

Injecting Reason: Prison Syringe Exchange and Article 3 of the European Convention on Human Rights●

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High rates of HIV infection and injecting drug use are major concerns in prisons across Europe. There is a broad international consensus that people in prison are entitled to a standard of health care equivalent to that available outside of prisons, yet only four Council of Europe countries provide sterile syringes to prisoners as an HIV prevention measure. This failure places prisoners who inject drugs at increased vulnerability to HIV infection simply because of their status as prisoners, raising serious human rights and public health concerns. Article 3 ECHR provides an important tool for advocating for the rights of prisoners to HIV prevention measures, including syringe exchange. The European Court's recent Art.3 case law indicates that the ECHR can be used to advocate in favour of prison syringe exchange programmes.

Introduction

“Realization of human rights and fundamental freedoms for all is essential to reduce vulnerability to HIV/AIDS.”¹

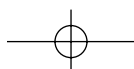
In November 2004, John Shelley initiated legal action against the British Home Secretary under the UK Human Rights Act.² A prisoner in HMP Long Lartin, Shelley claimed that

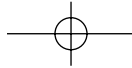
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¹ Declaration of Commitment on HIV/AIDS (June 27, 2001) UNGA Res S-26/2, UN Doc A/Res/S-26/2, p.9.

² D. Valette, “Legal action on needle exchange programs in prisons dismissed” (2005) 10 *HIV/AIDS Policy & Law Review* 51.

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the health of prisoners who injected drugs was being jeopardised by a lack of access to syringe exchange programmes. This, Shelley argued, forced prisoners to share used syringes, putting them at high risk of HIV infection. Shelley claimed that the failure of the Government to provide prisoners with access to sterile syringes was in violation of Arts 2, 3 and 8 of the European Convention on Human Rights (ECHR).³

The *Shelley* case highlights a major concern for AIDS and prisoners' rights advocates across Europe, namely the denial to prisoners in most countries of effective HIV prevention measures such as sterile syringes, placing them at risk of preventable HIV infection.⁴ Across Europe, high rates of HIV prevalence among prisoners, coupled with significant levels of injecting drug use and syringe sharing, create a high risk environment for the rapid spread of HIV infection. Although syringe exchange programmes outside of prisons are commonplace, only five Council of Europe Member States have expanded them into prisons.⁵ This situation raises significant concerns for both public health and human rights.⁶

Shelley is not the first prisoner to use the courts in an effort to secure HIV prevention and treatment services. Domestic courts have been used by prisoners and their advocates in a number of countries (both successfully and unsuccessfully) to obtain HIV/AIDS services.⁷ In Canada, Elliott has argued that prohibitions on cruel and unusual punishment in the Canadian Charter of Rights and Freedoms could provide a basis for successfully litigating the issue of prison syringe exchange in that country.⁸ Could Art.3 ECHR be similarly used?

This article will explore the compatibility of state practice with regard to prison syringe exchange against the Art.3 obligations to prohibit torture, inhuman or degrading

³ *ibid.*

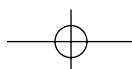
⁴ "Dublin Declaration on HIV/AIDS in Prisons in Europe and Central Asia" (2005) 1 *International Journal of Prisoner Health* 91.

⁵ H. Stöver and R Lines, "Silence still = Death: 25 years of HIV/AIDS in Prisons" in S. Matic, J. Lazarus and M. Donoghoe, eds, *HIV/AIDS in Europe: Moving from death sentence to chronic disease management* (WHO Regional Office for Europe, Copenhagen, 2006), p.67; R. Jürgens, "HIV/AIDS and HCV in Prison—From Evidence to Action" (paper presented at *International Prisoner Health—achieving international standards in prison health care* conference, June 20, 2006), p.2.

⁶ See Stöver and Lines, *ibid.*, p.70; G. Betteridge, "Prisoners' Health and Human Rights in the HIV/AIDS Epidemic" (Draft background paper by the Canadian HIV/AIDS Legal Network for *Human Rights at the Margins: HIV/AIDS, Prisoners, Drug Users and the Law—A satellite of the XV International AIDS Conference*, July 9, 2004), p.14; D. Valette, "AIDS Behind Bars: Prisoners' Rights Guillotined" (2002) 41 *Howard Journal of Criminal Justice* 107; Dublin Declaration, fn.4 above.

⁷ See *Prisoners A-XX Inclusive v State of New South Wales* (1995) 38 N.S.W.L.R. 622; *Van Biljon v Minister of Correctional Services* (1997) 50 B.M.R. 206. G. Betteridge, "Alberta Court Orders Methadone Maintenance Therapy for Prisoner on Interim Basis" (2003) 8 *HIV/AIDS Policy & Law Review* 53; R. Jürgens, "South African Prisoner Wins Payout After Prison HIV Infection" (2003) 8 *HIV/AIDS Policy & Law Review* 55; "US judge: Inadequate medical care for HIV-positive prisoners is a violation of rights" (2004) 9 *HIV/AIDS Policy & Law Review* 48; *EN v Government of the RSA* (Case No.4576/2006), Durban and Local Coast Division, judgment of June 22, 2006.

⁸ R. Elliott, "Prisoners' Constitutional Right to Clean Needles and Bleach" in R. Jürgens, ed., *HIV/AIDS in Prisons: Final Report* (Canadian HIV/AIDS Legal Network, Montreal, 1996), apps 2, 5.



treatment or punishment.⁹ It will review the situation of HIV and unsafe drug injecting in European prisons, the approach of various international instruments to the question of prisoners' rights to health care and HIV prevention measures, and the jurisprudence of the European Court of Human Rights on Art.3 with specific focus on prison health care. It will conclude by exploring the strongest elements of the case law for arguing in favour of a right of people who inject drugs to access sterile syringes while in prison.

