HEALTHCARE FOR PRISONERS

1. In this talk I will focus upon the following areas: (i) international standards on prison healthcare; (ii) the transfer of responsibility for prison healthcare to the NHS in the UK; and (iii) particular issues that have arisen in connection with prison healthcare in domestic and ECHR case law.

INTERNATIONAL STANDARDS ON PRISON HEALTHCARE

2. Sullivan J observed in *R (Bernard) v London Borough of Enfield*\(^1\) that:
   "a prisoner is in a uniquely vulnerable position: detained against his will, he is literally at the mercy of the prison authorities".

3. International standard setting bodies have sought to address this vulnerability. They have emphasised that:
   (i) prisoners' rights cannot be removed as a result of imprisonment and indeed that there is a particular need to protect those rights in view of the vulnerability of prisoners;
   (ii) prisoners are entitled to equivalence of healthcare, i.e. the same standard of care as that available to the non-prison population, save where this is unavoidable in detention;
   (iii) healthcare is distinct from the punitive purpose of detention and the health and welfare of the prisoner should be the central purpose of the care provided.

4. Article 3 ECHR\(^2\) prohibits inhuman and degrading treatment. In *Kudla v Poland*\(^3\) the ECtHR\(^4\) held that the conditions of a prisoner's detention must not:
   "subject him to distress or hardship of an intensity exceeding the unavoidable level of suffering inherent in detention and that, given the practical demands of imprisonment his health and well being are adequately secured by, among other things, providing him with the requisite medical attention"

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\(^1\) [2003] UKHRR 148 (paragraph 29)
\(^2\) European Convention on Human Rights
\(^3\) Application 30210/96; (2002) 35 EHRR
\(^4\) European Court of Human Rights
5. Article 10 ICCPR\(^5\) provides specific protection for prisoners against inhuman treatment. General Comment 21 provides:

“3. Article 10, paragraph 1, imposes on States parties a positive obligation towards persons who are particularly vulnerable because of their status as persons deprived of liberty, and complements for them the ban on torture or other cruel, inhuman or degrading treatment or punishment contained in Article 7 of the Covenant. Thus, not only may persons deprived of their liberty not be subject to treatment that is contrary to article 7, including medical or scientific experimentation, but neither may they be subjected to any hardship or constraint other than that resulting from the deprivation of liberty; respect for the dignity of such persons must be guaranteed under the same conditions as for that of free persons. Persons deprived of their liberty enjoy all the rights set forth in the Covenant, subject to the restrictions that are unavoidable in a closed environment. Treating all persons deprived of their liberty with humanity and with respect for their dignity is a fundamental and universally applicable rule. Consequently, the application of this rule, as a minimum, cannot be dependent on the material resources available in the State party. This rule must be applied without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status...”

6. The new European Prison Rules 2006 set out detailed provision in respect of the health and welfare of prisoners at Part III. The following rules are of particular relevance:

"Organisation of prison health care
40.1 Medical services in prison shall be organised in close relation with the general health administration of the community or nation.
40.2 Health policy in prisons shall be integrated into, and compatible with, national health policy.
40.3 Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation.
40.4 Medical services in prison shall seek to detect and treat physical or mental illnesses or defects from which prisoners may suffer.
40.5 All necessary medical, surgical and psychiatric services including those available in the community shall be provided to the prisoner for that purpose[...]

Duties of the medical practitioner
42.3 When examining a prisoner the medical practitioner or a qualified nurse reporting to such a medical practitioner shall pay particular attention to:
 a. observing the normal rules of medical confidentiality;
 b. diagnosing physical or mental illness and taking all measures

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\(^5\) Civil and Political Rights Covenant

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necessary for its treatment and for the continuation of existing medical treatment;
c. recording and reporting to the relevant authorities any sign or indication that prisoners may have been treated violently;
d. dealing with withdrawal symptoms resulting from use of drugs, medication or alcohol;
e. identifying any psychological or other stress brought on by the fact of deprivation of liberty;
f. isolating prisoners suspected of infectious or contagious conditions for the period of infection and providing them with proper treatment;
g. ensuring that prisoners carrying the HIV virus are not isolated for that reason alone;
h. noting physical or mental defects that might impede resettlement after release;
i. determining the fitness of each prisoner to work and to exercise; and
j. making arrangements with community agencies for the continuation of any necessary medical and psychiatric treatment after release, if prisoners give their consent to such arrangements[...]

47.2 The prison medical service shall provide for the psychiatric treatment of all prisoners who are in need of such treatment and pay special attention to suicide prevention."

7. The UN General Assembly adopted a set of Principles of Medical Ethics Relevant to the Role of Health Personnel in 1982. Further, the 3rd report of the European Committee on Prevention of Torture offered observations on good practice in relation to healthcare in prisons. Both stressed the prisoner's rights to equivalence of care with that provided to the non-prison population and that the sole role of healthcare personnel is to provide evaluation and treatment of prisoners, not to have a role in the punitive aspect of the regime.

