

# **Guidance on Physical Healthcare in a Prison Context**

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# Guidance on Physical Healthcare in a Prison Context

Presented to the Minister for Justice and Equality pursuant to Part 5 of the Prisons Act 2007.

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## Acknowledgement

The guidance that I give in this Report to the Irish Prison Service and prison management on the provision of physical healthcare in Irish Prisons is based on wide ranging research.

I am indebted to Ms. Aoife Watters (Researcher) for her diligence and patience in researching “best practice” on the physical healthcare that should be available to prisoners in our prisons. This was a time consuming exercise which she carried out in addition to her other duties such as inspecting prisons and researching other aspects of penal policy. Ms. Watters also assisted me in the writing of this Report and for that I thank her.

Unfortunately, Ms. Watters has left my office to pursue her further studies. She is a big loss to my small team and will be sadly missed. She was the sole researcher in my office and as such was responsible for researching many aspects of prison life which enabled me publish Standards for the Inspection of Prisons and many Reports on important aspects of penal policy which give guidance to the Irish Prison Service and the senior management of prisons on “best practice” in such areas. I wish her well in her future life.

Judge Michael Reilly  
Inspector of Prisons

18<sup>th</sup> April 2011

## **Chapter 1**

### **Introduction**

- 1.1 It has been my practice in previous reports, when giving guidance to the Irish Prison Service and the management of prisons, to set out in detail the practices that prevail in Irish Prisons in order that the guidance that I give can be put in context.
  
- 1.2 Deficiencies have been identified in the standard of healthcare provided in a number of Irish Prisons by the Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (hereinafter referred to as the “CPT”) and others. I concur with this statement. From my inspections of prisons I have also concluded that the standard of healthcare varies from prison to prison. Therefore, in this Report, I do not set out the present practice regarding the provision of healthcare in the Irish prisons as this would entail a complete trawl through all prisons which would be a time consuming exercise and result in individual reports on the standard of healthcare being provided in each prison.
  
- 1.3 The purpose of this Report is to point to the guidance available from all relevant sources which, if accepted, should lead to best practice in the provision of healthcare in our prisons. It is a matter for the Irish Prison Service to ensure that best practice is found in all prisons.
  
- 1.4 I will expect that, as and from the 1<sup>st</sup> July 2011, all prisons and those responsible for the provision of healthcare will be aware of their obligations and will ensure that best healthcare practice will prevail in all prisons.
  
- 1.5 This Report is relevant not only to the Irish Prison Service and local management of prisons but also to all those who contribute to the healthcare of prisoners be they working within the Irish prison system or as contractors to the system.

- 1.6 The issue of health can be divided into two categories - physical health and mental health. This Report deals with physical health explaining that prisoners have a right to health, that they are entitled to the same healthcare as is available in the community and details the duties owed by healthcare professionals to the prisoners in their care.
- 1.7 Chapter 2 of this Report deals with the general right to health which all citizens are entitled to.
- 1.8 Chapter 3 of this Report deals with the right to health in a prison context.
- 1.9 The mental health of prisoners is a complex matter. Evidence from mental health experts, those working in the prisons, anecdotal evidence and my observations suggest that there are many prisoners who suffer from mental illness, many of which are vulnerable and should not be accommodated in our prisons.
- 1.10 I am aware that the Commission of Investigation into the killing of Mr. Gary Douch is tasked, *inter alia*, to:-

*“review policies, practice and procedures regarding the safety of prisoners in custody whether in prison, a place of detention, the Central Mental Hospital or other institution; and, in particular to review protocols for those prisoners with specific behavioral problems or vulnerabilities (psychiatric, violent or disruptive) or those in need of additional protection and to make recommendations on what policies and/or legislative measures should be adopted in the future for the management and treatment of such prisoners with a view*

- 1. to promoting the safety and health of prisoners*
- 2. to providing a secure and safe environment for prisoners and persons dealing with prisoners, and*

3. *to safeguard the public interest; and to ensure that lessons are learnt and that recurrence of such tragedy is prevented.*”

- 1.11 Subject to paragraph 1.10, and being mindful of its terms of reference, I will defer further comment on this aspect of medical care until after the publication of the Report of the Commission of Investigation into the killing of Mr. Gary Douch. If I feel that there are outstanding issues that I have identified and where I feel guidance should be given I will submit a further report to the Minister for Justice and Equality (hereinafter referred to as the “Minister”). This further report, if necessary, will follow the same format as this Report and will be informed by International best practice.
- 1.12 I have stated at paragraph 1.9 that certain vulnerable prisoners with mental illness should not be accommodated in our prisons. When such prisoners are identified by a medical team led by a consultant psychiatrist as requiring treatment in the Central Mental Hospital (hereinafter referred to as the “CMH”) or other medical facility immediate arrangements must be put in place to facilitate such transfer.
- 1.13 During the course of my inspections of prisons since 1<sup>st</sup> January 2008, I have encountered numbers of prisoners who fall within the category referred to in paragraph 1.9 who could not be transferred to the CMH because there was no bed available.
- 1.14 I have been informed that there are, as of the date of this Report, 94 in-patient beds in the CMH and 6 in the community (Westlodge, Lucan) for male prisoners. The CMH operates an 8 bed acute admissions unit where all male prisoners are initially placed. There are 10 in-patient beds for female patients. There are 3 to 4 beds in an acute admissions unit where female prisoners are initially placed. Both male and female patients progress from the acute admissions units to other semi-acute units within the CMH campus. Such progression is guided by medical best practice and the best interest of the patient.

- 1.15 Understandably, the turn over of beds in the CMH is slow. There are not sufficient beds in the acute admissions units of the CMH to cater for those prisoners (male and female) diagnosed as requiring treatment in the CMH. In order that this country complies with its obligations to this cohort of prisoners it is necessary that this matter is addressed. The Criminal Law Insanity (Amendment) Act 2011 may have the effect of freeing up some beds in the CMH.
- 1.16 Chapter 4 of this Report gives a case history of one case which illustrates the urgency of addressing this issue.



## Chapter 2

### The Right to Health

- 2.1 The right to health is a fundamental right. Traditionally the right to health has been referred to as the right “*to the enjoyment of the highest attainable standard of health*”<sup>1</sup> but is now generally referred to as the right to health. The existence of a right to health was first mooted internationally in the **World Health Organisation’s Constitution** of 1946 in which ‘health’ was defined as “*a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity*”. The right to health was then included in the **Universal Declaration of Human Rights** in 1948. Article 25(1) reads “*Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services*”.
- 2.2 Article 12(1) of the **International Covenant on Economic, Social and Cultural Rights** urges State Parties “*to recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.*” This definition is generally accepted as being the international definition of the right to health. Article 12(2) outlines the requirements on the State to recognise this right including, *inter alia*, the necessary steps that should be taken for the prevention, treatment and control of epidemic, endemic, occupational and other diseases and the creation of conditions which would ensure the provision of all medical services and medical attention in the event of sickness.
- 2.3 A fundamental principle of human rights law is that human rights are interdependent, indivisible and interrelated. The right to health is fundamental to the realisation of other rights, including, *inter alia*, the rights to food, housing, human dignity and the prohibition against torture and vice-versa. The principles of non-discrimination and equality are important to the

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<sup>1</sup> See the Preamble to the WHO Constitution and Article 12 of the International Covenant on Economic Social and Cultural Rights

realisation of the right to health. Article 2(2) of the **International Covenant on Economic, Social and Cultural Rights** prohibits discrimination regarding all rights contained in the Covenant, including the right to health, on the following grounds:- race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. The **Committee on Economic, Social and Cultural Rights** has taken ‘other status’ to include health status (e.g. HIV/AIDS), sexual orientation and civil, political or social status<sup>2</sup>.

