

BETWEEN:

John SHELLEY

Applicant

- and -

THE UNITED KINGDOM

Respondent Government

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**RESPONSE OF THE INTERVENORS**  
**the IRISH PENAL REFORM TRUST and the CANADIAN HIV/AIDS LEGAL NETWORK**  
**to the OBSERVATIONS OF THE GOVERNMENT OF THE**  
**UNITED KINGDOM ON ADMISSIBILITY AND MERITS**

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1. The Irish Penal Reform Trust (“IPRT”) and the Canadian HIV/AIDS Legal Network (“Legal Network”) respectfully submit that the submission of the UK Government (‘Respondent’) contains numerous factual errors concerning: (1) the evidence of injecting drug use and the sharing of syringes in prisons; (2) the evidence and current status of prison needle exchange programmes (“PNEPs”) internationally; (3) the efficacy of bleach/disinfectants as an HIV and HCV prevention measure; and (4) the security risks posed by PNEPs. These factual errors are repeated throughout the Respondent’s submission, which fails to provide any documentation or scientific evidence in support of such assertions of fact. The result is a deeply flawed and inaccurate portrayal of PNEPs as they have existed for years in numerous countries, and the public health and legal rationales supporting such programmes. This submission addresses the inaccuracies and failings in the Respondent’s submission. Moreover, we argue that the failure to provide PNEP undermines the legitimate aims identified by the UK government, which it claims are central to its current policy in relation to injecting drug use and health in prison.

Factual errors regarding the current status of injecting drug use in prisons

2. The Respondent claims that there is “powerful evidence that the vast majority of injectors cease injecting when they are in prison” (at para. 20, and repeated at para. 35.3). As detailed in paras. 6 to 9 of our original submission as intervenors, research from countries across Contracting States demonstrates that: (1) significant numbers (0.3 to 34%, depending on the country and study) of prisoners in the European Union and Norway continue to inject drugs while incarcerated; and (2) a significant percentage (0.4 to 21%, depending on the country and study) of prisoners who inject drugs *inject illicit drugs for the first time in their lives* while incarcerated.
3. The fact that some people cease injecting upon incarceration does not undercut the position that the health and human rights of those people who do inject while in prison are deleteriously affected by the lack of PNEPs. The failure to provide PNEPs to prisoners who do inject creates an undeniable public health risk. Research has demonstrated that incarceration affects patterns of injecting and decisions about injecting in various ways, often with the result of increasing the risk of transmission of HIV and other blood-borne diseases (at paras. 6 to 9 of our submission). Moreover, the human rights guarantees in the *Convention for the Protection of Human Rights and Fundamental Freedoms* (“*European Convention on Human Rights*”) are guaranteed to individuals

*qua* individuals; the fact that many people cease injecting in prison is irrelevant to the determination of whether the human rights of individuals who inject in prison have been infringed.

4. In para. 20, the Respondent claims that “concerns amongst inmates...about infectious diseases” is a factor in decision-making about drug injecting in prisons. The Respondent provides no evidence of this. Nonetheless, the Respondent theorizes at para. 21 that the provision of PNEPs would reduce this “disincentive” and therefore make injecting more prevalent. This theory is demonstrably false, and is refuted by the scientific evidence of PNEPs in operation, showing that the introduction of sterile syringes in prisons in Contracting States has not resulted in either an increase in drug use or drug injecting (at paras. 19 and 20 of our submission).
5. Finally, even if the Respondent were to provide some scientific evidence in support of its theory, it would be irrelevant to the legal issues involved in this case. As argued in paras. 29, 32 and 35 of our submission, the state’s aspiration to create a drug-free environment does not over-ride its positive obligations under Arts. 2 and 3 of the *European Convention* to safeguard and protect the lives and well-being of persons it holds in detention, even where the activity in question is prohibited or in violation of prison rules.

#### Factual errors regarding PNEPs internationally

6. The Respondent states that “As is the position in all other Contracting States, the [UK] policy does not involve the provision in all prisons of ‘needle exchange’ schemes” (at para. 13). This statement, repeated at paras. 26.1 and 36, is false. As detailed at para. 21 of our submission, the Government of Spain has directed the implementation of PNEPs in all prisons. Although full completion of this directive is not yet complete, the number of prisons with PNEPs has been growing steadily, and by January 2006 programmes had been established in 38 of the country’s 69 prisons.<sup>1</sup> Luxembourg has PNEPs operating in the country’s only major penitentiary, representing implementation for the majority of prisoners in its system.<sup>2</sup> Although they are not Contracting States, it is worth noting that in Kyrgyzstan, PNEPs are currently in operation in all eleven of the country’s prisons,<sup>3</sup> and in Belarus, the Ministry of the Interior has stated its willingness to extend PNEPs into all prisons in the country.<sup>4</sup>
7. The Respondent describes the scope of PNEPs internationally as being limited to “trials” and “pilot schemes” (at paras. 25 and 36). This statement is false. In fact, the evidence demonstrates that over the past decade there has been a steady growth in acceptance and implementation PNEPs. As detailed in paras. 4, 5 and 15 of our submission, since the first PNEP was introduced in Switzerland in 1992, the number of countries that have introduced them has steadily grown, and the number of prisons with PNEPs within states that have introduced these programmes has steadily expanded. In some countries, including some Contracting States, PNEPs are in operation in a significant percentage of all prisons (i.e. Spain – 38 of 69 prisons with PNEP, Moldova – 7 of 19 prisons, Luxembourg – 1 of 2 prisons, Kyrgyzstan – 11 of 11 prisons). In countries where PNEPs are in operation in only a small number of prisons, such as Germany (1 prison) and Switzerland (7 prisons), these programmes have been in operation since the 1990s, and represent part of the mainstream prison health services in those institutions, rather than “trials”.
8. It is true that PNEPs are not currently the norm across all Contracting States. Indeed, the provision of bleach/disinfectants and methadone were equally controversial at one time, and as a result not the norm across Europe. Yet these programmes are now available in prison systems across the region, including England and Wales, and reflect the European mainstream in prison health services. This illustrates not only the reality that controversial programmes can be implemented in