FROM PRISONER TO PATIENT: TRANSFER OF PRISON HEALTHCARE TO THE NHS

Background

8. Rules 20-22 of the Prison Rules 1999 make provision for prisoners to receive medical attention whilst serving their sentences or on remand. Historically this care was the responsibility of the Home Office and was provided by the Prison Medical Service. The transfer of responsibility for prison healthcare to
the NHS has long been argued for, due to disquiet about the quality of care being provided to prisoners. The prison population presented particular problems in healthcare because of the challenge of caring for a large population with a particularly high incidence of mental illness, drug addiction, HIV/AIDS and risk of self-harm. For medical professionals in the prison service there was a tension between their welfare and discipline roles. Further, because prison healthcare professionals were not part of the mainstream NHS there were problems with 'skills decay', inadequate training and loss of morale.

9. On 1 April 2003, funding responsibility for health services in publicly run prisons in England was transferred from the Home Office to the Department of Health. By April 2006, responsibility for commissioning prison health services in England will be fully devolved to NHS primary care trusts (PCTs). This has been a staged process and commissioning responsibility transferred in most public prison-PCT partnerships in April 2005. By 2006 PCTs will commission all services for publicly run prisons, and may provide some themselves. Once that is achieved the Governing Governor of a prison will relinquish overall responsibility for healthcare in prisons, but will still be expected to work in partnership with the local NHS.

Achieving equivalence of care

10. Prison Service Order 3200 on Health Promotion also came into force on 23rd October 2003 as a result of the formal partnership between HM Prison Service and the NHS. It emphasises:

(i) The need for prisoners to have access to health services that are broadly equivalent to those the general public receives from the NHS;
(ii) The 'whole prison approach'. Health promotion requires the involvement of workers across the prison, not merely health professionals;
(iii) The need to prevent deterioration of prisoner's health during or because of custody;
(iv) The need to help prisoners adopt healthy behaviours that can be taken back into the community;
(v) The need to address five specific areas: Mental health and well being; smoking cessation; healthy eating and nutrition; healthy

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lifestyles including sex and relationships and active living; drug and other substance misuse.

11. The Prison Service Standard on Health Services issued in 2004 sets out an auditable standard "to provide prisoners with access to the same range and quality of services as the general public receives from the National Health Service". Specific provision is made for the following:

   (i) All newly received prisoners must have their healthcare needs assessed within 24 hours of arrival by an appropriately trained member of the healthcare team to identify any existing problems, including physical or mental health problems, drug or alcohol abuse, risk of suicide and self-harm and to plan future care;
   
   (ii) Where a prisoner does not have immediate healthcare needs, they must still be offered a general health assessment within a week following reception.
   
   (iii) Continuity of care: A discrete medical record should be created and efforts made to merge it with previous periods in custody. So long as the prisoner consents, staff should request any information required from the prisoner's GP or other relevant service, and upon release, information must be passed to the prisoner's GP.
   
   (iv) Admissions to the hospital wing of prisons are to be made at the sole discretion of the clinical head of healthcare and based on a recorded clinical need. Conditions in prison hospitals should allow for access to normal activities and sufficient time to be spent out of the room.

12. In addition there have been various Prison Service Instructions as part of the strategy, e.g.:

   (i) PSI 07/2002 sets out the details of the National Framework for Diabetes, which aims to "support prison healthcare staff in delivering a service to people with Diabetes in prison broadly equivalent to that delivered by the NHS;"
   
   (ii) PSI 05/2003 gives guidance to doctors about the particular difficulties inherent in prison medicine;
   
   (iv) PSI 29/2003 and PSI 38/2003 issued guidelines for clinical appraisals and basic checks of doctors working in prisons;
   
   (iii) PSI 48/2003 introduced Health Care Assistants at nursing grades A and B to the Prison Service to improve the skills base of healthcare teams and enable prisons to reflect NHS structures and compete for staff;
(iv) PSI 46/2005 introduced new procedures to minimise the risk of self-harm occurring as a reaction to undergoing certain drugs treatment.

13. The Prison (Amendment) (No. 2) Rules 2005\(^8\) modernised responsibilities which historically could only be undertaken in prison by a medical officer - that term itself is described in the Rules as outdated and the intention stated to replace it in primary legislation with the word 'doctor'. The medical officer's tasks may now be delegated to a doctor, nurse or other healthcare professional as appropriate. The changes are designed to make best use of health care resources - e.g. where a registered mental nurse is better able to assess whether punishment by cellular confinement is suitable. This will be assessed by way of a Segregation Safety Algorithm, and all inmates on segregation will have their health checked by a doctor or nurse every day.

**Inadequate care**

14. The transfer raises issues as to who the correct Defendant may be in cases where prison healthcare is alleged to be inadequate. It may be that where policy decisions are made in relation to the prison's healthcare services that are inconsistent with the care provided in the community at large, the correct Defendant to an application for judicial review will be the PCT. Where, however, there is a more straightforward allegation of clinical negligence it seems likely that the correct Defendant will be dictated by whoever is the employer of the individual alleged to be negligent.

