4. Health Care

Issues/ Rules covered:

- Provision of health-care (Rules 24-27, 30 and 31)
- Medical ethics (Rules 32 and 46)
- Role of doctors in case of signs of torture or other ill-treatment (Rule 34)

General Principles

States are under an international obligation to ensure the right to the highest attainable standard of health[1]. The fulfilment of this obligation is particularly acute in prisons as a combination of factors can make prison environments detrimental to health and wellbeing and place prisoners in a position of vulnerability as a result. Compared to the general population, the health needs within the prison population are typically higher in relation to physical and mental health and drug dependencies.[2]

Prisoners fully depend on the authorities to access health-care. Any act or omission by the authorities can have a serious impact on a prisoner's health and well-being. It is therefore critical that there are:

- qualified staff;
- continuity of care between prisons and the community;
- robust health-care services and infrastructure are provided within prison[3];

[1] UN Committee on Economic, Social and Cultural Rights, *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12)*. Adopted at the Twenty-second Session of the Committee on Economic, Social and Cultural Rights, on 11 August 2000 (Contained in Document E/C.12/2000/4) at para 43(a) available at: http://www.ohchr.org/Documents/Issues/Women/WRGS/Health/GC14.pdf (*General Comment No. 14)*

[2] World Health Organization Europe, *Good governance of prison health in the 21st century. A policy brief on the organization of prison health* (2013) available at: http://www.euro.who.int/__data/assets/pdf_file/0017/231506/Good-governance-for-prison-health-in-the-21st-century.pdf?ua=1 (*WHO, Good governance of prison health in the 21st century)*

[3] United Nations Office for Project Services, *Technical Guidance for Prison Planning: Technical and Operational Considerations Based on the Nelson Mandela Rules* (2016) at 151 – 157 (setting out the minimum elements that must be provided in prisons including that: '[Prison facilities must include a dedicated space for the provision of physical and mental health services, as well as dental services. Prisons that house women must include provisions for pre- and post-natal care, and other gender-specific health care services') available at: https://www.unops.org/SiteCollectionDocuments/Publications/TechnicalGuidance_PrisonPlanning.pdf (*UNOPS, Technical Guidance for Prison Planning*); Sub-Committee on the Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, *Report of the Sub-Committee on the Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment to Kyrgyzstan* CAT/OP/KGZ/1 (2014) at paras. 90 - 94 (identifying the needs of a healthcare system to include adequate equipment, qualified and adequately paid staff including mental health experts, adequate and free medical supplies, a high standard of diagnostic and therapeutic services, adequate sanitary conditions, adequate central heating and adequate training including in the assessment and response to human rights violations) available at:

- prisoners' health does not deteriorate but rather treatment is aimed at recovery and rehabilitation;
- the prison administration always follows the medical advice and recommendations of health-care staff;[4]
- wherever possible women physicians and nurses attend to women prisoners to conduct examinations or treatment.[5]

Caregiving Mission of Health-Care Staff

The Essex Group noted that Rule 25 of the Nelson Mandela Rules pinpoints caregiving as the fundamental mission of health-care staff in prisons. The experts advised that the rest of the Rules on health-care should be read from this starting point as it provides the framework for health-care in prisons in line with international human rights standards and norms.[6] They also pointed out that the implementation of this fundamental mission requires states to ensure the adequate allocation of resources to health-care in prisons.

Interdisciplinary Team

Rule 25(2) requires the health-care service within prison to comprise an interdisciplinary team, including with expertise in psychology, psychiatry, dental care and pre- and post-natal care.[7] This is reiterated in Rule 78 of the Nelson Mandela Rules that provide that '[s]o far as possible, prison staff shall include a sufficient number of specialists such as psychiatrics, psychologists, social workers, teachers and trade instructors'.

Read together with Rule 29(1)(b) which requires provision for child-specific health-care, the interdisciplinary team must include a child-health specialist where children are in prison with a parent. This aligns with the UN Rules for the Treatment of Women Prisoners and Non-Custodial Measures for Women Offenders (Bangkok Rules) which require that a child health specialist is available 'to determine any treatment and medical needs'[8] of a child accompanying a parent.[9]

Full Clinical Independence

Rule 25(2) underscores the full clinical independence of the health-care service. This reflects the range of international standards and norms providing for the clinical independence of

---

http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CAT%2fOP%2fKGZ%2f1&Lang=en (*Kyrgyzstan CAT/OP/KGZ/1)*

[4] European Court of Human Rights, Thematic *Report Health-related issues in the case-law of the European Court of Human Rights* (2015) Chapter IV. Health of Detainees. A. Introduction (p. 13) available at: http://www.echr.coe.int/Documents/Research_report_health.pdf

[5] Due to common histories of violence, including sexual violence, the need for sexual and reproductive healthcare and due to cultural reasons it is generally acknowledged that female health-care staff should attend to women prisoners wherever possible. Rule 10(2), *United Nations Rules for Treatment of Women Prisoners and Non-Custodial Measures for Women Offenders* (*the Bangkok Rules*) A/C.3/65/L.5 (6 October 2010) requires that an examination is undertaken by a woman physician or nurse if a woman prisoner requests so, unless this is not possible and the situation requires urgent medical attention.

[6] See *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.* United Nations General Assembly Resolution 37/194. New York, United Nations, 1982 available at: http://www.un.org/documents/ga/res/37/a37r194.htm (*UN Principles of Medical Ethics)*

[7] UN Committee against Torture, *Observations of the Committee on the revision of the United Nations Standard Minimum Rules for the Treatment of Prisoners* (SMR), 16 December 2013, UN-Doc. CAT/C/51/4, para. 24 available at: http://www.refworld.org/docid/53429c014.html

[8] Rule 9.

