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IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND

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KING'S BENCH DIVISION
(JUDICIAL REVIEW)

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IN THE MATTER OF AN APPLICATION BY ROBERT CLARKE FOR JUDICIAL REVIEW

IN THE MATTER OF AN APPLICATION BY PAUL POLLINS FOR JUDICIAL REVIEW

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Mr Donal Sayers KC with Mr Michael Halleron (instructed by Mr Ruaidhri Currie of Finucane Toner, Solicitors) for the First Applicant
Mr Desmond Hutton KC with Mr Mark O'Hara (instructed by Mr Chris McCann of Harte, Coyle Collins, Solicitors) for the Second Applicant
Mr Philip Henry KC with Dr Gordon Anthony (instructed by Ms Cora Murphy a Solicitor employed in the Directorate of Legal Services in the Business Services Organisation) for the Respondent
Dr Tony McGleenan KC and Mr Michael Neeson (instructed by Ms Louise Crilly, the Departmental Solicitor for Northern Ireland) for the Department of Health, a Notice Party

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McALINDEN J

Introduction

[1] The first applicant, Mr Robert Clarke, born on 17 September 1994, is presently a sentenced prisoner in HMP Magilligan. The respondent is the South Eastern Health and Social Care Trust, the public body with responsibility for the provision of healthcare to the prison population in Northern Ireland in all prison estates. It is alleged that there has been a long-standing commitment to ensuring that those in prison receive the same standard of healthcare as those in the community (the principle of equivalence). Due to his drug addiction issues, the first applicant has been flagged as someone whose suitability for opiate substitution therapy should be assessed. Despite this, the first applicant has not undergone such an assessment in prison and has been waiting for such an assessment for over two years. The first applicant challenges the failure of the respondent to provide him with appropriate healthcare treatment for his addiction issues. The first applicant seeks a declaration

that there is an ongoing, unjustified distinction in healthcare between prisoners on the one hand and individuals in the community on the other with regard to the availability of staff and facilities for the assessment of suitability for and/or the commencement of opiate substitution therapy ("OST"). He seeks a declaration that the failure of the respondent to provide prisoners with healthcare consistent with and equivalent to the healthcare provided to those at liberty in the community is contrary to articles 8 and 14 of the European Convention on Human Rights ("ECHR") and contrary to section 6 of the Human Rights Act 1998 ("HRA") and that the failure to do so in his case entitles him to claim damages. In his Order 53 Statement, he argued that the failure to provide him with an assessment of suitability for opiate substitution therapy constitutes a breach of rules 2 (b), 2 (j) and 80 of the Prison and Young Offender Centre Rules (Northern Ireland) 1995 (as amended) ("the 1995 Rules") in circumstances where the relevant rules provide a duty in respect of staffing and equipment for the treatment of sick prisoners. This argument was not pursued with any vigour at the oral hearing. It is alleged that the respondent has failed to take into consideration the relevant prison rules on healthcare when considering its responsibilities under section 2(2) of the Health and Social Care (Reform) Act (Northern Ireland) 2008 and has failed in its duty to have a proper understanding of the extent of the legal powers available to it in that the respondent has asserted that the 1995 Rules do not apply to the first applicant. Again, this was not pursued at the oral hearing.

[2] In support of his claims, the first applicant avers that drugs have been a significant issue for him throughout most of his adult life. He has abused cocaine, illegally obtained benzodiazepines and "a range of other drugs." The first applicant avers that his drug problems are at the root of his offending. His affidavit is dated 26 January 2024 and at that time the first applicant was awaiting assessment of his suitability for commencement on OST. He states that he continues to take illicitly obtained drugs in prison on a daily basis. He specifically refers to Subutex or Espranor and if he cannot get his hands on these drugs, he will abuse Tramadol instead. He has a diagnosis of epilepsy and has been advised by a prison doctor that he should not take Tramadol as this drug can bring on seizures. Despite this advice, the first applicant continues to take Tramadol if he cannot access a supply of Subutex or Espranor. The first applicant avers that he has failed a recent drugs test in prison and has refused to be tested on four occasions. As of January 2024, the first applicant had a number of prison disciplinary adjudications arising out of his illicit drug taking in prison and he had a pending adjudication due to prison staff finding Subutex in his cell. The first applicant specifically relies upon the fact that during his time in custody, he made an application to the Parole Commissioners for re-release on licence and the Panel who dealt with his application for re-release on licence specifically referred to the applicant's unaddressed drug addiction problem as being a matter which had to be taken into account when assessing relevant risk. The Panel decision specifically recommended that the applicant should engage fully with any assessment of his suitability for the commencement of OST in the prison environment.

[3] The second applicant, Paul Pollins, who was born on 28 July 1990, was, until recently, a sentenced prisoner in HMP Magilligan. From 5 February 2021, up to the time of his release in April 2024, he too was waiting to be assessed for suitability for OST. This applicant specifically alleges that the failure to carry out such an assessment and, thereafter, to commence treatment, constituted a breach of article 3 and/or article 8 ECHR and section 6 of the HRA in that this applicant specifically informed the respondent that he was self-medicating with illicitly obtained Subutex within the prison, in the absence of being provided with OST. The applicant informed the respondent that he was concerned that he would overdose on this illicit drug, with fatal consequences. He also alleges that his general prison records and his prison medical records contain numerous references to intense mental suffering, distress and anxiety being experienced and exhibited by this applicant arising directly from his unaddressed drug dependency. This suffering, distress and anxiety crossed the threshold of severity so as constitute a breach of article 3 ECHR.

[4] It is alleged that article 3 ECHR imposes a positive obligation on the state to ensure that this applicant as a detained prisoner was detained under conditions that were compatible with respect for human dignity; that the manner and method of his detention did not subject him to distress and hardship exceeding the unavoidable level of suffering inherent in detention; and that, given the practical demands of imprisonment, his health and well-being were adequately secured by, among other things, the provision of the requisite medical assistance and treatment.

[5] It is alleged that medical treatment provided within prison facilities must be appropriate, that is, at a level comparable to that which the state has committed itself to provide to the population as a whole. It is alleged that if the applicant had been in the community, during the relevant time, he would have been assessed for his suitability for OST within a relatively short timescale. In addition to alleging a substantive breach of article 3 ECHR, the applicant also calls in aid the provisions of article 14 ECHR. The applicant alleges that he is in an analogous situation to drug addicts in the community seeking OST. He alleges that he has been treated differently based on his status as a prisoner. He alleges that there is no objective or reasonable justification for this difference in treatment. It is alleged that this difference in treatment does not pursue a legitimate aim and there is no reasonable relationship of proportionality between the means employed and the aim sought to be realised.

[6] The second applicant alleges that article 8 ECHR protects his right to respect for his private and family life, his home and his correspondence. It is alleged that these concepts are broad and, inter alia, encompass a person's physical and psychological integrity. He alleges that the provision of OST and the assessment of suitability for such treatment are measures implemented by the state which have a direct impact on the physical and psychological integrity of drug addicts both in the community and in prison. The second applicant alleges that his physical and psychological integrity has been interfered with and, indeed, harmed, by reason of the state's failure to provide him with an assessment of suitability for OST whilst he was in custody. It is alleged that this interference was entirely unjustified and, in the

alternative, it is alleged that, given the stark difference is the availability of assessment opportunities provided to drug addicts in the community on the one hand and drug addicts in prison in the other, this applicant's rights under article 14 ECHR have been breached.

[7] In support of his claims, this applicant specifically relies upon the fact that during his time in custody, he made numerous applications to the Parole Commissioners for release on licence and on a number of occasions, the panels who dealt with his application for release on licence specifically referred to the applicant's unaddressed drug addiction problem as being a matter which had to be taken into account when assessing relevant risk. These panel decisions specifically comment upon the delay in providing an assessment of suitability for OST and in one decision, there is specific criticism of such delay.

[8] Following the second applicant's release from prison in April 2024, he underwent assessment of his suitability for the commencement of OST in the community and was in fact commenced on OST. Therefore, this applicant can no longer seek the quashing of any decision not to provide him with an assessment of his suitability for treatment or, indeed, treatment. The remedies the second-named applicant seeks are declarations that the failure to provide an assessment of suitability for treatment and/or OST treatment itself was in breach of this applicant's rights and the state's obligations under articles 3, 8 and 14 ECHR.

[9] In support of his claims, the first applicant has sworn an affidavit dated 26 January 2024. He also relies upon three affidavits sworn by his solicitor Mr Ruaidhri Currie, sworn on 8 February 2023, 28 March 2023 and 16 January 2024 and the content of these will be addressed below. In support of his claims, the second applicant has sworn three affidavits dated July 2023, 20 June 2024 and 24 June 2024. He also relies upon a number of affidavits sworn by his solicitor, Mr Chris McCann. The first of these affidavits was sworn on 26 July 2023. The second was sworn on 20 December 2023, and this exhibits a report prepared by Professor R J Davidson, Consultant Clinical Psychologist, dated 26 November 2023. The third affidavit of Mr McCann was sworn on 20 June 2024. The fourth affidavit of Mr McCann was sworn on 24 June 2024 with the fifth and final affidavit being sworn by him on 26 July 2024.

[10] In addressing the claims made by both applicants. the respondent has filed three affidavits prepared by Mr Stephen McGarrigle, Assistant Director of Prison Healthcare in the South Eastern Health and Social Care Trust, two of which were sworn on 15 March 2024, with the third one being sworn on 4 June 2024. The first affidavit of Mr McGarrigle exhibits a medical report from Dr Siobhan Flanagan dated 14 March 2024 and this relates to the second applicant, Paul Pollins. Dr Flanagan is a Consultant Psychiatrist presently employed by the respondent as the head of the Clinical Addictions Team in the prisons in Northern Ireland. The second affidavit sworn by Mr McGarrigle on 15 March 2024 deals with the first applicant Robert Clarke. The respondent also relies on affidavit evidence sworn by

Dr Richard Kirk, Clinical Director of Prison Healthcare, sworn on 6 June 2024. The respondent also relies upon the contents of an affidavit sworn by Dr Siobhan Flanagan, Consultant Psychiatrist, on 6 June 2024 and three affidavits, two of which were sworn on 8 May 2024 and the third one being sworn on 20 June 2024 by Ms Heather Stevens, Director of Mental Health in the Department of Health.

[11] The first applicant's legal team have submitted a skeleton argument dated 26 April 2024. The respondent's legal team responded on 8 May 2024. The second applicant's legal team filed a skeleton argument on 24 April 2024 and the respondent filed a skeleton argument in reply on 8 May 2024. The hearing of this matter took place on 15 May 2024, 20 June 2024, 21 June 2024 and 24 June 2024. At the close of the hearing, the court invited the second applicant and the respondent to file additional submissions dealing with the claim that there was a substantive breach of article 3 ECHR in Mr Pollins' case. These additional submissions were filed on behalf of the second applicant on 5 July 2024 and on behalf of the respondent on 5 August 2024. The court is grateful to the parties' legal representatives for the quality of the written and oral advocacy in this case.

The evidence adduced by the parties

First applicant

[12] Prior to 2008, the Northern Ireland Prison Service had overall responsibility for the provision of healthcare services in prisons in Northern Ireland. There were concerns about disparities between the provision of healthcare in the custodial environment when compared to that provided in the community and as a result it was decided that the Department of Health should take over the responsibility for the provision of healthcare in prisons in 2008 and the respondent was designated as the Health Trust with day-to-day responsibility for the provision of healthcare services in all prisons in Northern Ireland. The respondent Trust was provided with a specific annual budget to enable it to fulfil its responsibilities in providing prison healthcare. A partnership agreement was entered into between the Northern Ireland Prison Service and the Department of Health in February 2009. One of the primary goals of this partnership agreement was to ensure that prisoners had access to the same range and quality of healthcare services as individuals at liberty in the community. The NICE Guidance on Drug Misuse and Dependency: UK Guidelines on Clinical Management (2009 updated in 2017) contain a section dealing with "Prisons and other secure environments" at section 5.4.1 onwards:

> "5.4.1 The purpose of healthcare in prison, including care for drug and alcohol problems, is to provide an excellent, safe and effective service to all prisoners, equivalent to that in the community.
>
> 5.4.5.1 The principle of equivalence: the provision to individuals in prison of care equivalent to that provided to

> individuals in the community (including evidence based and clinically-effective interventions and pathways), should always be appropriately applied."

[13] Some eight years after the commencement of this partnership agreement, the first applicant was made the subject of a number of determinate custodial sentences ("DCS") between 9 October 2017 and 12 April 2018 and he was detained in HMP Magilligan. Each sentence included a custodial element and a licence element. The offences involved were robbery, attempted robbery, burglary and attempted burglary. The pre-sentence report ("PSR") prepared for the first sentencing exercise referred to the first applicant's drug addiction and the thrust of the report was that the offending was motivated by a desire to fund his drug habit. The first applicant was released from custody on supervised licence in February 2021. He was subject to a number of conditions including engaging with drug addiction services in the community. He quickly reoffended and he was recalled to prison in September 2021. The first applicant subsequently received a further DCS for this fresh offending in March 2024. In the meanwhile, the decision to recall the first applicant was upheld by the Parole Commissioners in February 2022. The panel specifically commented on the need for the first applicant to address his drug addiction issues. The panel recommended that the first applicant should engage fully with the Alcohol and Drugs: Empowering People Through Therapy ("AD:EPT") programme in the prison and that he should indicate a willingness to be assessed for suitability for OST.

[14] The first applicant then engaged meaningfully with the AD:EPT programme and was placed on a waiting list for the assessment of his suitability for the commencement of OST in prison. In the absence of any progress in this regard, the first applicant's solicitor sought assurances that the first applicant would be assessed as quickly as possible, bearing in mind the specific recommendations of the Parole Commissioners. The first of a number of letters was directed to Prison Healthcare in May 2022. The response that was forthcoming was that the first applicant was on the waiting list to be seen by the Clinical Addictions Team ("CAT") in the prison and that the funding arrangements then in place only allowed for a limited number of prisoners to be on the OST programme at any one time and the problem was compounded by a dramatic increase in the number of referrals for assessment of suitability for OST. The first applicant's solicitor was also informed that all referrals received are reviewed and prioritised by clinical staff and that individuals on the waiting list may not be seen in order of referral.

[15] The exchange of correspondence culminated in the service of a pre-action protocol ("PAP") letter by the first applicant's solicitor on 10 October 2022. A response was received on 31 October 2022 and this detailed all the various forms of support that were available in the prison for those prisoners with drug addiction issues. The response also highlighted the difficulties experienced meeting the demand for OST in the custodial setting which meant that at present the demand could not be met.

[16] However, this was not a new problem. Over a year earlier, the Regulation and Quality Improvement Authority ("RQIA") conducted a detailed review of the provision of healthcare in prisons in Northern Ireland and in its report entitled: "Review of Services of Vulnerable Persons Detained in Northern Ireland" which was published in October 2021, it concluded that prison healthcare was:

> "significantly underfunded … in comparison to other regions in the United Kingdom. Equally, the needs assessment, planning and commissioning arrangements require substantial improvement. Existing services are under considerable pressure, with demand greatly exceeding capacity."

[17] On 27 January 2022, the Department of Justice prepared a briefing note for the Justice Committee at Stormont on the impact of that year's draft budget on the Northern Ireland Prison Service. This briefing note contains the following commentary on the RQIA report referred to above:

> "In assessing our budget, it is important to recognise the challenges NIPS face in managing an increasingly complex population. 50% of those entering our prisons have addictions, 32% have mental health issues, and 54% are at risk of suicide and self-harm.
>
> As prison healthcare is, according to the RQIA Review of Services for Vulnerable Persons Detained in Northern Ireland Prisons, "significantly underfunded," there is a clear lack of equivalence with healthcare in the community.
>
> Prison staff are consistently required to manage the shortfall in healthcare provision. There is a clear impact for community healthcare, which is being given additional funding, if the Prison Service is not able to address the complex needs of many prisoners during their time in custody."

[18] Following the initiation of proceedings in this matter, the first applicant's solicitor made a Freedom of Information ("FOI") request to the Belfast Health and Social Care Trust concerning its OST programme. Four questions were posed. These were:

> "(1) How does one be assessed in the community?
>
> (2) How long between assessment and treatment?

(3) Is there a prioritisation system or is it done based on the referral/date of presentation?

(4) Roughly how long the waiting list is from date of referral/assessment before a decision is made and/or someone is being placed on OST?"

[19] In response to these questions the Belfast Trust, which is not involved in these proceedings, indicated that a patient in that Trust is assessed by nursing or key working staff and medical staff. A full medical, mental health and social assessment is carried out usually over the course of two appointments. Urine drug screens ("UDS") are also performed. When the results are known the case is then discussed at a multidisciplinary meeting and a decision is made regarding appropriate treatment. The patient is then given written information about the opioid substitution medications that are available in the Trust and the patient's preference is taken into account when making a decision. The Trust's Substitute Prescribing Team can be accessed via the Trust's Drug Outreach Team or through a referral from the Community Addiction Team. It usually takes two to three weeks from the initial assessment to the commencement of treatment. During the first week a nursing assessment is performed. During the second week there is a nursing and medical joint assessment. The Trust considers the giving of advice and the provision of psychoeducation as treatment/intervention and this can occur during the initial contacts. In terms of prioritisation, individuals are ordinarily seen based on the date of referral but pregnant women and individuals with a HIV diagnosis are given priority. As of February 2023, the time interval between referral and assessment in the Belfast Trust area was six to seven weeks.

[20] The first applicant's solicitor made a similar FOI request to the respondent Trust on 13 May 2023 and he received a reply on 17 May 2023. In its response, the respondent Trust stated that in its area a referral is received from the patient's GP or allied health professional to the local Community Addictions Team. As of May 2023 the Trust aimed to see, conduct the necessary assessment and, if appropriate, have treatment agreed and commenced within two to four weeks. In relation to the issue of prioritisation, the Trust assesses each case individually. However, priority may be given to IV drug users, patients who are HIV and/or hepatitis C positive or patients who are pregnant. The decision as to who is appropriate for OST is made by a Consultant within the Addictions Team. Following the initial assessment and when three urine drug screens confirming the presence of opiates have been received, an appointment with the Consultant will usually take place within two to four weeks from referral.

Second applicant

[21] In 2013 the second applicant was convicted of an offence of aggravated burglary with intent to steal. He initially received an indeterminate custodial sentence ("ICS") in November 2013 but his sentence was varied on appeal to an extended

custodial sentence ("ECS") of six years in custody followed by five years on licence. His parole eligibility date ("PED") was 13 April 2016. His custody expiry date ("CED") was 13 April 2019 and his sentence licence expiry date ("SLED") was 13 April 2024. Social Services were involved with the second applicant from an early age. He was diagnosed with ADHD in primary school and was statemented. He started abusing alcohol and cannabis at the age of 15 and his addiction problems have worsened since that time. Following his incarceration in 2013, the second applicant was released on 13 April 2019. He was arrested just over a month later when he was found to be in possession of an offensive weapon and was heavily under the influence of drugs. His licence was revoked in May 2019 and he was returned to prison. Despite applying to the Parole Commissioners on a number of occasions thereafter, his release was never directed and he was detained until his SLED in April 2024.

[22] One such panel decision which was handed down on 3 October 2022 made the following recommendation: "That an assessment for Opiate Substitution programme be completed as soon as possible." As of November 2022, it was recorded that the second applicant had completed fourteen sessions with AD:EPT but was still on the waiting list for consideration of the OST programme. When his case was reviewed by another panel in May 2023, the panel made the following relevant comments:

> "25. The central aspect of this case … (is) … that it is regrettable that Mr Pollins has remained on the waiting list for the OST programme to address identified risks relating to his addictions.
>
> 27. … the panel is – frankly- **appalled** that a prisoner has been waiting since 5 February 2021 to get to the assessment stage for suitability for the OST programme. The panel finds this length of time for assessment utterly unacceptable and states this with particular emphasis. It is plainly neither in the public interest nor in the interests of Mr Pollins' rehabilitation that this delay is countenanced. Were it within the panel's power to do so, it would direct that the assessment is expedited as a matter of urgency. The panel says this owing to the evidence in the Custody Profile Report of 26 January 2023 (which disclosed suicidal ideation and self-harm on 9 December 2022) and with regard to the e-mail from Mr Pollins' Solicitors of 3 May 2023 which referenced their concerns about "risk to life at this stage." If there is a right to life issue, there is a plain-to-be-seen urgency about getting Mr Pollins assessed for suitability for the OST programme. That is why, in the panel's recommendations, it recommends this appointment be expedited with all due urgency. In the absence of this, Mr Pollins continues to misuse substances on an almost daily basis within the prison environment.

> 33.1 Within 28 days of the issue of this decision, there should be a multi-disciplinary Case Conference convened to discuss;
>
> How to **urgently** expedite the referral to the South Eastern Health and Social Care Trust for Mr Pollins' assessment for suitability for the OST programme; …
>
> 33.2 Further to the recommendations at 33.1 above, the panel recommends that:
>
> A comprehensive report is made available to the Parole Commissioners on the steps taken to expedite the referral to the South Eastern Health & Social Care Trust for Mr Pollins' assessment for suitability for the OST programme, and the progress to date on that issue; …"

The court has not been provided with any evidence which would indicate that any such case conference was ever convened or any such report was furnished to the Parole Commissioners.