2.4 Additional steps may have to be taken to secure “*the right to the enjoyment of the highest attainable standard of health*” for vulnerable groups such as women, babies and children, elderly people and people with mental health difficulties and to ensure they are not discriminated against.

2.5 The **United Nations Economic and Social Council** has stated that the right to the highest attainable standard of health included in Article 12 of the **International Covenant on Economic, Social and Cultural Rights** comprises of four essential elements<sup>3</sup>:

- (a) Availability - sufficient functioning healthcare facilities, goods, programmes and services must be available.
- (b) Accessibility - healthcare facilities etc. have to be available to everyone within the jurisdiction of the State without discrimination. This element also requires that services etc. are physically accessible and affordable for all.
- (c) Acceptability - healthcare facilities etc. must be respectful of medical ethics and culturally appropriate.
- (d) Quality - health facilities etc. must be scientifically and medically appropriate and of good quality.

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<sup>2</sup> See CESCR, General Comment No.14, “The right to the highest attainable standard of health”, (2000), para.18

<sup>3</sup> Ibid at para 12

2.6 Articles 40 to 44 of the **Irish Constitution** contain fundamental rights. The right to health is not listed as a specific right. The courts have inferred from Article 40.3.1, which reads “*The State guarantees in its laws to respect, and, as far as practicable, by its laws to defend and vindicate the personal rights of the citizen*”, a number of additional rights, known as unenumerated rights. The Irish courts have found that the following rights exist under Article 40.3.1:- the right to bodily integrity- *Ryan v Attorney General*<sup>4</sup>, a prisoner has a right not to have his/her health exposed to risk or danger- *the State (C) v Frawley*<sup>5</sup> and the right not to be subjected to inhuman or degrading treatment- *the State (C) v Frawley*. Ireland is a party to the **International Covenant on Economic, Social and Cultural Rights** which provides for the right of everyone to “*the enjoyment of the highest attainable standard of physical and mental health*”.

2.7 Entitlement to health services in Ireland is primarily based on residency and means<sup>6</sup>. Eligibility for access to health services is dependent on whether a person is a medical card holder or not. If a person has a medical card they are entitled to the following<sup>7</sup>:

- free General Practitioner services,
- prescribed drugs and medicines (subject to a 50c charge per item prescribed),
- public hospital services,
- dental, optical and aural services,
- maternity and infant care services,
- a range of community care and personal social services.

Healthcare should be provided to prisoners on the basis that they are entitled to the same treatment as people with medical cards.

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<sup>4</sup> [1965] 1 IR 295

<sup>5</sup> [1976] IR365

<sup>6</sup>As at

[http://www.citizensinformation.ie/en/health/entitlement\\_to\\_health\\_services/entitlement\\_to\\_public\\_health\\_services.html](http://www.citizensinformation.ie/en/health/entitlement_to_health_services/entitlement_to_public_health_services.html)

<sup>7</sup> *ibid*

## Chapter 3

### **The Right to Health in a Prison Context**

- 3.1 Persons deprived of their liberty retain their human rights except for those that are lawfully taken from them as a consequence of imprisonment. The right to health or the *'right to the highest attainable standard of health'* is a fundamental right. There is a heightened duty of care on the State to provide for the health needs of those persons who it deprives of their liberty.
- 3.2 It is generally accepted as International best practice that the provision of healthcare in prisons should be equivalent to that available in the community. The Irish Prison Service **Health Care Standards 2007** provide valuable guidance on the provision of healthcare in Irish Prisons.
- 3.3 The provision of adequate healthcare in a prison context is important in a number of respects. Firstly, according to the **World Health Organisation**, prison

*“populations contain an over-representation of members of the most marginalised groups in society: people with poor health and chronic, untreated conditions, drug users, the vulnerable and those who engage in risky activities such as injecting drugs and commercial sex work”<sup>8</sup>.*

Secondly, it can counteract some of the negative features of imprisonment such as overcrowding and ‘slopping out’.

Thirdly, it can help stop the spread of diseases such as TB, HIV, Hepatitis B and C which research shows spread faster in closed settings such as a prison<sup>9</sup>.

#### **Prisoners’ rights to adequate healthcare**

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<sup>8</sup> WHO, “Prison in Health Newsletter”, Newsletter No. 1 (2004) WHO Regional Office for Europe

<sup>9</sup> Lines, R., “From equivalence of standards to equivalence of objectives: The entitlement of prisoners to healthcare standards higher than those outside prisons”, (2006) 2(4) *International Journal of Prisoner Health* 269 at p. 271

- 3.4 In addition to the instruments detailed in Chapter 2 there are a number of instruments which specifically recognise that prisoners have a right to health. Recommendation 10 of the **Council of Europe’s Recommendation (98) 7 concerning the ethical and organisational aspects of healthcare in prisons** calls for prison healthcare services “*to provide medical, psychiatric and dental treatment and to implement programmes of hygiene and preventive medicine in conditions comparable to those enjoyed by the general public*”. Principle 9 of the **Basic Principles for the Treatment of Prisoners** urges that “*Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation*”. Principle 1 of the **Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment** states that “*Health personnel, particularly physicians, charged with the medical care of prisoners and detainees have a duty to provide them with protection of their physical and mental health and treatment of disease of the same quality and standard as is afforded to those who are not imprisoned or detained*”.
- 3.5 Prisoners’ rights to health are constantly developing as a result of both the jurisprudence of the **European Court of Human Rights** and the guidance given by the CPT. Both bodies have linked the importance of providing healthcare to prisoners to the prevention of torture and inhuman or degrading treatment or punishment.
- 3.6 The **European Convention on Human Rights** does not contain a right to health; neither does it specifically mention the rights of prisoners. The jurisprudence of the **European Court of Human Rights** has established that a right to health for those deprived of their liberty can be inferred from Article 3 of the Convention which prohibits the use of torture and inhuman or degrading

treatment or punishment. The Court first found that a prisoner was entitled to healthcare under Article 3 in *Kudla v Poland*<sup>10</sup> asserting at paragraph 94 that

*“the State must ensure that a person is detained in conditions which are compatible with respect for his human dignity, that the manner and method of the execution of the measure do 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 assistance”.*

The Court has reaffirmed this position in, *inter alia*, *Melnik v Ukraine*<sup>11</sup>, *Nevmerzhitsky v Ukraine*<sup>12</sup> and *Mc Glinchey v UK*<sup>13</sup>. The Court found in *Rhode v Denmark*<sup>14</sup> that a failure to provide the ‘requisite medical assistance’ can unnecessarily exacerbate a prisoner’s suffering and therefore may violate Article 3.