[9] The *Bangkok Rules* recognise the central role of both parents and clarify that in para. 12 of the preliminary observations that some of the rules apply equally to male prisoners and to offenders who are fathers.

health professionals working in prisons.[10]

Rule 24(2) provides that health-care services should be 'organised in close relationship to the general public health administration'. When read together with Rule 25(2), the Essex Group recalled international standards and norms that require the general public health administration to be the entity to employ the prison health-care staff rather than the prison director in order to safeguard clinical independence.[11]

The Essex Group also noted that as provided in Rule 27(2), the prison administration must have no influence or go against the decisions of the health-care team. The Rule underscores that decisions 'may only be taken by the responsible healthcare professionals and may not be overruled or ignored by non-medical prison staff'. This is in line with medical ethics including the World Medical Association's Declaration of Tokyo[12] which states that:

> *A physician must have complete clinical independence in deciding upon the care of a person for whom he or she is medically responsible. The physician's fundamental role is to alleviate the distress of his or her fellow human beings, and no motive, whether personal, collective or political, shall prevail against this higher purpose'.*[13]

Equivalence of Care

Rule 24 of the Nelson Mandela Rules emphasises that health-care in prison should be equivalent to that in the community as the right to the highest attainable standard of health under the International Covenant on Economic, Social and Cultural Rights applies throughout the state without distinction. Those in the community and in prisons have a right to the highest attainable standard of health-care based on assessed individual needs and the state is required to meet the obligation to the outside community and in prisons. Rule 24 requires the organization of health-care in 'close relationship to the general public health administration' as a means of ensuring equivalence and continuity of care.

The Essex Group noted that in some states health-care in the community may be very poor. In such circumstances, as outlined by the UN Office for Project Services in its interpretation

---

[10] *UN Principles of Medical Ethics*, the *Bangkok Rules*, the *UN Rules for the Protection of Juveniles Deprived of their Liberty* adopted by General Assembly resolution 45/113 on 2 April 1991, the Background Paper for the *Trencin Statement on Prisons and Mental Health* 2007 (*the Trencin Statement*), the Council of Europe Committee of Ministers' *Recommendation No. R (98) 7 Concerning the Ethical and Organisational Aspects of Health Care in Prison* 8 April 1998, and Principle X of the *Principles and Best Practices on the Protection of Persons Deprived of Liberty in the Americas* (2008) indicate international acceptance of such obligations. The provision of health-care services operated with full clinical independence has also been established in the Proposed *Guidelines & Institutional Mechanisms A Project of the International Dual Loyalty Working Group Guidelines for Prison, Detention and Other Custodial Settings* (*Dual Loyalty Guidelines*) and in the World Medical Association Declaration of Tokyo-*Guidelines for Physicians Concerning Torture and other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment* 1975, Rev. October 2016, available at: http://www.wma.net/en/30publications/10policies/c18/ (*WMA Declaration of Tokyo*)

[11] *WHO, Good governance of prison health in the 21st century*. In this document WHO suggests that in order for prisons to meet international human rights standards and to contribute to better public health the best organisational solution is that "health ministries should provide and be accountable for health care services in prisons and advocate healthy prison conditions." See also *Commentary to Recommendation REC(2006)2 of the Committee of Ministers to member states on the European Prison Rules*. Strasbourg, Council of Europe (2005) available at: http://www.coe.int/t/dghl/standardsetting/prisons/E%20commentary%20to%20the%20EPR.pdf. It reads (at p.17): "Organisation of prison health care. Rule 40. The most effective way of implementing Rule 40 is that the national health authority should also be responsible for providing health care in prison, as is the case in a number of European countries. (…). This will not only allow for a continuity of treatment but will also enable prisoners and staff to benefit from wider developments in treatments, in professional standards and in training." *(Commentary to Recommendation REC(2006)2)*

[12] *WMA Declaration of Tokyo*

[13] Principle 5

of the Nelson Mandela Rules, '[w]hile it is a typical expectation that health facilities should be equivalent to the standard of facilities serving the broader community, it must be recognized that the absence of local health facilities does not imply a lack of responsibility toward the healthcare of prisoners'.[14]

Continuity of Care

Rule 24(2) of the Nelson Mandela Rules addresses continuity of care, a key aspect of which is the organisation of health-care services in close relationship to the public health administration.[15] The Essex Group noted that continuity of care has two dimensions: first, continuity with care prior to and upon entering prison; and second, continuity with care in prison on release or transfer. (See Rule 26(2) concerning transfer of medical files upon transfer of prisoners). For example, on entering prison, Rule 24(2) would require prisoners to be able to bring drugs like an inhaler into prison in order to ensure continuity of care.[16]

Health-care staff have the duty to cooperate in the coordination of continuous care (see also Rule 30(a)).[17] The Essex Group noted that continuity of care extends to drug dependence, noting the importance of ensuring that treatment allowed in the community, like methadone, is also allowed in prisons in line with harm reduction and to avoid prisoners having to go 'cold-turkey'.[18] The UN High Commissioner for Human Rights, in his study on the impact of the world drug problem on the enjoyment of human rights, emphasised the entitlement of persons in custodial settings, to the same standard of health-care found on the outside, including with regard to prevention, harm reduction and antiretroviral therapy.[19] The importance of continuity of care with regard to treatment such as opioid substitution and antiretroviral therapy, has been underscored by the World Health Organization and UNAIDS, stressing that interrupting such treatment has serious health consequences.[20]

---

[14] *UNOPS Technical Guidance for Prison Planning* at 153.

[15] *Commentary to Recommendation REC(2006)2*. It reads: Organisation of prison health care. Rule 40. The most effective way of implementing Rule 40 is that the national health authority should also be responsible for providing health care in prison (..). (…). This will (..) allow for a continuity of treatment (..)."

[16] *Gladkiy v. Russia*, Application No. 3242/03 (ECHR, 21 December 2010) at para. 47

[17] *WMA Declaration of Lisbon on the Rights of the Patient* (1981/Rev. 2015), available at: (http://www.wma.net/en/30publications/10policies/l4/) Principle 1. Right to medical care of good quality (f). "The patient has the right to continuity of health care. The physician has an obligation to cooperate in the coordination of medically indicated care with other health care providers treating the patient. The physician may not discontinue treatment of a patient as long as further treatment is medically indicated, without giving the patient reasonable assistance and sufficient opportunity to make alternative arrangements for care." See also *Commentary to Recommendation REC(2006)2.* It reads (at p. 17): Organisation of prison health care. Rule 40. The most effective way of implementing Rule 40 is that the national health authority should also be responsible for providing health care in prison, as is the case in a number of European countries. (…). This will (..) allow for a continuity of treatment (..)." It also reads (at p. 19) "Rule 42.2 provides that if a prisoner is released before the completion of his treatment, it is important that the medical practitioner establishes links with medical services in the community so as to enable the prisoner to continue his treatment following release."