[23] The second applicant in his first affidavit sworn in July 2023 emphasised that he has been open with the prison authorities about his drug addiction issues, including the fact that he uses illicitly obtained Subutex to manage his addiction. He described how he purchased this drug from other prisoners who were prescribed it and how he flushed his system out with water in an attempt to ensure that he did not fail mandatory drug tests. He identified a number of risks which he alleges are inherent in these activities. He referred to the risk of contracting hepatitis C from ingesting a Subutex tablet which has been in another prisoner's mouth. However, it is relatively common knowledge that hepatitis C is a bloodborne virus and in, the context of drug addiction, it is most commonly spread by the reuse or sharing of syringes and needles. The second applicant also alleged that as he does not have access to a constant and sufficient supply of Subutex, in order to keep himself stable he has "to mix the Subs I can get my hands on with whatever drugs I can get to hold me over. This is where I run the risk of overdosing by taking a mixture of drugs." He alleged that if he had a proper and continuous supply through OST he would not have to take these risks.

[24] The second applicant went on to describe how the inability to obtain an adequate supply of Subutex affected him. He stated that:

> "When I can't get enough, I really struggle both physically and mentally. I feel sick and in physical pain. I become extremely depressed and struggle to go out. I hear voices

> in my head I want to kill myself. My mental health really plummets. It is unbearable.
>
> I am living in fear that my self-medicating will lead to me overdosing and dying. The fact that the proposed respondent has still refused to do anything after receiving my correspondence is deeply distressing. They shouldn't be able to leave me like this.
>
> I appreciate that I have been provided with other types of support with my addictions from the prison, for example working with AD:EPT. However, this isn't enough to deal with my issues. I need help to stop me chasing a hit every day."

[25] In his second affidavit sworn on 20 June 2024, the second applicant provided an update on his situation following his release from prison on 13 April 2024. He attended the Belfast Trust Drug Outreach Team as a walk in on 15 April 2024 and was immediately referred to the Belfast Community Addiction Service. He had his first appointment with this service on 28 May 2024 and a drug test was performed. He attended a second appointment on 6 June 2024 and a second drug test was performed. He was awaiting the formal results of these two tests when he swore his second affidavit. He was aware at that time that a further appointment had been offered to him for 21 June 2024.

[26] The second applicant's third affidavit was sworn on 24 June 2024. He averred that he had attended his third appointment on 21 June 2024 and was informed that he had been deemed suitable to commence OST in the community. A further appointment had been offered for 28 June 2024. The second applicant argues that the fact that he was deemed suitable for OST in the community means that he would have been deemed suitable for OST in prison if he had been assessed prior to his release. He argues that if he had been commenced on OST in prison "this would have alleviated the suffering I experienced waiting. He went on to state:

> "It is such a relief that I have now been assessed as suitable and have started the OST programme within such a short period of time since my release, as compared to the years I spent in custody waiting."

The second applicant then went on to aver that the respondent knew that he was using illicit drugs including opiates in prison and he referred to a bundle of his medical records which were exhibited to an affidavit sworn by Dr Flanagan which he alleged supported his case, in particular, a number of entries between 15 March 2021 and 21 December 2023 that allegedly contain references to the second applicant's upset, distress and anxiety resulting from the delay in conducting an assessment of his suitability for OST.

[27] Mr Chris McCann, the second applicant's solicitor has sworn five affidavits during the course of these proceedings. In his first affidavit sworn on 26 July 2023, he avers that he first wrote to Prison Healthcare on 3 May 2023 raising concerns about the delay in the second applicant being assessed for suitability for OST. The response which is dated 5 May 2023 contained an apology for the stress that waiting for services can have and went on to state:

> "… all referrals received are reviewed and prioritised by the clinical staff. Your client may not always be seen in order of referral. Your client can speak to a member of the healthcare team if they would like advice and support."

[28] Pre-action protocol correspondence followed this prior to the initiation of proceedings in late June 2023. In his first affidavit, Mr McCann specifically referenced and quoted from a report prepared by the Comptroller and Auditor General of Northern Ireland dated 30 June 2020 entitled Addiction Services in Northern Ireland. It would appear that in November 2017 there was a waiting time "high" of 57 weeks between referral and assessment for suitability for OST in the Belfast Trust area (Section 4.16). The report then details the steps taken by the Belfast Trust to reduce this time interval (Section 4.17). Section 4.13 of the report includes a table which refers to a target waiting time in Northern Ireland of nine weeks from referral to first appointment. As of 31 July 2019 only 2.9% of those referred for assessment had to wait more than nine weeks. Mr McCann then avers to the fact that on 16 June 2023, he wrote to the Belfast Trust enquiring what the waiting times in the Belfast Trust were at that time. On the same date the Belfast Trust responded, stating that the waiting time between referral and assessment in June 2023 was approximately three to four weeks.

[29] In his second affidavit, sworn on 20 December 2023, Mr McCann referred to an expert report which had been prepared by Professor R J Davidson Consultant Clinical Psychologist, dated 25 November 2023. Professor Davidson had access to the second applicant's GP records from 2008 to the present time and his Prison Healthcare notes and records, a probation report dated 9 May 2023, the second applicant's custody profile dated 11 May 2023, the Parole Commissioners' dossier on the second applicant dated January 2023, a Panel decision dated 22 May 2023, an Inmate Adjudication Report relating to the second applicant and Prison Drug Test results dated 12 May 2023 and 11 May 2023. However, I note in the body of his report, Professor Davidson refers to another drug rest result dated 3 May 2023 which is described in his report as being "the most recent drug test" in which there were positive results for Buprenorphine, Opiates, Pregabalin and Gabapentin. This would suggest that the second applicant was illicitly taking anything he could get his hands on in the prison.

[30] Professor Davidson interviewed the second applicant by video link on 25 September 2023. His report provides a helpful summary of the second applicant's relevant medical history. He has spent much of his life in the care system or prison.

He has a diagnosis of ADHD and borderline personality disorder (now more properly described as an emotionally unstable personality disorder) rendering him much less able to cope with adversity and more difficult to manage in a custodial setting. Anxiety issues were first recorded when he was fifteen years old. There was an impulsive suicide attempt by hanging in 2010 which resulted in an admission to hospital. Drug abuse was an issue at that time and he was already known to the local addiction service. There are references to opioid withdrawal symptoms, the first of these entries being dated July 2012. He was seen by an Addiction Consultant at that time and he gave a history of heroin use and opioid addiction. Since July 2012, the second applicant has largely been imprisoned with little or no contact with community addiction services until his recent release. In addition to the impulsive suicide attempt in 2010, the records reveal a second self-harm impulsive hanging and in June 2020 he self-harmed in prison by cutting his left forearm and apparently swallowing a blade. Professor Davidson made reference to an incident in 2021 when the second applicant had wrecked his prison cell and during the hearing of the case it was suggested by counsel that this was due to feelings of intense frustration at the delay in his assessment for suitability for OST. It would appear that the second applicant has a history of refusing mental health interventions and has not engaged well with AD:EPT. His notes and records contain numerous references to complaints being made by him about the delay in his assessment for suitability for OST. The records also indicate that the second applicant did inform Prison Healthcare staff about his illicit drug-taking in prison.

[31] Having assessed the second applicant (admittedly by video link) Professor Davidson expressed the view that the second applicant would clearly benefit from a structured OST programme. It is worthy of note that the second applicant was able to inform Professor Davidson that those individuals who had been on OST in the community and were then subsequently committed to prison were prioritised in relation to being placed on OST in prison. The second applicant also expanded on his illicit drug use in prison. Professor Davidson records that prior to the Covid pandemic, the second applicant was able to obtain a relatively uninterrupted supply of illicit drugs including Subutex that were brought into the prison by visitors. With the Covid related cessation of prison visits, the supply of illicit drugs coming into the prison greatly reduced and this meant that the second applicant became reliant on drugs that he was able to acquire from other prisoners. This supply was expensive and unpredictable. The second applicant gave a history of frequently experiencing withdrawal symptoms and regularly experiencing headaches, restlessness, insomnia, cold sweats, diarrhoea and poor appetite. He stated that this made it difficult for him to attend appointments. Professor Davidson administered the Leeds Dependence Questionnaire and having considered the results concluded that the second applicant had a serious polydrug problem. He stated that: "Essentially, his life in prison is characterised by sourcing drugs, paying for drugs and using drugs." The results of psychometric assessments were interpreted by Professor Davidson as being consistent with the description in the GP Notes and Records of a lifetime of mild depression but with significant anxiety.

[32] In his opinion section Professor Davidson recognised the difficulties healthcare professionals have in treating prison inmates with drug addiction issues. He stated that: "Treatment in prison is not the same but should be equivalent." He described an option to provide monthly injections of Buvidal as a successful form of OST which did away with the risk of oral OST medication not being ingested by the patient so that it could be sold within the prison. Professor Davidson also opined that the Buvidal injections also meant that staff did not have to spend time supervising prisoners to ensure that oral medication was ingested and could, therefore, be engaged in other tasks.

[33] Mr McCann's third, fourth and fifth affidavits sworn on 20 June 2024, 24 June 2024 and 26 July 2024 exhibit documentation from the second applicant's GP and the Belfast Addiction Service to confirm that the second applicant was initially referred for assessment of suitability for OST on 9 May 2024 and was put on the community OST programme on 21 June 2024, a time interval of just over six weeks.

The respondent

[34] Mr Stephen McGarrigle, the Assistant Director of Prison Healthcare in the respondent Trust has sworn three affidavits (two dated 15 March 2024 and the third dated 4 June 2024). Mr McGarrigle is a physiotherapist by training. In the affidavit sworn on 15 March 2024 which relates to the application brought by the first applicant, Mr McGarrigle avers that as of 6 March 2024, the first applicant was positioned 16th on the OST waiting list and he would be seen "as soon as possible in light of clinical need." Mr McGarrigle then sets out a table which shows the CAT caseload of each of the five Trusts in Northern Ireland and Prison Healthcare, based on the "OST Dashboard for December 2023." These statistics are collected and collated by the Strategic Planning and Performance Group ("SPPG"), the body within the DOH responsible for the commissioning of healthcare services in Northern Ireland. The table also lists the numbers on the CAT waiting list in each Trust and in Prison Healthcare. Estimates of the population numbers served by the Trusts and the precise number of prisoners incarcerated in December 2023 are also set out in the table. On the right side of the table there are two columns of percentages for each Trust and Prison Healthcare. These represent in percentage terms (a) the CAT caseload as a fraction of the population of the relevant Trust or the prison system; and (b) the CAT waiting list as a fraction of the population of the relevant Trust or the prison system.

[35] In Northern Ireland in December 2023, the total CAT caseload was 1,615 with 124 on the waiting list. The total population was estimated at 1,895,532. The total CAT caseload represented 0.09% of the total NI population and the CAT waiting list represented 0.007% of the total NI population. The Trust with the biggest population was the Northern Trust (479,400). The CAT caseload in the Northern Trust was 445. Only six people were on the waiting list. The CAT caseload stated as a percentage of the population was 0.09%. The CAT waiting list represented 0.001% of the population of the Trust. The Belfast Trust had the biggest CAT caseload at 453. The waiting list was eight. The CAT caseload stated as a percentage of the population was 0.13%. The

CAT waiting list represented 0.002% of the population of the Trust. The South Eastern Trust had the third biggest population at 363,800. It had the smallest community case load of any Trust at 178. The community waiting list was also the joint smallest amongst the Trusts at two. The CAT caseload stated as a percentage of the population was 0.05%. The CAT waiting list represented 0.001% of the population of the Trust.

[36] The prison population in Northern Ireland in December 2023 was 1832. This means that in December 2023, the prison population in Northern Ireland was 0.097% of the total population. The CAT caseload of Prison Healthcare was 178. 102 prisoners were on the waiting list. The CAT caseload stated as a percentage of the prison population was 9.72%. The CAT waiting list represented 5.568% of the prison population.

[37] The point being made by Mr McGarrigle is that it is completely inappropriate to compare OST provision in prison with OST provision in the community because the demand for OST in the prison environment, taking into account population size, is vastly greater than the demand for OST in the community. If one compares the South Eastern Trust with Prison Healthcare, as a percentage of the respective populations the CAT caseload is 194.4 times greater in prison than in the South Eastern Trust. If the same percentage of the South Eastern Trust population were on the CAT caseload as the percentage of the prison population on the CAT caseload (9.72%) this would mean that 35,361 people would be on the CAT caseload in the South Eastern Trust. This is the scale of the problem of drug addiction in the prison population and it is a much greater problem in the prison population than in the general population. As a result, it is argued that comparisons are inappropriate.

[38] Risking the repetition of a trite observation, statistics can be interpreted in many different ways. The applicants invited the court to take into account the fact that the South Eastern Trust was the Trust with specific responsibility for the provision of healthcare in the Northern Ireland prison estate. It was suggested that the Prison Healthcare figures should be combined with the South Eastern Trust community figures and then a comparison should be made with other Trusts.

[39] When the suggested calculations are performed, the following results are obtained. The combined population of the South Eastern Trust and the prison population in Northern Ireland in December 2023 was 365,632. The combined total CAT caseload was 356 with a combined total of 104 on the waiting list. The total CAT caseload represented 0.097% of the combined population and the CAT waiting list represented 0.028% of the combined population.

[40] Even when the Prison Healthcare figures are combined with the South Eastern Trust figures, the totals and the calculated percentages show that the South Eastern Trust is better placed than the Belfast Trust in terms of waiting lists and is under less pressure in terms of demand for OST. When the statistics are interpreted in this way, the applicants argue that it is hard to justify the disparity in performance between the provision of OST in prison and the community. Irrespective of how these statistics

are interpreted, one fact jumps out from the table in Mr McGarrigle's affidavit. There is a very severe drug addiction problem in the Northern Ireland prison population.

[41] Mr McGarrigle also highlights the issue of the increase in the prison population in Northern Ireland between December 2022 and 2023; up from 1692 to 1832. Mr McGarrigle also highlights that:

> "the health service in Northern Ireland … is subject to severe funding pressures, and the same is true of Prison Healthcare … Prison Healthcare continues to operate in a context of limited and insufficient funds for the tasks it must perform … The reality is that Prison Healthcare works in an environment in which there are limited resources, an increasing number of prisoners, and an increasing number of prisoners seeking OST."

He avers that in the year financial year 2022/2023, the Department of Health provided approximately £10.89million for Prison Healthcare but even with that level of provision, he notes that the RQIA 2021 report identified a shortfall of approximately £4million per year in the Prison Healthcare budget.

[42] Mr McGarrigle also highlights that the principal aim of the 2009 Partnership Agreement that has already been referred to above, is set out at para 2.2 of the Agreement and it is:

> "to provide prisoners with access to health and social care services equivalent to those the general public receives …"

[43] Mr McGarrigle then deals with the current provision of healthcare in the prison estate in Northern Ireland and states that a community-based model of primary care is provided on a "24/7 basis." He describes a three-stage assessment for each prisoner who is newly received into custody. There is an initial healthcare assessment on the day of committal, a comprehensive healthcare assessment within the first seven days of committal and a face-to-face mental health screening within five days of committal in keeping with NICE guidance NG 66 NG 57. Each prison has an enhanced primary care team consisting of a GP and primary care nurses. This team is supported by specialists in musculoskeletal and respiratory physiotherapy, SLT, OT, dietetics, dentistry and radiography. There is one onsite pharmacy in HMP Maghaberry that serves all the prisons in NI and is staffed with pharmacists, pharmacy technicians and medicines management technicians. That means that pharmacy staff have to transport medications to other prisons in NI. All of these professionals other than radiologists are employed by the Trust solely for the purposes of providing services in prison. Radiology is an in-reach service. Secondary or tertiary care needs are identified by the primary care teams in the prison and appropriate referrals are made with prisoners being transported to the appropriate hospital/clinic by prison staff.

[44] In relation to the mental health needs of the prison population, Mr McGarrigle avers that mental health services are provided on a "community stepped care model" by a mental health team comprising of mental health practitioners (from a nursing, OT or social work background), psychologists, cognitive behavioural therapists and psychiatrists. A relatively recent innovation has been the creation of an expanded CAT to address the problem of drug addiction in the prison population. The team consists of "1.0 Whole Time Equivalent ("WTE") Addictions Consultant" for the medical assessment/review of patients and "4.0 WTE Band 6 Addictions Nurses" who act as key workers to case manage the patient while under the service. Since 2009 an independent service provider, Start 360, has been engaged to provide the AD:EPT service within the prison environment. This programme offers a range of psychosocial interventions to support patients with a history of substance abuse.

[45] Prior to 2016, the NI Prison CAT service consisted of one general adult psychiatrist (not an addictions specialist) and one nurse based in HMP Maghaberry. Only prisoners who were on OST in the community immediately before committal were provided with OST within the prison estate. The Criminal Justice Inspectorate in its report on HMP Maghaberry dated November 2018 highlighted at para 2.74 that 17 of the 18 patients who had been receiving OST in the community were maintained on this treatment in prison but that no patients were started on OST "during their sentence because there were no specialist prescribers and long national waiting lists for community treatment." Following on from this report, a permanent Addictions Consultant and 3.0 WTE Addictions Nurses were recruited in 2018 and this team was subsequently expanded by the addition of another WTE Addictions Nurse in the late summer of 2023 due to a dramatic increase demand for the service. This increase in demand is said to be demonstrated by the following statistics. In August 2018 there were 36 patients on OST in the NI prison population. In December 2019, the prison caseload had increased to 95 with an additional 38 on the waiting list. One year later, the caseload was 152 with 92 on the waiting list. In December 2021, the caseload was 164 with 107 on the waiting list. In December 2022, the caseload was 172 with 100 on the waiting list. The December 2023 figures were caseload: 178; waiting list: 102. It does not form part of the evidential matrix set out in Mr McGarrigle's report but it is relevant to note the fact that prison visits in Northern Ireland were stopped due to COVID on 23 March 2020.

[46] The main thrust of Mr McGarrigle's first affidavit is that Prison Healthcare deals with an intensity of demand for OST that simply is not reproduced in the community and that the two populations are not analogous. He also points out that the work of the Prison Healthcare CAT team has been recognised as being of a very high standard as evidenced by the conferring of the Managing Substance Dependency in the Community Award at the Northern Ireland Healthcare Awards in 2021 and the GP Practice/Healthcare Centre of the Year Award at the Northern Ireland Health and Social Care Awards in 2023. These awards, according to Mr McGarrigle, are proof that the respondent Trust is managing and deploying its limited resources as best it can and has been recognised as excelling in the quality of care provided using those resources.

[47] Pausing there, it should be remembered that neither applicant is alleging that the prison population is analogous to the community population in terms of the scale of healthcare needs. The two populations are clearly not analogous. It is well recognised that the prevalence of mental health problems, including personality disorders and substance abuse problems, are much higher in the prison population than the prevalence found in the community. The case being articulated by the applicants is that the principle of equivalence must be looked at from the perspective of the individual and, in particular, the healthcare needs of that individual. The opiate dependent person in the prison population is analogous to the opiate dependent person in the community and each person's access to high quality healthcare to effectively address this dependency should be equivalent. What is clear from Mr McGarrigle's affidavit is that a lot more financial resourcing would be needed to achieve such equivalence and it would seem that such resourcing is not available. The stark question for the court to answer is whether the paucity of resources provides justification for the state body responsible for the provision of healthcare services in the prisons in Northern Ireland providing that population with an OST programme which is clearly not equivalent to that provided in the community.

[48] In relation to the healthcare provision presently available to prisoners with opiate addiction issues, it is clear from Mr McGarrigle's affidavit that if an individual is already on OST in the community, OST will be automatically continued in the prison. No in-depth assessment is considered necessary for such patients prior to continuing OST in prison. In March 2024, 86.5% of those prisoners on OST in prison in Northern Ireland had "entered prison on script." Mr McGarrigle argues that this means that "there is less capacity to assess new patients or patients who have not previously been in receipt of OST." Viewed from the individual perspective, the statistics could be interpreted as demonstrating that the present level of funding for OST in prison is just about sufficient to provide the level of appropriately trained staff to ensure that those who enter prison on OST are maintained on OST but not sufficient to timeously assess those in prison suffering from opiate addiction/dependency as to their suitability for OST. It would appear that the fallback position for these patients is that they are directed towards AD:EPT for support. AD:EPT can then refer them for assessment of suitability for OST but, as is clearly recognised by all involved in these two cases, the waiting time for assessment is very significant and can stretch into years. As a safety net, prisoners can be seen by the prison GP service and the mental health team who can provide support and can, in appropriate cases, provide medication to ameliorate symptoms of withdrawal.

[49] In the prison environment, as in the community, OST operates on a twin track basis with the provision of substitute opioid medication proceeding in tandem with the provision of appropriate psychosocial support. Both treatment modalities are important. Mr McGarrigle avers that it has been shown that a well-run OST programme reduces the mortality and morbidity risks for those deemed suitable for the programme. According to Mr McGarrigle, it has been shown that there are also enhanced social outcomes with reduced reoffending rates, improved relationships,

and an enhancement of the ability to obtain and maintain accommodation and work/training opportunities. Although not specifically stated by Mr McGarrigle, I interpret this to mean that these improved outcomes are seen when one compares those on OST with those addicts on no form of therapy or support and, importantly, are also seen when one compares those on OST and those who are not but, as a fallback, have support from AD:EPT combined with medical treatment for the amelioration of withdrawal symptoms. If this were not the case then what would be the justification for funding and providing the OST programme at all?

