

# Healthcare in Irish Prisons

Report by Judge Michael Reilly

Inspector of Prisons

November 2016

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I would particularly like to thank the many experts from other jurisdictions who shared their experiences with me including Dr Marzena Ksel (1<sup>st</sup> Vice-President of the Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT)), Professor Hans Wolff (Member of the CPT) and Dr. Alan Mitchell (Expert to the CPT), Members of the Royal College of General Practitioners Secure Environments Group led by Dr. Jake Hard, Dr. Eamonn O'Moore (National Lead for Health and Justice, Public Health England and Director of the UK Collaborating Centre for the WHO Health in Prisons Project) and the many doctors and other health professionals that I met in the course of researching this subject.

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Judge Michael Reilly  
Inspector of Prisons

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# **Chapter 1**

## **Introduction**

1.1 In a report dated 18 April 2011 – *Guidance on Physical Healthcare in a Prison Context* (hereinafter referred to as ‘2011 report’) – I drew attention to the standard of healthcare in our prisons. I stated that the Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) had identified deficiencies in the standard of healthcare provided in a number of Irish Prisons and that I concurred with this statement. I also stated that, from my inspections of prisons, I had concluded that the standard of healthcare varied from prison to prison. In my 2011 report I dealt with the general right to health that all citizens are entitled to. In addition, I detailed the right of prisoners to healthcare in a prison context.

1.2 In my ‘2011 report’ I made the case for the provision of appropriate healthcare for prisoners.

1.3 In paragraph 1.4 of my ‘2011 report’ I stated:

*I will expect that, as and from 1 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.*

1.4 Unfortunately, there are still deficiencies in the provision of healthcare in our prisons and that which is provided varies from prison to prison.

1.5 Following their last visit to Ireland in September 2014 the CPT stated that -

*the situation has improved in some prisons while it has deteriorated in others, such as Midlands Prison.*

1.6 However, the CPT findings from the 2014 visit -

*highlighted poor management of prison healthcare services and disjointed through care provision. Doctors working in prisons appeared disconnected from the national healthcare service and prison healthcare did not receive the necessary management support, with clinical opinions not acted upon and lack of escort staff available within prisons resulting in numerous prisoners missing medical appointments.*

- 1.7 The CPT recommended in its Report to the Government dated 17 November 2015 that:

*the Irish authorities identify an appropriate independent body to undertake a fundamental review of the healthcare services in Irish prisons. Furthermore, it would appreciate the observations of the Irish authorities on the question of bringing prison healthcare under the responsibility of the Ministry of Health.*

- 1.8 The Department of Justice and Equality responded to the CPT in November 2015. Included in this response was the following:

*The IPS healthcare service aims to provide prisoners with access to the same quality and range of health services as that available to those entitled to public health services in the community and which are appropriate to the prison setting....*

*In regard to the request for observations on moving responsibility for primary care services to the Ministry for Health, the IPS is aware of an emerging trend in other European jurisdictions for national healthcare service providers to assume responsibility for prison healthcare delivery. In addition, as recently as 2013, the World Health Organisation (WHO) and the United Nations Office on Drugs and Crime (UNODC) published a policy brief on the organisation of prison health – entitled Good Governance for Prison Health in the 21<sup>st</sup> Century, which concluded that the management and coordination of health services to prisoners is a whole of Government responsibility and*

*that “Health Ministries should provide, and be accountable for healthcare services in prisons, and advocate health prison conditions”. In the light of the CPT remarks, the aforementioned emerging trend of shifting responsibilities in this area and the conclusions of the WHO/UNODC policy briefing, discussions are ongoing between IPS, the Department of Justice and Equality, the Department of Health and the Health Service Executive on the future delivery model for healthcare in Irish prisons.*