Background

HIV/AIDS and injecting drug use in European prisons

According to the World Health Organization (WHO), the issues of HIV/AIDS and unsafe injecting drug use in prisons represent an overlap of "two of the greatest public health problems facing all societies".¹⁰ Across Europe, rates of HIV infection among prisoners are many times higher than that found in the population outside prisons. While some European countries exhibit relatively low rates of infection among prisoners (under 1 per cent), others have rates of infection approaching 10 per cent and higher.¹¹ Research has also found that rates of Hepatitis C infection—another chronic and potentially fatal bloodborne infection spread primarily through unsafe injecting practices—are generally between 20–40 per cent among prison populations.¹² This high prevalence of bloodborne diseases is primarily linked to injecting drug use and the sharing of syringes, both in prisons and in the wider community.¹³

In addition to high rates of HIV and Hepatitis C infection, high levels of injecting drug use and the sharing of syringes have been documented in prison in many countries. As described by one prisoner in a recent Irish study:

"It's a merry go round, it's a breeding ground for drugs, you know? . . . I'm 39 years of age, I seen young fellas coming here at 20 years of age and they never have used a drug in their life and, I only seen recently, in the last two weeks, fifteen of them using one works [syringe], between them . . . 15 using one works and two spikes. There could be five works between 35 people or 40 people . . . each time there's a search, there could be a works down so that lessens it."¹⁴

⁹ The term "syringe exchange" or "needle exchange" is used to refer to the one-for-one exchange of a used syringe for a sterile syringe, as well as to the distribution of sterile syringes without exchange. Unless otherwise indicated explicitly or by context, the terms "needle" and "syringe" mean a device used to inject fluids into the body, and are used interchangeably throughout the paper.

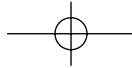
¹⁰ *Status Paper on Prisons, Drugs and Harm Reduction* (WHO Regional Office for Europe, Copenhagen, 2005), p.2.

¹¹ See R. Lines *et al.*, *Prison Needle Exchange: Lessons from a Comprehensive Review of International Evidence and Experience* (Canadian HIV/AIDS Legal Network, Montreal, 2004), p.6; Jürgens, fn.5 above, p.2.

¹² Lines, *ibid.*, p.8.

¹³ WHO, UN Office on Drugs and Crime and UNAIDS, *Policy Brief: Provision of Sterile Injecting Equipment to Reduce HIV Transmission* (WHO, Geneva, 2004) Doc. No.WHO/HIV 2004.3, p.1.

¹⁴ M. Seymour and L. Costello, *A Study of the Number, Profile and Progression Routes of Homeless Persons Before the Court and in Custody* (Government of Ireland, Dublin, 2005), p.89.



Reports of widespread syringe sharing are not limited to prisoners. As described by Antonio Maria Costa, Executive Director of the United Nations Office on Drugs and Crime:

"I cannot forget visiting a prison where I met an inmate who made a significant amount of money 'renting out' a crude syringe he had fashioned out of a ballpoint pen. This fellow charged inmates 1 cent to use this syringe one time, and he told me he was making \$3 a day from 300 injections."¹⁵

According to the European Monitoring Centre on Drugs and Drug Addiction (EMCDDA), as many as 34 per cent of prisoners in some European countries have injected drugs while incarcerated and as many as 21 per cent inject for the first time in prison.¹⁶ The EMCDDA notes: "This raises issues of access to sterile injection equipment ... among the prison population and the potential spread of infectious diseases."¹⁷

The combination of significant rates of HIV and Hepatitis C infection and of injecting drug use create a high-risk environment for the spread of bloodborne diseases via syringe sharing. Transmission of HIV and/or Hepatitis C linked to shared syringes has been documented in the prisons of several European countries including Scotland,¹⁸ Germany¹⁹ and Lithuania.²⁰

HIV and Hepatitis C infection are both incurable and both are preventable. According to a recent policy brief published jointly by the WHO, the United Nations Office on Drugs and Crime and UNAIDS:

"The provision of access to sterile injection equipment for injecting drug users and the encouragement of its use are essential components of HIV/AIDS prevention programmes, and should be seen as a part of overall comprehensive strategies to reduce the demand for illicit drugs."²¹

Most European countries have successfully implemented syringe exchange programmes in the community as a public health measure to reduce the sharing of syringes among people who inject drugs.²² Research commissioned by the WHO concluded that there is "compelling evidence" that this approach "contributes substantially to reductions in the rates of HIV transmission".²³

¹⁵ A.M. Costa, "Remarks by Mr. Antonio Maria Costa, Executive Director, United Nations Office on Drugs and Crime, to the CCO Ministerial Meeting—Session Five: Injecting Drug Users and HIV/AIDS in Prisons, Moscow" (April 1, 2005) available from www.unodc.org.

¹⁶ EMCDDA, *Annual report on the state of the drugs problem in the European Union and Norway* (EMCDDA, Lisbon, 2002), p.46.

¹⁷ EMCDDA, *Annual Report 2005: The state of the drugs problem in Europe* (EMCDDA, Lisbon, 2005), p.81.

¹⁸ D.L. Yirrell *et al.*, "Completing the molecular investigation into the HIV outbreak at Glenochil prison" (1999) 123 *Epidemiology and Infection* 277.

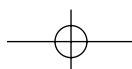
¹⁹ K. Keppler *et al.*, "Transmission of infectious diseases in prisons—results of a study for women in Vechta, Lower Saxony, Germany" (1996) 42 *Sucht* 98 at 104.

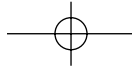
²⁰ L. Dapkus, "Prison's rate of HIV frightens nation", *Associated Press*, September 29, 2002.