15. In *Knight v Home Office*\(^9\), it was suggested that the standard of psychiatric care in prisons could not be expected to meet the standard of hospitals outside on grounds of resources. This is inconsistent with the current position on equivalence of care. In any event, in *Brooks v Home Office*\(^10\) it was held that women in prison are entitled to the same standard of obstetric care as those

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\(^8\) 2005 No 3437
\(^9\) [1990] 3 All ER
\(^10\) [1999] FLR 33
outside. Prisoners may also be able to invoke the ECHR to demonstrate that the standard of prison healthcare is inadequate: in *Keenan v UK* 11 the ECtHR held that there had been a violation of article 3 where a prisoner committed suicide whilst being held on the segregation unit. The lack of medical care was criticised, including the inadequacy of the records and failure to refer to a psychiatrist. Further, in *McGlinchy v UK* 12 the court found that there had been a failure to provide appropriate medical treatment amounting to a breach of Article 3 for a prisoner who died when suffering from heroin withdrawal. She suffered serious weight loss, was dehydrated as a result of uncontrolled vomiting symptoms and an inability to eat or hold down fluids, and collapsed. The Court noted the failure of the prison to provide accurate means of establishing her weight loss, which was a factor which should have alerted it to the seriousness of her condition. It also criticised the fact that there was a gap in the monitoring of her condition at crucial moments and the failure of the prison to take more effective steps to treat her condition, such as admission to hospital to ensure the intake of medication and fluids intravenously or to obtain more expert assistance in controlling the vomiting.

**Current status of the transfer**

16. A House of Lords debate on the issue of what progress has been made since the intention to transfer prison healthcare to the NHS was announced took place on 10th November 2005. It seems from this that the problems that have always existed in relation to the health of the prison population continue to cause grave concern. Some of the participants had recently visited prisons where the transfer had already taken place. These are some of the points made in the debate:

(i) The condition of some healthcare inpatients living in very small rooms was described as still being 'horrible and totally inappropriate';

(iii) There remains the problem, especially with category C prisons that *the revolving prison gate feeds further public health problems back into localised community* as prisoners go

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11 (2001) 33 EHRR 38
12 29th April 2003
through the cycle of 'prison, treatment, release, relapse into crime and drugs use and back to into prison'

(iv) The funding streams for various resources in prison are not clear. There was a query as to whether PCT's would be responsible only for commissioning care or providing it themselves;

(v) There was a demand for the needle share scheme to be introduced;

(vi) A career structure with requirements for training such as a Diploma in Prison Medicine needed to be introduced into prison service medical teams;

(vii) Nutrition needs should be addressed on the basis of recent studies about the effect of nutrition on behaviour. Reference was made to the success of the Jamie Oliver project for schools;

(viii) The needs of particular groups such as diabetics should be addressed - in particular their dietary needs and need to self-medicate. Early diagnosis was particularly important

(ix) The real need for a primary care IT system appropriate for use in all prisons, in particular to be used at reception. In the absence of this attempts to provide continuity and equivalence of care would be severely hampered.

17. The minister's reply acknowledged that there was a long way to go, but that progress had been made. In particular funding for an integrated IT system has been identified and plans were under way.

PARTICULAR ISSUES ARISING IN PRISON HEALTHCARE CASE LAW

Women and children

18. Respect for family life under Article 8 involves a positive obligation to reunite parents with their children. The ECtHR has repeatedly said that the mutual enjoyment by parent and child of each other's company constitutes a fundamental element of family life, and domestic measures hindering such enjoyment amount to an interference with the right protected by article 8.
19. The issue of when mothers may be separated from their offspring was considered at length in \( R(P \& Q) \) \( V \) Home Secretary\(^{13} \), regarding the legality of a policy that children should cease to reside with their mothers in prison once they are 18 months old. The Court of Appeal noted that compulsory separation was, on the face of it, a serious interference by the state with children’s right to respect for that family life. It noted that the previous cases had all involved care proceedings, in which the possible justification for keeping the children away from their parents had to be found either in the "protection of health or morals" or in the "protection of the rights and freedoms of others", and the ECtHR had consistently held that protection of the interests of children fell within these aims.

20. Article 8(2) recognised that there may be justifications for interference other than the protection of the child. The initial imprisonment of the mother had to be justified under article 5 if it were to be lawful at all. But the consequent interference with her and her family's family life may be justified under article 8(2) in the interests of public safety or for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others. The interference, however, had to be necessary.

21. The court held that the policy, which admitted of no exceptions, should have admitted of greater flexibility for two reasons. Firstly, the policy’s own declared aim was to promote the welfare of the child and if the effect of the policy on a child’s welfare was catastrophic, it was not fulfilling this objective. Secondly, the interference with the particular child’s family life had to be justified under Article 8(2). Three considerations were relevant:

"First, there are the necessary limitations on the mother's rights and freedoms brought about by her imprisonment. She cannot expect to be provided with a child care facility for the whole of her sentence. The service is entitled to expect that she will accept their offer of a place at an MBU knowing what those limitations are. She must accept that her primary parental responsibility is to make the best possible arrangements for the care of her child throughout her sentence. This means that, if her sentence will last longer than the age for which the

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\(^{13}\)[2001] 1 WLR 2002
facilities are suitable, she should be expected to make sensible plans for their separation or to co-operate with the plans made by others. Indeed it is sensible to offer places at the outset for a target length of time, to expect the mother to have some exit strategy (even if it is local authority accommodation), and to review this strategy regularly during the placement.

The second is the extent to which any relaxation in the policy would cause problems within the prison or the Prison Service generally. In particular, how would it affect good order and discipline within the prison itself? Would this be perceived as favouritism, not only by other mothers but also by other prisoners? This will depend to some extent upon the particular arrangements within the particular prison. But there may be wider implications, if the demand for places continues to rise and has to be denied because some children are staying longer. The length of the mother's sentence must be an important consideration here.