- 1.9 To date there has not been a review of the provision of prison healthcare. I understand that the discussions between the IPS, the Department of Justice and Equality, the Department of Health and the Health Service Executive (HSE) are still ongoing one year after the response to the CPT referred to in paragraph 1.8.
- 1.10 When I carry out inspections of prisons it is difficult to establish if in fact the healthcare interventions offered to prisoners are appropriate. It is also difficult to establish if the level of healthcare provision in any prison is such that it meets the healthcare needs of prisoners. This is because no health needs assessment of prisoners and no staffing needs analysis has been carried out. One cannot carry out a staffing needs analysis without first ascertaining the health needs assessment in each prison.
- 1.11 The purpose of this report is threefold, namely;
- To point out again the absolute entitlement of prisoners to healthcare and the case for such healthcare to be provided by the Department of Health. (Chapter 2).
  - To point to the necessity of carrying out a health needs assessment of prisoners and a staffing needs analysis in each of our prisons. (Chapter 3).
  - To give guidance to the Irish Prison Service (IPS), to the management of prisons and the providers of healthcare in the prisons as to what will be expected of them in the area of healthcare when inspections are carried out by my office. (Chapter 4).

1.12 In Chapter 5, I set out my recommendations.

1.13 As this is an urgent issue having been highlighted by me and by such an august body as the CPT it is not unreasonable that a public response be forthcoming either accepting the thrust of this report and giving time lines for implementing my recommendations or rejecting this report. If the recommendations in this report are rejected it would be reasonable to expect that reasons for such rejection would be given.



## Chapter 2

### **The obligation to provide healthcare in prisons**

#### 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

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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

of non-discrimination and equality are important to the 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 €2.50 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.

2.8 The legally binding general obligation of the **International Covenant** referred to earlier in this chapter is reinforced by Principle 9 of the **Basic Principles for the Treatment of Prisoners**.

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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*

## Prisoners' rights to adequate healthcare

- 2.9 It is clear from paragraphs 2.1 to 2.8 that all citizens have an absolute right to health.
- 2.10 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 IPS **Health Care Standards** provide valuable guidance on the provision of healthcare in Irish prisons.
- 2.11 In addition to the instruments detailed in paragraphs 2.1 to 2.8 there are a number of International instruments which specifically recognise that prisoners have a right to health.
- 2.12 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.*

- 2.13 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.*

- 2.14 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.*

2.15 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 and the WHO. All such bodies have linked the importance of providing healthcare to prisoners to the prevention of torture and inhuman or degrading treatment or punishment.

2.16 The CPT has declared that the provision of healthcare in prisons is of direct relevance to their mandate<sup>8</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>9</sup>.*

2.17 Therefore, healthcare should be provided to prisoners on the basis that they are entitled to the same treatment as people in the free community who are entitled to medical cards as referred to in paragraph 2.7. However, it is important to point out that the prescription charge of €2.50, referred to in paragraph 2.7, should not apply to prisoners as prisoners **do not and should not pay** for that medication which they receive in prison.

#### The case for healthcare to be provided by the Department of Health

2.18 It is well established that the majority of prisoners come from the lower socio-economic sectors of our communities. Many present with mental health and other pre-existing health problems which often result from a chaotic lifestyle. It is therefore important to stress that the healthcare provided in prisons not

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<sup>8</sup> CPT 3<sup>rd</sup> General Report [CPT/Inf (93) 12] at para. 30

<sup>9</sup> Ibid at para. 30

alone acknowledges this fact but also that, for a significant number of prisoners, imprisonment can have a damaging effect on their physical and mental well-being. In this regard the following is relevant:

*When a state deprives people of their liberty, it takes on a responsibility to look after their health in terms both of the conditions under which it detains them and of the individual treatment that may be necessary. Prison administrations have a responsibility not simply to ensure effective access for prisoners to medical care but also to establish conditions that promote the well-being of both prisoners and staff.... This applies to all aspects of prison life, but especially to healthcare<sup>10</sup>*

- 2.19 In Ireland healthcare services in prisons, in the main, are provided by the IPS. An exception is the provision of in-reach mental health psychiatric services by the Central Mental Hospital (CMH) which come at no cost to the IPS as this service is funded by the HSE. Doctors are engaged either on a full time or part time basis. I have been advised by the IPS that the recruitment of full time doctors is proving difficult. As a result, the IPS are over-reliant on locum doctors, who by their nature are transitory, to provide medical services in our prisons. Nurses are employees of the IPS and as such are answerable to the governors of those prisons to which they are attached.
- 2.20 There can be a perception of, if not an actual tension between healthcare providers and prison management when matters of security are balanced against a trustful clinician / patient relationship.
- 2.21 To a degree the relationship between healthcare personnel and prisoners is different from that between healthcare personnel in the community and patients. In the community patients can choose their GP and GPs their patients. In prisons there is no such choice available.

