersrand
7 (0) 11 717 8609
7 (0) 82 491 6643
le Bag 3 | Wits 2050 | South Africa

CALS
Centre for Applied Legal Studies

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Filing Notice ito Rule 16A(3)

Notice of Motion and Founding Affidavit (A)

From: **Sheena** sheena.swemmer@wits.ac.za
Subject: Nicole Levenstein and Others v Sidney Lewis Frankel and Others (Case no. 29573/2016)
Date: 16 November 2016 at 10:34
To: Ian Levitt ian@ianlevitt.co.za, Angelike Charalambous angelike@ianlevitt.co.za, info@ianlevitt.co.za
Cc: Gina Snyman gina.snyman@wits.ac.za, khuraisha Patel khuraisha786@gmail.com, Zeenat Sujee Zeenat.Sujee@wits.ac.za

Dear Ian

The Centre for Applied Legal Studies acts on behalf of the Teddy Bear Clinic in the above matter. As per our agreement with you for electronic service, kindly find attached the Teddy Bear Clinic's application to intervene as an amicus curiae in the matter of Nicole Levenstein and Others v Sidney Lewis Frankel and Others (Case no. 29573/2016) consisting of:

1. The Notice of Motion and Founding Affidavit with annexures; and
2. The Filing Notice and correspondence in terms of Rule 16A (3)

Kindly acknowledge receipt.

Best

Sheena

Sheena Swemmer
Researcher: Gender

Centre For Applied Legal Studies
University of The Witwatersrand

T: (011) 717 8609
F: (086) 491 6646

Private Bag 3 | Wits 2050 | South Africa

CALS

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Notice of Motion and Founding Affidavit (B)

Ian Levitt

ATTORNEYS

YOUR REF: **S SWEMMER** **DATE:** **4 OCTOBER 2016**

OUR REF: **I LEVITT/A CHARALAMBOUS/MAT1643**

CENTRE FOR APPLIED LEGAL STUDIES

PER EMAIL: SHEENA.SWEMMER@WITS.AC.ZA

Dear Sirs,

RE: NICOLE LEVENSTEIN & OTHERS // SIDNEY LEWIS FRANKEL

1. The above matter as well as your letter dated 21 September 2016 refers.

2. We confirm that we consent to the Teddy Bear Clinic intervening as *amicus curiae* in this matter.

3. We trust you find the above in order.

Yours faithfully

IAN LEVITT ATTORNEYS
PER: ANGELIKE CHARALAMBOUS

Sent electronically and therefore unsigned

19th Floor, Office Towers, Sandton Shopping Centre, cnr Rivonia & 5th Street, SANDTON
P.O.BOX 783244, SANDTON, 2146
Docex No. DX 54 SANDTON SQUARE
Tel: (011) 784-3310 Cell: 082-445-1586 Fax (011) 784-3309
Website: www.ianlevitt.co.za
Ian Levitt B.Com., LLB (Wits), HDip Tax Law (Wits)
E-mail: ian@ianlevitt.co.za
Assisted by: **Michael Strauss** BA Law (Stellenbosch) LLB (RAU)
E-mail: michael@ianlevitt.co.za
Assisted by **Jeanne Bosman Strauss** LLB.LLM, Cert in Medicine & Law (Cum Laude)
E-mail: Jeannebosman@iburst.co.za
Assisted by **Pieter De Weerdt** B.Com., LLB (Stellenbosch)
E-mail: pieter@ianlevitt.co.za
Assisted by **Sadiyah Samrod** B.Com., LLB (UJ)
E-mail : sadiyah@ianlevitt.co.za
Assisted by **Angelike Charalambous** B.Com., LLB (UJ)
E-MAIL : angelike@ianlevitt.co.za

BILLY GUNDELFINGER

ATTORNEY-AT-LAW

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E-MAIL TRANSMISSION

23rd September 2016

Our Ref: Billy Gundelfinger/ew
Your Ref: S. Swemmer

CENTRE FOR APPLIED LEGAL STUDIES
Per E-Mail: Sheena.Swemmer@wits.ac.za
c.c. Ian Levitt Attorneys - angelike@ianlevitt.co.za
Office of The State Attorney Pretoria - Fax No. 012-309-1649
Advocate A Chauke - Achauke@npa.gov.za

Dear Sirs,

RE: NICOLE LEVENSTEIN and OTHERS // SIDNEY FRANKEL

1. I acknowledge receipt of your e-mail of the 21st instant.

2. My client neither supports nor opposes your application.

Sincerely,

BILLY GUNDELFINGER

Director of Public Prosecutions
Gauteng Local Division

NATIONAL PROSECUTING AUTHORITY
South Africa

Reference Number: 10/2/5/7 2016/245
Cr 10/2/4/1 2015/60
Enquiries: Ms S Greef
Telephone Number: (011) 220-4186