[18] Principle 6, UNODC/WHO, *Principles of Drug Dependence Treatment Discussion Paper* (March 2008), available at: https://www.unodc.org/documents/drug-treatment/UNODC-WHO-Principles-of-Drug-Dependence-Treatment-March08.pdf; The UN Committee on Economic, Social and Cultural Rights, the Special Rapporteur on the Right to Health and the UN High Commissioner for Human Rights have all mentioned harm reduction as part of the right to health: UN Committee on Economic, Social and Cultural Rights, *Concluding Observations: Tajikistan* (24 November 2006) UN Doc No E/C.12/TJK/CO/1, at para. 70; UN Human Rights Council, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, *Paul Hunt, Mission to Sweden* (28 February 2007) UN Doc No A/HRC/4/28/Add.2, at para. 60 and UN General Assembly, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health* (6 August 2010) A/65/255, at para. 60;
United Nations High Commissioner for Human Rights, *Study on the impact of the world drug problem on the enjoyment of human rights* (4 September 2015) UN Doc A/HRC/30/65, at paras. 21-23 (*OHCHR Study on the impact of the world drug problem)*.

[19] *OHCHR Study on the impact of the world drug problem*, para. 21

[20] WHO, UNODC and UNAIDS, *Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users* (2009) available at: http://www.who.int/hiv/pub/idu/idu_target_setting_guide.pdf, p. 26, and WHO, *Consolidated Guidelines on HIV*

Continuity of care is also critical as a means of preventing overdoses in opioid-dependent prisoners in the immediate post-release period. Pre-release drug services should be coordinated with and linked to appropriate after-care.[21]

The Essex Group noted the importance of training and education of the prison administration on drug dependency.

The Essex Group also noted the importance of reading the requirement to provide continuity of care together with Rule 2(2) of the Nelson Mandela Rules which provides that prison administrations need to 'take account of the individual needs of prisoners, in particular the most vulnerable categories in prison settings' and adopt '[m]easures to protect and promote the rights of prisoners with special needs'.

When non-national prisoners are released, they may be transferred to their country of origin which may complicate the requirement to provide continuity of care. International standards and norms require states 'to facilitate the continuation of medical treatment of foreign prisoners who are to be transferred, extradited or expelled, which may include the provision of medication for use during transportation to that State and, with the prisoners' consent, the transfer of medical records to the medical services of another state'.[22]

Provision of Healthcare Free of Charge

Rule 24 provides that health-care should be free of charge.[23] The World Health Organization has clarified that 'free of charge' should be interpreted literally without any qualifications or ceilings. For example, 'free of charge' does not mean that prisoners should only be provided with free access to health-care facilities (such as being transported to a hospital but then being charged for the treatment needed) or that medications should be bought by the family.[24] Rather, it means that access to health-care and all necessary treatment, care and medication must be free of charge.

When read together with Rule 25, the Essex Group suggested that a clear way to understand the requirement to provide health-care free of charge is to understand it as all treatment and medicine that a qualified clinician deems necessary. Medical necessity can only be determined by medical staff and on a case-by-case basis (see Rule 27(2)). Rule 24

Prevention, Treatment And Care For Key Populations (July 2014), available at: http://apps.who.int/iris/bitstream/10665/128048/1/9789241507431_eng.pdf?ua=1&ua=1 ,p. 5.

[21] WHO, *Preventing overdose deaths in the criminal-justice system,* 2010 (updated 2014) available at: http://www.euro.who.int/__data/assets/pdf_file/0020/114914/Preventing-overdose-deaths-in-the-criminal-justice-system.pdf?ua=1

[22] Council of Europe: Committee of Ministers, *Recommendation CM/Rec(2012)12 of the Committee of Ministers to member States concerning foreign prisoners*, 2012 available at: https://wcd.coe.int/ViewDoc.jsp?p=&Ref=CM/Rec(2012)12&Language=lanEnglish&Ver=original&Site=CM&BackColorInternet=C3C3C3&BackColorIntranet=EDB021&BackColorLogged=F5D383&direct=true) Rule 31.9. Further, reference could also be made to Rule 35.5 CM/Rec(2012)12 and Council of Europe: Committee of Ministers, *Commentary to Recommendation CM/Rec(2012) 12 of the Committee of Ministers to member States concerning foreign prisoners,* 2012 available at: http://www.coe.int/t/dghl/standardsetting/prisons/Rec(2012)12Commentary_E.pdf

[23] *Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment* (1988), A/RES/43/173. Principle 24. A proper medical examination shall be offered to a detained or imprisoned person as promptly as possible after his admission to the place of detention or imprisonment, and thereafter medical care and treatment shall be provided whenever necessary. This care and treatment shall be provided free of charge. (http://www.un.org/documents/ga/res/43/a43r173.htm).

[24] Møller L, Stöver H, Jürgens R, Gatherer A and Nikogasian H, (eds.), *Health in prisons, A WHO guide to the essentials in prison health*, WHO Europe (2007), available at: http://www.euro.who.int/__data/assets/pdf_file/0009/99018/E90174.pdf, at 10 (*A WHO guide to the essentials in prison health*)

should therefore be read together with Rules 30(a) and 25(2) on clinical independence; Rule 27(2) providing that clinical decisions are the sole province of health-care professionals; and Rule 32(1) providing that treatment can only be based on clinical grounds.

The Essex Group noted that 'necessary' does not refer only to life-saving treatment, procedures or basic healthcare. Rather, it refers to the care that is necessary to maintain the established health needs of the prisoner[25] in line with Rule 25 and the prohibition of torture and other cruel, inhuman or degrading treatment or punishment[26].