²¹ WHO/UNODC/UNAIDS, fn.13 above, p.1.

²² WHO, fn.10 above, p.11.

²³ WHO/UNODC/UNAIDS, fn.13 above, p.2.





Despite the effectiveness of syringe exchange as an HIV prevention measure, the implementation of these programmes in all European countries (with the possible exceptions of Cyprus and Malta)²⁴ and the evidence of HIV and Hepatitis C infection and injecting drug use among prisoners, only five Council of Europe countries have expanded needle exchange programmes into prisons.²⁵ These programmes have proved effective at preventing HIV transmission among prisoners who inject drugs, and have been implemented with no adverse effects on institutional safety or security.²⁶ Despite this success, needle exchange programmes remain the exception rather than the rule in European prisons. As a result, people who inject drugs in prisons are effectively denied access to an essential health programme available to people outside prisons—increasing their vulnerability to HIV and Hepatitis C infection solely because of their status as prisoners.

International law, policy and practice

Prisoners do not surrender their rights upon incarceration, but instead retain all rights “subject to the restrictions that are unavoidable in a closed environment”.²⁷ There is broad consensus that people in prison should not be subjected to substandard health care simply because of their incarceration. Declarations and guidelines from numerous international bodies and organisations—including the United Nations and the WHO—support the principle that people in prison have a right to be provided with a standard of health care equivalent to that available in the community.²⁸ This

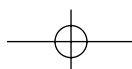
²⁴ M.C. Donohoe, “Injecting drug use, harm reduction and HIV/AIDS” in S. Matic, J. Lazarus and M. Donoghoe, eds, *HIV/AIDS in Europe: Moving from death sentence to chronic disease management* (WHO Regional Office for Europe, Copenhagen, 2006), p.47.

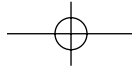
²⁵ Spain, Germany, Switzerland, Moldova, Luxembourg; see Lines, fn.11 above, p.ii; Jürgens, fn.5 above. Jürgens notes that Ukraine is also preparing to initiate pilot prison syringe programmes.

²⁶ See Lines, fn.11 above; WHO, UN Office on Drugs and Crime and UNAIDS, *Policy Brief: Reduction of HIV Transmission in Prisons* (WHO, Geneva, 2004) Doc. No. WHO/HIV/2004.05, p.2.

²⁷ Human Rights Committee, “General Comment 21: Humane treatment of persons deprived of liberty (Art.10)” (April 10, 1992) Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies UN Doc.HRI/GEN/1/Rev.6, para.3.

²⁸ Basic Principles for the Treatment of Prisoners (1990) UNGA Res 45/111, annex 45 UN GAOR Supp. (No.49A) at 200, UN Doc. A/45/49, para.9; WHO, *Guidelines on HIV Infection and AIDS in Prisons* (WHO, Geneva, 1993) Doc.No.UNAIDS/99.47/E, para.A(1); *HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings: A Framework for an Effective National Response* (UNODC/WHO/UNAIDS, New York, 2006), p.10; Joint United Nations Programme on HIV/AIDS, “Statement on HIV/AIDS in Prisons to the United Nations Commission on Human Rights at its Fifty-second session, April 1996” in *Prison and AIDS: UNAIDS Point of View* (UNAIDS, Geneva, 1997), p.3; *International Guidelines on HIV/AIDS and Human Rights* (1997) UNCHR Res 1997/33, UN Doc.E/CN.4/1997/150, guideline 4. Guideline 6 (as revised in 2002 to take account of advances in HIV prevention and treatment) urges that “States’ legislation, policies, programmes, plans and practices should include positive measures to address factors that hinder the equal access of vulnerable individuals and populations to prevention” measures, including “clean needles and syringes”. Prisoners are specifically identified in the revised Guideline 6 as one of these vulnerable populations; Office of the *HIV/AIDS International Guidelines: Revised*





“principle of equivalence” is fundamental to the promotion of human rights and proper health care standards within prisons.

At the European level, the principle of equivalence is endorsed by the Council of Europe²⁹ and in the European Prison Rules.³⁰ The European Committee for the Prevention of Torture (CPT) has been unequivocal in its support, expressing the position that: “An inadequate level of health care can lead rapidly to situations falling within the scope of the term ‘inhuman and degrading treatment’ ”.³¹ The CPT has noted that the principle of equivalence is reflected in national prison legislation or policy in most European states.³²

Although none of these documents or declarations enjoys the status of international law, they are useful in considering international perspectives on the right of prisoners to access sterile injecting equipment. As consensual policy documents formulated by international bodies in collaboration with state representatives, these declarations and guidelines provide direction to states on domestic laws and policies necessary to fulfil human rights obligations.³³ According to Betteridge, this creates at least an “ethical obligation” to meet these commitments, as these instruments “establish norms that arguably should be followed by states”.³⁴

The Court’s approach to Article 3 in the context of prison syringe exchange

Unlike some human rights treaties,³⁵ the ECHR contains no explicit right to health. Therefore, the Convention would appear an imperfect tool for advancing the health care rights of people in prison. However, within the context of detention, the right to health of prisoners is engaged under the Art.3 prohibition of “torture or . . . inhuman or degrading treatment or punishment”.³⁶ As a non-derogable right without limitation or qualification, Art.3 underlines the fundamental nature of this principle within European

Guideline 6 (UN High Commissioner for Human Rights and Joint UN Programme on HIV/AIDS, Geneva, 2003), Doc. No. UNAIDS/02.49E, p.16.

²⁹ Committee of Ministers to Member States Concerning the Ethical and Organisational Aspects of Health Care in Prison Recommendation No.R (98) 7 (April 8, 1998) Council of Europe.