The third is the welfare of the individual child. Here there are three main factors to be considered. The first is the extent of the harm likely to be caused by separation from the mother. This will depend upon the quality of the relationship between them, the arrangements made for the transition and the arrangements made for contact after the separation. The second is the extent of the harm likely to be caused by remaining in the prison environment. This will depend upon the nature of that environment, the facilities there and the facilities which could be provided by local social services to make good the deficiencies in the prison environment. The third is the quality of the alternative arrangements. A good local foster placement is quite different from a placement of dubious quality a long way away."

22. The Court considered that in the great majority of cases almost all of these considerations would point to separating mother and child at or before the age of 18 months: “After that age the harm to the mother’s family life could not normally outweigh the harm to the welfare of the child or to the good order of the prison”. However, the policy had to have room for individual discretion since “there may be very rare exceptions where the interests of mother and child coincide and outweigh any other considerations.”

23. In this particular case, P had a long sentence left to serve and in the circumstances it was difficult to conclude that the harm done to her child by separation was sufficient to outweigh all other considerations. However, in the case of Q, who was serving a shorter sentence, the potential harm to her child
combined with the current lack of any acceptable plan for the child's future, the very different regime in an open prison and the possibility that the demands of the prison regime would not be such as to outweigh the clear harm to the child.

24. See also Brooks above - a female prisoner is entitled to the same standard of obstetric care as that available outside prison.

Disabled prisoners
25. In Price v UK\textsuperscript{14}, the failure of the police to do anything to alleviate the suffering of a severely disabled prisoner detained overnight in a cell where she was unable to sleep properly or reach the bell to call for assistance with the toilet, and where her requests for blankets went unanswered, contributed to a finding of breach of Article 3 even though she was only detained for a short period.

26. Part 3 of the Disability Discrimination Act 1995 places a duty upon the prison service not to discriminate against the disabled in the provision of goods, facilities and services. Prisons are required to assess the disability needs of disabled prisoners. The Act requires reasonable adjustments to be made to their policies and practices to cater for the disabled. PSO 2855 provides guidance on the duties of the prison service in relation to the disabled. Aids such as appropriate wheelchairs, crutches and specialised footwear in good working condition must be provided in order that disabled prisoners have full access to facilities.\textsuperscript{15}

Detention of the elderly and ill
27. The Strasbourg authorities have held that detention which could cause extreme suffering, for example, the detention on remand of an elderly and ill individual, could amount to a violation of Article 3. In B v Germany \textsuperscript{16} the

\textsuperscript{14} App 33394/96 (2002) 34 EHRR 53
\textsuperscript{15} See Mr W and others (2004) Prison Report, by Sean Humber
\textsuperscript{16} App 13047/87 55 DR 271
applicant, who had spent 5 years of his life in a Nazi concentration camp, claimed that he was not able to endure any deprivation of liberty as it forced him to relive psychologically the years of incarceration during the war. The European Commission on Human Rights stated that:

“The detention today of a person such as the applicant...might well raise serious issues under Article 3 of the Convention, if, as a direct consequence of his detention, he is allegedly forced to relive and suffer again the terrible experiences of the years 1940-45”

However, it found that the applicant had not substantiated his allegations.

28. In Farbtuhs v Latvia (2004)\(^\text{17}\) The applicant ('F') complained of a violation of Art.3 European Convention on Human Rights arising from his prolonged imprisonment. F was found guilty of crimes against humanity and genocide. He was sentenced to five year's imprisonment. A medical report, ordered by the criminal division of the Supreme Court, stated that F was severely disabled and required constant care and regular treatment. Following examination by a panel of experts, it was suggested that F should be released on the basis that he was suffering from many incurable diseases. Subsequently the prison governor made a formal application for his release, which was unsuccessful. After contracting two further illnesses whilst in prison, F was excused from serving the remainder of his sentence.

29. The European Court of Human Rights held by a majority that there had been a violation of Art.3 of the Convention. Having regard to the circumstances of the case, the Court found that, in view of his age, infirmity and condition, F's continued detention was not appropriate. The situation in which he had been put was bound to cause him permanent anxiety and a sense of inferiority and humiliation so acute as to amount to degrading treatment within the meaning of Art.3 of the Convention. By delaying his release from prison for more than a year in spite of the fact that the prison governor had made a formal application for his release supported by medical evidence, the Latvian authorities had failed to treat F in a manner that was consistent with the

\(\)\(^\text{17}\) Application No.: 0004672/02
provisions of Art.3. F was awarded 5,000 euros for non-pecuniary damage and 1,000 euros for costs and expenses.

30. Accordingly, where a prisoner’s state of health is very poor and/or treatment cannot be provided in hospital, compliance with Article 3 may require the prisoner to be released (see also Chartier v Italy\(^{18}\)). However, where sufficient medical care is provided and account is taken of his physical and mental condition, a decision not to release would be unlikely to violate Article 3. In Grice v UK\(^{19}\), the detention of an individual suffering from AIDS was held on the facts not to constitute a violation of Article 3. Material to that decision was the fact that the applicant had since been released, his health had improved and he did not appear to have suffered adversely as a result of detention. In particular, he had been subjected to continuous monitoring whilst detained and there was no evidence that his life expectancy had been reduced as a result of detention.