[50] Mr McGarrigle then goes on to describe what is involved in carrying out an assessment of suitability for OST in the prison environment. This involves a comprehensive consideration of the substances the patient is dependent upon, any associated medical or psychiatric problems, any prescribed medications that the patient is currently taking, any social issues and, most importantly, the patient's motivation to engage in treatment with a view to effecting change. The short-terms goal of OST is to reduce illicit opiate use and to reduce the risks associated with this. The long-term goal is to enable the patient to stop using illicit opiates completely. OST is only recommended for patients who have an established opiate dependency. The assessment process in the prison, therefore, involves the analysis of two urine samples given one week apart for the presence of opiates and the patient must also be observed in a state of opiate withdrawal. Treatment can be by way of daily oral medication (liquid Methadone or Buprenorphine in tablet or wafer form) or monthly subcutaneous injection of extended-release Buprenorphine. Regular monitoring is required in the drug induction phase with initial bi-weekly reviews, reducing to once per week after two weeks. When a patient is safely established on OST then the focus of the treatment becomes psychosocial with a review by the CAT nursing staff every four to six weeks and a medical review every three months. Regular urine drug screens are also carried out.

[51] In the community, daily oral OST is administered mainly in community pharmacies. In Northern Ireland prisons, the burden of administering daily oral OST falls on the Prison Healthcare teams. Two members of staff are required to attend with each patient and observe the ingestion of the drug in order to protect against the medication being secreted and then sold for use by other prisoners. In November 2023, there were 135 patients on daily oral OST. According to Mr McGarrigle, this is a demanding service for staff in a prison context. He specifically avers that delivery is not analogous to the equivalent service in a community setting in terms of the resources that are needed to deliver it.

[52] Pausing there, the applicants' cases relate to the delay in assessing them in relation to their suitability for OST. There would seem to be no material difference in the assessment process in the community and the assessment process in prison. There appears to be no material difference between the process of administering a monthly subcutaneous injection in the community and administering such an injection in prison. The difference highlighted by Mr McGarrigle is the difference between the administration of oral OST medication in the community and the administration of

oral OST medication in prison. It would seem that Community pharmacies perform this service in the community. It would appear that two members of the Prison Healthcare team perform this service in the prison. Mr McGarrigle avers that one is a registered nurse and the other is a "suitably qualified member of healthcare staff." He avers that this imposes a very significant demand on CAT. Does it? There is no evidence to indicate that the daily administration of oral OST requires the input from one let alone two specially trained members of the CAT in the prison. It is difficult to see how the absence of the option of community pharmacy delivery of a daily oral OST service in the prison environment significantly impacts on the ability of the specialist CAT medical and nursing staff to perform assessments of suitability for OST in prison.

[53] Mr McGarrigle avers that the greatly increased demand for OST in prison and a rise in the cost of the medication has resulted in a very significant increase in the amount of money expended on OST medication rising from £39,867 in the 2020 calendar year to £138,959 in the 2023 calendar year. This he argues must be viewed in the context of significant budgetary pressures. Mr McGarrigle also refers to the 2021 RQIA report and highlights the following passages of the report:

> "Whilst it was clear that the Prison Service and the South Eastern Health and Social Care Trust have made great efforts and commendable progress, particularly in relation to Supporting People at Risk Evolution, partnership-working and governance, they can only continue to improve within the constraints of existing resources.
>
> During the course of the review, we encountered a number of very capable and committed staff across both the prison service and within healthcare in prison. The Expert Review Team was impressed by their compassion and dedication to making things better for people in custody. In particular, Safer Custody arrangements and recent improvements within the Addiction Service are testament to the commitment of those talented individuals. Equally, the Health and Wellbeing Engagement work and initiatives such as Towards Zero Suicide demonstrate the potential for collaborative efforts to lessen the mental health challenges faced by the prison population. However, in order to achieve improved and sustained outcomes for vulnerable people in custody there needs to be a co-ordinated effort across both the criminal justice and health and social care system.
>
> In comparison with healthcare in prison budgets in England and Wales, the Expert Review Team have

> determined through bench-marking that the Northern Ireland budget for healthcare in prison is significantly less per head of the prison population; this equates to a shortfall of approximately £4 million per year. This disparity has arisen because the funding for healthcare in prison has been determined by a historical figure, supplemented by an annual uplift, rather than being founded on a meaningful formula or needs assessment. The precise figure for mental health funding has not been delineated at the time of fieldwork but one can extrapolate that it falls below par: All of this occurs in spite of a higher demand for mental health provision within the general Northern Ireland population. The increased level of need is such that there is an argument for even greater funding to be provided within Northern Ireland prisons, not less.
>
> Therefore, it is crucial that bench-marking augmented by robust needs assessment informs the commissioning of prison mental health services going forward; the Expert Review Team consider that it is likely a significant funding uplift is required."

[54] To my mind, this last para encapsulates the real issue in this case. The CAT in the prison estate in Northern Ireland are doing their very best to provide a decent service for prisoners with addiction issues, but in relation to OST, the service provided lags well behind the services provided by any of the Trusts to the general population. The reason for this is the inadequate funding of healthcare in prisons which per head of prison population is much less than that provided in England and Wales. The RQIA report recommended that Northern Ireland's healthcare in prison services should be benchmarked with prison healthcare services in the rest of the UK. Where deficits are identified through benchmarking, a needs assessment should inform additional funding arrangements.

[55] This is clearly a highly unsatisfactory state of affairs. The question for the court is whether this unsatisfactory state of affairs is also unlawful by virtue of the incorporation of the prohibitions and protections contained in the ECHR following the enactment of the HRA.

[56] A partial answer to this question may be contained in another passage of the RQIA report that Mr McGarrigle quotes from at length in his first affidavit:

> **"Accessibility of addiction services**
>
> Provision for addiction treatment within the prison service has improved following the recruitment of a consultant

addictions psychiatrist and the introduction of prolonged-release injections to treat opioid dependence. Beneficially, the Addiction Service has also expanded its remit to provide care and treatment for those with a history of alcohol misuse. The team work closely with AD:EPT (Alcohol and Drugs: Empowering People through Therapy), a service delivered by Start 360, who are an independent organisation providing therapeutic services across the three sites.

In addition to an addiction's psychiatrist, the service is provided by specialist nurses and GPs with a special interest in addiction. However, whilst three specialist addictions nurses have been appointed by the SEHSCT, we were told by frontline staff that at the time of fieldwork only one nurse was currently working. As stated in the SEHSCT policy, induction on to Opiate Substitution Therapy (OST) is dependent not only on the criteria set out in the United Kingdom Guidelines on Drug Misuse and Dependence 2017 but also on the availability of appropriately trained nurses and prescribers across the prison sites; as such, any lack of nursing capacity presents a considerable challenge.

Demand for OST is described as significant; the waiting time for an addiction's appointment was seven months at the time of fieldwork with 90 individuals on the waiting list. Whilst this represents an improvement, it is clear that many prisoners are still waiting too long to be seen. Not only does this perpetuate a demand for illicit drugs within the prisons, it also means that some prisoners will experience acute withdrawal symptoms. This falls short of expected standards when it comes to both best practice and human rights.

Recommendation 9 **Priority 1**

Commissioners (currently the HSCB) and providers (SEHSCT) should work together to review the current capacity and capability of the addiction service to meet the needs of prisoners who require treatment and support for addiction. Urgent consideration should be given to increasing the number of specialist nurses in order to increase Opiate Substitution Therapy provision and to shorten waiting times."

[57] Mr McGarrigle goes on to describe the results of the benchmarking exercise that was performed by a "Benchmarking Task and Finish Group" in response to the recommendation in the RQIA report. Amongst the findings, the following were made:

> "(i) When compared with prisons in North-East England, a lower Northern Ireland resourcing of £1.01m was identified and, for comparator prisons in South-West England, £1.4m of under resourcing was identified (for mental health services alone).
>
> (ii) A comparison of the number of whole-time equivalent staff providing mental health care if provided at levels of whole time equivalent per capita for the comparator regions in England identified a gap ranging from 24 to 34 in NI."

[58] Mr McGarrigle also refers to an independent report on prison addiction services in England which was authored by Dame Carol Black in August 2021. One of the issues considered by Dame Carol was the issue of the caseload of the drug treatment and recovery workforce. At 3.1 of the report, she stated:

> "The drug treatment and recovery workforce has deteriorated significantly in quantity, quality and morale in recent years, due to excessive caseloads, decreased training and lack of clinical supervision. A recent workforce survey showed that drug workers had caseloads of between 50 and 80, sometimes rising as high as 100 people. Good practice suggests a caseload of 40 or less, depending on complexity of need. Each practitioner should have a caseload of 40 persons or less (depending on complexity). Such high caseloads reduce the quality of the care provided and the effectiveness of treatment."

[59] Mr McGarrigle then highlights that in December 2022 the relevant capacity of addictions specialist staff was 3.0 WTE staff for 172 patients, giving an average of 57 patients per practitioner which is "significantly above the maximum recommended by Dame Carol." Mr McGarrigle avers that the respondent Trust has sought additional funding for addiction services and in 2022/2023 succeeded in securing £30,000 recurring funding for administrative support and communication with community services.

[60] In the year 2023/2024, three tranches of additional funding have been secured. During the first quarter, an additional £220,000 of recurring investment was secured to enable an additional Band 6 Addictions Specialist to be recruited, bringing the complement of Addictions Specialists up to 4.0 WTE from 3.0 WTE. Additional primary care and pharmacy staff were also recruited. Two GPs with a special interest

in addictions have been recruited and this will facilitate a move towards a shared care model of care provision which will reduce the addictions case load to a more manageable level. A further £220,000 of recurrent funding was secured in October 2023 and this has been used to recruit a Band 7 Addictions Team Lead which will further increase clinical capacity. It is also intended to recruit primary care and pharmacy staff in order to increase capacity in relation to the dispensing and administering of medication. In November 2023, £77,000 of non-recurrent funding was confirmed to fund a temporary part-time social worker post and assistant psychologist. It is hoped that these appointments will enhance the multidisciplinary approach to the management of patients with addictions.

[61] Mr McGarrigle goes on to aver that despite this additional funding, waiting lists remain high due to an increased demand for the service and the fact that two members of staff have been absent, one due to illness and one due to maternity leave. It has not proved possible to obtain temporary cover for these members of staff.

[62] Mr McGarrigle also avers that in 2022, the Regional Health and Social Care Board commissioned a report from Dr Nat Wright an English GP expert to "undertake a rapid review and consultation to understand current issues regarding demand and capacity in relation to OST and substance use issues within the prison system in Northern Ireland, including the link to community addiction services." Dr Wright's report dated May 2022 identified a problem of underfunding of prison healthcare in Northern Ireland. Dr Wright made the following recommendation:

> "Capacity needs to be built to facilitate Opioid Substitution Treatment (OST) initiation in prison, according to clinical need and without any significant waiting times, to support stability upon release from prison. Recruiting more specialist addiction nurses will support such capacity building."

[63] In May 2023, a "workforce planning exercise" which was presented by the respondent Trust to the SPPG of the Department of Health concluded that prison healthcare in Northern Ireland had 37.31 full-times nurses less than the workforce that would be needed to operate "normal business." A series of staggered (phased) business cases have been presented by the respondent Trust to the SPPG and some limited additional funding has been provided with little signs of improvement in capacity.

[64] The last issue dealt with by Mr McGarrigle in his first affidavit relates to the management of the waiting list for assessment of suitability for OST. Patients are not assessed in strict chronological order but on the basis of clinical need. For instance, priority will be given to a patient with a confirmed history of opioid dependence, or who is injecting opiates, especially where there are established complications of injecting drugs such as deep venous thrombosis, abscess formation, hepatitis C, HIV or endocarditis, or where the existence of multiple drug dependencies is established,

or where the prisoner has a proximate release date, or where the prisoner is a life sentence prisoner who is working towards a parole hearing where unaddressed addiction issues might damage his chances of being released on licence.

[65] In his second affidavit sworn on 15 March 2024, which related to the second applicant, Mr McGarrigle accepts on behalf of the respondent that there has been a delay in assessing the second applicant's "eligibility for the OST programme." That delay is, according to Mr McGarrigle, a result of the circumstances within which prison healthcare must operate. He avers that prison healthcare operates in an environment in which there are limited resources, an increasing number of prisoners and an increasing number of prisoners seeking access to OST. Mr McGarrigle was able to inform the court that as of March 2024, the second applicant was placed third on the waiting list for assessment. We know that he was not assessed in prison prior to his release in April 2024. Thereafter, he was promptly assessed in the community and commenced on OST.

[66] Mr McGarrigle's affidavit then exhibits a report from Dr Siobhan Flanagan in an effort to demonstrate that while the second applicant remained on the waiting list for assessment, he was able to avail of other services in prison and these other services were also described in his first affidavit. Before turning to the contents of Dr Flanagan's medical report, I will summarise the evidence contained in Mr McGarrigle's third affidavit sworn on 4 June 2024.

[67] Additional information set out in Mr McGarrigle's third affidavit include the results of a joint RQIA/CJINI inspection of HMP Maghaberry in October 2022. This concluded that the level of illicit drug use in the prison was concerning and that substance abuse therapy was severely under-resourced and the number of patients who could receive treatment was capped. "This is concerning and places patients at risk of harm. The access to treatment must be reviewed to ensure the best practice is followed." The report went on to state:

> "There were long delays to access the clinical substance misuse treatment service. … Overall services were severely under-resourced … Clinical prescribing arrangements did not meet the needs of the population and it was concerning, giving the findings of serious drug problems, that providers had capped the number of patients who could receive Opiate Substitution Therapy (OST) due to workforce and other constraints. This has resulted in 128 patients who were waiting for an assessment of their needs, for longer than nine weeks. Clinical reviews of patients on OST were not taking place in line with best practice and oversight of reviews was weak. Patients we spoke to expressed frustration at not being able to access the service. The Trust should review the assessment process and access to OST and ensure that best practice is

> followed. An area for improvement has been stated for a second time."

The report recommended:

> "The South Eastern Health and Social Care Trust must ensure patients have timely access to opioid substitution treatment and a full range of clinical and psychosocial support which meets NICE 5 guidance and the needs of the population."

[68] The report recognised the difficult situation which the respondent Trust was facing in providing a NICE guidance compliant addictions service:

> "There has been an exponential rise in demand for Opioid Substitution Therapy within Healthcare in Prison, which currently exceeds the commissioned capacity within the existing service without compromising patient safety. This is compounded by the sharp rise in those patients entering prison with an active script from the community, limits the opportunity for new inductions … A new shared care pathway has been designed to improve access to experienced clinicians providing addictions treatment. The pathway will develop shared care within Clinical Addictions Team in prison with GPs with experience in addictions will take over care of stable patients enabling the addictions team to focus on clinical priorities including new patients requiring OST. Extra addictions and primary care nursing staff have been recruited to help with the ongoing demand and improve access to addictions treatment in prison."

[69] There was a similar joint RQIA/CJINI inspection of HMP Magilligan in October 2023. Amongst its findings were the following:

> "There were significant delays in accessing the opiate substitution therapy programme. About 100 prisoners across all three prison sites were on the waiting list and many had waited for between one to two years, driven by a significant increase in demand for clinical addiction services. This inevitably had a negative impact on prisoners' sentence planning and reducing drug use.
>
> The complement of SEHSCT commissioned staff to deliver addictions services across the three prison sites had

increased by one whole-time equivalent, however there was limited evidence of a reduction in waiting times."

[70] Mr McGarrigle then goes on to set out the steps taken by the respondent Trust to attempt to secure much more substantial funding for prison healthcare addictions services. In 2021 a draft business case for £664,446 was prepared with the aim of enabling the respondent Trust to make the much-needed improvements to the OST programme, including the recruitment of staff. According to Mr McGarrigle, the SPPG response to this draft business plan was to indicate that the respondent Trust "would be more likely to secure additional funding if we asked for smaller amounts and staggered, or phased, our requests." The additional funding subsequently secured has already been addressed in Mr McGarrigle's first affidavit.

[71] Returning to Mr McGarrigle's second affidavit that exhibits the report from Dr Flanagan. It is to be noted that the report from Dr Flanagan is dated 14 March 2024. Dr Flanagan is a consultant psychiatrist working in the field of adult psychiatry with a specialist interest in substance abuse. She has been working as an Addictions Consultant in prison healthcare since January 2020. Dr Flanagan's report is based on her consideration of the second applicant's prison healthcare records, his AD:EPT records, her personal involvement with the second applicant and her consideration of Professor Davidson's report dated 26 November 2023. It would appear that the second applicant has been referred to the prison addiction service on seven occasions since 2012; twice in 2012, once in 2015, once in each of the years 2017, 2018 and 2019 and then in February 2021. The second applicant was offered two appointments with Dr Flanagan in February and March 2020 but did not attend.

[72] The second applicant was first seen by the addictions team in the prison on 7 February 2012. There was a history of polysubstance abuse, including heroin. He was examined for signs and symptoms of opiate withdrawal and had a score of 3/45 (no clinically significant withdrawal symptomology). The second applicant denied injecting drugs. He wanted help to come off all drugs apart from cannabis which he planned to continue to use. It was felt that he had not yet developed an opiate dependency and it was considered that he may benefit from Naltrexone medication which reduces cravings and the feelings of euphoria associated with opiate abuse. He was offered support to stop taking opiates including the prescription of Lofexidine, a medication that reduces the symptoms of opiate withdrawal. A urine drug screen was taken on 9 February 2012 and symptomatic relief medication was prescribed. The urine drugs test showed no drugs present. These findings were consistent with a diagnosis of non-dependent opiate use. The second applicant was released from prison before further work could be undertaken.

[73] It was not long before the second applicant was back in prison again and was offered an appointment with the addiction team on 13 March 2012. It would appear that his mental health had deteriorated and he was seen by the prison mental health team and was prescribed a course of Olanzapine 5mg. He was then seen by the addictions team 2 July 2012. He gave a history of smoking heroin in the prison. He

was examined and deemed not to be in withdrawal. His urine drug test was negative for all drugs. A more sophisticated laboratory assessment revealed evidence of cannabis but no other drugs. The nurse practitioner diagnosed non-dependent use of heroin. He was prescribed Lofexidine to help alleviate self-reported opiate withdrawal symptoms. The second applicant was seen by the addiction's consultant on 16 July 2012, as Naltrexone treatment was still being considered. The second applicant volunteered that he had recently taken Tramadol and as a result Naltrexone could not be commenced as a period of 10-14 days abstinence from opiates is required before commencing Naltrexone. A review appointment was arranged.

[74] The second applicant refused to attend for required daily Lofexidine observations from 25 July 2012, informing staff that he no longer needed this treatment. He refused to attend a review with the addiction consultant when the prescription of Naltrexone was due to be discussed. Further non-engagement meant he was discharged from the caseload. On 15 December 2012, the second applicant had to be seen at a local A&E as he was under the influence of drugs. He reported taking benzodiazepines and cannabis. Prison records also record that he damaged his cell whilst under the influence of drugs in August 2014. He was next referred to the addictions team by his AD:EPT counsellor on 5 November 2015. He was seen on 11 November 2015 when the history obtained was that he took illicit opiates and Pregabalin once or twice per week in prison. He stated that his drug of choice in the community was cannabis but when in prison he tended to use a variety of drugs, in essence, whatever was available. He denied injecting drugs but gave a history of an accidental overdose two years earlier when taking opioids and benzodiazepines. At that stage, he was requesting Lofexidine and Naltrexone. He did not wait to be seen by the addictions' consultant on 10 December 2015 and 21 December 2015. He reported that he was too unwell to attend an appointment on 23 December 2015. He was subsequently discharged due to non-engagement.

[75] The next referral occurred in May 2017 on the basis of ongoing Tramadol addiction. He refused to attend two appointments in September 2017 and was discharged. He was referred again in October 2018 by AD:EPT following a failed drug test for Tramadol. When seen, there were no obvious signs of opiate withdrawal. He declined a urine test. He was ambivalent about treatment and stated that opiates were not his drug of choice in the community. He declined Naltrexone. He received Naloxone training (how to administer Naloxone by injection in order to reverse the effects of an accidental overdose of opiates). The plan was to provide him with a Naloxone kit on his release from prison. The next referral occurred in May 2019 with a history of smoking heroin in the community and in prison. He refused an appointment with Dr Flanagan on 17 February 2020. A urine test taken on 13 January 2020 was clear. He was seen by an addictions nurse the following day. He was offered another appointment with Dr Flanagan and was also offered further Naloxone training as his release was imminent. He stated he was off all drugs and no longer needed to be seen. He expressed an interest in commencing Naltrexone and an appointment with Dr Flanagan was organised for 2 March 2020. However, he refused to attend to provide a urine sample on 21 February 2020 and also refused to attend his

appointment with Dr Flanagan on 2 March 2020, despite telephone encouragement from Dr Flanagan. No further appointments were offered and he was referred to AD:EPT for Naloxone refresher training and other pre-release work.