- 3.7 The CPT has declared that the provision of healthcare in prisons is of direct relevance to their mandate<sup>15</sup>, explaining that *“an inadequate level of healthcare can lead rapidly to situations falling within the scope of the term ‘inhuman and degrading treatment’.* Further, the healthcare service in a given establishment can potentially play an important role in combating the infliction of ill-treatment...”<sup>16</sup>. The CPT has stressed that a State cannot derogate from its responsibility to provide adequate healthcare, even in times of economic hardship<sup>17</sup>:- *“regardless of the difficulties faced at any given time, the act of depriving a person of his liberty always entails a duty of care which calls for effective methods of prevention, screening, and treatment.”*

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<sup>10</sup> Judgement of 26<sup>th</sup> October 2000, Application No. 30210/96

<sup>11</sup> Judgement of 28<sup>th</sup> March 2006, Application No. 72286/01

<sup>12</sup> Judgement of 5<sup>th</sup> April 2005, Application No. 54825/00

<sup>13</sup> Judgement of 29<sup>th</sup> April 2003, Application No. 50390/99

<sup>14</sup> Judgement of 21<sup>st</sup> July 2005, Application No. 69332/01

<sup>15</sup> CPT 3<sup>rd</sup> General Report [CPT/Inf (93) 12] at para. 30

<sup>16</sup> *Ibid* at para. 30

<sup>17</sup> CPT 11<sup>th</sup> General Report [CPT/Inf (2001) 16] at para. 31

3.8 In its 3<sup>rd</sup> **General Report** the CPT laid out seven criteria which it uses to benchmark the level of healthcare provided in prisons against:

- A. Access to a doctor,
- B. Equivalence of care,
- C. Patient's consent and confidentiality,
- D. Preventive healthcare,
- E. Humanitarian assistance,
- F. Professional independence,
- G. Professional competence.

I set out hereunder the obligations owed to prisoners having regard to each criterion.

**(A) Access to a doctor**

3.9 Primary care is the most effective and efficient element of healthcare in any public health system<sup>18</sup>. Prisoners must have access to a doctor and nursing staff without undue delay at all times, irrespective of the prison regime. Access to a doctor or other healthcare professional in a prison is largely dependent upon the availability of prison staff to escort prisoners. In this regard security considerations must be balanced against a prisoner's right to health and in extreme cases his/her right to life. Prisoners should be seen on committal by a doctor (or a nurse reporting to a doctor). As part of primary care provision the services of a psychiatrist and a dentist should also be available in prison. Prison healthcare services should, as a minimum, be able to provide emergency treatment and a level of care equivalent to that provided in hospital outpatient departments. Healthcare staff should follow up outpatient appointments/treatment. The preceding principles which are fundamental to the provision of adequate healthcare in prisons are reinforced by the following international instruments:-

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<sup>18</sup> WHO, "*Primary healthcare. Report of the International Conference on Primary Healthcare*", USSR, 6-12 September 1978

(a) **United Nations Standard Minimum Rules for the Treatment of Prisoners (1955)**

Rule 22(1) states:- *“At every institution, there shall be available the services of at least one qualified medical officer who should have some knowledge of psychiatry”*.

Rule 22(3) states:- *“The services of a qualified dental officer shall be available to every prisoner”*.

Rule 24 states:- *“The medical officer shall see and examine every prisoner as soon as possible after his admission and thereafter as is necessary”*.

Rule 25(1) states:- *“The medical officer shall have the care of the physical and mental health of the prisoners and should daily see all sick prisoners, all who complain of illness and any other to whom his attention is specifically directed”*.

(b) **Recommendation No. R (98) 7 concerning the ethical and organisational aspects of healthcare in prisons**

Rule 1 states:- *“When entering prison and later on while in custody, prisoners should be able at any time to have access to a doctor or a fully qualified nurse, irrespective of their detention regime and without undue delay, if required by their state of health. All detainees should benefit from appropriate medical examinations on admission”*.

Rule 2 states:- *“In order to satisfy the health requirements of the inmates, doctors and qualified nurses should be available on a full-time basis in the large penal institutions, depending on the number and the turnover of inmates and their average state of health”*.



Rule 3 states: - *“A prison's healthcare service should at least be able to provide out-patient consultations and emergency treatment. When the state of health of the inmates requires treatment which cannot be guaranteed in prison, everything possible should be done to ensure that treatment is given, in all security, in health establishments outside the prison”*.

Rule 4 states:- *“Prisoners should have access to a doctor, when necessary, at any time during the day and the night. Someone competent to provide first aid should always be present on the prison premises”*.

Rule 5 states:- *“An access to psychiatric consultation and counselling should be secured. There should be a psychiatric team in larger penal institutions. If this is not available as in the smaller establishments, consultations should be assured by a psychiatrist, practising in hospital or in private”*.

Rule 6 states:- *“The services of a qualified dental surgeon should be available to every prisoner”*.

### **(c) The European Prison Rules (2006)**

Rule 41.1 states:- *“Every prison shall have the services of at least one qualified general medical practitioner”*.

Rule 41.2 states:- *“Arrangements shall be made to ensure at all times that a qualified medical practitioner is available without delay in cases of urgency”*.

Rule 41.3 states:- *“Where prisons do not have a full-time medical practitioner, a part-time medical practitioner shall visit regularly”*.

Rule 41.4 states:- “*Every prison shall have personnel suitably trained in healthcare*”.

Rule 41.5 states:- “*The services of qualified dentists and opticians shall be available to every prisoner*”.

**(d) Irish Prison Rules 2007**

Rule 101(2) states:- “*A prison doctor shall, in particular, be responsible for the provision of primary healthcare to prisoners*”.

Rule 102(2) states:- “*The prison doctor, nurse officer or other members of the prison healthcare staff shall, as soon as practicable, assess a prisoner in respect of whom information has been received under paragraph (1)*”.

Rule 102(3) states:- “*In the case of a medical emergency involving a prisoner, or where a prisoner is otherwise in need of urgent medical attention, a prison doctor, nurse officer or other member of the prison healthcare staff shall, immediately upon receiving information under paragraph (1), attend the prisoner and administer or arrange for the administration of medical care to him or her*”.

**(e) Judgements of the European Court of Human Rights**

In *Nevmerzhitsky v Ukraine*<sup>19</sup> the Court found that a failure to examine a prisoner when there are indications that it may be necessary to do so amounts to inadequate medical assistance.

In *Pilcic v Croatia*<sup>20</sup> the Court confirmed that a prisoner has a right of access to medical care without undue delay, irrespective of the regime of the prison.