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<sup>10</sup> Commentary to Recommendation REC(2006) 2 of the Committee of Ministers to member states on the European Prison Rules, Strasbourg, Council of Europe 2005.

2.22 The CPT in recognising this challenge has stated:

*The healthcare staff in any prison is potentially a staff at risk. Their duty of care for their patients may often enter into conflict with considerations of prison management and security. These can give rise to difficult ethical questions and choices<sup>11</sup>.*

2.23 **Principle 3** of the **United Nations General Assembly Resolution 37/194**<sup>12</sup> states:

*It is a contravention of medical ethics for health personnel, particularly physicians, to be involved in any professional relationship with prisoners or detainees the purpose of which is not solely to evaluate, protect or improve their physical and mental health.*

2.24 Therefore, professional independence is critical and was recognised as such by the **Committee of Ministers of the Council of Europe** in paragraph 20 of **Recommendation R(98)7**<sup>13</sup> when they stated:

*Clinical decisions and any other assessments regarding the health of detained persons should be governed only by medical criteria. Healthcare personnel should operate with complete independence within the bounds of their qualifications and competence.*

2.25 It could be argued that this country could comply with best international practice by ensuring that the present prison administered healthcare services could form close links with the HSE. However, the Department of Justice and Equality have acknowledged (see paragraph 1.8) that the international trend is to a

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<sup>11</sup> Report to the Albanian Government on the visit to Albania carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment from 23 May to 3 June 2005. (CPT/inf 2006) 24.

<sup>12</sup> 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, inhumane or degrading treatment or punishment. United Nations General Assembly Resolution 37/194. New York, United Nations, 1982.

<sup>13</sup> Recommendation R(98)7 of the Committee of Ministers to member states concerning the ethical and organisational aspects of healthcare in prison. Strasbourg, Council of Europe, 1998

service that is within the responsibility of the Department of Health. In order to copper fasten this statement I wish to refer to the following statement of the **Committee of Ministers of the Council of Europe** in its official commentary to the revised and updated European Prison Rules 2006:

*The most effective way of implementing rule 40 (organisation of healthcare) is that the national health authority should also be responsible for providing healthcare in prison, as is the case in a number of countries<sup>14</sup>.*

The **Committee of Ministers** went on to state:

*This will not only allow for continuity of treatment but will also enable prisoners and staff to benefit from wider developments in treatments, in professional standards and in training.*

## Resources

- 2.26 There may well be resource issues in transferring responsibility for prisoner healthcare from the IPS to the HSE and the Department of Health.
- 2.27 However, this **cannot** be used as an excuse for delaying such transfer of responsibility. In this regard it must be borne in mind that the State **accepts a heavy responsibility** when it detains a person to ensure the well-being of that person. It is internationally acknowledged that lack of financial means cannot reduce this responsibility. This has been made clear by the **Council of Europe** in numbers of its instruments.

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<sup>14</sup> Commentary to Recommendation REC(2006)2 of the Committee of Ministers to member states on the European Prison Rules.