[76] The second applicant was referred to the addiction team by AD:EPT on 1 February 2021 with a history of illicit buprenorphine and pregabalin use. He had not received an appointment for a comprehensive assessment prior to his release in April 2024, a period of three years and two months. In the meanwhile the second applicant received "psychosocial intervention" from AD:EPT between 14 June 2021 and 30 March 2022. AD:EPT requested Dr Flanagan to prescribe symptomatic relief medication to the second applicant for withdrawal symptoms on 18 February 2022. When seen by AD:EPT on 7 April 2023, the second applicant reported that he was still struggling with substance abuse. He received a further eight sessions of psychosocial intervention from AD:EPT between 30 May 2023 and 11 August 2023. This intervention was terminated at the request of the second applicant. The second applicant was verbally abusive and threatening towards the AD:EPT counsellor during this last session with the result that prison staff had to intervene to protect the AD:EPT practitioner. He had no further involvement with AD:EPT during the rest of his sentence. Dr Flanagan summarises the results of the second applicant's most recent drug tests. These indicate polydrug use including opiates. The second applicant's EMIS records only record four requests for symptomatic relief medication for opiate withdrawal between 2012 and his release in 2024. In February and November 2022 he was prescribed Mebeverine for stomach cramps and Imodium for diarrhoea. He received Cyclizine for nausea in May 2019. He received Lofexidine to alleviate opiate withdrawal symptoms in July 2012. Dr Flanagan doubts the veracity of the second applicant's complaint to Professor Davidson of experiencing opiate withdrawal symptoms twice weekly.

[77] Dr Flanagan describes what is involved in the assessment of suitability for OST and the provision of OST. Most of what is recorded in her report has already been dealt with in Mr McGarrigle's first affidavit. In relation to injectable OST, I note that in the induction phase Buvidal is administered on a weekly basis and then is administered monthly. Buvidal injections have been available in the prisons since 2020 and as of February 2024, 30% of the prisoners in receipt of OST were receiving Buvidal injections. Dr Flanagan also highlights the problems of diversion with buprenorphine in tablet or wafer form. They have a considerable financial value when sold or traded. In addition to seeking financial gain, some prisoner can be bullied into diverting their supply. In her report Dr Flanagan candidly states that the prison addiction team is under-resourced and faces very real challenges in addressing the needs of patients in prison. Dr Flanagan also raises the issue of additional pressures resulting from the introduction of body scanners in the prisons in the spring of 2023. If a prisoner fails a body scan, all medication including OST is withheld. If that occurs, then the prisoner has to be promptly seen by the addictions team so that OST can be safely reinstated. This has led to an increased workload for an already overstretched workforce. She candidly accepts that there is very little capacity to comprehensively assess, induct and follow up new patients. I interpret her to mean that levels of

resourcing for addictions services in prison are such that only those already on OST in the community who are then imprisoned can be guaranteed to be maintained on OST in prison. Those on the waiting list to be assessed for their suitability for OST in prison are prioritised on the basis of perceived risk of harm (comorbid severe and enduring mental illness, comorbid physical ill-health such as HIV, clear history of regular and high-risk intravenous drug use or clear history of accidental overdose). According to Dr Flanagan, the second applicant did not fall into any of these high-risk categories. She reiterates that the second applicant was offered the opportunity for assessment in February and March 2020 but declined to attend. While he was on the waiting list for assessment between February 2021 and his release, he was able to avail of help and support from primary care nurses, prison GPs and AD:EPT.

[78] In addition to providing a medical report, Dr Flanagan also swore an affidavit dated 6 June 2024. In this affidavit, she describes her significant experience working at a senior level in the NHS Scotland and Northern Ireland in the area of addictions management. She led the in-patient addiction unit in the respondent Trust from 2007 to 2020 and has been working with addiction patients within the prisons in Northern Ireland since January 2020. She has "developed the addiction service in prison within the limits of the resources available to me."

[79] Dr Flanagan avers that the provision of OST was introduced into prison healthcare in 2018. It is a relatively new treatment in the Northern Ireland prison regime. Previously there was a very low rate of intravenous drug use in Northern Ireland. This has changed in recent years with a sharp increase in heroin use and intravenous drug use. The number of patients on OST in the community has increased considerably over the past ten years. There has been a rapid escalation in demand for OST in the prison estate in Northern Ireland and this must be seen in the context of a significant disparity in the funding of prison healthcare in Northern Ireland when compared with the rest of the UK. Because of the high number of prisoners being incarcerated who are already on OST in the community and because it is:

> "vital patients who have been prescribed OST are continued on it without interruption … the continual acceptance of community OST patients into the prison system (both on remand and sentenced prisoners) has a significant limiting effect on the number of new cases which can be assessed in respect of prisoners who wish to be assessed for commencement of OST while in prison. … Prison healthcare simply has not been resourced for the rapid growth in the level of need within the prison and the increased number of committals who are already established on OST. This point has been recognised in all of the reports in the prison estate."

[80] Dr Flanagan also highlights the long-term nature of OST and the multi-faceted nature of the treatment, involving much more than just the administration of medication. Retention of patients on OST is a sign of success and as a result a successful OST programme will accumulate patients as they are not discharged following initiation of treatment. She states that:

> "The long term and ongoing nature of OST is a unique feature the commissioners who provide funding will have to recognise and grapple with."

[81] Dr Flanagan is at pains to emphasise that OST is "not a panacea for all drug addiction." It can only be used in cases where there is proven opiate dependence, evidenced by positive test results and the observation of opiate withdrawal symptoms. Dependency on other drugs when combined with occasional opiate use is not a scenario that is amenable to OST. The commencement of OST in such a case will lead to opiate addiction in the case of "someone who was simply misusing opiates (rather than being physically addicted in the clinical sense) and will increase the risk of an accidental overdose death due to ongoing poly-substance abuse on top of OST." As a result, comprehensive assessment of suitability is essential and complex.

[82] Dr Flanagan then expands on the impact which the introduction of body scanners has had on OST waiting lists in Northern Ireland prisons. In her report, she highlighted the fact that if a prisoner on OST tests undergoes a scan which results in the detection of drugs in a body cavity, OST is automatically stopped and then the addictions teams has to carefully re-induct the prisoner onto the OST programme. In the first twelve months of body scanners being used to detect drugs, the addictions team had to re-induct 41 prisoners onto the OST programme, meaning that there was less capacity to deal with the waiting list. Patients being re-inducted need to be seen on average weekly by nursing staff for at least six weeks. This is more intense than the review of a new OST patient.

[83] Dr Flanagan is adamant that there is no clinical basis to restrict the choice of OST medication to monthly injections in an effort to increase the capacity of the programme. Indeed, such an approach would be professionally irresponsible. The decision as to which treatment is best for any particular patient is a matter for clinical judgment taking into account patient preference which is important when trying to ensure that the patient is and remains positively motivated. Dr Flanagan then provides further details of the basis of prioritisation of the waiting list for OST. She reiterates that patients are prioritised on the basis of associated physical and mental health problems and risks associated with ongoing drug use. She also indicates that if a patient on the waiting list becomes unwell ie if the risk profile changes, they may then be prioritised for treatment. Dr Flanagan avers that this rarely happens because patients are generally safer in prison, they use less drugs, have little access to needles to inject, have better access to a good diet and good quality healthcare when in prison compared to their lifestyles in the community. Dr Flanagan avers that patients are at

most risk of harm at the time of release. The risk of accidental overdose is highest in the first two weeks following release as prisoners have lost tolerance for street drugs.

[84] Dr Flanagan avers that in the period between 2021-2023, she was advised by her managers that she could not commence any new patients on OST. The strain on the workforce in having to supervise oral medication on a daily basis was resulting in primary care nurses having to cancel other routine duties and general prison healthcare was suffering as a result. Lead nursing staff concluded that it would be unsafe to commence more patients on OST. Dr Flanagan avers that if too many patients are inducted onto OST, the system risks becoming unsafe and overwhelmed resulting in patients not been reviewed in a timely fashion; with problems presenting late; increased distress for patients; medical and nursing staff burnout; and recruitment and retention problems. The addictions team have no control over the number of prisoners being committed to prison who are already on OST and need to be maintained on OST, nor have they any control on the number of prisoners on OST that fall off OST due to a positive finding on a body scan who have to be urgently re-inducted.

[85] Dr Flanagan has included a number of graphs in her affidavit, one of which shows that there has been a steadily increasing uptake of OST by monthly injection and a corresponding fall in the daily oral administration of liquid Methadone between September 2020 and March 2024. Between April 2023 and April 2024 (13 months) forty patients had to be re-inducted onto the OST programme, having undergone a body scan with positive results. The net result of all this is that patients on the waiting list for OST have to wait until a prisoner on OST is released from prison before they get onto the OST programme in prison.

[86] Dr Flanagan then comments on the criticisms expressed by the Parole Commissioners panels in the two determinations referred to earlier in this judgment. She opines that the panels were not in possession of the full facts and, if they had been, perhaps they would have been less inclined to express such trenchant criticism. That may well be the case but even though the Trust is not represented at a Parole Commissioners' hearing, the Department for Justice is and one would have hoped that lines of communication between the DOJ, DOH and SEHSCT were sufficiently open to ensure that the Parole Commissioners were appraised of the difficulties of dealing with the OST assessment waiting list in the prison estate.

[87] Dr Flanagan then comments on the second applicant's prison medical records, reiterating much of what she stated in her medical report which need not be repeated here. She concludes her affidavit by stating the following:

> "If a prisoner is experiencing withdrawal or any other medical problem associated with drug addiction, that will be treated promptly and effectively by prison healthcare. Such treatment will be provided whether or not the prisoner is in receipt of OST. They will also have other

> addiction services available to them, other than OST. While I accept that it is a matter for the court to determine, notwithstanding the delays and waiting lists, I do not consider that patient on the waiting list are being subjected to inhumane or degrading treatment by the healthcare team."

[88] Ms Heather Stevens is the Director of Mental Health in the Department of Health ("DOH") with policy responsibility for the: "Improving Health within the Criminal Justice" strategy which includes the policy area of healthcare in prisons. The team in the Department with responsibility for the commissioning of healthcare services in Northern Ireland is the SPPG. In her first affidavit sworn on 8 May 2024, Ms Stevens avers that the commissioning of services by the SPPG is dependent upon and limited by the funding allocation the DOH receives from the UK Government via the Executive. She avers that the DOH has faced extremely difficult budget positions for the last number of years which is compounded by the fact that only single year budgets have been allocated to the DOH since 2015/2016, rendering long-term strategic planning all the more difficult.

[89] Ms Stevens refers to the "Preventing Harm, Empowering Recovery – Substance Abuse Strategy" which the DOH published in September 2021. It was estimated that an additional £6.2million of recurrent funding would be required to implement the strategy. This has not been forthcoming and as a result the strategy has never been fully implemented.

[90] In relation to the funding of healthcare in the prison estate in Northern Ireland, Ms Stevens avers that in the year 2023/2024 the respondent Trust was allocated £10.9 million. Quarterly meetings are convened involving SPPG, the Public Health Authority and the respondent Trust to consider performance, strategic progress and to "reflect on issues within prison healthcare, including any funding challenges." Ms Stevens then goes on to set out the additional allocations of tranches of funding provided by the Department to the respondent Trust for the prison OST programme in the financial years 2022/2023 and 2023/2024. She states that "the additional funding provided has occurred in circumstances where the Department continues to face extremely challenging funding issues, with an overspend already forecast." Despite this she states that the DOH continues to work with the respondent Trust to identify potential funding sources to increase the capacity of OST treatment services in prison. In her second affidavit, sworn on 20 June 2024, Ms Stevens updates the court on the progress of setting a budget for the DOH for 2024/2025. This has now been set and agreed by the Executive and it is significantly less than what is required to meet existing need across health and social care in Northern Ireland. There is a reduction of 2.3% on 2023/2024 giving rise to an anticipated significant shortfall. It may not be possible to maintain some existing services and difficult decisions will have to be made.

[91] The DOH carried out a "Health Budget Assessment" following the announcement of the budget in May 2024 and the summary section of this report makes the following prediction:

> "… the scale of cuts to current levels of service provision proposed to deliver breakeven is unprecedented in Northern Ireland. There are grave concerns about the deliverability of these plans by Trusts, given the level of impact on their ability to deliver quality services, maintain flow and manage demand in both acute and community services."

[92] In spite of this dire prediction, it would seem that the SPPG is in the process of allocating an additional sum of £250,000 of recurrent funding to the five Trusts and Prison Healthcare in relation to substance abuse treatment. This will mean an additional annual sum being given to the respondent Trust for prison healthcare of £41,666.

[93] The final piece of affidavit evidence relied upon by the respondent Trust is an affidavit sworn by Dr Richard Kirk, on 6 June 2024. Dr Kirk is a GP employed by the respondent Trust as Clinical Director of Healthcare in Prisons in Northern Ireland since 2017. He is also a member of the Faculty of Forensic and Legal Medicine. He also represents Northern Ireland on the Royal College of General Practitioners' Secure Environments Group which is the body responsible for policy development and education of all GPs working in the prison estate in the UK. Between January 2018 and January 2020, Dr Kirk was also the clinical lead for addictions in the prison estate in Northern Ireland. Dr Flanagan took over this role in 2020.

[94] Dr Kirk makes the following points:

(a) Whilst equivalence of care is important and is strived for, the RCGP statement on equivalence of care states that: "equivalence does not mean that care provision in secure environment should be 'the same' as provided in the community."

(b) Dr Kirk confirms that in the context of OST, the daily provision of oral medication is carried out by community pharmacy staff in the community and by primary care nurses in the prisons. He states that the community addiction teams' resources are not consumed by daily and monthly dispensing whilst the addictions team's resources in the prison are. But is this really the case? As I have commented earlier, if the primary care nurses employed in the prisons and not the specialist addictions team nurses are performing the daily oral administration of OST medication in the prison, then this is not a valid point. The repeated references to primary care nurses performing this role in prison does not support the case being put forward by the respondent Trust. If specialist addictions nurses were required to administer daily oral OST

medication, then how is it safe to have it administered by pharmacy staff in the community? Surely the truth of the matter is that pharmacy staff are well capable of supervising the taking of oral OST in the community, leaving the addictions teams in the community to deal with other tasks but in prison there are no community pharmacies so the prison primary care nurses perform that role. In both scenarios the specialist addictions nurses do not ordinarily perform that role.

(c) Capping of numbers on the OST programme "is not something that the Trust wants to do. It is purely a resource driven requirement." On the basis of present levels of funding, once the number of prisoners on OST passes 180, it becomes difficult to safely adhere to the relevant guidance concerning follow up and review. In essence if you cannot follow up and review patients on OST in prison in a timely fashion in prison, it is safer not to start them on OST.

[95] Before setting out the various arguments and submissions made by the parties' legal representatives in these matters, I will make the following observations. Immediately before the commencement of this case, the trial bundles in respect of both applicants contained approximately 2,650 pages. During the course of the hearing a further 1,354 pages of material were added to these bundles. These numbers do not include the bundles of authorities. The hearing of these cases occurred over three and one-half days. The limited hearing time meant that a considerable volume of the material provided to the court was only referred to briefly or in passing. However, I have spent a considerable amount of time during the summer recess considering all the materials contained in the trial bundles to satisfy myself that I have a complete grasp of the issues involved in these cases.

Parties' submissions

First applicant

[96] The first applicant has been on the waiting list for the assessment of his suitability for OST for over two years now. In the community, the respondent Trust aims to see, assess and (where appropriate) commence OST within two to four weeks from referral. In accordance with the "principle of equivalence" healthcare available to prisoners should be comparable to that which the state has committed itself to providing to the population generally. This is clearly not the case here. At the core of the first applicant's case is the stark difference in treatment of those in the community and those in custody in respect of healthcare in the form of assessment for OST. The issue is whether this difference in treatment unjustifiably discriminates against the first applicant as a prisoner in the enjoyment of his right to respect for private life, contrary to article 14 of the ECHR taken together with article 8.

[97] The policy that lay behind the transfer of responsibility for prison healthcare in the UK to the NHS in 2005 was to achieve healthcare delivery in prisons equivalent to that delivered in the community – that is, to primary care level, with referral to

secondary and tertiary care services operated outside the prisons as and when required. Equivalence in healthcare means that in addition to ensuring that the same standard of healthcare is available, steps are taken to ensure that, when receiving healthcare, insofar as it is compatible with the custodial setting, a prisoner is treated as a patient. See *Razumas v MOJ* [2018] EWHC 215 (QB), paras [12] to [14]. The respondent Trust has had responsibility for the clinical management of substance misuse in prison since October 2008. The objective of the 2009 Partnership Agreement was primarily "to ensure that services provided to prisoners as patients are equivalent to those in the community."

[98] The first applicant refers to a number of International Law treaties and instruments that address the issue of equivalence in healthcare for prisoners:

(i) The United Nations International Covenant on Economic, Social and Cultural Rights 1966 (ICESCR) which was ratified by the UK on 20 May 1976. Article 1211:

> "The right of everyone to the enjoyment of the highest attainable standard of physical and mental health."

(ii) The UN Covenant on Civil and Political Rights 1996 ("ICCPR") also ratified by the UK in 1976. General Comment 2112:

> "Persons deprived of their liberty enjoy all the rights set forth in the Covenant subject to the restrictions that are unavoidable in a closed environment."

(iii) UN General Assembly Resolution 37/194 in 1982:

> "those 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 affordable to those who are not imprisoned or detained."

(iv) UN General Assembly Resolution 45/111 of 14 December 1990, Basic Principles for the Treatment of Prisoners:

> "9. Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation."

(v) UN Standard Minimum Rules for the Treatment of Prisoners 70/175 of 2015: Rule 1: "All prisoners shall be treated with the respect due to their inherent dignity as value as human beings. No prisoner shall be subjected to, and all prisoners shall be protected from, torture and other cruel, inhuman, or

degrading treatment or punishment, for which no circumstances whatsoever may be invoked as a justification. The safety and security of prisoners, staff, service providers and visitors shall be ensured at all times."

Rule 24: "The provision of health care to prisoners is a state responsibility. Prisoners should enjoy the same standards of health care that are available in the community, and should have access to necessary health-care services free of charge without discrimination on the grounds of their legal status."

(vi) Chapter III of the 3rd report of the European Committee on Prevention of Torture (CPT/Inf (93) 12, §38) which stresses the importance of equivalence without discrimination on the basis of legal status.

(vii) European Prison Rules:

Rule 39: "Prison authorities shall safeguard the health of all prisoners in their care."

Rule 40.1: "Medical Services in Prison shall be organised in close relation with the general health administration of the community or nation."

Rule 40.3: "Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation."

[99] The first applicant calls in aid a number of decisions of the Strasbourg Court including the case of *Blokhin v Russia* (Grand Chamber, 23 March 2016). The first applicant homes in on para [137] but the preceding and subsequent paragraphs setting out the general principles applicable to a case of this nature are worthy of consideration:

> "**General principles**
>
> 135. The court reiterates that Article 3 of the Convention enshrines one of the fundamental values of democratic society, prohibiting in absolute terms torture or inhuman or degrading treatment or punishment (see, among other authorities, *Stanev v Bulgaria* [GC], no. **36760/06**, § 201, ECHR 2012). However, to come within the scope of the prohibition contained in Article 3, the treatment inflicted on or endured by the victim must reach a minimum level of severity. The assessment of this minimum level of severity is a relative one, depending on all the circumstances of the case, such as the duration of the treatment, its physical and mental effects and, in some cases, the sex, age and state of health of the victim (see *M.S. v the United Kingdom*, no. **24527/08**, § 38, 3 May 2012, and

Price v the United Kingdom, no. **33394/96**, § 24, ECHR 2001-VII).

136. Article 3 further imposes an obligation on the State to protect the physical well-being of persons deprived of their liberty by, among other things, providing them with the requisite medical care (see *Kudła v Poland* [GC], no. **30210/96**, § 94, ECHR 2000-XI; *Mouisel v France*, no. **67263/01**, § 40, ECHR 2002-IX; and *Khudobin v Russia*, no. **59696/00**, § 93, 26 October 2006). Thus, the court has held on many occasions that lack of appropriate medical care may amount to treatment contrary to Article 3 (see, for example, *M.S. v the United Kingdom*, cited above, §§ 44-46; *Wenerski v Poland*, no. **44369/02**, §§ 56-65, 20 January 2009; and *Popov v Russia*, no. **26853/04**, §§ 210-13 and 231-37, 13 July 2006).

137. In this connection, the "adequacy" of medical assistance remains the most difficult element to determine. The court reiterates that the mere fact that a detainee is seen by a doctor and prescribed a certain form of treatment cannot automatically lead to the conclusion that the medical assistance was adequate (see *Hummatov v Azerbaijan*, nos. **9852/03** and **13413/04**, § 116, 29 November 2007). The authorities must also ensure that a comprehensive record is kept concerning the detainee's state of health and his or her treatment while in detention (see *Khudobin*, cited above, § 83), that diagnosis and care are prompt and accurate (see *Melnik v Ukraine*, no. **72286/01**, §§ 104-06, 28 March 2006, and *Hummatov*, cited above, § 115), and that, where necessitated by the nature of a medical condition, supervision is regular and systematic and involves a comprehensive therapeutic strategy aimed at adequately treating the detainee's health problems or preventing their aggravation, rather than addressing them on a symptomatic basis (see *Popov*, cited above, § 211; *Hummatov*, cited above, §§ 109 and 114; and *Amirov v Russia*, no. **51857/13**, § 93, 27 November 2014). The authorities must also show that the necessary conditions were created for the prescribed treatment to be actually followed through (see *Holomiov v Moldova*, no. **30649/05**, § 117, 7 November 2006, and *Hummatov*, cited above, § 116). Furthermore, medical treatment provided within prison facilities must be appropriate, that is, at a level comparable to that which the State authorities have committed themselves to provide to the population as a whole.