³⁰ Council of Europe Committee of Ministers Recommendation Rec (2006) 2 of the Committee of Ministers to Member States on the European Prison Rules (adopted January 11, 2006), para.40.3.

³¹ CPT, *3rd General Report on the CPT’s activities covering the period 1 January to 31 December 1992* (1993), para.31.

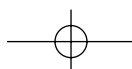
³² *ibid.*, p.30; e.g. Irish Prison Service, *Health Care Standards* (Irish Prison Service, Dublin, 2004), p.6; [UK] Department of Health, *Health Services for Prisoners: Prison Service Performance Standard No.22* (2004), p.1.

³³ Betteridge, fn.6 above, p.14.

³⁴ *ibid.*, p.14.

³⁵ International Covenant on Economic, Social and Cultural Rights (ICESCR) (adopted December 16, 1966, entered into force January 3, 1976) 993 U.N.T.S. 3, Art.12; Convention on the Rights of the Child (CRC) (adopted November 20, 1989, entered into force September 2, 1990) 1577 U.N.T.S. 3, Art.24; African Charter on Human and Peoples’ Rights (African Charter) (adopted June 27, 1981, entered into force October 21, 1986) (1982) 21 I.L.M. 58, Art.16.

³⁶ European Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR) (September 3, 1953) 213 U.N.T.S. 222, Art.3.



human rights law.³⁷ Yet despite its fundamental nature, the Court has historically been reluctant to engage Art.3 to address the question of prison conditions, particularly when it comes to enforcing positive obligations on states to provide humane standards of custody.³⁸

However, while Art.3 jurisprudence has traditionally addressed cases of deliberate ill-treatment by state actors against persons in detention, more recent case law finds the intent to inflict inhuman or degrading treatment unnecessary for a violation to occur.³⁹ This development has significant implications for applications to the Court on conditions of detention, and illustrates the expansion of the Court's approach to include not only the negative obligation of states under Art.3 to refrain from inflicting harm, but also the positive obligation to "ensure that a person is detained under conditions which are compatible with respect for his human dignity".⁴⁰ In recent years, the Court's expanded interpretation of inhuman or degrading treatment has resulted in states being found in breach of Art.3 based upon poor or inadequate conditions of confinement such as overcrowded and unsanitary conditions,⁴¹ inadequate size, lighting and ventilation,⁴² and inadequate toilet facilities.⁴³ The Court has also established that inadequate medical care can infringe Art.3.⁴⁴

The evolution of the European Court's Art.3 jurisprudence therefore provides a potential tool to advocate for the right to sterile syringes for prisoners who inject drugs. It is therefore useful to review the Court's approach to interpreting state obligations under Art.3, and how they might be engaged when addressing the issue of HIV prevention in prisons.

The positive obligation to protect the health of prisoners

Article 3 imposes upon states a positive obligation, or "duty to protect",⁴⁵ the well-being of the people it holds in custody. This "duty to protect" includes "a positive obligation to protect the physical well-being of persons deprived of their liberty",⁴⁶ a duty "to take the practical preventive measures necessary to protect the physical integrity and

³⁷ "Article 3 (Art.3) enshrines one of the fundamental values of the democratic societies making up the Council of Europe . . . and is generally recognised as the internationally accepted standard." *Soering v United Kingdom* (1989) 11 E.H.R.R. 439 at [88].

³⁸ S. Livingstone, "Prisoners' rights in the context of the European Convention on Human Rights" (2000) 2 *Punishment & Society* 309 at 321.

³⁹ *Price v United Kingdom* (2001) 34 E.H.R.R. 53 at [24]; *Melnik v Ukraine* (App. No.72286/01), judgment of March 28, 2006 at [110].

⁴⁰ *Poltoratskiy v Ukraine* (2004) 39 E.H.R.R. 43 at [132].

⁴¹ *Dougoz v Greece* (2002) 34 E.H.R.R. 61 at [45]-[46]; *Mayzit v Russia* (App. No.63378/00), judgment of January 20, 2005 at [41].

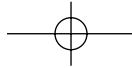
⁴² *Peers v Greece* (2001) 33 E.H.R.R. 51 at [70]; *Poltoratskiy v Ukraine* (2004) 39 E.H.R.R. 43 at [136]; *Kehayov v Bulgaria* (App. No.41035/98), judgment of January 18, 2005 at [67]-[69].

⁴³ *Peers v Greece, ibid.*, at [75]; *Kehayov v Bulgaria, ibid.*, at [71].

⁴⁴ e.g. *Mouisel v France* (2004) 38 E.H.R.R. 34; *McGlinchy v United Kingdom* (2003) 37 E.H.R.R. 41; *Melnik v Ukraine* (App. No.72286/01), judgment of March 28, 2006.

⁴⁵ *Keenan v United Kingdom* (2001) 33 E.H.R.R. 38 at [91].

⁴⁶ *Hurtado v Switzerland* (App. No.17549/90), judgment of January 28, 1994 at [79].



the health of persons who have been deprived of their liberty”,⁴⁷ and a duty to “do everything that could reasonably [be] expected . . . to prevent the occurrence of a definite and immediate risk to [a prisoner’s] physical integrity, of which [the authorities] knew or should have known”.⁴⁸

The state’s positive obligation in this regard has been affirmed by the Court in a number of cases,⁴⁹ and the jurisprudence is clear that the “duty to protect” the physical integrity of people deprived of liberty includes the obligation to provide them with health care.⁵⁰ In *Pantea v Romania*, the Court found that the “positive obligation to protect the applicant’s physical integrity” extends beyond state actors to include the obligation of authorities to provide protection against the foreseeable harmful actions of private third parties, including other prisoners.⁵¹

Significantly, the state’s positive obligation to “prevent any harm from being inflicted on [the] physical integrity”⁵² of people in detention is not lessened in circumstances where the behaviour of the prisoner in question is illegal or prohibited. The case law is clear that Art.3 protections are “absolute”, and apply “irrespective of the victim’s conduct”,⁵³ even if that conduct is unlawful or violates prison rules.⁵⁴ Therefore, the state’s positive obligation to protect the physical integrity of prisoners who inject drugs remains despite the prohibited nature of the activity, which is particularly relevant in engaging Art.3 protections in the context of prison syringe exchange.