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<sup>19</sup> Ibid at fn no. 12

<sup>20</sup> Judgement of 17<sup>th</sup> January, Application No. 33138/06

In *Hurtado v Switzerland*<sup>21</sup> the Court found the State violated Article 3 because of a delay by the authorities presenting prisoners for medical treatment.

**(f) Extracts from the CPT's 3<sup>rd</sup> General Report- CPT/Inf (93) 12**

Paragraph 33 states:- *“The CPT has recommended that every newly arrived prisoner be properly interviewed and, if necessary, physically examined by a medical doctor as soon as possible after his admission. It should be added that in some countries, medical screening on arrival is carried out by a fully qualified nurse, who reports to a doctor. This latter approach could be considered as a more efficient use of available resources”.*

Paragraph 34 states:- *“While in custody, prisoners should be able to have access to a doctor at any time, irrespective of their detention regime”.*

Paragraph 35 states:- *“A prison's healthcare service should at least be able to provide regular out-patient consultations and emergency treatment. The services of a qualified dentist should be available to every prisoner...As regards emergency treatment, a doctor should always be on call”.*

- 3.10 In its recent **Report on Ireland** the CPT advised that doctors' clinical time should be reviewed to take into consideration the size of the prisons and the actual clinical time doctors should spend with prisoners<sup>22</sup>. An argument is sometimes made that it may be desirable to have a doctor or a number of doctors working on a part-time basis in prisons as this will facilitate the doctor(s) to keep abreast of medical developments on the outside<sup>23</sup>.

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<sup>21</sup> Judgement of 8<sup>th</sup> July 1993, Application No. 17549/90

<sup>22</sup> CPT, Report to the Government of Ireland, CPT/Inf (2011) 3, see paras 60-64

<sup>23</sup> Van Zyl Smit, D. & Snacken, S., *“Principles of European Prison Law and Policy- Penology and Human Rights”*, (2009) Oxford University Press, at p.152

## **(B) Equivalence of care**

- 3.11 The principle of equivalence of care with that available in the community is a basic premise. The CPT advises that “*a prison healthcare service should be able to provide medical treatment and nursing care, as well as physiotherapy, rehabilitation or any other necessary special facility, in conditions comparable to those enjoyed by patients in the outside community*”<sup>24</sup>. This is the minimum required in a prison healthcare context and entitles prisoners to the same care as that available in the community. In *Khudobin v Russia*<sup>25</sup> the **European Court of Human Rights** accepted that medical assistance provided in prisons may not always be at the same level as in the best medical institutions for the general public. The Court at paragraph 93 stated that “*Nevertheless, the State must ensure that the health and well-being of detainees are adequately secured by, among other things, providing them with the requisite medical assistance...*”.
- 3.12 Equivalence of care also applies to the staff that provides the care and the facilities within which the healthcare in prisons is provided. Rule 11 of **Recommendation No. R (98) 7 concerning the ethical and organisational aspects of healthcare in prisons** requires that “*The prison healthcare service should have a sufficient number of qualified medical, nursing and technical staff, as well as appropriate premises, installations and equipment of a quality comparable, if not identical, to those which exist in the outside environment*”. As prisons in Ireland do not have hospital facilities prisoners often have to be transferred to a public hospital for both outpatient and inpatient treatment. Prisoners must have the same access to these hospital services as people in the community. Transferring prisoners to outside hospitals may pose serious security considerations if high profile prisoners are involved. In this connection the CPT urged Ireland to put in place the necessary procedures to facilitate the timely emergency transfer to hospital of high security prisoners<sup>26</sup>.

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<sup>24</sup> CPT 3<sup>rd</sup> General Report [CPT/Inf (93) 12] at para. 58

<sup>25</sup> Judgement of 26<sup>th</sup> January 2007, Application No. 59696/00

<sup>26</sup> CPT, Report to the Government of Ireland, CPT/Inf (2011) 3, see para. 62

- 3.13 Prison healthcare providers should adhere to the same national codes of professional practice and standards as professionals in the community<sup>27</sup>. The health needs and best interests of the prisoner should always be the primary concern of healthcare professionals and security considerations should not take precedence<sup>28</sup>. I refer to this in greater detail at paragraph 3.47.
- 3.14 The principle of equivalence of care also means that appropriate care is available for different cohorts of prisoners. Care equivalent to that available in the community must be available in prison to provide for women prisoners, older prisoners, prisoners who may not be suitable for continued detention, juvenile prisoners and prisoners with mental health problems.
- 3.15 The CPT has stated that women prisoners should have access to the following<sup>29</sup>:- healthcare professionals who have specific training in women's health issues including gynaecology, contraception, preventive healthcare screening for, *inter alia*, breast and cervical cancer and any other specialist treatment which may be required by women. In women's prisons where there are pregnant women and mothers with babies all of the requisite medical assistance should be provided<sup>30</sup>.
- 3.16 Research in England has shown a high incidence of ailments amongst the older prison population such as poor hearing and vision, respiratory and heart disease, diabetes, arthritis, bladder problems, Alzheimer's, Parkinson's, hypertension and mental illness<sup>31</sup>. Prison healthcare services should be able to provide the necessary medical assistance to this cohort of prisoners.
- 3.17 The **European Court of Human Rights** considered the issue of old age, ill health and release from prison in the case of *Papon v France*<sup>32</sup>. The applicant

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<sup>27</sup> Fraser, A., "Primary Healthcare in Prisons" in "*Health in Prisons: A WHO guide to the essentials in prison health*", (2007) WHO, at p. 27

<sup>28</sup> Rule 19, R (98) 7 concerning the ethical and organisational aspects of healthcare in prisons

<sup>29</sup> CPT 10<sup>th</sup> General Report, [CPT/Inf (2000) 13] at paras. 32 & 33

<sup>30</sup> Ibid at paras 26-29 and Rules 9- 13 UN Standard Minimum Rules for the Treatment of Female Prisoners and Non-Custodial Measures for Women Offenders (Bangkok Rules)

<sup>31</sup> See Crawley, E., "Imprisonment in Old Age" in Jewkes, Y., "*Handbook on Prisons*", (2007) Willan Publishing, at p. 232

<sup>32</sup> Decision of the 7<sup>th</sup> June 2001 (inadmissible), Application No. 64666/01

was 90 years of age and in prison in France. He claimed that keeping a man of his age in prison was contrary to Article 3 of the **European Convention on Human Rights**. The case was declared inadmissible as the Court felt his treatment was not severe enough to bring it within the scope of Article 3. The Court did not exclude the possibility that in certain circumstances the continued detention of an elderly prisoner may raise an issue under Article 3 and that each case should be decided on a case by case basis.

- 3.18 The age of a prisoner, *per se*, is not required to be taken into account under Irish law or International best practice when considering the release of a prisoner. The prisoner's state of health may be taken into account. An issue which may arise then is whether a prisoner should be released if he/she has received a short term fatal prognosis. In this connection Rule 51 of **Recommendation No. R (98) 7 concerning the ethical and organisational aspects of healthcare in prisons** states:

*“The decision as to when patients subject to short term fatal prognosis should be transferred to outside hospital units should be taken on medical grounds. While awaiting such transfer, these patients should receive optimum nursing care during the terminal phase of their illness within the prison healthcare centre. In such cases provision should be made for periodic respite care in an outside hospice. The possibility of a pardon for medical reasons or early release should be examined”.*

This is reinforced by Rule 25(2) of the **Standard Minimum Rules for the Treatment of Prisoners**.