Nevertheless, this does not mean that every detainee must be guaranteed the same level of medical treatment that is available in the best health establishments outside prison facilities (see *Cara-Damiani v Italy*, no. **2447/05**, § 66, 7 February 2012).

138. On the whole, the court reserves sufficient flexibility in defining the required standard of health care, deciding it on a case-by-case basis. That standard should be "compatible with the human dignity" of a detainee, but should also take into account "the practical demands of imprisonment" (see *Aleksanyan v Russia*, no. **46468/06**, § 140, 22 December 2008) …

139. The court further stresses that allegations of ill-treatment must be supported by appropriate evidence. In assessing evidence, the court has adopted the standard of proof "beyond reasonable doubt." However, it has never been its purpose to borrow the approach of the national legal systems that use that standard. Its role is not to rule on criminal guilt or civil liability but on Contracting States' responsibility under the Convention. In the proceedings before the court, there are no procedural barriers to the admissibility of evidence or pre-determined formulae for its assessment. It adopts conclusions that are, in its view, supported by the free evaluation of all evidence, including such inferences as may flow from the facts and the parties' submissions. According to its established case-law, proof may follow from the coexistence of sufficiently strong, clear and concordant inferences or of similar unrebutted presumptions of fact. Moreover, the level of persuasion necessary for reaching a particular conclusion and, in this connection, the distribution of the burden of proof are intrinsically linked to the specificity of the facts, the nature of the allegation made and the Convention right at stake. The court is also attentive to the seriousness that attaches to a ruling that a Contracting State has violated fundamental rights (see *Nachova and Others v Bulgaria* [GC], nos. **43577/98** and **43579/98**, § 147, ECHR 2005-VII, with further references; *Labita v Italy* [GC], no. **26772/95**, § 121, ECHR 2000-IV; *Amirov*, cited above, § 80; and *Ananyev and Others v Russia*, nos. **42525/07** and **60800/08**, § 121, 10 January 2012).

140. In this connection it should be noted that the court has held that Convention proceedings do not in all cases

lend themselves to a strict application of the principle *affirmanti incumbit probation* (he who alleges something must prove that allegation). According to the court's case-law under Articles 2 and 3 of the Convention, where the events in issue lie wholly, or in large part, within the exclusive knowledge of the authorities, as in the case of persons under their control in custody, strong presumptions of fact will arise in respect of injuries, damage and death occurring during that detention. The burden of proof in such a case may be regarded as resting on the authorities to provide a satisfactory and convincing explanation (see *Çakıcı v Turkey* [GC], no. **23657/94**, § 85, ECHR 1999-IV; *Salman v Turkey* [GC], no. **21986/93**, § 100, ECHR 2000-VII; and *Amirov*, cited above, § 92). In the absence of such an explanation the court can draw inferences that may be unfavourable for the respondent Government (see, for instance, *Orhan v Turkey*, no. **25656/94**, § 274, 18 June 2002, and *Buntov v Russia*, no. **27026/10**, § 161, 5 June 2012)."

[100] The first applicant relies on three further Strasbourg decisions to support the proposition that state authorities must adequately assess a prisoner's state of health and provide appropriate treatment. The first is the decision of *McGlinchey and Others v United Kingdom* (29 July 2003):

"**General principles**

45. The court reiterates that ill-treatment must attain a minimum level of severity if it is to fall within the scope of Article 3. The assessment of this minimum is relative: it depends on all the circumstances of the case, such as the duration of the treatment, its physical and/or mental effects and, in some cases, the sex, age and state of health of the victim (see, among other authorities, *Tekin v Turkey*, judgment of 9 June 1998, *Reports of Judgments and Decisions* 1998-IV, p. 1517, § 52).

46. Under this provision the State must ensure that a person is detained in conditions which are compatible with respect for her human dignity, that the manner and method of the execution of the measure do not subject her to distress or hardship of an intensity exceeding the unavoidable level of suffering inherent in detention and that, given the practical demands of imprisonment, her health and well-being are adequately secured by, among other things, providing her with the requisite medical

assistance (see, *mutatis mutandis*, *Aerts v Belgium*, judgment of 30 July 1998, *Reports* 1998-V, p. 1966, §§ 64 et seq., and *Kudła v Poland* [GC], no. **30210/96**, § 94, ECHR 2000-XI)."

{101] The second is the decision of *Wenner v Germany* (1 December 2016), a case involving OST:

"**Recapitulation of the relevant principles**

54. The court reiterates that to come within the scope of the interdiction contained in Article 3 of the Convention the treatment inflicted on or endured by the victim must reach a minimum level of severity. The assessment of this minimum level of severity is a relative one, depending on all the circumstances of the case, such as the duration of the treatment, its physical and mental effects and, in some cases, the sex, age and state of health of the victim (see, *inter alia*, *Blokhin v Russia* [GC], no. **47152/06**, §135, ECHR 2016, with further references).

55. The court further reiterates that Article 3 of the Convention imposes on the State a positive obligation to ensure that a person is detained under conditions which are compatible with respect for human dignity, that the manner and method of the execution of the measure do not subject the individual to distress or hardship exceeding the unavoidable level of suffering inherent in detention and that, given the practical demands of imprisonment, the person's health and well-being are adequately secured by, among other things, the provision of the requisite medical assistance and treatment (see *Kudła v Poland* [GC], no. **30210/96**, § 94, ECHR 2000-XI; *McGlinchey and Others v the United Kingdom*, no. **50390/99**, § 46, ECHR 2003-V; and *Farbtuhs v Latvia*, no. **4672/02**, § 51, 2 December 2004). In this connection, the "adequacy" of medical assistance remains the most difficult element to determine. Medical treatment provided within prison facilities must be appropriate, that is, at a level comparable to that which the State authorities have committed themselves to provide to the population as a whole. Nevertheless, this does not mean that every detainee must be guaranteed the same level of medical treatment that is available in the best health establishments outside prison facilities (see, *inter alia*, *Blokhin*, cited above, § 137).

56. The court has clarified in this context that it was essential for a prisoner suffering from a serious illness to undergo an adequate assessment of his or her current state of health, by a specialist in the disease in question, in order to be provided with appropriate treatment (compare *Keenan v the United Kingdom*, no. **27229/95**, §§ 115-116, ECHR 2001-III, concerning a mentally ill prisoner; *Khudobin v Russia*, no. **59696/00**, §§ 95-96, ECHR 2006-XII (extracts), concerning a prisoner suffering from several chronic diseases including hepatitis C and HIV; and *Testa v Croatia*, no. **20877/04**, §§ 51-52, 12 July 2007, concerning a prisoner suffering from chronic hepatitis C).

57. The prison authorities must offer the prisoner the treatment corresponding to the disease(s) the prisoner was diagnosed with (see *Poghosyan v Georgia*, no. **9870/07**, § 59, 24 February 2009), as prescribed by the competent doctors (see *Xiros v Greece*, no. **1033/07**, § 75, 9 September 2010). In the event of diverging medical opinions on the treatment necessary to ensure adequately a prisoner's health, it may be necessary for the prison authorities and the domestic courts, in order to comply with their positive obligation under Article 3, to obtain additional advice from a specialised medical expert (compare *Xiros*, cited above, §§ 87 and 89-90; and *Budanov v Russia*, no. **66583/11**, § 73, 9 January 2014). The authorities' refusal to allow independent specialised medical assistance to be given to a prisoner suffering from a serious medical condition on his request is an element the court has taken into account in its assessment of the State's compliance with Article 3 (compare, for instance, *Sarban v Moldova*, no. **3456/05**, § 90, 4 October 2005).

58. The court further reiterates, being sensitive to the subsidiary nature of its role, that it is not its task to rule on matters lying exclusively within the field of expertise of medical specialists and to establish whether an applicant in fact required a particular treatment or whether the choice of treatment methods appropriately reflected the applicant's needs (see *Ukhan v Ukraine*, no. **30628/02**, § 76, 18 December 2008; and *Sergey Antonov,* no. **40512/13**, § 86, 22 October 2015). However, having regard to the vulnerability of applicants in detention, it is for the Government to provide credible and convincing evidence showing that the applicant concerned had received

comprehensive and adequate medical care in detention (see *Sergey Antonov,* ibid.).

[102] The third is also a decision concerning OST, *Abdyusheva and Others v Russia* (15 April 2020):

"**General principles**

111. The court recalls that the Convention does not guarantee the right to health as such (*see Vasileva v Bulgaria*, paragraph No. **23796/10**, § 63, 17 March 2016) or the right to a specific medical treatment desired by the applicant (*see Wenner*, cited above, §§ 55-58). However, complaints relating to the denial of access to certain types of medical treatment or medicinal products have been brought before the court (*Dubská and Krejzová v the Czech Republic* [GC], nos. **28859/11** and **28473/12**, 15 November 2016, *Hristozov and Others*, Costa *and Pavan v Italy*, no. **54270/10**, §§ 52-57, 28 August 2012, *Durisotto*, cited above, § 64, and *A.M. and A.K. v Hungary* (Dec.), nos. **21320/15** and **35837/15**, § 39) which it examined from the point of view of Article 8 of the Convention, the concept of 'private life' of which is underpinned by the concept of personal autonomy.

112. The court proceeded on the basis that public health matters fall within a wide margin of appreciation of the domestic authorities, which are best placed to assess priorities, the use of available resources and the needs of society (*Shelley v United Kingdom* (Dec.), no. **23800/06**, 4 January 2008, *Hristozov and Others*, cited above, § 119, and *Durisotto*, cited above, § 36). The extent of that margin depends on a number of factors determined by the circumstances of the case. Where there is no consensus among the member States of the Council of Europe either on the relative importance of the interest at stake or on the best means of protecting it, the margin of appreciation is wider, especially where sensitive moral or ethical issues are at stake (*see Dubská and Krejzová*, cited above, § 178, and *Parrillo v Italy* [GC], no. **46470/11**, § 169, ECHR 2015, with further references). The State is usually given wide latitude to take general measures in economic or social matters. Thanks to first-hand knowledge of their society and its needs, national authorities are in principle in a better position than the international court to determine what is in the public interest in economic or social matters, and the court respects in principle the way in which the

> State conceives the imperatives of public utility, unless its judgment proves to be 'manifestly lacking a reasonable basis.' *Dubská and Krejzová*, cited above, § 179, *Shelley*, cited above, and *Hristozov*, cited above, § 119)."

[103] The first applicant also relies on the "domestic" decision of the English High Court, *R (on the application of Nathan Brooks) v Secretary of State for Justice and Isle of White Primary Care Trust* [2008] EWHC 3041 Admin in which Collins J stated:

> "5. … there is nothing between the parties because it is accepted, and the law is clear, that prisoners have to be treated in a way which respects their right to proper treatment and it is again accepted by both the Ministry of Justice, who are responsible for the prisons, and the healthcare trusts … that prisoners are entitled, in so far as is possible, to the same attention as would be provided to any person under the terms of the National Health Service.
>
> 6. There are, of course, as must be recognised, some constraints which are inevitable because of security considerations, and those have to be taken into account, but they must not result in a situation which means that the prisoner does not receive the proper medical attention that he or she needs."

[104] In advancing his article 14 discrimination claim in respect of article 8, the first applicant draws on the assistance of the decision of *R (on the application of Stott) Secretary of State for Justice* [2018] UKSC 59 and in particular a passage from Lady Black's judgment:

> "**The approach to an Article 14 claim**
>
> 8. In order to establish that different treatment amounts to a violation of Article 14, it is necessary to establish four elements. First, the circumstances must fall within the ambit of a Convention right. Secondly, the difference in treatment must have been on the ground of one of the characteristics listed in Article 14 or "other status." Thirdly, the claimant and the person who has been treated differently must be in analogous situations. Fourthly, objective justification for the different treatment will be lacking. It is not always easy to keep the third and the fourth elements entirely separate, and it is not uncommon to see judgments concentrate upon the question of justification, rather than upon whether the people in question are in analogous situations.

Lord Nicholls of Birkenhead captured the point at para 3 of *R (Carson) v Secretary of State for Work and Pensions* [2005] UKHL 37; [2006] 1 AC 173. He observed that once the first two elements are satisfied:

> 'the essential question for the court is whether the alleged discrimination, that is, the difference in treatment of which complaint is made, can withstand scrutiny. Sometimes the answer to this question will be plain. There may be such an obvious, relevant difference between the claimant and those with whom he seeks to compare himself that their situations cannot be regarded as analogous. Sometimes, where the position is not so clear, a different approach is called for. Then the court's scrutiny may best be directed at considering whether the differentiation has a legitimate aim and whether the means chosen to achieve the aim is appropriate and not disproportionate in its adverse impact.'"

[105] The UKSC in *Hilland* [2024] UKSC 4 endorsed Lady Black's analysis. The first applicant submits that the facts of this case bring it within the ambit of article 8 and relies in support of this proposition upon the Strasbourg decision of *Passannante v Italy* (1 July 1998) where the Commission considered that:

> "…. where the State has an obligation to provide medical care, an excessive delay of the public health service in providing a medical service to which the patient is entitled and the fact that such delay has, or is likely to have, a serious impact on the patient's health could raise an issue under Article 8(1) of the Convention."

[106] The first applicant argues that the assessment as to the suitability for medical treatment such as OST falls within the ambit of the right to respect for private life protected by article 8. See paras [39] and [40] of Lord Reed's judgment in *R (SC) v SSWP* [2021] UKSC 26:

> **"(i) The ambit of Article 8 and A1P1**
>
> 39. According to the case law of the European Court, the alleged discrimination must relate to a matter which falls within the "ambit" of one of the substantive articles. This is a wider concept than that of interference with the rights guaranteed by those articles, as Judge Bratza

explained in his concurring judgment in *Adami v Malta* (2006) 44 EHRR 3, para 17.

> 40. For example, in *Petrovic* the refusal to grant a father a parental leave allowance which was paid to mothers was held not to constitute an interference with the right guaranteed by Article 8, "since Article 8 does not impose any positive obligation on states to provide the financial assistance in question" (para 26). Nevertheless, since "[b]y granting parental leave allowance states are able to demonstrate their respect for family life within the meaning of Article 8", it followed that "the allowance therefore comes within the scope of that provision" (para 29), with the consequence that Article 14 taken together with Article 8 was applicable."

[107] The first applicant relies on the "other status" provision of article 14. He submits that the relevant "other status" for the purposes of article 14 is that of a prisoner. See *Shelley v United Kingdom* (4 January, 2008):

> "Insofar as the Government argued that the applicant could not claim that being a prisoner was a status for the purposes of attracting the prohibition against discriminatory treatment, the court would observe that being a convicted prisoner may be regarded as placing the individual in a distinct legal situation, which even though it may be imposed involuntarily and generally for a temporary period, is inextricably bound up with the individual's personal circumstances and existence, as may be said, variously, of those born out of wedlock or married. Prisoners' complaints do not therefore fall outside the scope of Article 14 on this ground. The legal status of a prisoner is, however, very relevant to the assessment of compliance with the other requirements of Article 14.
>
> For the purposes of Article 14, a difference in treatment between persons in analogous or relevantly similar positions is discriminatory if it has no objective and reasonable justification, that is if it does not pursue a legitimate aim or if there is not a reasonable relationship of proportionality between the means employed and the aim sought to be realised. Moreover, the Contracting States enjoy a margin of appreciation in assessing whether and to what extent differences in otherwise similar situations justify a different treatment (see *Camp and Bourimi v the Netherlands*, no. 28369/95, § 37, ECHR 2000-X).

> Noting first that the applicant's complaint falls, in the wide sense, within the ambit of Article 8 of the Convention (*e.g. Zarb Adami v Malta*, no. 17209/02, § 42, ECHR 2006-...) and that Article 14 is therefore engaged, the court has considered the Government's argument that the applicant cannot claim, as a prisoner, to be in a comparable position to those in the community. However, while there are, inevitably, clear differences between those who are deprived of their liberty in conformity with Article 5 of the Convention and those who are not, the court recalls that prisoners do not forfeit the protection of the other fundamental rights and freedoms guaranteed under the Convention (*Hirst v the United Kingdom (no. 2)* [GC], no. 74025/01, § 69, ECHR 2005-....; *Dickson v the United Kingdom* [GC], no. 44362/04, §§ 67-68, 4 December 2007), although the manner and extent to which they may enjoy those other rights will inevitably be influenced by the context. Whether or not the applicant prisoner can claim to be in an analogous position will therefore depend on the subject-matter of his complaint. In this case the applicant complains of different standards of health care being applied in prison. The court would observe that the European Prison Rules, the Committee for the prevention of Torture (CPT) and the domestic prison regulations themselves provide that the health care in prisons should be the same as that in the community. For the purposes of the present application, therefore, the court is prepared to assume that prisoners can claim to be on the same footing as the community as regards the provision of health care (see also *Mathew v the Netherlands*, no. 24919/03, §§ 186, 193, ECHR 2005...)"

[108] The first applicant argues that a prisoner awaiting assessment of suitability for OST in prison is in an analogous situation to a person awaiting assessment of suitability for OST in the community and that the principle of equivalence is in effect recognition that they are in analogous situations.

[109] The first applicant argues that the issue of justification is central to the outcome of this application. In this regard, it is argued that the court must have close regard to the four-stage (proportionality) test set out in para [41] of *R (Steinfeld) v Secretary of State for International Development* [2018] UKSC 32. The four stages are:

> (i) Is there a legislative objective (or legitimate aim) which is sufficiently important to justify limiting a fundamental right?

(ii) Is the measure rationally connected to the objective?

(iii) Is it no more than necessary to accomplish it – that is, could a less intrusive measure have been used without unacceptably compromising the achievement of the objective?

(iv) Does it strike a fair balance between the rights of the individual and the interest of the community?

[110] It is important to remember that it is for the respondent Trust to establish that a difference in treatment is justified (paras [20] and [39] of *Steinfeld*). What requires justification is not the measure at issue but the difference in treatment between one person and another or one group and another (para [42] of *Steinfeld*). It is for the court to objectively assess the issue of justification, giving due weight to the decision-maker's view (*Re Brewster* [2017] UKSC 8). The first applicant accepts that the state has a wide margin of discretion in the organisation of healthcare systems (*Nittecki v Poland* No-65653/01. Dec 21 March 2002). In relation to the approach to be adopted by the court when addressing the issue of justification, para [161] of Lord Reed's judgment in *SC* gives important guidance:

> "It follows that in domestic cases, rather than trying to arrive at a precise definition of the ambit of the "manifestly without reasonable foundation" formulation, it is more fruitful to focus on the question of whether a wide margin of judgment is appropriate in light of the circumstances of the case. The ordinary approach to proportionality gives appropriate weight to the judgment of the primary decision-maker: a degree of weight which will normally be substantial in fields such as economics and social policy, and matters raising sensitive moral and ethical issues. It follows as the Court of Appeal noted in *R (Joint Council for the Welfare of Immigrants) v Secretary of State for the Home Department* [2021] 1 WLR 1151 and *R (Delve) v Secretary of State for Work and Pensions* [2021] ICR 236, that the ordinary approach to proportionality will accord the same margin to the decision-maker as the "manifestly without reasonable foundation" formulation in circumstances where a wide margin is appropriate."

[111] The first applicant argues that the respondent Trust's evidence does not provide justification for the difference in treatment between prisoners waiting for an assessment of suitability for OST (over two years) and persons in the community waiting for such an assessment (two to four weeks). The first applicant relies on a passage from Lord Kerr's judgment in *Steinfeld* at para [42]:

> "To be legitimate, therefore, the aim must address the perpetration of the unequal treatment, or … the aim must be intrinsically linked to the discriminatory treatment. In this case it is not. The respondent does not seek to justify the difference in treatment … To the contrary, it accepts that the difference cannot be justified. What it seeks is tolerance of the discrimination while it sorts out how to deal with it. That cannot be characterised as a legitimate aim."

[112] The first applicant also relies on the decision of *R (Coll) v Secretary of State for Justice* [2017] UKSC 40, where Lady Hale stated at para [40] of her judgment:

> "Saving cost is, of course, a legitimate objective of public policy. But, as the Court of Justice of the European Union emphasised in *O'Brien v Ministry of Justice* [2012] ICR 955, "budgetary considerations cannot justify discrimination" (para 66). In other words, if a benefit is to be limited in order to save costs, it must be limited in a non-discriminatory way. There was no evidence and no finding that the aim was to ensure that men and women were accommodated in similarly appointed premises. Given that the Act permits different provision to be made if their needs are different, this would not by itself be a sound basis for the discrimination."