The Essex Group noted that Rule 24(1) requires that free health-care is provided 'without discrimination on the grounds of their legal status'.[27] The experts pointed to the particular risk to non-national prisoners and pre-trial detainees and underscored that the requirement to provide health-care free of charge applies to all prisoners without distinction on grounds of nationality or otherwise.

The Essex Group pointed out that prisoners' health problems can be aggravated by the prison facilities. Therefore, Rule 24 should be read together with the obligation of the prison administration to ensure that prisons are safe as set out in Rules 12, 13 and 35 by ensuring that the prison is maintained in a way that does not worsen or aggravate prisoners' health.

Medical Ethics

The Essex Group recalled that informed consent, patient autonomy and confidentiality are key components of the right to health and the cornerstones of a trustful patient-doctor relationship which is also a precondition for effective public health.

Rule 32(1) provides that the same ethical and professional standards shall apply to the relationship between the doctor and the prisoner-patient as between the doctor and the patient in the community[28].

Rule 31(1)(d) also sets out, '[a]n absolute prohibition on engaging, actively or passively, in acts that may constitute torture or other cruel, inhuman or degrading treatment or punishment, including medical or scientific experimentation that may be detrimental to a prisoner's health, such as the removal of a prisoner's cells, body tissues or organs'.

The Essex Group noted that in order to ensure that this requirement is met in the prison context, training for all staff (particularly medical staff) on human rights and medical ethics

---

[25] Council of Europe: Committee of Ministers, *Recommendation No. R (98) 7 of the Committee of Ministers to member states concerning the ethical and organisational aspects of health care in prison*, 1998 (available at: https://rm.coe.int/CoERMPublicCommonSearchServices/DisplayDCTMContent?documentId=09000016804fb13c) makes clear that "necessary" refers to established health needs of individual prisoners according to their right to health, see: *Main characteristics of the right to health care in prison. A. Access to a doctor. 2.* "In order to satisfy the health requirements of the inmates, doctors and qualified nurses should be available (..), depending on the number and the turnover of inmates and their average state of health."

[26] Council of Europe: European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, *CPT standards*, 2015 (CPT/Inf/E (2002) 1 - Rev. 2015) Standard on Health care services in prisons, No. 30 p. 38: "An inadequate level of health care can lead rapidly to situations falling within the scope of the term 'inhuman and degrading treatment'". Available at: http://www.cpt.coe.int/en/documents/eng-standards.pdf (*CPT Standards*)

[27] UN Committee against Torture, *Observations of the Committee on the revision of the United Nations Standard Minimum Rules for the Treatment of Prisoners (SMR),* 16 December 2013, UN-Doc. CAT/C/51/4, para. 24 (*CAT SMR revision observations*).

[28] The World Medical Association (WMA) gives a good collection of useful resources regarding Medical Ethics. See: http://www.wma.net/en/20activities/10ethics/

will be needed[29].

Informed Consent and Autonomy

Of particular importance to medical ethics and the right to the highest attainable standard of health is a strong understanding of informed consent and prisoner-patient autonomy as set out in Rule 32(1)(b).

The Essex Group noted that prison authorities are under an obligation to make sure that informed consent is documented through a written procedure.

As set out above, prisoner-patient autonomy and confidentiality are cornerstones of a trustful patient-doctor relationship. The absence of a trustful relationship may mean that prisoners may not feel comfortable revealing health conditions that could be of public health relevance. Where treatment is proposed, the principles of informed consent and patient autonomy mean that the prisoner must be able to refuse treatment if he or she does not wish to receive it.[30]

The information on the proposed treatment must be explained in a language that the prisoner understands. In the very narrowest of circumstances, the Essex Group noted that medical staff may act where the prisoner is unable to consent, for example, where the prisoner is unconscious and requires emergency treatment. However, following the Declaration of Lisbon, where clear prior wishes to the contrary have been expressed, even such emergency treatment is not permissible. This Declaration provides that, 'if a legally entitled representative is not available, consent of the patient may be presumed, unless it is obvious and beyond any doubt on the basis of the patient's previous firm expression or conviction that he/she would refuse consent to the intervention in that situation'.[31]

The experts recalled that no vaginal examination of women prisoners must be undertaken without consent and that virginity tests are prohibited explicitly by Rule 8 of the Bangkok Rules.

Rule 32(2) addresses informed consent in the context of participation in 'clinical trials and other health research accessible in the community'. Informed consent is always critical for participation in clinical trials or research.[32] It is magnified in the context of deprivation of

---

[29] *WHO, Good governance of prison health in the 21st century* reflects on State's core obligations under the right to health according to *General Comment No. 14* and concludes with regard to health staff's professional and ethical conduct and their clinical independence (at p. 9) "(..) such an understanding of their role implies the necessity for all people working in prisons to be trained in and respect human rights and medical ethics". The Norwegian Medical Association, in cooperation with the World Medical Association, has developed a web-based course *Doctors Working in Prison: Human Rights and Ethical Dilemma*. Oslo, Norwegian Medical Association, 2001, available at: http://www.wma.net/en/70education/10onlinecourses/20prison/ , or https://nettkurs.legeforeningen.no/enrol/index.php?id=39). See also *UN Principles of Medical Ethics* and the Council of Europe's Manual on *Prison health care and medical ethics* (2015), available at: http://www.coe.int/t/dgi/criminallawcoop/Presentation/Documents/Publications_HealthCare_manual_Web_A5_E.pdf .

[30] *A WHO guide to the essentials in prison health*, at 37- 38; UN General Assembly, *Interim report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*, (28 July 2008) UN doc A/63/175, paras. 47, 74.

[31] *WMA Declaration of Lisbon on the Rights of the Patient* (1981/Rev.2015), available at: http://www.wma.net/en/30publications/10policies/l4/, Principle 4 b.