31. Paragraph 70 of the CPT’s 3\(^{rd}\) General Report gives the following examples of prisoners who should not be detained: those who are the subject of a short-term fatal prognosis, those who are suffering from a serious disease which cannot be properly treated in prison conditions, who are severely handicapped or of an advanced age. It warns that “the continued detention of such persons in a prison environment can create an intolerable situation” and that in cases of this type, it lies with the prison doctor to draw up a report for the responsible authority, with a view to suitable alternative arrangements being made.

**Hunger strikes, force feeding, consent and advance directives**

32. According to ECHR jurisprudence, where a prison refuses medical assistance to hunger strike participants, the authorities cannot be held responsible for his consequent suffering. Thus, in the case of hunger strikes in Poland, the Commission held that in restricting access to medical help, the prison

\(^{18}\) App 9044/80 33 DR 41
\(^{19}\) App 22564/93 77A DR 90
authorities had not adopted an inflexible approach aimed at punishing the prisoners and that the prisoners were largely responsible for their own suffering R, S, A and Claimant v Portugal\(^{20}\).

33. In \(X v\) Germany\(^{21}\), the applicant complained that he was subjected to inhuman and degrading treatment in that he was forcibly fed. The Commission held that the force feeding of a person does involve degrading elements which in certain circumstances may be regarded as prohibited by Article 3. However, the State also had obligations under Article 2. The Commission observed:

“\(\text{When...a detained person maintains a hunger strike this may inevitably lead to a conflict between an individual’s right to physical integrity and the High Contracting Party’s obligations under Article 2 of the Convention – a conflict which is not solved by the Convention itself. The Commission recalls that under German law this conflict has been solved in that it is possible to force-feed a detained person if this person, due to a hunger strike, would be subject to injuries of a permanent character, and the forced feeding is even obligatory if an obvious danger for the individual’s life exists. The assessment...is left for the doctor in charge but an eventual decision to force-feed may only be carried out after judicial permission has been obtained.}\)

The Commission is satisfied that the authorities acted solely in the best interests of the applicant when choosing between either respect for the applicant’s will not to accept nourishment of any kind and thereby incur the risk that he might be subject to lasting injuries or even die, or to take action with a view to securing his survival although such action might infringe the applicant’s human dignity. Furthermore, having regard in particular to the relatively short period during which the treatment was carried out, the Commission finds that the circumstances of the present case do not reveal that this measure, taken with a view to securing his health or even saving his life, subjected to applicant to more constraint than necessary to achieve that goal.”

Accordingly, there was no violation of Article 3.

34. The domestic case law has not followed this approach. In \(R v SSHD ex p Robb\) [1995] 1 All ER 67, Thorpe J held that self-determination was paramount and that force-feeding was not lawful:

\(^{20}\) App 9911/82 36 DR 200
\(^{21}\) (1985) 7 EHRR 152
“an adult of sound mind was entitled to refuse all nutrition even if suicide was the intention and the result. A prisoner has the same rights as any other citizen in this respect. It does not matter whether the prisoner’s reasons for wanting to die are rational or irrational. Self-determination means that individuals decide their own fate.”

There was no reference to *X v Germany* in this case.

35. In *Airedale NHS Trust v Bland*\(^22\), Lord Keith of Kinkel stated that:

“... the principle of the sanctity of life ... is not an absolute one ... It does not authorise forcible feeding of prisoners on hunger strike.’

36. When determining whether an adult can give consent, the test for capacity is as formulated in *Re MB*\(^23\) (at p 437D):

“A person lacks capacity if some impairment or disturbance of mental functioning renders the person unable to make a decision whether to consent to or refuse treatment. That inability to make a decision will occur when:

(a) the patient is unable to comprehend and retain the information material to the decision, especially as to the likely consequences of having or not having the treatment in question

(b) the patient is unable to use the information and weight it in the balance as part of the process of arriving at the decision.”

37. Those with mental disorder may retain capacity notwithstanding that disorder (c.f s.63, s.57 and s.58 Mental Health Act 1983). Indeed, even where a mental illness impacts upon one’s ability to make a decision to some extent, a person may still be found sufficiently capable in law. In *Re C*\(^24\), Thorpe J found that “plainly C’s capacity is reduced by his mental illness”. However he identified the question under consideration as whether “C’s capacity is so reduced by his chronic illness that he does not sufficiently understand the nature, purpose and effects of the proffered treatment”. Mr C, a chronic schizophrenic who expressed the delusion of an international career in medicine during the course of which he had never lost a patient was found sufficiently capable of refusing life saving treatment.

\(^{22}\) (1993) 12 BMLR 64 at 107, [1993] AC 789 at 859
\(^{23}\) [1997] 2 FLR 426
\(^{24}\) [1994] 1 All ER 819
38. As to advanced directives, a capable statement consenting to or refusing a treatment in advance of the proposed treatment is binding:

"Moreover the same principle applies where the patient's refusal to give his consent has been expressed at an earlier date before he became unconscious or otherwise incapable of communicating. Though in such circumstances especial care is necessary to ensure that then prior refusal of consent is still properly to be regarded as applicable in the circumstances which have subsequently occurred." (Airedale NHS Trust v Bland case at 864F)

39. In Re W (Adult : Refusal of treatment)25 the Claimant sought a declaration that he had mental capacity and as such had the right to choose whether or not to accept medical treatment. W was a Category A prisoner at a high-security prison serving a life sentence for murder and a concurrent sentence of eight years for aiding and abetting suicide. W suffered from a severe psychiatric disorder and after conviction was transferred to Broadmoor Hospital for assessment as to treatment in the hospital environment. In December 2001 he cut open his lower right leg and thereafter kept it open, forcing various foreign objects into it. All three psychiatrists who interviewed him were of the view that W was not suffering from a mental illness, mental impairment or severe mental impairment but was suffering from a psychopathic disorder that did not impair his mental capacity to weigh the information required to reach a decision about his state of health. He understood that, by refusing to accept treatment, the leg wound and possible ensuing septicaemia would lead to his death. The court held that a mentally-competent patient had an absolute right to refuse to consent to medical treatment for any reason, rational or irrational or for no reason at all, even where the decision could lead to his or her own death.