[113] Paring it down to its very core, the respondent Trust's justification for the difference in treatment of those on the waiting list for assessment of suitability for OST in the prison estate and those in the community is that the maintenance of newly committed prisoners who are already on OST in the community and the re-induction of prisoners whose OST has been stopped due to a positive finding on a body scan take up all the available resources so that the waiting list in prison cannot be effectively dealt with. This, it is argued by the first applicant does not provide any justification at all. It cannot be said to serve a legitimate aim in that it flies in the face of the principle of equivalence. How can a measure be said to be aimed at protecting the provision of prison healthcare if it effectively blocks fresh access to a key part of the prison healthcare system for a significant number of prisoners? There is no rational connection between the measure and the stated objective. There is a non-intrusive means to achieve the objective and that is to properly fund prison healthcare so that it is equivalent to that provided by the same Trust in the community. This measure does not strike a fair balance between the interests of the individual and the interests of the community. It actually damages both interests. In the case of assessing suitability for OST treatment in prison it is in the first applicant's best interests and the best interests of the community that this should take place in that if the first applicant is deemed suitable to commence OST and he is successfully

established and maintained on the programme, the risks of reoffending upon release are reduced.

Second applicant

[114] Mr Sayers KC on behalf of the first applicant concentrated on the article 14 in conjunction with article 8 discrimination aspect of these cases. Mr Hutton KC adopted these arguments and then concentrated on the substantive article 3 and article 8 aspects of his client's case. The second applicant was on the waiting list for assessment of suitability for OST for over three years and was never assessed prior to his release into the community. Upon release he was promptly assessed and deemed suitable for OST treatment and has been commenced on OST in the community. It is argued that the court can readily and reasonably conclude that if he had received a timeous assessment of suitability for OST in prison, he would have been deemed suitable for OST at a much earlier stage and would have been inducted onto OST and as a result he would have been spared three years of anxiety, distress and general mental and physical suffering resulting from his untreated addiction issues. The nature, extent and duration of the anxiety, distress and suffering are such as to significantly interfere with his physical and mental integrity to the extent that his article 8 rights are breached. He has been detained in conditions that do not comply with article 3. Not only that; his suffering reached such intensity as to constitute a breach of his article 3 rights. It is to be remembered that Professor Davidson, in his report, specifically stated that the second applicant would experience regular physical/psychological withdrawal symptomology in the absence of OST therapy. In the face of this definitive opinion of Professor Davidson, it is argued that the report of Dr Flanagan can best be characterised as more an illustration of what the healthcare team in the prison did not know about the second applicant as a result of their failure to assess him. The need for a proper assessment has been mandated by the European Court in para [56] of *Wenner*, set out above.

[115] Mr Hutton KC on behalf of the second applicant seeks to rely on a number of Strasbourg decisions to support his substantive article 3 case. He seeks to rely on *A and Others v United Kingdom* (2009) and in particular paras [126] to [128]:

> "126. The court is acutely conscious of the difficulties faced by States in protecting their populations from terrorist violence. This makes it all the more important to stress that Article 3 enshrines one of the most fundamental values of democratic societies. Unlike most of the substantive clauses of the Convention and of Protocols Nos. 1 and 4, Article 3 makes no provision for exceptions and no derogation from it is permissible under Article 15 § 2 notwithstanding the existence of a public emergency threatening the life of the nation. Even in the most difficult of circumstances, such as the fight against terrorism, and irrespective of the conduct of the person concerned, the

Convention prohibits in absolute terms torture and inhuman or degrading treatment and punishment (see *Ramirez Sanchez*, cited above, §§ 115-16).

127. Ill-treatment must attain a minimum level of severity if it is to fall within the scope of Article 3. The assessment of this minimum depends on all the circumstances of the case, such as the duration of the treatment, its physical or mental effects and, in some cases, the sex, age and state of health of the victim (see *Kafkaris v Cyprus* [GC], no. **21906/04**, § 95, ECHR 2008). The court has considered treatment to be "inhuman" because, *inter alia*, it was premeditated, was applied for hours at a stretch and caused either actual bodily injury or intense physical or mental suffering. It has deemed treatment to be "degrading" because it was such as to arouse in the victims feelings of fear, anguish and inferiority capable of humiliating and debasing them (see, among other authorities, *Kudła v Poland* [GC], no. **30210/96**, § 92, ECHR 2000-XI). In considering whether a punishment or treatment was "degrading" within the meaning of Article 3, the court will have regard to whether its object was to humiliate and debase the person concerned and whether, as far as the consequences are concerned, it adversely affected his or her personality in a manner incompatible with Article 3. However, the absence of any such purpose cannot conclusively rule out a finding of a violation of Article 3. In order for a punishment or treatment associated with it to be "inhuman" or "degrading", the suffering or humiliation involved must go beyond that inevitable element of suffering or humiliation connected with a given form of legitimate treatment or punishment (see *Ramirez Sanchez*, cited above, §§ 118-19).

128. Where a person is deprived of his liberty, the State must ensure that he is detained under conditions which are compatible with respect for his human dignity and that the manner and method of the execution of the measure do not subject him to distress or hardship exceeding the unavoidable level of suffering inherent in detention (see *Kudła*, cited above, §§ 92-94). Although Article 3 cannot be construed as laying down a general obligation to release detainees on health grounds, it nonetheless imposes an obligation on the State to protect the physical and mental well-being of persons deprived of their liberty, for example by providing them with the requisite medical assistance

(see *Hurtado v Switzerland*, 28 January 1994, Series A no. 280-A, opinion of the Commission, § 79; *Mouisel v France*, no. **67263/01**, § 40, ECHR 2002-IX; *Aerts v Belgium*, 30 July 1998, § 66, *Reports* 1998-V; and *Keenan v the United Kingdom*, no. **27229/95**, § 111, ECHR 2001-III). When assessing conditions of detention, account has to be taken of the cumulative effects of those conditions, as well as the specific allegations made by the applicant (see *Ramirez Sanchez*, cited above, § 119). The imposition of an irreducible life sentence on an adult, without any prospect of release, may raise an issue under Article 3, but where national law affords the possibility of review of a life sentence with a view to its commutation, remission, termination or the conditional release of the prisoner, this will be sufficient (see *Kafkaris*, cited above, §§ 97-98)."

[116] The second applicant relies heavily on the *Wenner* decision, referred to and quoted from above and in addition to paras [54] to [57], he relies on paras [58] to [61] of the judgment:

"58. The court further reiterates, being sensitive to the subsidiary nature of its role, that it is not its task to rule on matters lying exclusively within the field of expertise of medical specialists and to establish whether an applicant in fact required a particular treatment or whether the choice of treatment methods appropriately reflected the applicant's needs (see *Ukhan v Ukraine*, no. 30628/02, § 76, 18 December 2008; and *Sergey Antonov,* no. 40512/13, § 86, 22 October 2015). However, having regard to the vulnerability of applicants in detention, it is for the Government to provide credible and convincing evidence showing that the applicant concerned had received comprehensive and adequate medical care in detention (see *Sergey Antonov,* ibid.).

(b) Application of these principles to the present case

59. The court is called upon to determine whether, in the light of the foregoing principles, the respondent State complied with its positive obligation under Article 3 of the Convention to ensure that the applicant's health was adequately secured during his detention by providing him with the requisite medical treatment, at a level comparable to that which the State authorities have committed themselves to provide to persons in freedom.

60. The court observes that it is contested between the parties whether, in the circumstances of the case, drug substitution therapy was to be regarded as the necessary medical treatment which had to be provided to the applicant in order for the State to comply with its said obligation.

61. The court accepts that the States have a margin of appreciation in respect of the choice between different suitable types of medical treatment for a prisoner's diseases. This holds true, in particular, where medical research does not lead to a clear result as to which of two or more possible therapies is more suitable for the patient concerned. The court, having regard to the material before it, is aware of the fact that drug substitution therapy with methadone entails the replacement of an illicit drug with a synthetic opioid. While drug substitution treatment has become increasingly widespread in the Council of Europe Member States during the past years, the measures to be taken to treat drug addiction are still the subject of controversy. The States' margin of appreciation in respect of the choice of medical treatment for a prisoner's diseases applies, in principle, also to the choice between abstinence-oriented drug therapy and drug substitution therapy and to the setting-up of a general policy in this field, as long as the State ensures that the standards set by the Convention in the field of medical care in prison are complied with."

[117] Reliance is also placed on the case of *Krivolapov v Ukraine* (2 January 2019) and para [76] in particular. By way of providing context, paras [74] and [75] are also set out:

"74. The court reiterates that, under Article 3 of the Convention, the State must ensure that a person is detained in conditions which are compatible with respect for his human dignity, and that the manner and method of execution of the measure do not subject him to distress or hardship of an intensity exceeding the unavoidable level of suffering inherent in detention (see *Kudła v Poland* [GC], no. **30210/96**, § 94, ECHR 2000-XI).

75. The court notes that information about the material conditions of detention falls within the knowledge of the domestic authorities. Accordingly, applicants might experience certain difficulties in procuring evidence to

> substantiate a complaint in that connection. Even so, in such cases applicants may well be expected to submit at least a detailed account of the facts complained of and provide – to the greatest possible extent – some evidence in support of their complaints. The court has considered as evidence in such situations, for example, written statements by fellow inmates or photographs provided by applicants in support of their allegations (see, for example, *Golubenko v Ukraine* (dec.), no. **36327/06**, § 52, 5 November 2013, with further references).
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> 76. The court furthermore reiterates that an unsubstantiated allegation that medical care has been non-existent, delayed or otherwise unsatisfactory is normally insufficient to disclose an issue under Article 3 of the Convention. A credible complaint should normally include, among other things, sufficient reference to the medical condition in question; medical treatment that was sought, provided, or refused; and some evidence – such as expert reports – which is capable of disclosing serious failings in the applicant's medical care (see, for example, *Valeriy Samoylov v Russia*, no. **57541/09**, § 80, 24 January 2012, and *Yevgeniy Bogdanov v Russia*, no. **22405/04**, § 93, 26 February 2015)."

[118] The second applicant's case is that he has been detained in conditions which are not compatible with respect for human dignity. He has been subjected to distress and hardship exceeding the unavoidable level of suffering inherent in detention due to the lack of treatment in the form of assessment of suitability for and subsequent commencement on OST. The duration of this distress has been very prolonged. The State authorities have failed to provide the second applicant with the requisite medical treatment, at a level comparable to that which the State authorities have committed themselves to provide to persons in freedom.

[119] It is strongly argued that the provision of requisite medical treatment at a level comparable to that which the State authorities have committed themselves to provide to persons in freedom is an important part of the article 3 test. That such a test is an appropriate test is underscored by the Partnership Agreement between the DOH and the NIPS that has the principal aim of providing prisoners with access to healthcare services equivalent to those provided to the general public.

[120] Having regard to the mandatory language of para [58] of *Wenner:* "… having regard to the vulnerability of applicants in detention, it is for the Government to provide credible and convincing evidence showing that the applicant concerned had received comprehensive and adequate medical care in detention (see *Sergey Antonov,* ibid.)", and taking into account the unqualified nature of the article 3 prohibitions and

that the State authority's margin of appreciation is not enhanced by a lack of funding, the only available defences to an alleged article 3 violation due to lack of adequate healthcare provision in prison is credible and convincing evidence showing that the applicant concerned had received comprehensive and adequate medical care in detention or demonstrating that the level of distress, hardship or suffering did not cross the article 3 threshold of severity.

[121] In relation to the issue of funding, the second applicant is compelled to address the issues raised in the Grand Chamber Strasbourg case of *Lopez de Sousa Fernandes v Portugal* (17 December 2017), paras [173] to [176]. Para [175] of this decision was relied upon by Colton J in his first instance judgment of *Wilson and Kitchen* [2023] NIKB 2 which the respondent Trust seeks to rely upon. *Lopez de Sousa Fernandez* was a medical negligence case in which the widow of the deceased sought to establish that the medical neglect that her late husband suffered also constituted a breach of article 2. In the context of this case, the court had this to say at paras [173] to [175]:

> "173. The court has further held that an issue may arise under Article 2 where it is shown that the authorities of a Contracting State have put an individual's life at risk through the denial of the health care which they have undertaken to make available to the population generally (see *Cyprus v Turkey*, cited above, § 219).
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> 174. Until recently, the type of cases which were examined by the court with reference to the aforementioned principle concerned applicants who were claiming that the State should pay for a particular form of conventional treatment because they were unable to meet the costs it entailed (see, for example, *Nitecki v Poland* (dec.), no. **65653/01**, 21 March 2002; *Pentiacova and Others v Moldova* (dec.), no. **14462/03**, ECHR 2005-I; *Gheorghe v Romania* (dec.), no. **19215/04**, 22 September 2005; and *Wiater v Poland* (dec.), no. **42290/08**, 15 May 2012) or that they should have access to unauthorised medicinal products for medical treatment (see *Hristozov and Others v Bulgaria*, nos. **47039/11** and **358/12**, ECHR 2012 (extracts)). The court did not find a breach of Article 2 in any of these cases, either because it considered that sufficient medical treatment and facilities had been provided to the applicants on an equal footing with other persons in a similar situation (see *Nitecki* and *Gheorghe*, both cited above) or because the applicants had failed to adduce any evidence that their lives had been put at risk (see *Pentiacova and Others*, cited above). In *Hristozov and Others,* cited above, the court did not find fault with the regulations governing access to unauthorised medicinal products in situations where

> conventional forms of medical treatment appeared insufficient, and considered that Article 2 of the Convention could not be interpreted as requiring access to unauthorised medicinal products for terminally-ill patients to be regulated in a particular way (ibid. § 108).
>
> 175. In this connection the court reiterates that issues such as the allocation of public funds in the area of health care are not a matter on which the court should take a stand and that it is for the competent authorities of the Contracting States to consider and decide how their limited resources should be allocated, as those authorities are better placed than the court to evaluate the relevant demands in view of the scarce resources and to take responsibility for the difficult choices which have to be made between worthy needs (see *Wiater*, § 39, *Pentiacova and Others* and *Gheorghe*, all cited above)."

[122] It is accepted by the second applicant that at a macro-political level decisions made about the allocation of public resources to healthcare systems are generally not justiciable or reviewable. That is clear from para [175] of *Lopez de Sousa Fernandes* and paras [94] to [96] of Colton J's first instance judgment in *Wilson and Kitchen*. The second applicant argues that his case does not involve a challenge to funding decisions. It is a case about the conditions in which he is held as a prisoner and whether those conditions give rise to a breach of article 3 and/or article 8 and it is a case about discriminatory treatment in relation to accessing healthcare while being detained as a prisoner. Viewed from this perspective the second applicant's claims are justiciable and the decision-making of the state is reviewable. This proposition is supported by the European Court's reference in para [173] to the "denial of the health care which they have undertaken to make available to the population generally." If such behaviour by the state can give rise to a breach of article 2 of the Convention, then surely, it is argued, it can give rise to a breach of article 3. This argument is further strengthened by the European Court's stated explanation for dismissing a number of such cases which is set out in para [174] of the judgment:

> "The court did not find a breach of Article 2 in any of these cases, either because it considered that sufficient medical treatment and facilities had been provided to the applicants on an equal footing with other persons in a similar situation …"

[123] In relation to the issue of funding, the second applicant's arguments are limited to asserting that resourcing or funding issues cannot excuse the detention of a prisoner in conditions which breach article 8, nor can resourcing or funding issues justify discrimination of the nature suffered by the second applicant in this case. In this regard, the second applicant places reliance on the Strasbourg case of *Cosovan v*

Moldova (22 June 2022). In that case the applicant complained that her late husband had not been given medical treatment required by his condition (severe liver disease) and that his state of health was incompatible with detention. Reliance was placed on article 3. The second applicant relies on paras [73] to [78] and [83] of the Second Chamber judgment and in particular paras [77] and [83]:

> "73. The court reiterates that ill-treatment must attain a minimum level of severity if it is to fall within the scope of Article 3. The assessment of this minimum level of severity is relative; it depends on all the circumstances of the case, such as the duration of the treatment, its physical and mental effects and, in some cases, the applicant's sex, age and state of health (see, among other authorities, *Dorneanu*, cited above, § 75, with further references).
>
> 74. As regards, in particular, persons deprived of their liberty, Article 3 of the Convention imposes on the State the positive obligation to ensure that a person is detained in conditions which are compatible with respect for his human dignity, that the manner and method of the execution of the measure do not subject him or her to distress or hardship of an intensity exceeding the unavoidable level of suffering inherent in detention. The suffering which flows from natural illness, whether physical or mental, may fall foul of Article 3 where it is, or risks being, exacerbated by conditions of detention for which the authorities can be held responsible (see *Dorneanu*, cited above, § 76). The prisoner's health and well-being must be adequately secured by, among other things, providing him with the requisite medical assistance. Thus, the detention of a person who is ill in inappropriate material and medical conditions may, in principle, amount to treatment contrary to Article 3 (see *Gülay Çetin v Turkey*, no. 44084/10, § 101, 5 March 2013, with the references therein).
>
> 75. In order to determine whether the detention of a person who is ill complies with Article 3 of the Convention, the court considers three different factors (see, for example, *Dorneanu*, cited above, §§ 77-80, with the references therein).
>
> 76. The first factor is the applicant's state of health and the effect on the latter of the manner of his imprisonment. Conditions of detention may under no circumstances subject a person deprived of his liberty to feelings of fear,

> anxiety or inferiority capable of humiliating and debasing him and possibly breaking his physical or moral resistance.
>
> 77. The second factor to be considered is the adequacy or inadequacy of the medical care and treatment provided in detention. It is not sufficient for the prisoner to be examined and a diagnosis to be made; it is vital that treatment suited to the diagnosis be provided, together with appropriate medical aftercare.
>
> 78. The third and last factor is the decision on whether or not to continue the person's detention in view of his state of health. Clearly, the Convention does not lay down any "general obligation" to release a prisoner for health reasons, even if he is suffering from a disease which is particularly difficult to treat. Nevertheless, the court cannot rule out the possibility that in particularly serious cases, situations may arise where the proper administration of criminal justice requires remedies in the form of humanitarian measures.
>
> 83. With reference to the principle of equivalence of treatment in and outside prisons (see paragraph 43 above; see also *Wenner v Germany*, no. 62303/13, § 66, 1 September 2016), the court considers that, where a certain treatment is generally available outside the prison and except for extraordinary circumstances, medical treatment required by a prisoner's condition should not be denied or only partially carried out simply because no such treatment (or specialist doctor) is available in prison or with reference to the scarcity of resources."

[124] The second applicant further argues that it is clear from para [55] of *Wenner* that resourcing or funding issues will not provide a defence to a claim that conditions of detention brought about by a failure to provide appropriate medical treatment give rise to a breach of article 3. The issue of the relevance of resources and funding and the issue of what constitutes a breach of article 3 in the context of the conditions of detention were discussed in the Strasbourg decision of *Muršić v Croatia* (26 October 2016). The second applicant relies on paras [96] to [101].

> "96. Article 3 of the Convention enshrines one of the most fundamental values of democratic society. It prohibits in absolute terms torture or inhuman or degrading treatment or punishment, irrespective of the circumstances and the victim's behaviour (see, for example, *Labita v Italy* [GC], no. 26772/95, § 119, ECHR

2000-IV; and *Svinarenko and Slyadnev v Russia* [GC], nos. 32541/08 and 43441/08, § 113, ECHR 2014 (extracts)).

97. Ill-treatment must attain a minimum level of severity if it is to fall within the scope of Article 3. The assessment of this minimum is relative; it depends on all the circumstances of the case, such as the duration of the treatment, its physical and mental effects and, in some cases, the sex, age and state of health of the victim (see, among other authorities, *Ireland v the United Kingdom*, 18 January 1978, § 162, Series A no. 25; *Jalloh v Germany* [GC], no. 54810/00, § 67, ECHR 2006-IX; *Idalov*, cited above, § 91; and also, *Kalashnikov v Russia*, no. 47095/99, § 95, ECHR 2002-VI).

98. Ill-treatment that attains such a minimum level of severity usually involves actual bodily injury or intense physical or mental suffering. However, even in the absence of these, where treatment humiliates or debases an individual, showing a lack of respect for or diminishing his or her human dignity, or arouses feelings of fear, anguish or inferiority capable of breaking an individual's moral and physical resistance, it may be characterised as degrading and also fall within the prohibition of Article 3 (see, among other authorities, *Idalov*, cited above, § 92; and also, *Pretty v the United Kingdom*, no. 2346/02, § 52, ECHR 2002-III; *Ananyev and Others*, cited above, § 140; *Varga and Others*, cited above, § 70). Indeed, the prohibition of torture and inhuman or degrading treatment or punishment is a value of civilisation closely bound up with respect for human dignity (see *Bouyid v Belgium* [GC], no. 23380/09, § 81, ECHR 2015).

99. In the context of deprivation of liberty, the court has consistently stressed that, to fall under Article 3, the suffering and humiliation involved must in any event go beyond that inevitable element of suffering and humiliation connected with detention. The State must ensure that a person is detained in conditions which are compatible with respect for human dignity, that the manner and method of the execution of the measure do not subject him or her to distress or hardship of an intensity exceeding the unavoidable level of suffering inherent in detention and that, given the practical demands of imprisonment, his or her health and well-being are adequately secured (see *Kudła v Poland* [GC], no. 30210/96,

§§ 92-94, ECHR 2000-XI; *Idalov*, cited above, § 93; *Svinarenko and Slyadnev*, cited above, § 116; *Mozer v the Republic of Moldova and Russia* [GC], no. 11138/10, § 178, ECHR 2016; and also, *Valašinas v Lithuania*, no. 44558/98, § 102, ECHR 2001-VIII; and *Ananyev and Others*, cited above, § 141).