- 3.19 The **European Court of Human Rights** has addressed the issues of release on health grounds in a number of cases. In *Khudobin v Russia*<sup>33</sup> the Court having referred to the case of *Farbtuhs v Latvia*<sup>34</sup> at paragraph 93 stated that “Article 3 (of the Convention) cannot be construed as laying down a general obligation to release detainees on health grounds”. However, it explained

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<sup>33</sup> Judgement of 26<sup>th</sup> January 2007, Application No. 59696/00

<sup>34</sup> Judgement of 2<sup>nd</sup> December 2002, Application No. 4672/02

that if the authorities decide “to place and maintain a seriously ill person in detention, they should demonstrate special care in guaranteeing such conditions of detention that correspond to his special needs resulting from his disability”.

3.20 Health information on issues of particular relevance to young people should be available in prisons where juveniles are accommodated<sup>35</sup>. Healthcare professionals working in a juvenile prison should receive training in health issues which are of relevance to young people. Prison healthcare services should be able to provide the necessary medical assistance to this cohort of prisoners equivalent to that available to young people in the community.

3.21 Prisoners who are mentally ill are entitled to the same treatment and services that are available in the community. If necessary and subject to paragraph 1.10, I will deal with this subject in a later report.

3.22 **The European Court of Human Rights** has found that in order to provide healthcare in prisons to a standard equivalent to that available in the community the following obligations are owed under Article 3 of the **European Convention on Human Rights**:-

- medical assistance must be adapted to the particular needs of a prisoner who is ill and the assistance must be medical in nature - *Farbtuhs v Latvia*<sup>36</sup>
- the medical assistance must be appropriate to the prisoner’s state of health - *Testa v Croatia*<sup>37</sup>
- where the absence of a correct diagnosis is attributable to a failure to act on the part of the state authorities the State may be held

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<sup>35</sup> CPT 9<sup>th</sup> General Report [CPT/Inf (99) 12] at para.41

<sup>36</sup> Op cit fn 35

<sup>37</sup> Judgement of 12<sup>th</sup> July 2007, Application No. 20877/04

responsible - *Popov v Russia*<sup>38</sup>

- the State was found to violate Article 3 due to the prison authorities failure to make arrangements for a specific diet which according to his doctors was necessary in order to improve his health - *Gorodnichev v Russia*<sup>39</sup>

3.23 Drug misuse and addiction is a feature in most Irish prisons. Healthcare staff has a role in the education of prisoners about the harmful affects of drug addiction. Counselling and drug treatment programmes should be available. In its recent Report on Ireland the CPT stated:

*“detoxification programmes with substitution programmes for opiate-dependent patients should be combined with genuine psycho-socio and educational programmes. The setting up of a drug-free wing in prisons for certain categories of prisoners, inter alia, those having completed treatment programmes prior to or during imprisonment, might also be considered”*<sup>40</sup>.

3.24 Not all prisons in the Irish Prison system have methadone maintenance programmes. This is a policy matter for the Irish Prison Service. The debate concerning the provision of methadone within the Irish Prison Service is part of a larger debate which is of concern not alone to the Irish Prison Service but to the community as a whole. It is not part of my mandate to enter this debate. Where methadone maintenance is available it must be clinically supervised and administered in accordance with best practice in the community. Prisoners on methadone maintenance programmes should be reviewed as required. The CPT stated that:-

*“methadone should only be prescribed as part of a comprehensive drug treatment programme which will include engagement with*

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<sup>38</sup> Judgement of 13<sup>th</sup> July 2006, Application No. 26853/04

<sup>39</sup> Judgement of 24<sup>th</sup> May 2007, Application No. 52058/99

<sup>40</sup> CPT, Report to the Government of Ireland, CPT/Inf (2011) 3, at para. 72



*addictions services (addiction counsellors, addiction nurses and as required an addiction psychiatrist). The dose of methadone prescribed as maintenance should be that required to stabilise a prisoner's drug use to the extent that the inmate injects or uses opiates less frequently and remains in contact with prison addiction services"*<sup>41</sup>.

- 3.25 Prisoners who, prior to entering prison, are on a methadone maintenance programme should not be at a disadvantage by being placed in a prison which does not operate such a programme. Neither should prisoners on a methadone maintenance programme be transferred to a prison without such a programme.
- 3.26 Prisoners who are suffering from withdrawal symptoms should receive adequate medical assistance or the State authorities may risk violating Article 3 of the **European Convention on Human Rights**. In **McGlinchey v UK**<sup>42</sup> a prisoner died in prison after suffering from heroin withdrawal symptoms. The **European Court of Human Rights** found that the State has a duty to ensure that prisoners are held in conditions compatible with respect for human dignity. The Court held that there had been deficiencies in the prisoner's treatment stating that:-

*"Having regard to the responsibility owed by prison authorities to provide the requisite medical care for detained persons, the Court finds that in the present case there was a failure to meet the standards imposed by Article 3 of the Convention. It notes in this context the failure of the prison authorities to provide accurate means of establishing Judith McGlinchey's weight loss, which was a factor that should have alerted the prison to the seriousness of her condition, but was largely discounted due to the discrepancy of the scales. There was a gap in the monitoring of her condition by a doctor over the weekend when there was a further significant drop in weight and a failure of the prison to take more effective steps to treat Judith McGlinchey's condition, such as her admission to hospital to ensure the intake of*

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<sup>41</sup> Ibid at para. 74

<sup>42</sup> Judgement of 29<sup>th</sup> April 2003, Application No. 50390/99

*medication and fluids intravenously, or to obtain more expert assistance in controlling the vomiting.*<sup>43</sup>.

The prisoner was found to have suffered inhuman and degrading treatment contrary to Article 3.

3.27 A model of healthcare provision that is finding favour in many European prison systems is that equivalence of care is easier to implement in a prison setting if the prison healthcare system is integrated with the public healthcare system. I refer in greater detail to this aspect in paragraphs 3.50 to 3.52.

### **(C) Patient's consent and medical confidentiality**

3.28 The CPT has stated that "*freedom of consent and respect for confidentiality are fundamental rights of the individual*". Medical confidentiality between a healthcare professional and a patient is of vital importance in a prison setting. A prisoner cannot choose his doctor as a person in the community can and so trust is essential in the doctor-patient relationship. This trust can be facilitated through the informed consent of the prisoner and the preservation of medical confidentiality.