prisons across Contracting States, but that programmes now seen as controversial often eventually become less so over time.

9. More fundamentally, while the controversial nature of PNEP may be a factor inhibiting their implementation in some countries, we respectfully submit that this should not be a factor in the Court's consideration of this issue. The Court is regularly called upon to decide controversial issues. Human rights guarantees are not dependent upon their acceptance by governments or public opinion. Therefore, the Respondent should not be permitted to justify the denial of the rights of persons in detention because fulfilling those rights might prove unpopular with the public.

#### Factual errors regarding the efficacy of bleach/disinfectants

10. The Respondent states that "Disinfectant tablets are an effective way of significantly reducing the risks associated with injecting drug." (at para. 22). As detailed extensively in paras. 11 to 13 of our submission, the provision of bleach is only of limited efficacy in preventing the transmission of HIV, and indeed may offer little or no protection against hepatitis C. For these reasons, bleach and disinfectant tablets are identified as, at best, a "second-line strategy" by both the World Health Organization and the UK Department of Health, and not a substitution for syringe exchange programmes.
11. In addition to being factually inaccurate, the Respondent's promotion of the supposed efficacy of bleach/disinfectants contradicts its theory, expressed at para. 21 of its submission, that fear of HIV or HCV infection "operate as powerful disincentives to injecting drugs in prison", and therefore that PNEP is unwarranted or ill-advised. If the Respondent believes: (a) this "disincentive" theory to be true, and (b) that "Disinfectant tablets are an effective way of significantly reducing the risks associated with injecting drugs" (at para. 22), then surely it is admitting that current UK prison policy to provide disinfectants must necessarily promote injecting in prisons. If so, its opposition to implementing PNEPs on this basis is logically unsound.

#### Factual errors regarding the record of safety of PNEPs

12. Throughout its submission, the Respondent makes numerous undocumented and unsubstantiated claims that the provision of PNEPs represents an unacceptable security risk (at paras. 24, 32, 33, 35.4, 35.5). As discussed in detail in our submission, at paras. 18 to 20, the issue of safety and security of PNEPs is one that has been studied and monitored in detail in states providing these programmes, and the operational experience without exception refutes the Respondent's claims in this regard.
13. The Legal Network's comprehensive review of the experience of PNEPs in six countries failed to identify a single instance where a syringe obtained through a prison needle exchange programme was used as a weapon either against prison personnel or other prisoners.<sup>5</sup> On the contrary, this report concluded that PNEPs resulted in increased institutional safety, and a decrease in accidental needle-stick injuries to staff, as the once chaotic and unregulated circulation of dirty syringes in the prison was now controlled, sterile programme syringes were stored safely and visibly rather than hidden, and used syringes were disposed of in a safe and hygienic manner.
14. More recently, the report of the Public Health Agency of Canada ("PHAC") prepared for the Correctional Service of Canada concluded that the current body of evidence indicates that PNEPs did not result in: (1) PNEP syringes being used as weapons; (2) increased institutional violence; or (3) increased needle-stick injuries to staff. Moreover, the PHAC report concluded that prison staff

in institutions with PNEPs see such programmes as an important and necessary addition to a range of harm reduction services and health and safety interventions.