40. An example of a case where a prisoner was held not to have capacity was R v Collins ex p Brady26. The Claimant, a prisoner on hunger strike, applied for

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26 [2000] Lloyd’s Rep Med 355
judicial review of the decision of his RMO to force feed him pursuant to s63 of the MHA 1983. Maurice Jay J refused the application on the ground that s63 was a derogation from the rights of self-determination and bodily integrity, the courts would review decisions under s63 particularly closely. However, on the facts of the case, the Claimant’s decision to go on hunger strike was a feature or manifestation of his personality disorder, within the meaning of s63. He accepted that the same measure made by somebody of sound mind would have to be respected, but decided that in this case the claimant’s decision and his continued adherence to it resulted from his personality disorder.

41. The European Court has more recently held that force-feeding a hunger-striking prisoner, where there was no medical necessity, where procedural safeguards had not been respected and where force and restraints had been used, amounted to torture: *Nevmerzhitsky v Ukraine* 27.

**Suicide and Self-harm**

42. The case of *Keenan v UK* 28 confirmed that the obligation under Article 2 extends to a duty to take positive steps to prevent suicides by persons in custody. The ECtHR emphasised the vulnerable position of prisoners and the duty of the authorities to protect them. It held that where a detainee is a known suicide risk, the authorities must take particular care to ensure that his physical or moral resistance is not broken by disciplinary measures, and that he receives adequate medical attention: *Kudla v Poland* 29. It rejected the submission that taking steps to prevent suicide would violate the individual’s rights under Article 5 and 8, holding that “there are general measures and precautions that will be available to diminish the opportunities of self-harm, without infringing personal autonomy”.

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27 App 54825/00
28 (2001) 33 EHRR 38
29 (2002) 35 EHRR 198 para 99
43. The following guidance was given in Osman v United Kingdom\textsuperscript{30}:

“…where there is an allegation that the authorities have violated their positive obligation to protect the right to life….it must be established to its satisfaction that the authorities knew or ought to have known at the time of its existence of a real and immediate risk to the life of an identified individual or individuals…and that they failed to take measures within the scope of their powers which, judged reasonably, might have been expected to avoid that risk[…] It is sufficient for an applicant to show that the authorities did not do all that could be reasonably expected of them to avoid a real and immediate risk to life of which they have or ought to have knowledge. This is a question which can only be answered in the light of all the circumstances of any particular case”

44. Where the protection of the life of a recognised vulnerable person – such as a child or a mentally ill person, is involved, there is an increased standard of vigilance Herczegfalvy v Austria\textsuperscript{31}.

45. In R (F) v Chief Constable of Norfolk Police\textsuperscript{32} (concerning the right of an informant to be able to claim protective custody in prison), Crane J noted that in terms of the State complying with its positive obligation to protect life

“the situation in prison is not identical to that in the community: first, the requirement that the authorities knew or ought to have known of the risk will usually be satisfied much more readily in relation to a prisoner, particularly one who has assisted the authorities, than in relation to a member of the community in general. Secondly, the authorities are in a position to take measures to avoid any risk to an extent much greater than are the police in relation to a member of the community. Thirdly, the authorities are likely to be less inhibited by restraints imposed on the scope of their actions by the need to respect the human rights of others, since providing a protective regime is unlikely to affect the rights of others.”

\textit{Conjugal visits/Artificial insemination}

46. Article 12 does not guarantee a prisoner’s right to “found a family” in the sense of a right to procreate or cohabit. In X and Y v Switzerland\textsuperscript{33}, the Commission stated that:

\textsuperscript{30} (1998) 29 EHRR 245 at para 116
\textsuperscript{31} (1993) 15 EHRR 437
\textsuperscript{32} [2002] EWHC Admin 1738
\textsuperscript{33} (1978) 13 DR 241
“Although the right to found a family is an absolute right in the sense that no restrictions similar to those in paragraphs 2 of Article 8 of the Convention are expressly provided for, it does not mean that a person must at all times be given the actual possibility to procreate his descendents”

Further, it noted that:

"...it is generally considered to be justified for the prevention of disorder in prison not to allow sexual relations of married couples in prison. The Commission accepts that in fact the security and good order in prison would be seriously endangered if all married prisoners were allowed to keep up their conjugal life in the prison. In this case the respect for privacy would require that the prison authorities renounce their right of constant supervision ... The fact that the applicants were kept in the same prison cannot be seen as changing the general situation. Other prisoners would consider the position of the applicants as privileged if this fact were to give them additional rights. The arguments which are valid for prisoners in general do, therefore, apply to the applicants as well."