[32] World Medical Association, D*eclaration of Helsinki - Ethical Principles for Medical Research Involving Human Subjects* adopted at 18th WMA General Assembly, rev. at 64th WMA General Assembly, Fortaleza, Brazil October 2013, available at: (http://www.wma.net/en/30publications/10policies/b3) paras 25 – 32 on informed consent in research (*WMA Declaration of Helsinki)*

liberty.[33]

As in the community, informed consent must be obtained through the provision of information to the prisoner-patient by those conducting the trials or research (such as a company or research institute). An ethics committee must also be involved in order to provide an independent view on whether the treatment would produce a 'direct and significant' benefit to health. The Essex Group noted that the prison authorities are under an obligation to ensure that the trial has been officially approved by an appropriate body and that this information and the means of conveying it to the prisoner must be the same as in the outside world.

Confidentiality

The Essex Group reiterated the overall principle of confidentiality as set out in the first Essex paper. In that paper, the experts stated that, the principle of medical confidentiality is a fundamental tenet of medical practice and derives from the right to privacy as recognized in the International Covenant on Civil and Political Rights. It has also been set out in Rule 8 of the Bangkok Rules, the World Medical Associations International Code of Medical Ethics 1949 (revised 2006), the World Medical Association Declaration of Lisbon on the Rights of the Patient, the Dual Loyalty Guidelines, Principle X of the Principles and Best Practices on the Protection of Persons Deprived of Liberty in the Americas, and the European Committee for the Prevention of Torture (CPT) Standards.

The Essex Group recalled that confidentiality in prisons should be understood in the same way as in the community at large.[34] Rule 32(1)(c) requires the confidentiality of medical information 'unless maintaining confidentiality would result in a real or imminent threat to the patient or others'. The Essex Group noted that the exception to confidentiality in Rule 32(1)(c) should be understood narrowly and not as applying to the whole medical file. Rather, it requires an assessment of which specific pieces of information need to be communicated and at what level on a 'need to know basis'.[35] The exception does not imply that the whole medical file should be shared but depending on the situation, a summary of the pertinent issues (such as whether illness may have contributed to a particular behaviour) may be necessary. Similarly, the medical staff may communicate that certain action is needed without communicating that the prisoner has a particular disease or illness. An assessment of who receives the information will also be needed bearing in mind the sensitivity and confidentiality of medical information.

Part of the obligation of confidentiality covers the storage of confidential records as set out in Rule 26. The Essex Group noted that these records should encompass a full medical file, not simply a summary. Standard 39 of the CPT Standards provides that,

> *A medical file should be compiled for each patient, containing diagnostic information as well as an ongoing record of the patient's evolution and of any special examinations he has undergone.*[36]

---

[33] See *WMA Declaration of Helsinki*; *CPT Standards*; Council of Europe: Committee of Ministers, *Recommendation No. R (93) 6 concerning prison and criminological aspects of the control of transmissible diseases including Aids and related health problems in prisons* (1993) available at: https://bip.ms.gov.pl/Data/Files/_public/bip/prawa_czlowieka/zalecenia/936.pdf; Council of Europe, *Additional protocol Human rights to the Convention on Human Rights and Biomedicine, concerning Biomedical Research*, Strasbourg 2005 (art 20), available at: https://www.coe.int/en/web/conventions/full-list/-/conventions/rms/090000168008371a

[34] *CAT SMR revision observations*, para.21

[35] World Medical Association, *Medical Ethics Manual* (3rd edition 2015), available at: http://www.wma.net/en/30publications/30ethicsmanual/pdf/ethics_manual_en.pdf, at 53-56

[36] At 40.

Standard 40 also provides that,

> *A personal and confidential medical file should be opened for each patient. The file should contain diagnostic information (including the results of any special examinations which the patient has undergone) as well as an ongoing record of the patient's mental and somatic state of health and of his treatment.*[37]

Standard 74 provides that,

> *Recording of the medical examination in cases of traumatic injuries should be made on a special form provided for this purpose, with body charts for marking traumatic injuries that will be kept in the medical file of the prisoner. Further, it would be desirable for photographs to be taken of the injuries, and the photographs should also be placed in the medical file.*[38]

The medical file should be kept separate from other files and in a lockable room that is only accessible by the health-care staff[39]. The Essex Group also pointed out that the right of the prisoner to access to files provided in Rule 26(1) includes the right to copy the files, not only look at them. The files should be understood as the property of the prisoner not the prison. The experts also noted that systems should be put in place to ensure continuity of access to medical files and care when a prisoner is transferred to another prison or another facility so that records follow the prisoner.

The experts recalled that for women prisoners confidentiality of medical information includes information about their sexual and reproductive health history. They noted that women prisoners may have reasons not to want to share such information, 'especially in countries or societies where out of marriage pregnancies and childbirth may be a cause for stigmatisation, and in some societies may be considered criminal acts. Information about any abortions is particularly sensitive, due to its criminalisation in many countries'.[40] They referred to the Bangkok Rules which acknowledge that women prisoners should only be requested to provide information about their reproductive health history on a voluntary basis, and that no woman should be forced to provide such information.[41]

The experts referred to specific guidance on confidentiality in the case of HIV and AIDS in Principles 32 and 33 of the World Health Organization (WHO) Guidelines on HIV Infection and AIDS in Prisons (1999):

> *32.Information regarding HIV status may only be disclosed to prison managers if the health personnel consider, with due regard to medical ethics, that this is warranted to ensure the safety and well-being of prisoners and staff, applying to disclosure the same principles as those generally applied in the community. Principles and procedures relating to voluntary partner notification in the community should he followed for prisoners.*
> *33.Routine communication of the HIV status of prisoners to the prison administration should never take place. No mark, label, stamp or other visible*

---

[37] At 52.
[38] At 98.
[39] *UNOPS Technical Guidance for Prison Planning* at 156.
[40] Pew Research Center, *Worldwide Abortion Policies* (October 2015), available at: http://www.pewresearch.org/interactives/global-abortion/
[41] Penal Reform International and Thailand Institute of Justice *Guidance Document on the Bangkok Rules* (2013), available at: https://www.penalreform.org/wp-content/uploads/2013/10/PRI-TIJ-Guidance-Document-on-Bangkok-Rules-October-2013.pdf, pp. 40 and 46.

sign should be placed on prisoners' files, cells or papers to indicate their HIV status.