#### *Informed consent*

3.29 The principle of informed consent applies to both medical examinations and treatment<sup>44</sup>. In order to provide informed consent the prisoner must be provided with all relevant information regarding his/her condition and possible treatment and medication<sup>45</sup>. Rules 14-16 of the **Recommendation No. R (98) 7 concerning the ethical and organisational aspects of healthcare in prisons** provide for an exception where the prisoner's consent may be waived as in the case where a prisoner suffers from an illness which makes them incapable of providing informed consent. Any waiver must be based upon law and be guided by the same principles which are applicable to the population as

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<sup>43</sup> At para. 57

<sup>44</sup> Van Zyl Smit, D. & Snacken, S., "*Principles of European Prison Law and Policy- Penology and Human Rights*", (2009) Oxford University Press, at pg. 165

<sup>45</sup> CPT 3<sup>rd</sup> General Report [CPT/Inf (93) 12] at para. 46

a whole. Rule 42.2 of the **European Prison Rules** provides guidance when dealing with a situation where the prisoner may not be able to give his/her consent by requiring that the doctor shall examine prisoners “*whenever necessary*”. As outlined at paragraph 3.6, it was established in *Nevmerzhitsky v Ukraine* that a failure to provide necessary medical assistance may violate Article 3.

3.30 The CPT acknowledged in its **3<sup>rd</sup> General Report** at paragraph 47 that a difficulty may arise when the patient’s decision conflicts with the doctor’s duty of care to the patient.

3.31 As a form of protest prisoners sometimes refuse to eat and go on ‘hunger-strike’. This may result in a conflict between a doctor’s duty of care to his/her patient and the patient’s decision.

#### *Medical Confidentiality*

3.32 Rule 13 of the **Recommendation No. R (98) 7 concerning the ethical and organisational aspects of healthcare in prisons** requires that “*medical confidentiality should be guaranteed and respected with the same rigour as in the population as a whole*”. Rule 42.3(a) of the **European Prison Rules** requires that “*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.....*”.

3.33 The CPT stated that the maintenance of medical files is the doctor’s responsibility<sup>46</sup>. In its latest Report on Ireland the CPT has advised<sup>47</sup> that the doctor and other healthcare professionals must include comprehensive medical notes on a patient’s file and all correspondence from hospitals must be included in the medical files. Hospital recommendations must be followed up by healthcare professionals while the prisoner is still in prison<sup>48</sup>.

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<sup>46</sup> Ibid at para. 50

<sup>47</sup> See CPT, Report to the Government of Ireland, CPT/Inf (2011) 3, at pages 36-38

<sup>48</sup> Ibid at para.63

- 3.34 Prisoners are escorted to and from healthcare appointments in the prison and hospital appointments by prison staff. The CPT has highlighted the importance of prison staff not being present in the room during medical examinations or procedures stating that “*all medical examinations of prisoners be conducted out of the hearing and- unless the doctor concerned requests otherwise in a particular case- out of the sight of prison officers*”. If prison staff is to be present during a medical examination they must be mindful of the need for medical confidentiality and must act to preserve such confidentiality. They must also respect and safeguard the privacy and dignity of the prisoner.
- 3.35 In dealing with female prisoners Rule 10.2 of the **Standard Minimum Rules for the Treatment of Female Prisoners and Non-custodial Measures for Women Offenders** known as the ‘**Bangkok Rules**’ states:

*“If a woman prisoner requests that she be examined or treated by a woman physician or nurse, a woman physician or nurse shall be made available, to the extent possible, except for situations requiring urgent medical intervention. If a male medical practitioner undertakes the examination contrary to the wishes of the woman prisoner, a woman staff member shall be present during the examination”.*

Rule 11.2 qualifies the above rule and states that if it is necessary for prison staff to be present during a medical examination of a female prisoner the prison staff must also be female.

#### **(D) Preventive healthcare**

- 3.36 The duty of healthcare professionals goes beyond providing assistance and treatment for prisoners who are ill. Preventive healthcare in prisons is important.

### *Hygiene*

3.37 The conditions in which prisoners live and the health status of prisoners are not mutually exclusive. In order to maintain a satisfactory level of hygiene in a prison **Rule 44 of the European Prison Rules** requires the prison doctor to inspect and advise the prison Governor on the following:-

- (a) *the quantity, quality, preparation and serving of food and water;*
- (b) *the hygiene and cleanliness of the institution and prisoners;*
- (c) *the sanitation, heating, lighting and ventilation of the institution; and*
- (d) *the suitability and cleanliness of the prisoners' clothing and bedding.*

3.38 In **Kalashnikov v Russia**<sup>49</sup> the applicant alleged that the overcrowding and unsanitary conditions in his cell and the length of time in which he was detained in such conditions had an adverse effect on his physical health and caused him humiliation and suffering. The **European Court of Human Rights** found that his conditions of detention amounted to degrading treatment.

### *Transmittable diseases*

3.39 At paragraph 3.3, I stated that research shows that diseases such as TB, HIV, Hepatitis B and Hepatitis C spread faster in closed settings such as a prison. Rule 42.3(f) of the **European Prison Rules** states that prisoners suspected of having infectious or contagious conditions should be isolated for the period of infection and should be provided with proper treatment. This rule does not mean that prisoners with HIV, Hepatitis and AIDS should be isolated from the rest of the prison population solely because of their health status<sup>50</sup>. Prisoners who have HIV, Hepatitis or AIDS should be able to keep their medical status confidential if they wish<sup>51</sup>.

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<sup>49</sup> Judgement of 15<sup>th</sup> October 2002, Application No. 47095/99

<sup>50</sup> Rule 42.3.g, European Prison Rules (2006)

<sup>51</sup> CPT 11<sup>th</sup> General Report [CPT/Inf (2001) 16] at para.31

3.40 The conditions in which prisoners are accommodated when they have transmittable diseases and the type of treatment which they receive are important. In this connection, the following judgements of the **European Court of Human Rights** are pertinent:

- (a) In *Melnik v Ukraine*<sup>52</sup> the Court held that a State's failure to prevent, diagnose and cure Tuberculosis, in conjunction with the existence of overcrowding and unsanitary conditions, amounted to degrading treatment and a violation of Article 3.
- (b) In *Nevmerzhitsky v Ukraine*<sup>53</sup> the Court found that the applicant had contracted eczema and scabies whilst in prison indicating that the overall prison conditions were inhuman and degrading.

3.41 Healthcare professionals can help in the curtailment of transmittable diseases through the education of prisoners<sup>54</sup>. The CPT recognizes that this is particularly important where young people are concerned as they have a propensity to engage in risk-taking behaviour<sup>55</sup>. Such an educational programme should, according to the CPT “*address methods of transmission and means of protection as well as the application of adequate preventive measures. More particularly, the risks of HIV or hepatitis B/C infection through sexual contacts and intravenous drug use should be highlighted and the role of body fluids as the carriers of HIV and hepatitis viruses explained*<sup>56</sup>”.