### Chapter 3

#### **The case for a health needs assessment of prisoners and a staffing needs analysis in each prison**

- 3.1 Irrespective of which body is responsible for healthcare in Irish prisons, be it the IPS or the HSE, a comprehensive assessment of the health needs of prisoners in the 13 prisons must be undertaken. This must be followed by a staffing needs analysis of healthcare personnel in each prison.
- 3.2 I have been informed that such an assessment of the health needs of prisoners has never been undertaken in this country.
- 3.3 In carrying out my inspections of prisons I have met the health providers who have, in the main, been critical of many aspects of the conditions under which they are expected to provide a healthcare service which is appropriate to the needs of those held in our prisons. These range from a workload that is impossible to manage, to a reduction in the numbers of nursing staff to a dangerous level, to the absence in some cases of medical cover at night or at weekends to name but three.
- 3.4 It is impossible for me or any other inspectorate to express a view on the adequacy of the healthcare presently provided in our prisons as it seems to operate on an *ad hoc* basis with no special regard for the needs of the different cohorts of prisoners in the individual prisons. This is not to be taken as a criticism of those many professionals who provide healthcare in our prisons to the best of their ability in a system where the specific needs of the various cohorts of prisoners are not formally acknowledged. In other words, the specific needs of remand prisoners will differ from those of committal prisoners. Similarly, the needs of female prisoners will differ from male prisoners and those of elderly prisoners will differ from those of young prisoners. It is also impossible to express a view on the adequacy of the numbers of healthcare staff in any one prison without knowing what needs such staff must deal with.

- 3.5 There are many models of health needs assessments in numbers of countries that might be looked at when deciding on a model for this country.
- 3.6 To take one example - in Northern Ireland a health needs assessment of the health needs of the prisoners in its three prison sites was carried out and reported on by the HSC Public Health Agency - *2013/14 Health Needs Assessment of Prisoners in Northern Ireland*.
- 3.7 In Northern Ireland the assessment referred to in paragraph 3.6 identified different specific needs in its different prisons. Obviously, the same would apply in this jurisdiction for the reasons referred to in the second part of paragraph 3.4.
- 3.8 The lead in any such assessment in this jurisdiction must be a clinician who has knowledge and experience of working with prisoners and evaluating their healthcare needs.
- 3.9 Rule 99(2) of the Prison Rules 2007 provides:
- The Minister shall appoint a registered medical practitioner to carry on and manage, and control generally, the administration of the prison healthcare services who shall be known as and is referred to in these Rules as the “Director of Prison Healthcare Services”.*
- 3.10 In the report - *Culture and Organisation in the Irish Prison Service a Road Map for the Future* - Professor Coyle and I observed that despite Rule 99(2) of the Prison Rules 2007 referred to in paragraph 3.9 the IPS had not appointed a Director of Healthcare. To date no such appointment has been made.
- 3.11 A Director of Healthcare who is a registered healthcare professional should be appointed immediately whose duty should not only be to manage the healthcare in our prisons but to oversee the transition of healthcare from the IPS to the HSE. This Director of Healthcare should be the clinical lead in the IPS and therefore the line manager for those providing healthcare in our prisons. The

necessity for a Director of Healthcare would cease when responsibility for the provision of healthcare is transferred to the HSE.

- 3.12 The staffing needs analysis referred to earlier in this report for each prison should be undertaken as soon as the health needs assessment of prisoners has been completed. It is important that such an analysis should be clinically led and should not be influenced by operational or other non-healthcare considerations **other than** the obvious interdependence of healthcare staff and custody staff working together e.g. in ensuring prisoners are escorted to the nurse/doctor appointment or to outside hospitals etc.
- 3.13 While it is stating the obvious it is important to acknowledge that the provision of healthcare is not confined to that which is provided by doctors and nurses but embraces all aspects of care including dental care, addiction services, psychiatric and psychology services.
- 3.14 In considering the healthcare needs of prisoners, consideration of external matters such as the proximity of prisons to hospitals would be important. In addition, such an assessment would, of necessity, advise on preventative healthcare in our prisons.
- 3.15 At this juncture I would like to sound a word of warning. Sectional interests should not influence any assessment of the health needs of prisoners or the healthcare staffing needs of our prisons.
- 3.16 The results of such assessments for each prison should be published as should the staffing needs analysis for each prison. The appropriate number of healthcare professionals and others working in the provision of healthcare should be published for each prison in order that I or any other investigative body can readily assess the level of healthcare being provided in any prison. It would, of course, be for a regulatory body of the HSE to investigate the quality of such healthcare when responsibility for the provision of healthcare is vested in it.