The Essex Group also noted that in Rule 26(2), confidentiality should also be ensured during transit.

Health-care Assessment on Admission

In Rule 30, a 'physician or other qualified health-care professional' is required to see the prisoner as soon as possible after admission. The rationale for this requirement is provided in Rule 24 which establishes that the state's responsibility for the health of prisoners begins upon admission to the prison. Assessment on admission is critical for the health of the individual. It should therefore be offered to prisoners on admission with health-care staff explaining the benefits to them of the assessment. Without knowing the state of an individual's health, it is not possible to take appropriate and medically necessary measures to protect, promote or improve his or her health.

An assessment on admission necessarily requires that the physician or other qualified health-care staff assess the prisoner's individual health needs and any specific risks to physical or mental health, including signs of psychological or other stress brought about by imprisonment and suicide risks. The health-care staff must also ensure that an appropriate treatment plan is established where needed and that the prisoner has access to the required medicines, including in continuity of care from before entering the prison as set out in Rule 30(c). It is also necessary to minimize withdrawal symptoms in prisoners who depend on substances and in order to identify any signs of torture or other ill-treatment.

Assessment on admission is also important from a public health perspective in order to assess whether newly entering prisoners carry any potential contagious diseases. Otherwise, it is not possible to effectively protect other prisoners and staff from possible transmission and prevent possible outbreaks (however, see the restrictions on isolation below).

The World Health Organization and the European Committee on the Prevention of Torture have both stated that 'as soon as possible' should be understood as within 24 hours.[42] This timeframe is not only important with regard to the prisoner's health[43] and public health[44] but also in order to identify possible signs of ill-treatment[45], signs of stress and the risk of suicide or self-harm[46].

The fulfilment of the requirements of this Rule requires record-keeping as set out in Rule 26(1). The Essex Group also noted that this Rule should be read together with Rule 25(2) to mean that in order to fulfil the requirements of this Rule prisons must have 'sufficient qualified personnel'. 'Qualified personnel' requires that the health-care staff are trained in applying the Manual on effective investigation and documentation of torture and other cruel, inhuman or degrading treatment or punishment ("the Istanbul Protocol).[47] Their qualifications

[42] *CPT Standards* para. 73 p. 98: "It is axiomatic that persons committed to prison should be properly interviewed and physically examined by a health-care professional as soon as possible after their admission. The CPT considers that the interview/examination should be carried out within 24 hours of admission. (…). The same procedure should be followed when a prisoner who has been transferred back to police custody for investigative reasons is returned to the prison."
[43] Rule 30(a).
[44] Rule 30(d).
[45] Rules 7(d), 30(b) and 34.
[46] Rule 30(c).
[47] *CAT SMR revision observations*, para.17; CAT, *Consideration of reports submitted by States parties under article 19 of the Convention: Concluding observations of the Committee against Torture* CAT/C/DEU/CO/5 12

should be commensurate with the nature of the decisions they are required to take and with their reporting responsibilities. For example, the head of a team should be a qualified medical doctor.

Rule 30(b) should be read together with Rule 34 on documentation. The Essex Group noted that ill-treatment is not only physical but can also be mental. In order to identify any ill-treatment, they pointed out that it is necessary to talk to the prisoner as not all signs of ill-treatment will be obvious or visible.

In Rule 30(c), the Essex Group noted that the requirement to identify 'any signs of psychological or other stress' is particularly important in relation to prisoners in the first 24 hours of detention, pre-trial and remand and high risk prisoners.[48]

The Essex Group underscored that Rule 30 must be read together with Rules 6 – 8 of the Bangkok Rules that set out the women-specific dimensions to the health screening (although some also apply to men) on entry. Rule 6 provides that this 'shall include comprehensive screening to determine primary health-care needs, and also shall determine:

> *(a) The presence of sexually transmitted diseases or blood-borne diseases; and, depending on risk factors, women prisoners may also be offered testing for HIV, with pre- and post-test counselling;*
> *(b) Mental health-care needs, including post-traumatic stress disorder and risk of suicide and self-harm;*
> *(c) The reproductive health history of the woman prisoner, including current or recent pregnancies, childbirth and any related reproductive health issues;*
> *(d) The existence of drug dependency;*
> *(e) Sexual abuse and other forms of violence that may have been suffered prior to admission.*

The Bangkok Rules also provide that 'if the existence of sexual abuse or other forms of violence before or during detention is diagnosed, the woman prisoner shall be informed of her right to seek recourse from judicial authorities'[49]. The Rules also reiterate the right to medical confidentiality 'including specifically the right not to share information and not to undergo screening in relation to their reproductive health history'.[50]

The Essex Group noted that HIV testing may be offered to prisoners with 'pre- and post-test counselling', however, such testing cannot be mandatory or required.[51]

Medical Assistance in Urgent Cases

The first sentence of Rule 27(1) requires prisons to 'ensure prompt access to medical assistance in urgent cases'. The Essex Group emphasised that the determination of urgency

---

December 2011, para 29; CAT, *Consideration of reports submitted by States parties under article 19 of the Convention: Concluding observations of the Committee against Torture* CAT/C/ETH/CO/1 20 January 2011, para 21; CAT, *Consideration of reports submitted by States parties under article 19 of the Convention: Concluding observations of the Committee against Torture* CAT/C/SVK/CO/2 17 December 2009, para 11*;* UN General Assembly, *Interim report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment* A/69/387 23 September 2014, paras 32-37

[48] *Bangkok Rules*, 6(a) - Medical Screening on entry -,7 - Procedures in case of sexual abuse or violence detected upon screening on entry, 8 - right to refuse screening related to reproductive health history, and 9 - right of accompanying children to undergo entry screening. Bangkok rule 9 should be linked to Nelson Mandela Rule 29.1 (b).

[49] Rule 7.

[50] Rule 8.

[51] *Bangkok Rules* 6(a).

should be made by a clinician, not the prison administration.

The Essex Group acknowledged that in situations in which health-care staff are not present, a non-medical person may have to take a decision on what to do. However, they noted that even in such situations it should still be possible to telephone a health-care specialist so that the decision and any subsequent action is informed by the advice of a health-care specialist.