#### *Suicide Prevention*

3.42 Article 2 of the **European Convention on Human Rights** places an obligation on the State to protect the lives of those who it deprives of their

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<sup>52</sup>Judgement of 28<sup>th</sup> March 2006, Application No. 72286/01

<sup>53</sup> Judgement of 5<sup>th</sup> April 2005, Application No. 54825/00,

<sup>54</sup> Rule 1, Recommendation No. R (93) 6 concerning Prison and Criminological Aspects of the Control of Transmissible Diseases including AIDS and Related Health Problems in Prison

<sup>55</sup> CPT 9<sup>th</sup> General Report [CPT/Inf (99) 12], at para. 41

<sup>56</sup> CPT 11<sup>th</sup> General Report [CPT/Inf (2001) 16] at para.31

liberty. In *Keenan v UK*<sup>57</sup> the **European Court of Human Rights** stated that the authorities are under an obligation to protect the lives of those who it knows, or ought to know, to be at risk.

3.43 The following steps should be taken to help prevent suicide in prisons:-

- Prisoners should be assessed on committal by healthcare staff to identify whether the prisoner poses a risk<sup>58</sup>.
- Provided a comprehensive risk assessment has been undertaken a prisoner can be appropriately accommodated within the prison.
- It must be borne in mind that a risk can never be completely eliminated but can be managed for the duration of time that the prisoner is considered to be at risk<sup>59</sup>.
- Prison staff should be made aware of indications of suicidal risk<sup>60</sup>.

#### *Prevention of violence*

3.44 At paragraph 3.7, I stated that the healthcare professionals in prison have a role in preventing torture and ill treatment from occurring. The CPT has stated that the systematic recording of injuries can contribute to the prevention of violence against prisoners<sup>61</sup>. It has further stated that injuries or marks discovered on a prisoner during the committal assessment should be recorded by the doctor, in addition to any conclusions/statements from the doctor<sup>62</sup>. Prisoners should also be examined by a doctor following a violent incident in the prison and the doctor should, *inter alia*, record the following:- any marks/injuries on the prisoner (these should also be photographed), the

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<sup>57</sup>Judgement of 3<sup>rd</sup> April 2001, Application No. 27229/95

<sup>58</sup> CPT 3<sup>rd</sup> General Report [CPT/Inf (93) 12], at para. 58

<sup>59</sup> CPT 3<sup>rd</sup> General Report [CPT/Inf (93) 12], at para. 59

<sup>60</sup> Ibid at para.58

<sup>61</sup> Ibid at para. 60

<sup>62</sup> Ibid at para. 61

allegations made by the prisoner and the doctor's conclusions regarding the marks/injuries<sup>63</sup> and the allegations made.

#### **(E) Humanitarian Assistance**

3.45 In its **3<sup>rd</sup> General Report** the CPT states that prison healthcare services should pay special attention to the needs of vulnerable groups of prisoners including mothers and babies, adolescents, prisoners with personality disorders and prisoners unsuited for continued detention.

#### **(F) Professional Independence**

3.46 The guidance referred to in paragraph 3.47 to 3.50 refers to all healthcare professionals who deal with prisoners. For ease of reading paragraphs 3.47 to 3.50, I refer only to doctors.

3.47 In a prison healthcare setting conflicts may arise between a doctor's duty of care to his/her patients (the prisoners) on the one hand and prison management and security considerations on the other. The relationship between a doctor and his/her patient should be based on trust and in a prison setting the professional independence of the doctor is a basic element in this trust<sup>64</sup>. Professional independence of the doctor and the best interests of the prisoner are basic premises which should underpin the provision of healthcare in prisons. Rule 19 of **Recommendation R(98) 7 concerning the ethical and organisational aspects of healthcare in prisons** explains that "*the health needs of the inmate should always be the primary concern of the doctor*" and Rule 20 further clarifies the position stating that "*clinical decisions and any other assessments regarding the health of detained persons should be governed only by medical criteria*".

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<sup>63</sup> Ibid and Report to the Government of Ireland [CPT/Inf (2011) 3] at para. 67

<sup>64</sup> Van Zyl Smit, D. & Snacken, S., "*Principles of European Prison Law and Policy- Penology and Human Rights*", (2009) Oxford University Press, at pg. 158



- 3.48 In a prison there is always a danger that a doctor's relationship with a prisoner may be damaged due to the prisoner's perceived involvement of the doctor in shaping his/her prison regime, for example placing the prisoner in a special observation cell<sup>65</sup>.
- 3.49 Doctors should receive specific training on working in a prison. This should include issues which are of particular relevance such as the ethical aspects of working in a prison<sup>66</sup>. Doctors who work in prisons should also receive training with public healthcare professionals to keep them up to date with what is considered best practice in the community and to prevent them from succumbing to the prison culture<sup>67</sup>.
- 3.50 In order to secure doctors' independence the CPT recommends that "*such personnel should be aligned as closely as possible with the mainstream of healthcare provision in the community at large*"<sup>68</sup>. International standards support the integration of healthcare in prisons into the public healthcare system. The following standards are of relevance:-

(a) **The Moscow Declaration on Prison Health as a part of Public Health** states-

*"Member governments are recommended to develop close working links between the Ministry of Health and the Ministry responsible for the penitentiary system so as to ensure high standards of treatment for detainees, protection for personnel, joint training of professionals in modern standards of disease control, high levels of professionalism amongst penitentiary medical personnel, continuity of treatment between the penitentiary and outside society, and unification of statistics."*

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<sup>65</sup> Ibid at pg. 160.

<sup>66</sup> International Centre for Prison Studies, "*Guidance Note 10- Improving prison healthcare*", (2004) London, at pg. 6

<sup>67</sup> *ibid*

<sup>68</sup> CPT 3<sup>rd</sup> General Report [CPT/Inf (93) 12], at para 71

(b) **Recommendation R(98) 7 concerning the ethical and organisational aspects of healthcare in prisons** states:-

Rule 10- *“Health policy in custody should be integrated into, and compatible with, national health policy.”*

Rule 12- *“The role of the ministry responsible for health should be strengthened in the domain of quality assessment of hygiene, healthcare and organisation of health services in custody, in accordance with national legislation. A clear division of responsibilities and authority should be established between the ministry responsible for health or other competent ministries, which should co-operate in implementing an integrated health policy in prison.”*

(c) **The European Prison Rules** state:

Rule 40.1 - *“Medical services in prison shall be organised in close relation with the general health administration of the community or nation.”*

Rule 40.2 - *“Health policy in prisons shall be integrated into, and compatible with, national health policy.”*

Rule 40.3 - *“Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation.”*

3.51 **The World Health Organisation** and the **Council of Europe** have recommended that close links are in place between prison health services and public health services<sup>69</sup>. The principles which underpin prison healthcare -

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<sup>69</sup> Hayton, P. et al., “Patient or Prisoner: Does it matter which Government Ministry is responsible for the health of prisoners?”, Briefing Paper for meeting, Copenhagen October 2010, WHO: Copenhagen, at pg. 5

equivalence of care, decisions to be made on clinical grounds, patient consent and professional independence - are most likely to be met if the provision of healthcare in prisons is closely linked with the healthcare provided in the community<sup>70</sup>. There are many benefits to the two services being integrated<sup>71</sup>:

- the standard of care provided to prisoners can be improved,
- healthcare professionals who are not employed by the prison authorities will find it easier to base their judgements purely on clinical grounds and put the medical interests of the prisoner before security/management considerations,
- prisoners are more inclined to trust staff who are employed by the health authorities than by the prison authorities,
- it can ensure the continuation of treatment for prisoners coming into prison and prisoners leaving prison,
- it can ensure access to specialist services,
- it can ensure that healthcare professionals working in a prison can benefit from education and training programmes provided by the public health system.