Meeting the definition of injury or ill-treatment in Article 3

How might the Court determine whether the physical harm resulting from sharing syringes in prison constitutes a violation of Art.3? Clearly the strongest case would be if a person were HIV-negative at the time he or she was taken into custody, and was subsequently infected during the detention as a result of sharing contaminated syringes. Applying the Court’s approach in *Osman v United Kingdom*, the applicant could argue that the state had a procedural obligation to take “preventive operational

⁴⁷ *Pantea v Romania* (2005) 40 E.H.R.R. 26 at [189].

⁴⁸ *ibid.*, at [190].

⁴⁹ K.A. Reid, *A Practitioner’s Guide to the European Convention on Human Rights* (2nd edn, Thomson Sweet & Maxwell, London, 2004), p.526.

⁵⁰ e.g. *Hurtado v Switzerland* (App. No.17549/90), judgment of January 28, 1994 at [79]; *Kudla v Poland* (2000) 35 E.H.R.R. 11 at [94].

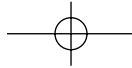
⁵¹ *Pantea v Romania* (2005) 40 E.H.R.R. 26 at [192].

⁵² *ibid.*

⁵³ *Chahal v United Kingdom* (1996) 23 E.H.R.R. 413 at [79]; see also *Kudla v Poland* (2000) 35 E.H.R.R. 11 at [90]; *Novoselov v Russia* (App. No.66460/01), judgment of June 2, 2005 at [38].

⁵⁴ *McFeeley v United Kingdom* (1981) 3 E.H.R.R. 161 at [45]–[46]. Irish Republican Army political prisoners on “dirty protest” in the Maze prison brought a case before the Commission, which included, in part, an Art.3 application. While the Commission found the Art.3 application inadmissible, it did find that the state’s duties under Art.3 exist in spite of any “self-inflicted” or “unlawful” behaviour by a person(s) in custody; see also *Iorgov v Bulgaria* (App. No.40653/98), judgment of March 11, 2004 at [85], “the applicant’s alleged rude behaviour towards medical staff and, indeed, any violation of prison rules and discipline by a detainee, can in no circumstances warrant a refusal to provide medical assistance”.





measures”—such as implementing effective HIV prevention programmes—to protect the physical well-being of the individual where it is known to be at risk.⁵⁵ This argument would be particularly resonant if the applicant were known to be an intravenous drug user by prison authorities, or if high levels of injecting drug use, HIV/Hepatitis C prevalence and/or syringe sharing in the country's prisons had been previously documented.

Whether proof of HIV infection in custody would in itself meet the “minimum level of severity”⁵⁶ set by the Court to trigger an Art.3 violation is a question that is unclear from the case law. Although the Court has found that prison conditions leading to the spread of disease can contribute to circumstances amounting to a breach of Art.3,⁵⁷ it has also found that acquiring tuberculosis (TB) while in prison is, on its own, insufficient to constitute a violation, particularly where the applicant receives medical treatment.⁵⁸ However, an applicant could make a reasonable case that infection with TB is not analogous to infection with HIV. Unlike TB, HIV is an incurable disease that is almost inevitably fatal (whether in the short, medium, or longer term). This fact would make it difficult for the Court to minimise the level of severity of the harm to an infected individual, even if treatment were provided. Also, TB is an airborne bacterium transmitted via casual contact, while HIV is transmitted through sexual or intravenous contacts where the risk of transmission can be minimised or prevented if proper measures are provided and used.

While proof of HIV infection during detention would be compelling, it can be argued that it is not necessary to meet the threshold of Art.3. The Court's jurisprudence has consistently found that “treatment is considered ‘degrading’ when it is such as to arouse in its victims feelings of fear, anguish and inferiority capable of humiliating them and possibly breaking their physical or moral resistance”.⁵⁹ It can be argued that in denying access to sterile syringes, the state creates conditions necessitating the sharing and reuse of contaminated injecting equipment among drug dependent prisoners, and with it the constant knowledge that each injection brings significant risk of infection with an incurable or fatal disease. It could be argued that the mental anguish, fear, humiliation and loss of dignity inherent under such conditions in and of itself meets the threshold of degrading treatment.

The obligation to take effective measures

In addition to its positive obligation to protect the health of prisoners, the state has a further responsibility to take effective measures to ensure this positive obligation is met.

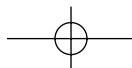
⁵⁵ *Osman v United Kingdom* (1999) 29 E.H.R.R. 45 at [115].

⁵⁶ *Ireland v United Kingdom* (1975) 2 E.H.R.R. 25 at [162].

⁵⁷ *Kalashnikov v Russia* (2003) 36 E.H.R.R. 34 at [98]. The fact that the applicant contracted a series of skin and fungal infections while incarcerated in an overcrowded prison cell was an element cited by the Court in finding the Russian Government in violation of Art.3; see also *Nevmerzhitsky v Ukraine* (App. No.54825/00), judgment of April 5, 2005 at [87].

⁵⁸ *Alver v Estonia* (App. No.64812/01), judgment of November 8, 2005 at [54].