The experts noted that 'urgency' does not only imply a life-threatening situation. Rather, it refers to the situation in which if the prisoner was in the community, he or she would need to go to the accident and emergency/emergency room of a hospital. The experts noted that this rule applies to both physical and mental health.

The second sentence of Rule 27(1) provides that '[p]risoners who require specialized treatment or surgery shall be transferred to specialized institutions or to civil hospitals'. The Essex Group pointed out that this sentence is broader than the first which only focuses on 'urgent' cases. This sentence addresses situations in which prisoners may need to be taken out of the prison if necessary in order to access specialist care. This may relate to the nature of the health complaint or the identity of the patient (for example, access to a paediatrician for a child or young person). Specialist care also includes mental health facilities.

Rule 27(2) provides that '[c]linical decisions may only be taken by the responsible health-care professionals and may not be overruled or ignored by non-medical prison staff'. This Rule makes clear that if the clinician determines that the prisoner needs to go to hospital, the prison administration cannot overrule or ignore this decision in any situation, including non-urgent cases.

The Essex Group also noted that this provision should be read together with Rule 26(1) as requiring a record to be made and maintained of the chain of decision-making as a means of protection against abuse and to ensure accountability.

Isolation and Segregation on Grounds of Public Health

The Essex Group noted that tuberculosis (TB) or other highly contagious diseases and threats of epidemics may require quarantine for medical reasons, as captured in Rule 30(d). It states that 'in cases where prisoners are suspected of having contagious diseases, providing for the clinical isolation and adequate treatment of those prisoners during the infectious period'.

The Essex Group recalled that Rule 30(d) should not be read to require the isolation or segregation of prisoners infected by HIV.[52]

Where isolation is deemed necessary this must only be for public health reasons and based on national health protocols. The World Health Organization has set out that,

> *Only a medical doctor can decide on the need for isolation. The beginning and end of quarantine measures are strictly medical decisions. The duration of isolation should be limited to the strictly necessary minimum. Medical and custodial staff will see to it that the rights of prisoners are guaranteed as far as possible (daily walk, legal assistance, contact with family). The quarantined sections of the prison (a cell, a section or the entire prison) must be marked by*

[52] The European Court of Human Rights has ruled that the segregation of prisoners with HIV, in the absence of a reasonable and objective justification, may amount to a violation of Article 3 in conjunction with Article 14 of the ECHR, see: *Martzaklis and Others v. Greece,* Application No. 20378/13 (ECHR, 9 July 2015)

biohazard signs (..) (such as posters and stickers) (..)[53].

The Essex Group noted that the justification for isolation would have to be the same as it would be outside of prison in order to prevent stigmatisation or discrimination.

Where there is separation, the input of additional health-care specialists will be required in order to guarantee adequate treatment; it should be for the shortest period of time; and accompanied by provision of information to prisoners including on the health implications of any decision to refuse treatment. While separated, the Nelson Mandela Rules still apply fully to the prisoner. Rule 46 provides direction on the role of health-care staff during a period of separation. Rule 42 also emphasises that '(g)eneral living conditions … including those related to light, ventilation, temperature, sanitation, nutrition, drinking water, access to open air and physical exercise, personal hygiene, health care and adequate personal space, shall apply to all prisoners without exception' including during any person of separation.

The Essex Group also noted that public health information should be given to staff on the particular disease or illness that is being treated as otherwise they may be fearful or influenced by inaccurate rumours about the disease or illness that could negatively impact on the treatment (including segregation) of prisoners.

Fitness to Work Determinations

When determining fitness to work in Rule 30(e), the Essex Group emphasised the duty of medical staff to make individual assessments of the prisoner's ability to work against the nature of the work he or she is offered in order to prevent prisoners from being assigned work that could result in further physical or mental harm to them or others due to the nature of a particular illness. Medical staff should read this Rule together with Rules 4(2), 5 and 96(1) which address activities such as work, education and sport as activities in which prisoners are entitled to engage – should they so wish on a voluntary basis - as a means of contributing to their well-being and rehabilitation as well as Rules 97 – 103 on the terms and conditions of prison labour.

Daily Access to Prisoners

Rule 31 of the Nelson Mandela Rules requires that physicians and 'where applicable, other qualified health-care professionals shall have daily access to all sick prisoners, all prisoners who complain of physical or mental health issues or injury and any prisoner to whom their attention is specially directed'. The Essex Group noted that the access referred to in Rule 31 implies that health-care professionals are informed of where all prisoners are. This Rule is also relevant to Rule 46 where prisoners are undergoing disciplinary sanctions as the medical staff need to know where the prisoners are.

No Role of Medical Staff in Discipline or Punishment

Rule 46 underscores that medical staff should have no 'role in the imposition of disciplinary sanctions or other restrictive measures'. This is in line with the UN 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

[53] World Health Organization Europe, *Prisons and Health* (2014) chapter 8 available at: http://www.euro.who.int/__data/assets/pdf_file/0005/249188/Prisons-and-Health.pdf

or Punishment.[54] Similar provisions are included in the World Medical Association Statement on Body Searches of Prisoners,[55] the International Council of Nurses Position Statement,[56] and the Dual Loyalty Guidelines.[57]

This means that doctors must not play a role in the disciplinary basis for the imposition of sanctions. It also means that they must not assess whether a prisoner is medically 'fit' for the imposition of a sanction such as isolation. This is because the role of medical staff is to provide health-care, and it is 'in the interests of safeguarding the doctor/patient relationship, that health-care staff should not be asked to certify that a prisoner is fit to undergo punishment'.[58] They must therefore not be involved in any decision-making which is not related to their patients' health needs.

Furthermore, sanctions such as solitary confinement are inherently harmful to a person's health. It would therefore violate medical ethics, Rule 43 of the Nelson Mandela Rules which prohibits restrictions or disciplinary sanctions that amount to torture or other cruel, inhuman or degrading treatment or punishment as well as the fundamental mission of medical staff in prisons to provide care as set out in Rule 25, to make an assessment of medical 'fitness'[59] for a sanction.