- 3.17 The healthcare being provided in each prison should be kept under ongoing review as the prison population can rise or fall and the cohort of prisoners in any prison can change from time to time.
- 3.18 The health needs assessment advocated in this Chapter for all prisons should be undertaken immediately followed by the staffing needs analysis.

## **Chapter 4**

### **Guidance on the expectations of the Inspector of Prisons when inspecting healthcare facilities in prisons**

- 4.1 In this Chapter I seek to give guidance on the type of information and records that I and/or my officials may require when inspecting healthcare facilities in prisons. I also wish to alert prison management that I will be paying particular attention to the physical environment in which healthcare is provided. Of course, should it be necessary to inspect the medical records of individual prisoners these will only be inspected by healthcare personnel in order to maintain medical confidentiality or by me and/or my officials but then only in such cases where the prior consent of relevant prisoners is furnished.
- 4.2 At any time on being requested prison governors and/or healthcare staff should be in a position to make available to me or my officials the following:
- (a) The health needs assessment for the prison.
  - (b) The staffing needs analysis for the prison.
  - (c) The number of nurses, doctors, psychiatrists, dentists, other specialists, psychologists, auxiliaries etc. engaged full-time or part-time and their hours of duty.
  - (d) The number of medical referrals to A&E hospital departments for a given period.
  - (e) The average time for transfer of prisoners to A&E departments referred to at (d) above with the longest and shortest time for a given period.
  - (f) The number of medical referrals to external consultants for a given period.
  - (g) The number of cancellations of appointments with external consultants with reasons for such cancellations for a given period.

4.3 When visiting prisons, I and my officials will pay particular attention to the following:

- (a) The adequacy of consultation rooms.
- (b) The access of prisoners to healthcare personnel. By this I mean whether prisoners who need to see a doctor or other member of the healthcare or therapeutic staff are facilitated by the prison staff.
- (c) The confidentiality of consultations or examinations by medical staff and where and under what conditions these take place.
- (d) The access of those prisoners on restricted regimes to healthcare.
- (e) The means for non-English speaking prisoners or those with communication difficulties to engage with healthcare personnel.
- (f) The time of distribution of night time medication. By this I mean that night sedation should be given at night and not at 6 pm. In making this statement I am not suggesting that this is the practice.
- (g) The procedure for emergency response during or outside working hours.
- (h) The medical staff on call outside working hours – who and how?

4.4 The information referred to in paragraphs 4.2 and 4.3 would not compromise the confidentiality enjoyed by patients (prisoners) and their doctors or other healthcare professionals. Therefore, in carrying out my inspections I will be seeking such information irrespective of whether the healthcare is provided by the IPS in the short term or subsequently by the HSE.

## Chapter 5

### **Recommendations**

- 5.1 Responsibility for the provision of healthcare should be transferred from the IPS to the HSE.
- 5.2 A health needs assessment of prisoners in all prisons should be undertaken immediately.
- 5.3 The lead in the assessment referred to in paragraph 5.2 must be a clinician.
- 5.4 A healthcare staffing needs analysis for each prison should be undertaken on the completion of the health needs assessment referred to in paragraph 5.2. This analysis should be clinically led.
- 5.5 The healthcare staffing needs analysis referred to in paragraph 5.4 must reflect the health needs assessment of prisoners in each particular prison.
- 5.6 It is important that such an analysis should be clinically led and should not be influenced by operational or other non-healthcare considerations **other than** the obvious interdependence of healthcare staff and custody staff working together e.g. in ensuring prisoners are escorted to the nurse/doctor appointment or to outside hospitals etc.
- 5.7 The health needs assessment of prisoners and the staffing needs analysis must be published for each prison.
- 5.8 The health needs of prisoners and by extension the staffing needs of each prison must be kept under constant review as prison populations change as do the cohort of prisoners in all prisons.
- 5.9 As this is an urgent issue and as this report must be published pursuant to Part 5 of the Prisons Act 2007 it is not unreasonable that a public response be

forthcoming either accepting the thrust of this report and giving time lines for implementing my recommendations or rejecting this report. If the recommendations in this report are rejected it would be reasonable to expect that reasons for such rejection would be given. I have already referred to this in paragraph 1.13.