⁵⁹ *Hurtado v Switzerland* (App. No.17549/90), judgment of January 28, 1994 at [67], citing *Ireland v United Kingdom* (1975) 2 E.H.R.R. 25 at [167] and *Soering v United Kingdom* (1989) 11 E.H.R.R. 439 at [100].



To illustrate this, it is useful to look beyond prison case law and examine other areas of the Court's jurisprudence under Art.3.

Like certain categories of prisoners, the Court has identified children as a "vulnerable" group particularly entitled to state protection.⁶⁰ In *A v United Kingdom*, which addressed corporal punishment, the Court found that Art.3, in conjunction with Art.1, "requires States to take measures designed to ensure that individuals within their jurisdiction are not subjected to torture or inhuman or degrading treatment or punishment".⁶¹ In *Z v United Kingdom*, a child neglect case, the Court affirmed this position, and further specified that Art.3, in conjunction with Art.1, requires that the measures taken should be "effective".⁶² The Court found, in this case, an Art.3 violation and specifically cited the failure of the authorities "to take any *effective steps* to bring [the ill-treatment] to an end".⁶³

Applying this approach to the issue of prisons, if Art.3 requires the state to take *effective* measures to prevent inhuman or degrading treatment, then its positive obligation to protect the health of prisoners who inject drugs is not satisfied simply by providing other forms of drug services that do not address the specific health risks posed by sharing syringes.⁶⁴ Taking effective measures, in this context, requires that prisons provide sterile syringes, as this is the intervention proven most effective at preventing the transmission of bloodborne diseases among people who inject drugs.⁶⁵ The Court's language in *Pantea*, which specified that states must take "all measures within their powers which, given reasonable consideration, would have avoided" the ill-treatment, suggests that the threshold of effectiveness of measures also applies in the prison context.⁶⁶

Vulnerability and the threshold of inhuman or degrading treatment

In recent years, the Court has demonstrated a willingness to interpret Art.3 in the context of the specific vulnerabilities of a particular detainee. In both *Keenan v United Kingdom*⁶⁷ and *Price v United Kingdom*,⁶⁸ the Court's findings of Art.3 violations were influenced by the unique vulnerabilities of the applicants in question (mental illness and physical disability respectively). In the Court's view, these vulnerabilities heightened the obligation on the state to provide adequate conditions of confinement (including health services) so as to prevent the occurrence of ill-treatment.

In *McGlinchey v United Kingdom*, the Court found the failure to provide adequate medical services to an imprisoned heroin user—a failure that resulted in her death—was

⁶⁰ *A v United Kingdom* (1998) 27 E.H.R.R. 611 at [22].

⁶¹ *ibid.*

⁶² *Z v United Kingdom* (2002) 34 E.H.R.R. 3 at [73].

⁶³ *ibid.*, at [70] (emphasis added).

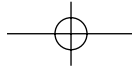
⁶⁴ e.g. drug treatment programmes, drug-free prison wings, bleach/disinfectant tablets, supply reduction efforts.

⁶⁵ WHO, fn.10 above, p.11; WHO/UNODC/UNAIDS, fn.13 above, p.2.

⁶⁶ *Pantea v Romania* (2005) 40 E.H.R.R. 26 at [190].

⁶⁷ *Keenan v United Kingdom* (2001) 33 E.H.R.R. 38.

⁶⁸ *Price v United Kingdom* (2001) 34 E.H.R.R. 53.



also a violation of Art.3.⁶⁹ If the Court were in future to interpret heroin dependency itself as constituting a special vulnerability which increases state obligations under Art.3, it would have significant implications for the possibility of a successful application on the issue of prison syringe exchange.

The *Pantea* case, in which the Court found that the vulnerability of the applicant (mental illness) obligated the state to act to prevent harm being inflicted at the hands of other prisoners, is relevant in this regard. Building on the principle established in Art.2 case law,⁷⁰ the Court's reasoning in *Pantea* suggests that the state can be held responsible for ill-treatment inflicted upon prisoners by individuals other than state actors where that harm could have been reasonably foreseen.⁷¹ Using this reasoning, if the state has an obligation to protect persons in custody against foreseeable harm from other prisoners, it can be argued that this obligation extends to protection against HIV or Hepatitis C infection via contaminated syringes.

Just as the Court found that prison authorities in Romania should have been aware that Mr Pantea was at risk of harm from other prisoners based upon his special vulnerability, it can be argued that prison authorities in countries with high levels of injecting drug use in prison should be able reasonably to foresee that a prisoner with a history of intravenous drug use has a unique vulnerability to injecting drugs inside the prison—a practice necessitating the sharing of syringes. Given evidence that large numbers of prisoners in some countries inject drugs for the first time while incarcerated, it could be argued that this vulnerability is not limited only to people with pre-existing injecting histories.

Engaging a right to sterile syringes under Article 3

Successfully arguing that the state's obligation to protect the health of prisoners includes providing access to syringe programmes would require the Court to interpret circumstances that in the past might not been judged as amounting to inhuman or degrading treatment (the denial of sterile syringes) as constituting a violation of Art.3 in light of present day knowledge and standards. Therefore, it would be essential that the Court's approach follow the evolutive principle, and consider Art.3 as a "living instrument which must be interpreted in light of present day conditions".⁷²

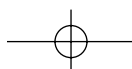
While the applicant would be seeking to provide a basis for the Court to interpret the Convention in this manner, the state would be seeking to protect against encroachment into domestic policy and legislation. The state can be expected to rely upon arguments rooted in public safety and security, areas in which the Court has traditionally been inclined to allow a significant margin of appreciation to the authorities. In response,

⁶⁹ *McGlinchy v United Kingdom* (2003) 37 E.H.R.R. 41.