15. To support its concerns, the Respondent claims that PNEPs would increase the number of syringes in circulation (at para. 24). It is axiomatic that PNEPs increase the number of syringes in circulation (whether in prisons or in the community), as the goal of this health intervention is to ensure that each person injecting drugs is provided with his/her own sterile syringe that is not shared with anyone else. In this manner, rather than ten prisoners injecting with a single shared syringe, an effectively operating PNEP would ensure that each person had his/her own syringe that was not shared (i.e. ten individual sterile syringes vs. one syringe shared ten times) which were then disposed of in a safe manner after use, rather than hidden for reuse at a later time. Far from being problematic, this outcome is the objective of syringe exchange programmes, both in prisons and in the wider community. For the Respondent to suggest that the very measure of the programme's effectiveness (i.e. ensuring each injector uses a single, sterile and unique syringe) is an illustration of a programmatic failing displays a remarkable lack of understanding of the goals, objectives and methods of these interventions.
16. While staff and prisoner safety must be taken into consideration when designing and implementing a programme appropriate to the environment of each institution, the evidence over more than a decade of operational experience in dozens of prisons in several Contracting States completely refutes the Respondent's theory that PNEPs lead to increased prison violence or create any added safety risk to prisoners or prison staff. Despite repeating this theory several times in its submission, the Respondent does not offer one piece of documentary evidence supporting this claim, or to refute the body of research to the contrary cited in our submission. For this reason, as well as those outlined in para. 34 of our submission, we thoroughly reject the Respondent's suggestion at para. 33 that it should be allowed a wide margin of appreciation in this case.

### Conclusion

17. The Respondent describes current UK policy denying PNEPs as pursuing three legitimate aims: (a) "to provide an effective form of protection for those who inject drugs in prison, thereby safeguarding their health", (b) "not to facilitate the...sharing of syringes", and (c) "to take into account both the the health need of those who inject drugs and those who come into contact with them, and the needs of security" (at para. 34). In fact, rather than pursuing these legitimate aims, the failure of the UK government to provide PNEP defeats each and every one.
18. Regarding point (a), it is oxymoronic to suggest that denying people access to the means to protect themselves from HIV/HCV infection is "to provide an effective form of protection". The Respondent in essence argues that the denial of prevention measures is a prevention measure. On the contrary, in order for the Respondent to achieve this legitimate aim of "safeguarding" the health of prisoners, it must provide access to those HIV/HCV prevention measures which have been medically and scientifically proven to be most effective in preventing the transmission of blood-borne viruses, namely programmes ensuring access to sterile syringes.
19. Regarding point (b), rather than preventing the sharing of syringes, current UK prison policy promotes the sharing and reuse of used syringes by denying prisoners who inject drugs access to sterile syringes. To put it another way, current UK policy ensures that prisoners who inject illicit drugs have no option but to share or reuse syringes obtained on the prison black-market as they cannot obtain sterile syringes. Again, current UK policy is therefore the complete opposite of its stated aim.

20. Regarding point (c), the failure to implement PNEPs does not promote the health of prisoners or prison staff, or the needs of prison security. The lack of PNEP increases the likelihood of HIV and HCV transmission via sharing used syringes, with the potential for serious outbreaks of infection (as detailed at para. 7 of our submission). In addition, the evidence from PNEPs, as reviewed in paras. 14 to 17 of our submission, shows that these programmes: (1) decrease needle-sharing practices among prisoners; (2) increase referrals of prisoners to drug addiction treatment programmes; (3) decrease need for healthcare interventions related to injection-site abscesses; and (4) decrease the number of overdose-related healthcare interventions and deaths. We submit that denying people in prison these proven health benefits ignores the needs of prisoners who inject drugs, and those of other prisoners and staff around them, rather than taking them into account.
21. Furthermore, as described in paras. 9 to 11 above, the operational experience of PNEPs is that they do not increase security problems or violence, but do yield a tangible increase in staff safety through a dramatic reduction in accidental needle-stick injuries. Current UK policy denying PNEP ensures that: (a) syringes in prisons are smuggled in and circulated in an uncontrolled fashion, rather than being regulated by prison health services; (b) smuggled syringes are hidden after use, rather than being disposed of in a safe manner, thereby increasing the likelihood of accidental needle stick injuries to staff and prisoners; and (c) the syringes in circulation in the prison have been used by multiple people and likely contaminated with disease, rather than sterile or used only once by a single person. It therefore cannot be argued that denying PNEP takes into account the needs of security. Rather, the current UK policy in this regard increases risk of illness and injury to prison staff and prisoners — an outcome completely opposite to the stated aim of the policy.

Respectfully submitted this 9<sup>th</sup> day of February, 2007  
by the Irish Penal Reform Trust and the Canadian HIV/AIDS Legal Network

## References

<sup>1</sup> R. Lines *et al.*, *Prison Needle Exchange: Lessons from a Comprehensive Review of International Evidence and Experience*, 2<sup>nd</sup> ed. (Canadian HIV/AIDS Legal Network, 2006) [Intervenors' Book of Authorities, Tab 1]

<sup>2</sup> PNEP has been established in Luxembourg's only major penitentiary in Schressig (population almost 700 prisoners) since August 2005. The only other penal institution in the country is a small (capacity 90 prisoners) half-open prison, where officials are considering implementing PNEP as well: Dr. Joseph Schlink, Private Correspondence, 13 June 2006 (on file).

<sup>3</sup> Lines *et al.*, *Prison Needle Exchange*, *supra* note 1.

<sup>4</sup> [original source(s) re Belarus], cited in Lines *et al.*, *Prison Needle Exchange*, *supra* note 1.

<sup>5</sup> Lines *et al.*, *Prison Needle Exchange*, *supra* note 1.