100. Even the absence of an intention to humiliate or debase a detainee by placing him or her in poor conditions, while being a factor to be taken into account, does not conclusively rule out a finding of a violation of Article 3 of the Convention (see, inter alia, *Peers v Greece*, no. 28524/95, § 74, ECHR 2001-III; Mandić and Jović, cited above, § 80; *Iacov Stanciu*, cited above, § 179; and generally under Article 3, *Svinarenko and Slyadnev*, cited above, § 114, and *Bouyid*, cited above, § 86). Indeed, it is incumbent on the respondent Government to organise its penitentiary system in such a way as to ensure respect for the dignity of detainees, regardless of financial or logistical difficulties (see, amongst many others, *Mamedova v Russia*, no. 7064/05, § 63, 1 June 2006; *Orchowski*, cited above, § 153; *Neshkov and Others*, cited above, § 229; and *Varga and Others*, cited above, § 103).

101. When assessing conditions of detention, account has to be taken of the cumulative effects of these conditions, as well as of specific allegations made by the applicant. The length of the period during which a person is detained in the particular conditions has also to be considered (see, amongst many others, *Idalov*, cited above, § 94; and also Orchowski, cited above, § 121; *Torreggiani and Others*, cited above, § 66; and *Ananyev and Others*, cited above, § 142)."

[125] The second applicant specifically relies on the requirement set out in para [99] for the prisoner's health and wellbeing to be adequately secured and the requirement set out in para [100] to ensure that the conditions of detention do not constitute a breach of article 3 "regardless of financial or logistical difficulties."

[126] In relation to specific issue of the level of distress, hardship and suffering experienced by the second applicant, I am in receipt of additional written submissions made on behalf of the second applicant dated 5 July 2024 and on behalf of the respondent Trust dated 5 August 2024. These submissions in the main purport to set out the content of relevant entries in the second applicant's prison medical notes and records with commentary on the significance of same and I must be careful in my consideration of these submissions because neither I nor the lawyers making the submissions based on their consideration of the records have any relevant expertise

in the interpretation of same and any comments on the records contained in the submissions must be considered in that context. Prior to February 2021, the second applicant relies upon a number of entries commencing in 2012 in which the misuse of opiates is referred to including two entries made in May 2019. On 23 May 2019, the second applicant is noted to have a history of polysubstance issue including opiates. He is noted as having a personality disorder, psychopathic traits anxiety and depression. His clinical opiate withdrawal score was six indicating mild withdrawal symptomology. On 24 May 2019, the second applicant requested that he be considered for OST. He had thoughts of putting a rope up. He reported increased anxiety and increased use of alcohol and heroin to assist him.

[127] After he was placed on the waiting list for assessment in February 2021, the second applicant was seen on 14 March 2021 after a self-harming event. He reported he was waiting to see the CAT and reported daily use of Tramadol and Subutex (opiates). On 21 June 2021 there is a reference to a diagnosis of anti-social personality disorder and there is a reference to the use of Tramadol. One week later there is a reference to the second applicant being irritable and swearing when talking about how long he was waiting to see Dr Flanagan. On 23 July 2021, the second applicant reported that the did not attend the previously arranged appointment because he was too anxious and that this was an ongoing issue for him. He referred to his continued use of opioids and his desire to get off same but he was too anxious to be able to do anything without them. He was keen to see the CAT and wanted the nurse to see if she could speed this along for him. He had declined to attend a recent outside appointment due to anxiety.

[128] On 4 Augus, 2021, a senior prison officer expressed concerns about the second applicant's serious addiction issues. It was noted that the second applicant was on the waiting list for assessment and that he was frustrated at the wait. Other prisoners who cut themselves or attempt suicide are given priority and this officer was concerned that the second applicant might see this as an option to bump himself up the waiting list. On 23 August 2021, the second applicant was noted to be "frustrated ++" about the wait to be assessed and he was chasing drugs each day to feed his habit. He was finding this very stressful and felt angry. On 24 August 2021, there is a note about the second applicant self-harming due to frustrations of waiting so long to see addictions. He felt his addiction was getting worse and he always needs something in him to function. He stated that he would keep self-harming worse and worse until he is seen. He was advised that such behaviours would not get him seen any sooner. He reported ongoing anxiety and stated that he did not attend appointments due to anxiety. He had sent a letter to Dr Flanagan and wanted to make sure it had been received. The nurse was asked to keep chasing addictions. It is a matter of no little concern that there is no reference to this letter in either Dr Flanagan's report or her more recent affidavit. On 3 September 2021 he stated that he believed if he changed his AD:EPT worker, someone else would get him seen sooner. It is recorded that he was assured that no one could move him up the list any quicker. On 8 September 2021, the second applicant is recorded as expressing his concern about being on the

waiting list to be assessed for many months. There is a note of him pushing his chair aggressively and stating that he was fed up being told the same thing.

[129] This theme is repeated on 17 November 2021 when the second applicant stated he was fed up waiting to be seen by CAT and he was struggling to open up and trust people. The following day he was complaining of hearing voices and seeing things moving in his cell. A history of paranoia and violent thoughts was obtained. It was felt that it would be for CAT to address these issues and it was noted that he was on the waiting list. On 18 January 2022 there is a further reference to the second applicant being too anxious to attend appointments and that he would not leave his house without being high. He does not feel up to it without drugs. That is why he tends not to come to appointments.

[130] On 27 January 2022, there are references to anti-social personality disorder and emotionally unstable personality disorder. There are also references to his use of illicit Subutex most days and his continued wait for a CAT appointment. On 11 January 2022 the second applicant's main issues were noted to be anxiety, anger, paranoia and substance misuse. His non-attendance at appointments was generally attributed to anxiety. He was noted to be easily irritated at times and prone to self-harming out of frustration in the belief that this is a way to get things done sooner including seeing CAT. On 15 February 2022 the Landing Staff made contact with Prison Healthcare in relation to the delay in the second applicant seeing CAT and being worried that he has been forgotten about as it had been so long and his addiction issues were getting worse. On 21 December 2023, the second applicant's mental health notes record that there was a long history of poly-substance abuse, including the daily use of Subutex. He was diagnosed with emotionally unstable personality disorder and anti-social personality disorder and he was requesting help with Subutex help. On 12 April 2024, there is a note to the effect that the second applicant was due for release and he was directed to Drug Outreach services in the Belfast Trust.

[131] On behalf of the second applicant it is argued that these records demonstrate a long history of opiate misuse which seems to have become more established in prison, repeated and progressively more desperate requests for help, and considerable anxiety and frustration at the absence of input from CAT. His anxiety appears to have prevented him from attending appointments with the primary care team and with AD:EPT. It is argued that the second applicant was detained in conditions that were incompatible with respect for human dignity. The manner and execution of his detention subjected the second applicant to distress and hardship exceeding the unavoidable level of suffering inherent in detention. The second applicant's health and well-being were not adequately secured by the provision of the requisite medical assistance and treatment and certainly not at a level equivalent to that provided to the population as a whole. The second applicant did not undergo an assessment of his state of health by any relevant specialist in order to be provided with appropriate treatment. There was no credible or convincing evidence from the respondent Trust that the second applicant received comprehensive and adequate medical care in respect of his condition; opiate addiction being a serious chronic disease, requiring

medical treatment. It is clearly demonstrated in the contemporaneous records that the second applicant endured considerable suffering and distress as a result of this lack of assessment and appropriate treatment. He experienced feelings of fear, anxiety capable of humiliating and debasing him. The respondent Trust's plea of a lack of resources is simply no excuse in circumstances where the state continued to detain the second applicant.

The respondent Trust

[132] The respondent argues that the applicants' article 14 claim insofar as it relies on article 8 is fatally flawed because the applicants' cases do not fall within the ambit of article 8. It is argued that domestic law is clear in that there is no positive obligation within article 8 to provide healthcare or, more particularly, healthcare within a certain time frame. In respect of the non-applicability of article 3, reliance is placed on the domestic decisions of *R (Watt) v Bedford Primary Care Trust and the Secretary of State for Health* [2003] EWHC 2228 (Admin) and *R v North West Lancashire Health Authority ex p A* [2000] 1 WLR 977 which deal with NHS waiting lists. Reliance is also placed on the *Northern Ireland Human Rights Commission* abortion case [2018] UKSC 27 and *AB* [2021] UKSC 28 in order to demonstrate that in order to find a substantive breach of article 3 there must be deliberate and serious acts that degrade and humiliate, with the state actor's intentions and motives being relevant. It is argued that article 3 has no part to play when one is dealing with policy decisions as to how to best utilise scarce resources. In respect of the non-applicability of article 8, reliance is placed on the first instance and Court of Appeal decisions in *Wilson and Kitchen*.

[133] In adopting this approach, I consider that the respondent Trust has in effect mischaracterised the case being made out by the applicants. Their cases arise out of their detention by the state and the duties that are incumbent on the state when the state detains someone. One such duty is to protect the physical and psychological integrity of the detainee by providing them with appropriate healthcare while they are detained in custody which is on a par with that provided to the general citizenry and it is on this basis that article 8 is clearly engaged, as is article 3. The respondent accepts for the purposes of these cases that a prisoner seeking an assessment of suitability for OST is an "other status" which falls within the catchment of article 14. It is clearly correct to state that "other status" is not a "suspect ground" such as race or religion. The respondent argues that this attracts a lower intensity of review by the court and that a difference in treatment is easier to justify. That test, it is argued, is manifestly without reasonable foundation. I do not consider that there is much between the parties here in that the applicants accept that the proportionality test is, in essence, the same as manifestly without reasonable foundation as explained by Lord Reed in para [161] of *SC*.

[134] It is alleged that the applicants are not in an analogous position to a comparator who seeks access to OST outside the prison estate in the community as the composition of the two populations is completely different. It is argued that the

overall circumstances of the comparators' situation have to be considered. Reliance is placed on the judgment of Lord Stephens in *Hilland* at paras [136] and [137]:

> "136. To establish that this different treatment amounts to a violation of article 14 there must be a difference in the treatment of persons in 'analogous or relevantly similar situations.' This does not mean that the comparator groups must be identical. However, the appellant must demonstrate that, having regard to the particular nature of his complaint, he was in a relevantly similar situation to others treated differently.
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> 137. As in *R (Stott)* the assertion that the practice in relation to the revocation of a DCS prisoner's licence and their recall to prison is out of step with comparable prisoners has an initial attraction. However, as Lady Black stated, the initial attraction is less compelling if the rest of the prisoners are not, in fact, in step with each other. In considering whether the rest of the prisoners are in step with DCS prisoners the focus should not be entirely upon the revocation and recall provisions. Rather, the sentencing regimes must be viewed as whole entities, each with its own particular, different, mix of ingredients, designed for a particular set of circumstances: see *R (Stott)* at paras 155, 180 and 193. Accordingly, the revocation and recall provisions about which the appellant complains should not be looked at on their own, but as a feature of the regime under which he has been sentenced. Furthermore, when assessing whether the appellant is in an analogous situation to other prisoners, in addition to taking a holistic approach, it is important to have regard to the reality that the statutory regime in Northern Ireland establishes separate sentencing regimes which have different characteristics."

[135] The respondent Trust argues that the applicants and their stated comparators (persons waiting for assessment of suitability for OST in the community), taking their respective circumstances as a whole, are not in an analogous position. It is argued that their situation is different because the demand for OST is much greater in prison (as a percentage of the entire prison population) when compared to the demand in the community as a percentage of the overall population of each Trust area. It is argued that there is clearly a much higher incidence of substance misuse in prison than in the community and this means that the two groups cannot be regarded as analogous. It is argued that the administration of OST in prison is different but this point has been addressed above at paras [52] and [94](b) and it is clear that irrespective of any differences in the way in which daily oral OST medication is administered in the

community and in prison, there are no differences in the assessment of suitability process and the differences in the way in which daily oral OST medication is administered in the community *viz a viz* the prison estate should not impact upon the ability of CAT nurses to assess patients. It is also alleged that the increase in the costs of drugs has had a much greater impact on the prison healthcare budget than the community healthcare budget.

[136] Again, these arguments represent somewhat of a mischaracterisation of the case being made. It is clear that the provision of medical treatment is personal and individual, and every patient must be treated as an individual. The fact that more individuals may suffer from a particular condition in one location than another location does not mean that their conditions are not analogous. This is especially so when one takes into account the undisputed fact that one of the reasons why there is such a concentration of substance abusers in prison is that those who abuse substances in the community are more likely to end up in prison than those that do not. The reason why there is a concentration of the problem in prison is that those with the problem in the community regularly end up engaging in criminal activities and being sentenced to prison. In effect, the state has been responsible for transferring significant numbers of substance abusers from the community to prison but then when the state is faced with a claim that it unlawfully discriminates between substance abusers in prison and substance abusers in the community in respect of the availability of effective treatment, it seeks to argue that the two groups of substance abusers are not analogous because there is a higher concentration of addiction problems in prison. Such an argument cannot prevail.

[137] In relation to the disproportionate impact of drug price rises, it is clear that the prison population contains a higher percentage of individuals suffering from mental illness than in the general community. Does that mean that if there was a rise in the costs of psychotropics or antipsychotics it would be alright to stop assessing persons in prison for mental illness because there wasn't the money in the budget to pay for their drugs if they were formally diagnosed as being in need of drug orientated therapeutic input? In the context of the present cases involving OST, is that actually what the prison healthcare provider is arguing? If so, such an argument cannot prevail.

[138] Put very bluntly, there are no material differences between someone who is addicted to opiates in Ballymena and someone who is addicted to opiates in Bangor or indeed someone who is addicted to opiates in Maghaberry or Magilligan. It has been compellingly demonstrated and it is accepted by the respondent that OST may be of great benefit, indeed a lifesaver, to any and all of them and so, in a properly functioning health service, any and all of them should have access to a service which assesses them for suitability for OST. It is their condition (the disease that they suffer or may suffer from) and it is the recognised treatment for that condition (OST) that places the detained prisoner who is or may be addicted to opiates and the person at liberty in the community who is or may be addicted to opiates in a clearly and transparently analogous position.

[139] The third limb of the respondent's defence to the article 14 discrimination claim is that in relation to healthcare policy, the state enjoys a wide area of discretionary judgment and, when properly analysed, the reasons behind the difference in treatment cannot be said to be manifestly without reasonable foundation. The respondent relies heavily on the NICA judgment in *Wilson and Kitchen* [2023] NICA 54 at paras [78] and [79]. This reliance does not withstand careful scrutiny. Hospital waiting lists are not the issue in this case. Macro-political decision making is not being challenged. What are challenged are the conditions of detention in prison and, when viewed from that perspective, the decision of *Wilson and Kitchen,* important as it undoubtedly is, is strictly irrelevant. Conditions of detention in Northern Ireland prisons are manifestly appropriate for judicial scrutiny and, if necessary, judicial intervention.

[140] When carefully analysed, the respondent's argument is that this case boils down to the resourcing of public services and the state's decisions in relation to the allocation of scarce public funds to provide for those public services. Such decisions are non-justiciable. That non-justiciability extends to convention-based discrimination cases where the issue of resourcing is raised by the respondent even in the context of the treatment of prisoners and even where article 3 or article 8 is engaged. Such an argument cannot possibly be right.

[141] In relation to the issue of equivalence of medical treatment, the respondent argues that the case of *R (Gallagher) Competition and Markets Authority* [2018] UKSC 25 means that any claim against a public authority where the applicant is alleging unequal treatment has to be judged by the irrationality standard. Lord Sumption at para [79] stated:

> "The common law principle of equality is usually no more than a particular application of the ordinary requirement of rationality imposed on public authorities."

[142] There is, however, a world of difference between the common law principle of equality in the context of a regulatory body performing its investigative and regulatory functions and the requirement of equivalent medical treatment for prisoners in the context of an article 3 or article 8 claim. A Convention rights-based claim necessitates a merits review, bearing in mind the pronouncements of the European Court in relation to article 3 mandating equivalent medical treatment. Therefore, the common law equality test is irrelevant. Further, these applicants are not making out the case that it is unlawful per se to fail to comply with international standards that are not specifically incorporated into domestic law. The case which the applicants advance is that where, as in this case, articles of the ECHR have been interpreted by the European Court as reflecting and mirroring those international standards, then, by virtue of the Human Rights Act 1998, those international standards may be used as yardsticks against which the lawfulness of the actions of the state can be assessed and determined.

[143] In relation to the issue of justification, it is argued in forceful terms that the decisions and choices made by the respondent Trust in relation to the effective stopping of the assessment process in respect of non-inducted prisoners in the prison estate is that they are prevented from doing otherwise due to budgetary constraints, an increasing prison population, an increased demand for OST and an increase in the cost of medication. The respondent Trust has reacted to such pressures by putting in bids for more funding and limited additional funding has been obtained but it is far short of what is needed. Hard choices have to be made and in order to safely provide medical treatment to the prison population, the assessment process in respect of non-inducted prisoners in the prison estate was effectively stopped. There is a safety net of services for those prisoners left on the waiting list in the form of mental health input, GP input and AD:EPT counselling. However, it is clear that this safety net does not constitute adequate treatment for the condition the second applicant complains of. The safety net may deal with and possibly alleviate some of the symptomology experienced by the second applicant as a result of his condition but it does not treat the condition itself. It, therefore, cannot constitute adequate treatment of the condition in a Convention compliant sense.

[144] The respondent Trust also relies upon the initial screening of prisoners on the waiting list to ensure that those at greatest risk are given priority. However, prioritisation also takes place in the community and, in any event, prioritisation in the prison setting is rendered relatively meaningless when resources are concentrated on processing persons newly committed to prison on OST in the community and prisoners whose OST has been stopped due to a positive body scan. The respondent Trust's overarching argument in respect of justification is that the court should not second guess the respondent Trust when it comes to such difficult decisions. It cannot be said that the respondent Trust's rationale is manifestly without reasonable foundation or disproportionate.

[145] As indicated above at para [109] of this judgment, it is argued on behalf of the first applicant that in relation to the discrimination claim, justification is the central issue and I am inclined to agree with the first applicant in that regard and I will address the issue of justification below.

[146] In relation to the second applicant's article 3 claim, the respondent Trust argues that article 3 is not engaged let alone breached because the minimum threshold of severity has not been passed. That argument constitutes a significant and unwarranted over-simplification of the correct test and when the correct test is applied, it is clear that that article 3 is engaged. All the Convention caselaw cited above would point to the engagement of article 3 having regard to the case being made out by the second applicant. The various aspects of the proper test in respect of the engagement and breach of article 3 are those set out in paras [54] *et seq* of the *Wenner* decision. If article 3 is engaged then the test as to whether there is a breach of article 3 is the minimum threshold of severity test. It must also be remembered that in relation to the conditions in which a prisoner is detained, article 3 is absolute in its

terms so that there is no room for a manifestly without reasonable foundation or proportionality assessment. The respondent Trust seeks to rely upon the House of Lords decision of *In Re E (a child) AP (Appellant) Northern Ireland* [2008] UKHL 66 which examined the absolute nature of the article 3 obligation in the context of the state's duty to prevent a third-party inflicting harm or treatment on an individual of such severity to constitute torture, inhuman or degrading treatment. The House of Lords considered that the issue was akin to that addressed in *Osman v UK* [1998] and that the duty imposed upon the state in such circumstances was to do all that was reasonable in the circumstances to protect the individual from a real and immediate risk of harm. However, in this case, it is not the actions of a third party that are the alleged cause of the second applicant's suffering, it is the alleged conditions of detention imposed upon the second applicant by the state and therefore, the *Osman* principle has no application.

[147] The respondent Trust challenges the second applicant's evidence concerning the alleged breach of article 3. It is argued that little weight should be attached to Professor Davidson's report in that he is not an OST expert and he only assessed the second applicant by video link. The central challenge to Professor Davidson's report is that as he is not an expert in OST he could not legitimately opine that "in my view, given his history and current presentation, *[Mr Pollins]* would be deemed suitable [*for OST*] by a CAT." The respondent Trust's argument is completely undermined by the fact that shortly after his release from prison, the second applicant was assessed as suitable for OST and commenced on the programme.

[148] The respondent Trust also argues that the comments of the Parole Commissioners were made without having before them the full facts and circumstances including the failure of the second applicant to attend two appointments in February and March 2020. The respondent Trust's points are well-made but irrelevant to the issue of whether article 3 has been breached. The Parole Commissioners' decisions do not directly speak to or address the issue of the conditions in which the second applicant was detained.

[149] The respondent Trust argues that the safety net services which the second applicant could and to an extent did avail of mean that any even if the second applicant did suffer as a result of being denied the opportunity of being commenced on OST in prison, the nature, extent and duration of any suffering did not cross the threshold of severity necessary to give rise to a substantive breach of article 3. The respondent Trust relies on the views expressed by Dr Flanagan in her report and subsequent affidavit, having regard to the contents of the second applicant's prison medical notes and records and AD:EPT records.

[150] The respondent Trust argues that the second applicant cherry picks certain entries from the records to support the case that the second applicant has a long history of opioid abuse and consequential anxiety which led to him being unable to attend appointments. The respondent Trust argues that a comprehensive review of the 99 pages of notes reveal a much more complex and nuanced situation. It is argued

that the second applicant received comprehensive medical care during his various spells in prison. It is clear that he received treatment for a broad range of conditions, complaints, diseases and illnesses but what he did not receive was adequate treatment of his addiction to opiates despite being on a waiting list for assessment between 5 February 2021 and his discharge from prison in April 2024. He only received appropriate treatment for his condition after his release from prison.