⁷⁰ *Osman v United Kingdom* (1999) 29 E.H.R.R. 45.

⁷¹ Prior to being applied to prisoners in *Pantea v Romania* (2005) 40 E.H.R.R. 26, the obligation to prevent the infliction of inhuman or degrading treatment by private non-state actors was cited by the Court in Art.3 applications pertaining to deportations (*HLR v France* (1997) 26 E.H.R.R. 29 at [40]) and the protection of children (*A v United Kingdom* (1998) 27 E.H.R.R. 611 at [22]; *Z v United Kingdom* (2002) 34 E.H.R.R. 3 at [73]).

⁷² *Selmouni v France* (1999) 29 E.H.R.R. 403 at [101].



an applicant would need to provide a basis for the Court to understand the issue of injecting drug use and HIV prevention in prisons within the broad context of current health research and human rights discourse rather than the narrow context of domestic policy and security.

The state might argue that the denial of sterile syringes does not constitute inhuman or degrading treatment as defined in Art.3. The Court has stated that in order for circumstances to constitute inhuman or degrading treatment, "[t]he suffering and humiliation involved must ... go beyond that inevitable element of suffering or humiliation connected with a given form of legitimate treatment or punishment".⁷³ The state may therefore make the case that its prohibition of syringe exchange does not exceed "the practical demands of imprisonment".⁷⁴ Expecting that prisoners refrain from using illegal drugs is a legitimate aim of imprisonment, and the decision against providing sterile syringes in this context is therefore part of a reasonable punishment, not an undue limitation on the rights guaranteed under the Convention. The state might also contend that its positive obligation to protect the well-being of prisoners does not extend to providing sterile injecting equipment because drug use is an illegal activity and a form of self-inflicted harm. Any ill-health effects suffered, such as HIV infection, are therefore the result of the applicant's own actions for which the state is not accountable.

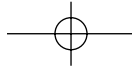
In response, an applicant can argue that the state's drug-free prisons aspirations do not override its positive obligation to protect the health of people in detention, and its requirement to take effective measures to do so. Nor does the prohibited or illegal nature of the activity reduce the state's positive obligations in this regard. The applicant could make a reasonable case that the provision of syringe exchange in no way conflicts with a drug-free policy, as illustrated by the operation of state-funded needle exchange programmes in countries across Europe in a legislative context where drug use remains illegal.

The applicant could also argue that despite existing drug-free policies, there is extensive scientific evidence of intravenous drug use, syringe sharing, HIV and Hepatitis C prevalence, and HIV/Hepatitis C transmission resulting from unsafe injecting in many European prison systems. This body of research makes it difficult for the state to suggest that a totally drug-free prison is even a realistic proposition, let alone one that addresses the risks to health from unsafe injecting in a manner consistent with its positive obligations under Art.3. Therefore, it follows that a state's obligations under the Convention should be interpreted in light of this scientific evidence, which comprises a pressing social need in the particular context of HIV/AIDS (an incurable disease easily and rapidly spread via shared syringes). It is reasonable to argue, against this backdrop, that the state's failure to provide prisoners who inject drugs with an effective means to protect themselves from HIV or Hepatitis C infection constitutes a violation of Art.3.

The state might argue that the decision to provide prisoners with sterile syringes is a matter of domestic policy in which the Court should not intervene. Furthermore, it could suggest that the small number of European states providing syringe exchange programmes in prisons illustrates the "existence of little common ground between

⁷³ *Kalashnikov v Russia* (2003) 36 E.H.R.R. 34 at [95].

⁷⁴ *Kudla v Poland* (2000) 35 E.H.R.R. 11 at [94].



the Contracting States” on this issue, and that as a result it is “an area in which [the Contracting States] enjoy a wide margin of appreciation”.⁷⁵

An applicant could respond that, although prison syringe exchange programmes are currently available in only five Council of Europe countries, the right of prisoners to access a standard of health care equivalent to that in the outside community without discrimination is recognised throughout Europe and internationally. Therefore, the failure of the state to provide prisoners with access to syringe exchange programmes, and the human rights issues engaged by this failure, should be considered in this wider context.

In assessing whether ill-treatment constitutes a violation of Art.3, the Court has stated that it “cannot but be influenced by the developments and commonly accepted standards in the penal policy of the member States of the Council of Europe”.⁷⁶ In recent years, the Court has also considered human rights reports and guidelines from various external expert bodies—including the CPT,⁷⁷ the WHO,⁷⁸ and the *International Guidelines on HIV/AIDS and Human Rights*⁷⁹—in its deliberations. This provides a reasonable basis for an applicant to suggest that the Court take international declarations and guidelines on HIV/AIDS and prisons into consideration when adjudicating the issue of prison needle exchange. On this basis, an applicant could argue that the Court should interpret the state’s margin of appreciation within the international consensus on health and human rights norms, including the principle of equivalence, rather than the number of prison systems that have acted to meet these standards.

The Court has previously found that Convention violations “may arise” in circumstances where the “State put an individual’s life at risk through the denial of health care which they have undertaken to make available to the population generally”.⁸⁰ It can therefore be argued that the fact that syringe exchange programmes are not the norm in European prisons, despite their wide availability outside prisons, is a reflection of the failure of states to meet international standards of prison health care, thereby placing the health of a vulnerable group at unnecessary risk.

The state’s likely counterargument would be that provision of sterile syringes to prisoners would create an undue security risk, jeopardising the safety of prison staff. A Court which found in favour of the applicant would, contrary to the existing jurisprudence, “impose on the authorities an intolerable or excessive burden”.⁸¹

The applicant could respond with reference to existing research showing there to be no evidence in support of the contention that prison syringe exchange programmes have negative outcomes on health or institutional security. Evaluations of existing prison syringe exchange programmes find they reduce the sharing of syringes and the

⁷⁵ *Cossey v United Kingdom* (1990) 13 E.H.R.R. 622 at [40].