It accepted as legitimate justification the need to prevent disorder in prison which the Swiss prison authorities feared would result from allowing married prisoners to enjoy sexual relations. Their worries related not only to the inevitable lack of supervision this practice would bring, but also the impact upon other prisoners who would see these applicants as privileged.

47. In *R v SSHD ex p Mellor*[^34] the Court of Appeal considered whether the claimant was entitled in the absence of conjugal visits to facilities in order to have a child with his wife by artificial insemination. He gave evidence that, by the time he was released, his wife may be too old to have a child safely. Lord Philips MR drew the following principles from the Strasbourg authorities:

(i) The qualifications on the right to respect for family life that were recognised by Art.8(2) of the Convention applied equally to Art.12 of the Convention;
(ii) Imprisonment was incompatible with the exercise of conjugal rights and therefore interfered with the rights contained in Arts.8 and 12 of the Convention;
(iii) The restriction was ordinarily justifiable under Art.8(2) of the Convention;

[^34]: [2002] QB 13
(iv) In exceptional circumstances it might be necessary to relax the imposition of detention in order to avoid a disproportionate interference with a human right;

(v) There was no authority in favour of a prisoner's right to found a family by artificial insemination.

(vi) A purpose of imprisonment was to punish a criminal by depriving him of certain rights and pleasures that he could enjoy when at liberty. A prisoner could not procreate by way of artificial insemination without the positive assistance of the prison authorities and, in the absence of exceptional circumstances, it was not an infringement of Art.12 of the Convention to decline to provide that assistance. In order to succeed, M had to demonstrate that the right to found a family extended to the right to do so by artificial insemination when justifiably excluded from the enjoyment of family life and conjugal rights and M had failed to demonstrate this. The interference with human rights permitted by Art.8(2) involved an exercise of proportionality and exceptional circumstances might require the normal consequences of imprisonment to yield where the effect was disproportionate.

48. He concluded:

“It is not obvious that the signatories to the Convention would have agreed that a man who had, by imprisonment, been justifiably deprived of the enjoyment of family life and the existence of conjugal rights, should be entitled to inseminate his wife artificially in order to produce a child in whose development and support he could play no part.”

However, he did consider that, while a refusal to allow artificial insemination will not generally be a disproportionate interference with a prisoner’s right to found a family under Article 12 ECHR, it may be disproportionate where the refusal does not merely delay, but actually prevents the founding of a family.

49. This seems to be a highly moralistic approach and the taking into account of the creation of a single parent family has been criticised by commentators as particularly regressive.

HIV/AIDS

50. In R v Home Secretary, ex p Fielding35 a challenge was made to the policy that prison doctors have authority to prescribe condoms if in their clinical

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35 (1999) Times 21 July

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judgement there was a risk of HIV infection. It was contended that condoms should be issued upon request. The court held that the prison service was entitled not to wish to be seen to encourage homosexual activity in prison. Further, that it was not unreasonable for this control to be exercised as the condoms could be used for other purposes and the issue was one of health so it was not irrational for the decision to rest with the medical officer.

51. This is another example of the way in which the activities of prisoners are controlled and scrutinised in a way that would never be tolerated outside prison. It seems that such control cannot be justified on the grounds of the health of the prison population and it is directly opposed to the policy of the NHS in non-prison populations.

Needle sharing

52. In R (Shelley) v Secretary of State for the Home Department\textsuperscript{36} the Claimant appealed against the refusal of permission to apply for judicial review in respect of the Prison Service policy of providing disinfecting tablets instead of a needle exchange for drug users in prison. The latter system has considerable support and has been adopted in Scotland. It was said that the failure to provide this facility amounted to a failure to take reasonable steps to prevent a real and immediate risk to life and amounted to a violation of Article 2 ECHR. Further, it was alleged that there was a breach of Article 3 in the failure of the prison service to follow its own standard of equivalence of care, bearing in mind that needle exchanges were the prevalent system in the community. This was said to amount to ill-treatment.

53. The evidence served on behalf of the Defendant argued that was not always possible to replicate exactly the health care provided in the community and that the disinfecting system was adequate. This was accepted by the court. Lady Justice Hallet had 'very real doubts' that Article 2 was engaged, but stated that if it was there was no breach of this or any other ECHR article. The

\textsuperscript{36} [2005] EWCA Civ 1810
court was satisfied that the Home Office had a sensible policy of assessing needle exchange programmes. There was evidence that they were not necessarily preferable to the disinfecting system. Accordingly, there were two schools of thought on the issue and it was not arguable that a needle exchange programme was mandatory. Importantly, however, the judgement of the made it clear that:

"the issue with which this application is concerned is fluid and that the issue will need to be kept, and indeed will be kept, under constant review. Further consideration of the appropriate way of dealing with these problems will no doubt continue. If it did not, I need say no more than this: the decision not to do so must itself be subject to criticism by way of judicial review"

54. These remarks suggest that it will be important for PCTs to look at the results of healthcare initiatives in the non-prison population and consider whether there is a need to introduce the system into prison populations, even if the position in the past has been that such initiatives are not appropriate in detention.

*Interference with medical correspondence*

55. In *R (Szuluk) v (1) Governor of Full Sutton Prison (2) Secretary of State for the Home Department*[^37], the appellants appealed against a decision that restrictions placed on the correspondence of the respondent (S) with his NHS consultant were unlawful. S was a Category B prisoner in a high security prison. He suffered from a life-threatening condition. The governor initially granted his request to correspond in confidence with his consultant neuroradiologist. Under Prison Service Order 1000 Ch.36.21 that correspondence had to be read as a matter of routine. The governor's decision was overruled by headquarters and S's medical correspondence was opened and checked for authenticity by the prison medical officer.