[151] It is accepted that the second applicant was seen frequently by the Mental Health Team (MHT) because of anxiety and self-harm. It is alleged that he received appropriate medical responses each time. He was not left untreated. That may well be the case but it is argued by the second applicant that the underlying cause of his anxiety and self-harming in the latter stages of his imprisonment was not addressed. It is clear that there was a history of self-harming before February 2021 and there can be no disputing that. However, the second applicant's case is that yes, he was prone to self-harming but the cause of his self-harming after February 2021 was his upset, distress and frustration at the delay in assessment of his suitability for OST. The same point can be made in relation to episodes of cell wrecking. There is a clear history prior to February 2021 but what was the main motivating factor for this behaviour after February 2021?

[152] It is clear that the second applicant was offered two dates for assessment for OST in February and March 2020. He refused to attend either. He argues that his anxiety prevented him from attending. This argument is not a recent invention. He was making that case during the appointments he did attend in prison. The respondent Trust cannot justify not assessing the second applicant for over three years after February 2021 because he did not attend two appointments in February and March 2020. It is argued that he did not approach community addiction services when released on licence in order to seek assessment of suitability for OST but again this was before 2021 and the respondent Trust cannot justify not assessing the second applicant for over three years after February 2021 because he did not make any form of approach to community addiction services when released on licence prior to that date.

[153] It is argued on behalf of the respondent Trust that the second applicant was described as manipulative, swallowing foreign bodies to remain in the prison hospital. He was frequently assessed as being fit to attend adjudication (disciplinary) hearings and when in CSU (solitary) he would have been assessed daily and never displayed any significant withdrawal symptoms during any of these assessments. It is argued that withdrawal symptoms were only raised as an issue by the second applicant on two occasions and on each occasion, he received appropriate treatment for these symptoms. It is argued that any distress, anxiety and frustration suffered by the second applicant did not approach the threshold of severity necessary to found a breach of article 3. There are no complaints of actual physical pain forming part of any withdrawal symptoms experienced by the second applicant and in terms of psychological suffering, the mental health input the second applicant received in prison would have been better than he is likely to have received in the community.

Court's assessment and determination of the issues

[154] The European Convention on Human Rights was created in response to the horrors of World War II and many of the most egregious examples of man's inhumanity to man during that conflict occurred in the context of the detention of individuals and groups by the state. This is why the Convention places considerable emphasis and importance on the protection of those who are detained by the state, recognising their vulnerability and the ease with which they can be mistreated, abused and neglected in the confines of a prison or a mental health institution away from the public gaze.

[155] Articles 3 and 8 of the Convention have been interpreted by the European Court as giving rise to duties on the part of the state when it comes to addressing the healthcare needs of prisoners. It has repeatedly been held that article 3 imposes an obligation on the state to protect the physical well-being of persons deprived of their liberty by, among other things, providing them with the requisite medical care. The European Court has held on many occasions that the lack of appropriate medical care may amount to treatment contrary to article 3. The state must ensure that diagnosis and care are prompt and accurate and that, where necessitated by the nature of a medical condition, supervision is regular and systematic and involves a comprehensive therapeutic strategy aimed at adequately treating the detainee's health problems or preventing their aggravation, rather than addressing them on a symptomatic basis. The medical treatment provided within prison facilities must be appropriate, that is, at a level comparable to that which the state authorities have committed themselves to provide to the population as a whole.

[156] The European Court has repeatedly declared that article 3 of the Convention imposes on the state a positive obligation to ensure that a person is detained under conditions which are compatible with respect for human dignity, that the manner and method of the execution of the measure do not subject the individual to distress or hardship exceeding the unavoidable level of suffering inherent in detention and that, given the practical demands of imprisonment, the person's health and well-being are adequately secured by, among other things, the provision of the requisite medical assistance and treatment. The court has clarified in this context that it is essential for a prisoner suffering from a serious illness to undergo an adequate assessment of his or her current state of health, by a specialist in the disease in question, in order to be provided with appropriate treatment. The prison authorities must offer the prisoner the treatment corresponding to the disease(s) the prisoner was diagnosed with. Having regard to the vulnerability of applicants in detention, it is for the state to provide credible and convincing evidence showing that the applicant concerned had received comprehensive and adequate medical care in detention.

[157] The European Court has emphasised that the Convention does not guarantee the right to health as such or the right to a specific medical treatment desired by the applicant. However, complaints relating to the denial of access to certain types of

medical treatment or medicinal products have been brought before the court which have been examined from the point of view of article 8 of the Convention, the concept of "private life" of which is underpinned by the concept of personal autonomy.

[158] Having regard to the above, it is quite clear that article 3 and article 8 may be engaged in the context of the provision or lack of provision of adequate and appropriate healthcare in the prison environment. The first applicant, Mr Robert Clarke, does not allege a substantive breach of either article. His is an article 14 discrimination case on the basis that the discriminatory treatment complained of impacts upon his physical and psychological integrity (personal autonomy) and as such in the context of a detained prisoner article 8 is engaged. The second applicant, Paul Pollins, in addition to the article 14 case that is common to both applicants, alleges that he has been detained in conditions which constitute substantive breaches of article 3 and article 8. The respondent Trust denies that there have been any substantive breaches of either article 3 or article 8 and further denies that either article is engaged in either case. If either article 3 or article 8 is engaged, the respondent Trust denies that any claim under article 14 can succeed because the chosen comparators are not in an analogous position and, in any event, it cannot be said that the decisions giving rise to any difference in treatment are manifestly without reasonable foundation.

[159] This court has carefully and comprehensively rehearsed the evidence produced by the parties in these two applications and has carefully considered the written and oral submissions ably made by counsel on behalf of the parties, and in light of this careful scrutiny and consideration, the court has reached the following conclusions.

[160] Article 3 and article 8 are clearly engaged in these cases in that these cases relate to the provision of appropriate medical healthcare by the state to those detained by the state. In relation to the second applicant's article 3 claim, it is abundantly clear that the state has failed to provide appropriate medical healthcare. He did not undergo an adequate assessment of his state of health in that his suitability for OST treatment was not assessed and the failure to do so for over three years clearly constitutes inappropriate healthcare and clearly represents a level of healthcare which is not comparable to that which the state has committed itself to provide to the population as a whole. Equivalence in terms of prison healthcare provision is a Convention requirement and it is a Convention requirement that has clearly been breached in the second applicant's case.

[161] In relation to the second applicant's article 3 claim, the court is clearly satisfied that there has been an actual breach of article 3 in that the court is satisfied on the cogent and compelling evidence adduced that if the second applicant had received a timely assessment of his suitability for OST in prison, he would have been assessed as suitable for the commencement of OST and he would or should have been commenced on OST shortly after his assessment. If he had been inducted onto the OST programme, the likelihood is that he would not have suffered regular opiate withdrawal symptoms including significant pain due to the interruption in the supply

of illicit drugs in the prison (and the court finds that he did so suffer such regular symptoms) and he would not have suffered the level of anxiety and distress which he evidently experienced while on the waiting list for assessment (a prolonged period of three years). In the opinion of the court, the nature, extent and duration of these symptoms do cross the level of severity necessary to give rise to a breach of article 3 and they clearly and manifestly mean that the second applicant was detained in conditions which were not compatible with human dignity. These symptoms did give rise to levels of prolonged hardship and distress clearly in excess of the unavoidable level of suffering inherent in detention. In coming to this conclusion, the court recognises and accepts that the respondent Trust did not intend to cause the second applicant the severe level of hardship and distress that he experienced but although the motivation or intention of the state actor is relevant it is, as is clear from para [100] of *Muršić,* not determinative of whether there has been a beach of article 3. In any event, in this case that severe level of hardship and distress flowed from the deliberate and intentional implementation of a decision in respect of the provision of healthcare rather than flowing from negligent medical treatment.

[162] The court has carefully considered whether the other aspects of prison healthcare which were available to the second applicant while he was on the waiting list and his engagement with those services mean that the symptoms complained of were kept at a level below the article 3 threshold of severity and the court concludes that the evidence clearly indicates that these other services did not have this effect. They were of some limited benefit in relation to the management of symptoms but were of absolutely no benefit in relation to addressing the underlying problem. In respect of article 3, the absolute nature of the duty means that resourcing issues are strictly irrelevant.

[163] The second applicant is entitled to a declaration that by reason of the failure of the state to provide him with adequate healthcare in prison, his conditions of detention breached article 3 of the Convention and in addition to such a declaration, the second applicant's entitlement to Convention based damages in the form of just satisfaction is made out. The court will allow the parties some time to attempt to formulate the appropriate declaration for approval by the court and the court also encourages the parties to discuss the issue of the appropriate level of damages and, if possible, to agree same. In the absence of such agreement, the court will convene another hearing to allow the issue of the level of damages to be the subject of submissions, followed by a further determination by the court on that issue, if necessary.

[164] In relation to the second applicant's article 8 claim, it follows from the above finding that there has been interference with the second applicant's physical and psychological integrity (personal autonomy) sufficient to fall foul of the protections set out in article 8(1). However, the rights and protections set out in article 8(1) are qualified rights in that the state can curtail or circumscribe those rights if it acts in accordance with the law and only to the extent that is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the

country, for the prevention of disorder and crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

[165] The assessment by the court as to whether the state can rely on the provisions of article 8(2) involves conducting a proportionality assessment as described in para [109] above. In the context of the second applicant's case, the court (adopting the approach of affording the state a wide margin of appreciation) can readily accept that the respondent Trust sought to pursue a broadly legitimate aim in that it's focus was on doing the best it could in terms of the provision of healthcare in prison in the context of having to operate under a seriously inadequate budget. However, I am strongly of the view that the measure complained of in this instance was not rationally connected to the objective. Firstly, the measure flew in the face of any notion of equivalence. Secondly, it cannot be said that a measure is rationally connected to the aim of protecting the provision of prison healthcare when it effectively blocks fresh access to a key part of the prison healthcare system for a significant number of prisoners. Thirdly, it would be entirely repugnant to Convention values if a court were to conclude that a measure which resulted in conditions in prison which gave rise to a finding of a substantive breach of the provisions of article 3 could be said to be rationally connected to a legitimate aim.

[166] In relation to the question of whether a less intrusive measure could have been implemented without unacceptably compromising the achievement of the objective, it is not the court's function to tell the respondent Trust how to run the prison healthcare system by constructing or devising alternative policies or approaches designed or intended to further the state's legitimate aim but the court can sketch out other options solely for the purpose of demonstrating that such alternatives exist and might be considered. In this case, the court is adamant in its view that a less intrusive measure (one which did not result in a substantive breach of article 3) could and should have been devised and implemented. The underlying problem in this case and in the related Clarke case is that the prison healthcare budget is based on a historic figure which is subject to some form of inflation linked increase, with this historic figure bearing little relationship to the healthcare needs of the prison population and certainly being well out of step with the per capita spend on prison healthcare in other parts of the United Kingdom. This was apparent to the respondent Trust, the Health and Social Care Board, the Department of Health and the Department of Justice. What was required was a principled revision of the methodology in place to determine the prison healthcare budget. What was needed was firm and definitive advice that in the absence of such a revision, the state ran the clear risk of falling foul of its Convention duties in respect of the treatment of prisoners detained by the state. What appears to have been missing from the business cases presented to the SPPG was a clear, authoritative and unambiguous warning about the legal consequences of failing to properly fund prison healthcare.

[167] In relation to the question of whether the measure strikes a fair balance between the rights of the individual and the interest of the community, there is really only one possible answer in light of the finding of a substantive breach of article 3 and that is a

resounding no. Firstly, a measure which directly results in the creation of conditions of detention that give rise to a breach of article 3 can never be said to strike a fair balance between the rights of the individual and the interests of the community. Secondly, bearing in mind the finding that there is no rational connection between the measure and the objective, there can be no question of a fair balance having been struck between the rights of the individual and the interest of the community. Thirdly, bearing in mind the individual and societal benefits to be reaped from the successful induction and maintenance of a patient on OST, the individual's rights and the community's interests coincide and both are, in effect, harmed by this measure. In summary, the measure fails the proportionality test and therefore is not saved by the provisions of article 8(2).

[168] The second applicant is entitled to a declaration that by reason of the failure of the state to provide him with adequate healthcare in prison, his conditions of detention breached article 8 of the Convention and in addition to such a declaration, the second applicant's entitlement to Convention based damages in the form of just satisfaction will have to be determined. It may well be that an appropriately worded declaration will also constitute just satisfaction of the second applicant's claim. The court will allow the parties some time to attempt to formulate the appropriate declaration for approval by the court and the court also encourages the parties to discuss the issue of the entitlement to damages in addition to a declaration, and if there is agreement as to the entitlement to damages, the court encourages the parties to give consideration to the appropriate level of damages and, if possible, to agree same. In the absence of such agreement, the court will convene another hearing to allow the issue of what is required to constitute just satisfaction in the circumstances of this case to be addressed, and to make a further determination of this issue in light of any submissions received.

[169] In relation to the second applicant's article 14 discrimination claim, I reiterate my conclusion that both articles 3 and 8 are clearly engaged and, therefore, in the language of the *Stott* test, the circumstances of the case fall within the ambit of rights protected by substantive convention provisions. In relation to the second limb of the *Stott* test, it is patently obvious on the facts of this case that the difference in treatment is on the ground of the second applicant's status as a prisoner who seeks to be assessed in relation to his suitability for commencement on OST as a treatment for opiate addiction. As I have already stated in paras [136] to [138] above, the patient in the community who is seeking such an assessment of suitability is in an analogous position to the patient in prison and the difference in treatment is that the patient in the community will be assessed within single digit weeks whereas the patient in prison may well have to wait years to be assessed or may not be assessed at all. The second applicant and the patient in the community who has been treated differently are clearly in analogous situations. Finally, in order to establish a breach of article 14 it is necessary to establish that objective justification for the different treatment is lacking. This involves a proportionality assessment which is the same as that performed in respect of the article 8 issue and it is clear from that assessment that the second applicant's article 14 case must succeed. One additional issue is relevant to the

proportionality assessment in relation to article 14 and that arises out of para [42] of Lord Kerr's judgment in *Steinfeld* and para [40] of Lady Hale's judgment in *Coll* in that it has been held that budgetary considerations cannot justify discrimination.

[170] The second applicant is entitled to a declaration that by reason of the difference in treatment provided to the second applicant as a prisoner who seeks to be assessed in relation to his suitability for commencement on OST as a treatment for opiate addiction compared to the treatment provided to a patient in the community in an analogous situation and the failure of the state to provide the second applicant with adequate healthcare in prison, the respondent Trust has unlawfully discriminated against the second applicant in breach of article 14 of the Convention when read together with article 3 and article 8 the Convention and in addition to such a declaration, the second applicant's entitlement to Convention based damages in the form of just satisfaction will have to be determined. It may well be that an appropriately worded declaration will also constitute just satisfaction of the second applicant's claim. The court will allow the parties some time to attempt to formulate the appropriate declaration for approval by the court and the court also encourages the parties to discuss the issue of the entitlement to damages in addition to a declaration, and if there is agreement as to the entitlement to damages, the court encourages the parties to give consideration to the appropriate level of damages and, if possible, to agree same. In the absence of such agreement, the court will convene another hearing to allow the issue of what is required to constitute just satisfaction in the circumstances of this case to be addressed, and to make a further determination of this issue in light of any submissions received.

[171] In relation to the first applicant, it has to be remembered that the first applicant's case is that he is the subject of unlawful discrimination contrary to article 14 primarily in relation to article 8 of the Convention. He does not allege a substantive breach of either article 3 or article 8. From what has been said above, article 8 is clearly engaged in the first applicant's case in respect of his physical and psychological integrity (personal autonomy). Again, adopting the language of *Stott,* the circumstances of the case fall within the ambit of rights protected by a substantive convention provision, namely article 8. In relation to the second limb of the *Stott* test, it is patently obvious on the facts of this case that the difference in treatment is on the ground of the first applicant's status as a prisoner who seeks to be assessed in relation to his suitability for commencement on OST as a treatment for opiate addiction. As I have already stated in paras [136] to [138] above, the patient in the community who is seeking such an assessment of suitability is in an analogous position to the patient in prison and the difference in treatment is that the patient in the community will be assessed within single digit weeks whereas the patient in prison may well have to wait years for an assessment or may not be assessed at all. The first applicant and the patient in the community who has been treated differently are clearly in analogous situations. Finally, in order to establish a breach of article 14 it is necessary to establish that objective justification for the different treatment is lacking. This involves a proportionality assessment where the court considers the question of whether the difference in treatment is manifestly without reasonable foundation.

[172] In the context of the first applicant's case, the court (adopting the approach of affording the state a wide margin of appreciation) can readily accept that the respondent Trust sought to pursue a broadly legitimate aim in that it's focus was on doing the best it could in terms of the provision of healthcare in prison in the context of having to operate under a seriously inadequate budget. However, I am strongly of the view that the measure complained of in this instance was not rationally connected to the objective. Firstly, the measure flew in the face of any notion of equivalence. Secondly, it cannot be said that a measure is rationally connected to the aim of protecting the provision of prison healthcare when it effectively blocks fresh access to a key part of the prison healthcare system for a significant number of prisoners.

[173] In relation to the question of whether a less intrusive measure could have been implemented without unacceptably compromising the achievement of the objective, it is not the court's function to tell the respondent Trust how to run the prison healthcare system by constructing or devising alternative policies or approaches designed or intended to further the state's legitimate aim but the court can sketch out other options solely for the purpose of demonstrating that such alternatives exist and might be considered. In this case, the court is adamant in its view that a less discriminatory approach could and should have been devised and implemented. The underlying problem in this case and in the related Pollins case is that the prison healthcare budget is based on a historic figure which is subject to some form of inflation linked increase, with this historic figure bearing little relationship to the healthcare needs of the prison population and certainly being well out of step with the per capita spend on prison healthcare in other parts of the United Kingdom. This was apparent to the respondent Trust, the Health and Social Care Board, the Department of Health and the Department of Justice. What was required was a principled revision of the methodology in place to determine the prison healthcare budget. What was needed was firm and definitive advice that in the absence of such a revision, the state ran the clear risk of falling foul of its convention duties in respect of the treatment of prisoners detained by the state. What appears to have been missing from the business cases presented to the SPPG was a clear, authoritative and unambiguous warning about the legal consequences of failing to properly fund prison healthcare. Another important issue is relevant to the proportionality assessment in relation to article 14 and that arises out of para [42] of Lord Kerr's judgment in *Steinfeld* and para [40] of Lady Hale's judgment in *Coll* in that it has been held that budgetary considerations cannot justify discrimination. One possible alternative non-discriminatory approach is to look at the entire budget for OST in Northern Ireland and to perform some form of reallocation involving not just the community services but the prison service too, based on actual need. As Lady Hale stated in para [40] of *Coll*:

> "If a benefit is to be limited in order to save costs, it must be limited in a non-discriminatory way."

[174] In relation to the question of whether the measure strikes a fair balance between the rights of the individual and the interest of the community, that question must be

answered in the negative. Bearing in mind the finding that there is no rational connection between the measure and the objective, there can be no question of a fair balance having been struck between the rights of the individual and the interest of the community. Further, bearing in mind the individual and societal benefits to be reaped from the successful induction and maintenance of a patient on OST, the individual's rights and the community's interests coincide and both are, in effect, harmed by this measure. In summary, the discriminatory treatment fails the proportionality test, it is manifestly without reasonable foundation and is, therefore, in breach of article 14.

[175] The first applicant is, therefore, entitled to a declaration that by reason of the difference in treatment provided to the first applicant as a prisoner who seeks to be assessed in relation to his suitability for commencement of OST as a treatment for opiate addiction compared to the treatment provided to a patient in the community in an analogous situation and the failure of the state to provide the first applicant with an assessment of his suitability for OST in prison, the respondent Trust has unlawfully discriminated against the first applicant in breach of article 14 of the Convention when read together with article 8 the Convention and in addition to such a declaration, the first applicant's entitlement to Convention based damages in the form of just satisfaction will have to be determined. It may well be that an appropriately worded declaration will also constitute just satisfaction of the first applicant's claim. The court will allow the parties some time to attempt to formulate the appropriate declaration for approval by the court and the court also encourages the parties to discuss the issue of the entitlement to damages in addition to a declaration, and if there is agreement as to the entitlement to damages, the court encourages the parties to give consideration to the appropriate level of damages and, if possible, to agree same. In the absence of such agreement, the court will convene another hearing to allow the issue of what is required to constitute just satisfaction in the circumstances of this case to be addressed, and to make a further determination of this issue in light of any submissions received.

[176] If I am wrong in my assessment of the second applicant's entitlement to a declaration that there has been a breach of the substantive provisions of article 3 or article 8 of the Convention then the approach adopted by the court in respect of the first applicant's article 14 claim applies equally to the second applicant and that means that he would succeed in his article 14 in conjunction with article 8 discrimination case in any event.

[177] The issue of costs will be addressed when I have finalised the declarations which will issue in these cases and have determined the issues of the entitlement to and quantum of damages or recorded the parties' agreement in respect of these issues.