3.52 While the policy as to who or what body should provide healthcare in prisons is a matter for the Minister and the Irish Prison Service the argument for an integrated system as outlined in paragraph 3.51 should not be ignored. Such an approach has been tried in, *inter alia*, Norway, France and the United Kingdom with largely positive results<sup>72</sup>.

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<sup>70</sup> Coyle, A., "Standards in prison health: the prisoner as a patient", in WHO, *Health in Prisons- A WHO guide to the essentials in prison health*, (2007) WHO: Copenhagen, at pg. 12

<sup>71</sup> See Fraser, A., "Primary healthcare in prisons", in WHO, *Health in Prisons- A WHO guide to the essentials in prison health*, (2007) WHO: Copenhagen, at pg. 30, International Centre for Prison Studies, "*Guidance Note 10- Improving prison healthcare*", (2004) London, at pg. 5

<sup>72</sup> Van Zyl Smit, D. & Snacken, S., "*Principles of European Prison Law and Policy- Penology and Human Rights*", (2009) Oxford University Press, at pg. 159

## **(G) Professional Competence**

- 3.53 The CPT has stated that “*prison doctors and nurses should possess specialist knowledge enabling them to deal with the particular forms of prison pathology and adapt their treatment methods to the conditions imposed by detention*”<sup>73</sup>.
- 3.54 Professional competence requires that there is sufficient healthcare staff employed in the prison. In a Report to the Government of Ireland the CPT recommended that the time actually spent by doctors seeing patients should correspond with the times that prisoners are out of their cells<sup>74</sup>. It also urged that the number of doctors be sufficient to cater for the prison population concerned<sup>75</sup>.

## **Conclusion**

- 3.55 The provision of adequate healthcare to prisoners should be regarded as a public health issue. Prisoners come from the community and the majority of them will return to the community at some point. In 2009 there was an average of 3,881 prisoners in our prisons on a daily basis and a total of 12,339 prisoners passed through the system that year<sup>76</sup>. There are not more up to date statistics but it is clear from the published statistics of the day to day prison population to date that the number for 2010 will greatly exceed those for 2009. I stated at paragraph 3.3 that prisoners are more likely to suffer from ill health than the general population. The public health hazard that this presents should not be underestimated<sup>77</sup>. It will benefit the community at large if prisoners return to the community in good health.

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<sup>73</sup> CPT 3<sup>rd</sup> General Report [CPT/Inf (93) 12], at para. 75

<sup>74</sup> CPT, Report to the Government of Ireland, CPT/Inf (2011) 3, at para. 61

<sup>75</sup> Ibid at para.64

<sup>76</sup> See Irish Prison Service Annual Report (2009)

<sup>77</sup> Penal Reform International, “Health in Prisons: realising the right to health”, (2007) at pg.13

## **Chapter 4**

### **A Case History**

- 4.1 I stated at paragraph 1.13 that because of a lack of accommodation in the CMH prisoners who should be in the CMH are detained in prisons.
- 4.2 I have seen at first hand a number of such prisoners. It is sufficient to give details of one case that I encountered in order to make the point that prisoners, who require treatment in the CMH or other like facility, should be transferred to such a hospital. The provision of sufficient beds in the CMH or other secure facility must be undertaken as a matter of urgency.
- 4.3 I have already stated at paragraph 3.7 that the CPT has stressed that a State cannot derogate from its responsibility to provide adequate healthcare, even in times of economic hardship<sup>78</sup>.
- 4.4 In order to respect issues of confidentiality I do not, in this Chapter, give details of the prison that I refer to or the gender of the prisoner.
- 4.5 During the course of an unannounced visit to a prison a prisoner was observed in a safety observation cell. The prisoner was naked, was crawling on all fours on the floor, was covered in their own excrement and completely incoherent.
- 4.6 The prisoner had been in the prison for six days prior to my visit. I was informed that the prisoner had been in the same condition as detailed at paragraph 4.5 since admission to the prison.
- 4.7 I was satisfied that the prisoner was in receipt of appropriate clinical care, that the prisoner was monitored by nurses on a four hourly basis and that the prisoner's life was not in danger.

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<sup>78</sup> CPT 11<sup>th</sup> General Report [CPT/Inf (2001) 16] at para. 31

- 4.8 I was satisfied that the prisoner was also observed by prison staff every fifteen minutes.
- 4.9 I make no criticism of the care that this prisoner was receiving from prison staff who were doing what they could to help the prisoner although not trained for the eventualities that they found themselves dealing with. Prison staff showered this very difficult prisoner on a regular basis. Prison staff are not trained to undertake such tasks.
- 4.10 I spoke to the Prison Governor, the Prison Doctor the healthcare staff in the prison and the Consultant Psychiatrist who was treating this prisoner. The professional view of all healthcare professionals was that this prisoner needed to be in a psychiatric hospital. The beds in the CMH were full and the prisoner could not be moved to any other psychiatric facility.
- 4.11 I kept this case under review and six days after my visit the prisoner was moved to the CMH.
- 4.12 It was the view of the Consultant Psychiatrist that this prisoner could not be appropriately treated in a safety observation cell in a prison setting as the prisoner required accommodation in a high observation unit.
- 4.13 I have been informed that if a person suffering from the same disorder as the prisoner mentioned above either presented at or was brought to a hospital he/she would immediately be transferred to an appropriate psychiatric hospital for treatment. This treatment would, initially, be in a high observation unit where such a person would be observed at all times by medically trained staff and would not be confined to a padded room. As treatment would progress such a person, as part of such treatment, would have greater freedom to move around the hospital, *albeit*, under supervision by hospital staff. This could not be provided in a prison setting where security issues in the prison would dictate that the prisoner would have to be effectively “locked down” in a safety observation cell until either they were transferred to the CMH or were “well enough” to rejoin the greater prison population.

- 4.14 This case history is not unique. While circumstances may change from case to case the underlying psychiatric condition of such prisoners makes it imperative that they are treated in appropriate conditions which in effect means that they should be treated in the CMH and not in a prison cell.
- 4.15 In cases, such as that mentioned above, where prisoners who should be in the CMH are detained in prisons (some for prolonged periods of time), it could not be said that Ireland is adhering to its obligations towards such prisoners and in my considered opinion this State, in similar circumstances, would find it difficult to defend an application before the **European Court of Human Rights**.
- 4.16 Prisoners such as the prisoner mentioned in this Chapter are the most vulnerable and marginalised in the Irish Prison System. I will be vigilant in ensuring that such prisoners who, because of their disability, do not have a voice are referred to as appropriate in my future reports.