However, once a prisoner is undergoing disciplinary measures, the Essex Group noted that health-care staff should pay particularly close attention to the health of prisoners held under any form of involuntary separation, including by visiting such prisoners on a daily basis and providing prompt medical assistance at the request of such prisoners or prison staff.

In the same vein, Rule 46(3) provides health-care staff with 'the authority to review and recommend changes to the involuntary separation of a prisoner in order to ensure that such separation does not exacerbate the medical condition or mental or physical disability of the prisoner'. The Essex Group noted that this access is protective and provides a route for the health-care staff to advise the prison administration on a harmful practice for so long as it persists and until it is phased out.

→ On the tension between medical ethics and the specific duty of care towards prisoners see also Chapter 5, Restrictions, discipline and sanctions – Role of medical personnel)

---

[54] Principle 3 of *UN Principles of Medical Ethics*: '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', and Principle 2: 'It is a gross contravention of medical ethics, as well as an offence under applicable international instruments, for health personnel, particularly physicians, to engage, actively or passively, in acts which constitute participation in, complicity or, incitement to or attempts to commit torture or other cruel, inhuman or degrading treatment or punishment'.

[55] *WMA Statement on Body Searches of Prisoners*, adopted by the 45th World Medical Assembly, Budapest, Hungary, October 1993 and editorially revised in May 2005 and October 2016, available at: http://www.wma.net/en/30publications/10policies/b5

[56] The International Council of Nurses, Position statement on *Nurses' role in the care of detainees and prisoners* (adopted in 1998, reviewed and revised in 2006 and 2011) available at: http://www.icn.ch/images/stories/documents/publications/position_statements/A13_Nurses_Role_Detainees_Prisoners.pdf

[57] *Dual Loyalty Guidelines*, Guideline 14: '15. The health professional should not participate in police acts like body searches or the imposition of physical restraints unless there is a specific medical indication for doing so or, in the case of body searches, unless the individual in custody specifically requests that the health professional participate. In such cases, the health professional will ascertain that informed consent has been freely given, and will ensure that the prisoner understands that the health professional's role becomes one of medical examiner rather than that of clinical health professional'. See also the *Trencin Statement*, 13-14.

[58] *CPT Standards*, para. 73, p. 47.

[59] Principle 3 and 4(b), *UN Principles of Medical Ethics*; *Commentary to Recommendation REC(2006)2*, Rule 43, p.21; *CPT Standards,* para. 73, p.47.

Documentation of Signs of Torture

Rule 34 requires medical staff to 'document and report (…) any signs of torture or other cruel, inhuman or degrading treatment or punishment' that they become aware of and to report these signs 'to the competent medical, administrative or judicial authority'. The Rule requires that 'proper procedural safeguards are followed in order not to expose the prisoner or associated persons to foreseeable risks of harm'.

The Essex Group noted that health-care staff must record all signs and traces of torture and other ill-treatment in a prisoner's medical file. The Committee against Torture has stated that medical 'examinations should be carried out in private by a health professional trained in the description and reporting of injuries, include an independent and thorough medical and psychological examination, and the results be kept confidential from police or prison staff, and shared only with the detainee and/or the detainee's lawyer, in accordance with the Istanbul Protocol'.[60]

The Essex Group suggested that it would also be desirable for the health-care team to compile periodic statistics on the types of injuries observed in prison and to submit this to the prison administration and ministry of justice.[61] However, such statistics should anonymise the data and ensure that re-identification is not possible to prevent further harm to prisoners.

The Essex Group noted that health-care professionals should systematically ask prisoners for their consent to report signs of torture or other ill-treatment. On its face, the obligation to report any signs of torture or other ill-treatment conflicts with the principles of informed consent and confidentiality in situations in which documentation and reporting is contrary to the prisoner's wishes, for example, for fear of reprisals. For this reason, the Essex Group recommended that the Rule should be interpreted as prohibiting automatic or systematic reporting of torture or other cruel, inhuman or degrading treatment or punishment without the informed consent of the prisoner.[62] The absence of informed consent would violate basic principles of medical ethics and the confidentiality and trust of the doctor-patient relationship.

This approach has also been taken in Rule 7 of the Bangkok Rules, which underscores the requirement of informed consent to report signs of torture and other ill-treatment. It states that if sexual abuse or other forms of violence before or during detention is diagnosed, the woman prisoner shall be informed of her right to seek recourse from judicial authorities and of the procedures and steps involved. However, it clarifies that the case can only be referred to the competent authority for investigation 'if the woman prisoner agrees to take legal action'.

The Istanbul Protocol provides that where the prisoner has not consented to reporting, the health-care professional is in a position of dual loyalty between the individual prisoner concerned and society at large 'which has an interest in ensuring that justice is done and perpetrators of abuse are brought to justice'[63]. In such a situation, the Istanbul Protocol suggests that, '[t]he fundamental principle of avoiding harm must feature prominently in consideration of such dilemmas. Health professionals should seek solutions that promote justice without breaching the individual's right to confidentiality. Advice should be sought from reliable agencies; in some cases this may be the national medical association or non-governmental agencies. Alternatively, with supportive encouragement, some reluctant patients may agree to disclosure within agreed parameters'.

---

[60] *Kyrgyzstan CAT/OP/KGZ* para. 57
[61] *CPT Standards* para. 62 p. 44
[62] Bangkok Rule 7
[63] paras. 69 and 72

The health-care professional may, therefore, assist the prisoner with identifying other routes to report the allegations of torture or other ill-treatment such as detention staff, forensic medical specialists, inspectors and monitors. Rule 7(2) of the Bangkok Rules also provides that '[w]hether or not the woman chooses to take legal action, prison authorities shall endeavor to ensure that she has immediate access to specialized psychological support and counselling'.

The experts considered that more detailed discussion and guidance is needed on how to deal with the situation of dual loyalty identified in the Istanbul Protocol and how to maintain confidentiality and informed consent while bearing in mind the do no harm principle.

→ See Chapter 2, Prison management – Inspections and external monitoring/ objectives for internal and external inspection
→ See Chapter 6, Incident management - investigations