⁷⁶ *Tyrer v United Kingdom* (1978) 2 E.H.R.R. 1 at [31]. See also *Soering v United Kingdom* (1989) 11 E.H.R.R. 439 at [102]; *Öcalan v Turkey* (2003) 37 E.H.R.R. 10 at [194].

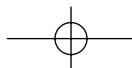
⁷⁷ e.g. *Henaf v France* (2005) 40 E.H.R.R. 44; *Kalashnikov v Russia* (2003) 36 E.H.R.R. 34; *Poltoratskiy v Ukraine* (2004) 39 E.H.R.R. 43; *Kehayov v Bulgaria* (App. No.41035/98), judgment of January 18, 2005; *II v Bulgaria* (App. No.44082/98), judgment of June 9, 2005.

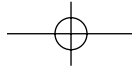
⁷⁸ *D v United Kingdom* (1997) 24 E.H.R.R. 423 at [32]–[33].

⁷⁹ *Enhorn v Sweden* (2005) 41 E.H.R.R. 30 at [29].

⁸⁰ *Cyprus v Turkey* (2002) 23 E.H.R.R. 244 at [219].

⁸¹ *Pantea v Romania* (2005) 40 E.H.R.R. 26 at [189].





transmission of bloodborne infections,⁸² improve workplace safety for prison staff, do not compromise institutional safety, and do not lead to an increase in drug use or drug injecting.⁸³ Therefore, it can be argued, the evidence does not support the state's contention that implementing syringe exchange would constitute an "undue burden". Lastly, the Court's jurisprudence is also clear that the financial constraints of a state cannot excuse prison conditions found to be in violation of Art.3,⁸⁴ and, it follows, as a basis to defend the lack of provision of these health programmes.

Conclusion

John Shelley's case before the UK courts was dismissed in April 2005.⁸⁵ This decision illustrates the barriers to mounting an effective case on the issue of prison needle exchange. As Malkin has noted, bringing a successful case in the courts would be a challenging endeavour:

"Establishing a breach of duty—a failure to exercise the degree of care that is reasonable in the circumstances—may be difficult. The central question is: what constitutes reasonable behaviour on the part of prison authorities? Answering it requires authorities to abandon arguments drawn from moralizing and breast-beating, compelling them to engage in a dialogue embracing notions of responsibility, practicality, and confrontation of harm and danger."⁸⁶

It is likely that these same challenges would exist at the level of the European Court.

While a survey of the Court's jurisprudence reveals a tendency to allow states a wide margin of appreciation on issues of prison conditions, recent case law demonstrates a more vigorous approach where poor conditions of confinement and inadequate prison health services are raised. This provides a basis for the Court to consider an application on the issue of needle exchange in prisons under Art.3 protections. Indeed, as Valette argues, Art.3 has the potential to be used to promote the provision of HIV prevention measures to prisoners. She notes that in failing to provide such measures, "a state not only violates the right of prisoners to health care, including against the transmission of diseases, but it also puts their lives and dignity at stake by exposing them to contracting a fatal diseases".⁸⁷ Valette concludes, "the ECHR may be used to prevent AIDS-related violations of human rights in prisons".⁸⁸

⁸² See H. Stöver and J. Nelles, "10 years of experience with needle and syringe exchange programmes in European prisons: A review of different evaluation studies" (2003) 14 *International Journal of Drug Policy* 437.

⁸³ *ibid.*; Lines, fn.11 above.

⁸⁴ *Poltoratskiy v Ukraine* (2004) 39 E.H.R.R. 43 at [148].

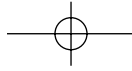
⁸⁵ *Shelley v Secretary of State for the Home Department* [2005] EWHC 1890. In September 2006, the case was ruled admissible by the European Court of Human Rights, which will hear the case in 2007.

⁸⁶ I. Malkin, "The Role of the Law of Negligence in Preventing Prisoners' Exposure to HIV While in Custody" in Jürgens, fn.8 above, apps 1, 6.

⁸⁷ Valette, fn.6 above, p.116.

⁸⁸ *ibid.*, p.119.





80 Injecting Reason

Foster agrees that Art.3 has “enormous potential ... [for] prisoners who wish to challenge the compatibility of their conditions of incarceration with the general human rights standards laid down by the Convention”.⁸⁹ However, he cautions:

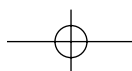
“Despite the absolute character of Art.3, the lack of uniform standards and practices on matters such as sentencing, security, and prison resources will lead to a wide margin of appreciation, in turn producing unpredictable case law. As a consequence of this deference, the ECtHR appears reluctant to make an authoritative ruling on specific aspects of prison conditions.”⁹⁰

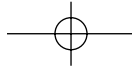
This reluctance might be even more pronounced in a ruling on an issue as controversial as providing sterile syringes to people in prison.

However, the Court’s recent willingness to find states in violation of Art.3 based solely upon poor prison conditions or poor standards of prison medical care—as well as the expanding body of jurisprudence underpinning the states’ positive obligation to protect the health of people in detention—suggests that the ECHR is a potential tool to advocate successfully for access to syringe exchange programmes for prisoners who inject drugs. A positive decision in such a case would not only help secure the rights of a most vulnerable population of people, but also make a significant contribution to the fight against HIV/AIDS across the region.

⁸⁹ S. Foster, “Prison Conditions, Human Rights and Article 3 ECHR” [2005] P.L. 35.

⁹⁰ *ibid.*, p.42.





QUERIES TO SWEET & MAXWELL

Q1. Kindly check and confirm the short title.