22 September 2016

DPP Gauteng
Local Division
Regional Office

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Innes Chambers
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Ms Seena Swemmer
Center for Applied Legal Studies
Private Bag 3
WITS UNIVERSITY
2050

FOR ATTENTION: MS SEENA SWEMMER
FAX NUMBER: 011 717 1702
E-MAIL ADDRESS: Sheena.Swemmer2wits.ac.za

Dear Madam,

NICOLE LEVENSTEIN AND EIGHT OTHERS versus THE MINISTER OF JUSTICE AND CORRECTIONAL SERVICES AND THE DIRECTOR OF PUBLIC PROSECUTIONS, GAUTENG

Receipt of your e-mail dated 21 September 2016 is hereby acknowledged.

It is hereby confirmed that a Notice of Motion in re the above noted action has been served to this Office.

The said application by Nicole Levenstein and Others to gain direct access to the Gauteng Local Division of the High Court in order to seek Constitutional relief relating to the application and provisions of section 18 of Act 51 of 1977 is not opposed.

Therefore, this Office has no view about your application.

Yours sincerely

M. CLINCKE
DIRECTOR OF PUBLIC PROSECUTIONS
GAUTENG LOCAL DIVISION, JOHANNESBURG

IN THE HIGH COURT OF SOUTH AFRICA

GAUTENG LOCAL DIVISION, JOHANNESBURG

Case No.: 29573/2016

In the application of *amicus curiae* to adduce evidence:

TEDDY BEAR CLINIC **Applicant**

In re: the matter between:

NICOLE LEVENSTEIN **First Applicant**
(ID NO. 6902130169080)

PAUL DIAMOND **Second Applicant**
(ID NO. 7110125007088)

GEORGE ROSENBERG **Third Applicant**
(ID NO. 7110305033086)

KATHERINE ROSENBERG **Fourth Applicant**
(ID 7411010057083)

DANIELA McNALLY **Fifth Applicant**

LISA WEGNER **Sixth Applicant**
(ID NO. 6411260037083)

SHANE ROTHQUEL **Seventh Applicant**
(ID NO. 7705015037085)

MARINDA SMITH — **Eighth Applicant**

And

SIDNEY LEWIS FRANKEL
(ID NO. 4810085014080) — **First Respondent**

MINISTER OF JUSTICE AND CORRECTIONAL SERVICES — **Second Respondent**

DIRECTOR OF PUBLIC PROSECUTIONS, GAUTENG — **Third Respondent**

NOTICE OF SET DOWN

KINDLY TAKE NOTICE that the applicants hereby set down the matter for argument on the unopposed motion roll for 1 February 2017.

Dated at **JOHANNESBURG** on the 24th day of November 2016.

CENTRE FOR APPLIED LEGAL STUDIES
Attorneys for the Applicant (in the application to be admitted as amicus curiae)

1st floor, DJ du Plessis Building
West Campus, University of the Witwatersrand
1 Jan Smuts Avenue
Johannesburg
Tel: 011 717 8600
Fax: 011 717 1702
Email: Sheena.Swemmer@wits.ac.za

TO: THE REGISTRAR OF THE ABOVE HONOURABLE COURT

RECEIVED
06 DEC 2016
IAN LEVITT ATTORNEYS

AND TO: IAN LEVITT ATTORNEY
Attorney for the applicants
19th Floor, Office Towers
Sandton City Office Towers
Cnr Rivonia & 5th Street
Ref:

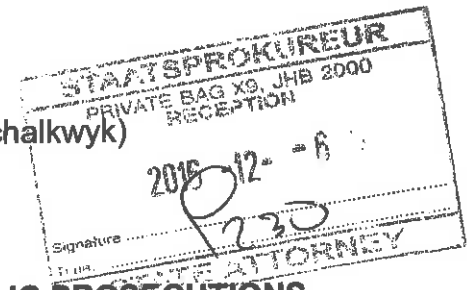
IAN LEVITT ATTORNEYS
TIME: 11:32
SIGNATURE: A.P Macaulay

AND TO: BILLY GUNDELFINGER
Attorney for the First Respondent
91 Iris Road
Norwood, Sandton
Tel: 011 728 7571
Ref: Billy Gundelfinger/ew

BILLY GUNDELFINGER
RECEIVED WITHOUT PREJUDICE
12:00
06/12/16

AND TO: THE MINISTER IF JUSTICE AND CORRECTIONAL SERVICES
Office of the State Attorney
North State Building
Cnr Albertina Sisulu & Kruis Street
Johannesburg

Ref: 5355/16/P45 (Van Schalkwyk)



AND TO: THE DIRECTOR OF PUBLIC PROSECUTIONS

South Gauteng

Cnr Von Brandis and Pritchard Street

Johannesburg

Ref: 10/2/5/7 2016/205