[^37]: [2004] EWCA Civ 1426; Independent, November 4, 2004
56. The court held that it was possible that Article 8 would make it disproportionate to refuse to waive, in relation to medical correspondence, the requirement in the that correspondence had to be read as a matter of routine. However, in the instant case, the reading of the respondent prisoner's correspondence was a proportionate interference with his Art.8 rights.

Monitoring of telephone calls on health grounds

57. In *R(on the application of Taylor) v Governor of HM Prison Risley*\(^ {38}\) the need to control a drugs problem meant that the operation of a blanket policy of restricting all prisoners' telephone calls by a system of call-enabling was a justified interference with a prisoner's rights under Article 8.

Nutrition

58. In *R v Governor of HM Prison Frankland, ex parte (1) Andrew Russell (2) Perry Wharrie*\(^ {39}\) (2000) two prisoners applied for judicial review of a decision of the Governor of HM Prison Frankland in respect of a policy concerning the provision of food to prisoners placed in the segregation unit of the prison who refused to wear prison clothes. The prisoners would leave their cells three times a day to collect food from the servery and take it back to their cells to eat it. The governor made a rule that prisoners who refused to wear prison clothes would not be allowed to collect their meals from the servery. With the necessary authority, the segregation of a prisoner in the unit could be extended over many months or for an indefinite period. Those prisoners not wearing the prison clothes were only brought one meal a day in their cells.

59. The court held that a Governor of a prison could lay down policies for the treatment and feeding of prisoners unwilling to wear prison clothes, but the policy had to be flexible and calculated to ensure in the case of each individual prisoner that he received adequate nourishment, and safeguards must be

\(^{38}\) (2004) QBD (Admin) 29/10/2004

provided to protect the prisoner's health. In the instant case the policy contained no provision for monitoring and safeguarding the health of the prisoner, and the imposition of the condition could be prolonged for an indefinite period. Therefore, the policy was unlawful and may well have been in breach of the fundamental rights protected by Art.3.

**Cumulative conditions in prison including healthcare alleged to amount to breach of Article 3**

60. In *Romanov v Russia*\(^{40}\) the ECtHR held in relation to the conditions of the Applicant's detention, including medical treatment, heating, artificial lighting and ventilation, that neither party had submitted evidence which could satisfy the Court "beyond reasonable doubt" as to whether they were acceptable from the point of view of Article 3. However, the Court took into account the fact that R had been allowed to take a shower once a week and that he became infected with scabies. Accordingly, R's conditions of detention, in particular the severe overcrowding and its detrimental effect on R, combined with the length of the period during which R was detained in such conditions, amounted to degrading treatment and there had been a violation of Article 3 of the Convention.

61. In *Becciev and Sarban v Moldova*\(^{41}\) the ECtHR had regard to the harsh conditions in the cell, the lack of outdoor exercise, the inadequate provision of food and the fact that B was detained in those conditions for thirty-seven days and held that the hardship B had endured went beyond the unavoidable level inherent in detention and reached the threshold of severity contrary to Article 3 of the Convention. As regards S, the failure to provide him with basic medical assistance when he clearly needed and had requested it, as well as the refusal to allow independent specialised medical assistance, together with other forms of humiliation, amounted to degrading treatment within the meaning of Article 3.

\(^{40}\) (2005) Application No.: 00063993/00

\(^{41}\) (2005) Application No.: 0009190/03 : 0003456/05
62. In Mathew v Netherlands\textsuperscript{42} M alleged that he had been physically abused by prison staff, placed in solitary confinement in abject conditions, and denied medical treatment. The ECtHR held that there had been no violation of Art.3 as regards the use of physical force against M, and the injuries allegedly resulting from the use of fetters. The force used against M in preventing or terminating violent episodes was not beyond what was strictly necessary in the circumstances. There had also been no violation of Art.3 concerning a denial of necessary medical care. In the circumstances, the absence of a second medical opinion regarding the need for surgery had not been the fault of the authorities. As regards a request for a wheelchair, the domestic authorities were entitled to consider it necessary, in the conditions existing at that time, to deny M the continued use of it. In relation to a request for physiotherapy, M was able to attend hospital as an outpatient for physiotherapy. Further M had been able to, despite going without treatment for nine months, walk a distance of at least 90 meters and carry out complex physical actions such as twisting his body and walking stairs. There had been no violation of Article 3 concerning M's complaint that he had been detained in unsanitary conditions.

63. However, there had been a violation of Art.3 in that M had been kept in solitary confinement for an excessive and unnecessarily protracted period, he was kept for at least seven months in a cell that failed to offer adequate protection against the weather and the climate, and he was kept in a location from which he could only gain access to outdoor exercise and fresh air at the expense of unnecessary and avoidable physical suffering. M was subjected to distress and hardship of an intensity considerably exceeding the unavoidable level of suffering inherent in detention and amounting to "inhuman treatment" under Article 3. He was awarded 10,000 euros for non-pecuniary damage and 3,000 euros for costs and expenses.

SHAHEEN RAHMAN
March 2006

\textsuperscript{42}(2005)Application No.: 00024919/03