



Royal College of
General Practitioners

Equivalence of care in Secure Environments in the UK

Position statement | July 2018

Secure Environments Group

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1. Introduction

The Royal College of General Practitioners Secure Environments Group is committed to the delivery of health care in the health and justice system to prisoners and detainees which is of the highest possible standards. It is well recognised from a legal perspective at international, regional (European) and local (UK) levels that health care provision in secure environments should be of an ‘equivalent’ standard to that provided in the wider community. We recognise the benefit to our patient group by striving for ‘equivalent’ care and furthermore recognise the benefits this provides to our society as a whole.

At present, there is no resource setting out how equivalent care should be defined, measured or compared within the secure setting to that in the wider community and importantly this has implications where there are or have been specific limitations or variations in the care being provided within the secure setting.

It must be recognised that there are aspects of care provision within secure settings that require a different approach or service model than would otherwise be available in the wider community. It must also be recognised that within the community setting there will be considerable variation in the provision and availability of services for a number of demographic reasons. It therefore stands to reason that on occasion the care provided in a secure settings may be *at least* equivalent to that available in the wider community.

This paper will set out the salient literature containing the historical and current ethical and legal context in which the concept of ‘equivalence’ has evolved and provide a working definition of ‘equivalence’ in order that further discussion and refinement can take place. Reference is made to quoted material where text has been italicised.

2. The Definition

‘Equivalence’ is the principle by which the statutory, strategic and ethical objectives are met by the health and justice organisations (with responsibility for commissioning and delivering services within a secure setting) with the aim of ensuring that people detained in secure environments are afforded provision of or access to appropriate services or treatment (based on assessed need and in line with current national or evidence-based guidelines) and that this is considered to be at least consistent in range and quality (availability, accessibility and acceptability) with that available to the wider community in order to achieve equitable health outcomes.

3. Context

It is important to note that ‘equivalence’ does not mean that care provision in secure environments should be ‘the same’ as that provided in the community.

It is well understood that those who are responsible for providing care in the secure and detained setting owe a ‘duty of care’ to that individual or group and in that way must accommodate that duty within their decision making in providing the care necessary for that individual or group.

It is recognised that there are variations in the care provided within the community setting, for example between different providers and for a variety of reasons, including patient demography, social and political factors. Inevitably, it can be also seen that variations in the care provided across secure settings also exist for these and additional reasons, such as role and status of a given secure environment (i.e. type of prison category, level of security and the profile of the detained population).

It can be seen that with regards to some conditions that ‘equivalence’ could and should be easily obtainable, for example in the treatment of hypertension where there would be no obvious reasons to provide a variation in practice. Where the consideration of ‘equivalence’ becomes more pertinent is where the provision of healthcare is in some way constrained or altered by the regime, its processes or other factors which could have an impact on care delivery. For example, a patient suffering from a suspected fracture in a secure setting will not normally be able to choose to take themselves to the local Emergency Department and therefore the model of care needs to be adapted to take into account this and additional factors to achieve the appropriate outcome. It also stands to reason that a person’s care needs thus becomes more complex and the more the potential for conflict between the health and security provision may arise.

It is well recognised that health care providers need to tailor the care to their patients in secure settings with regard to specific needs. For example, access to structured substance misuse and alcohol treatment (including acute detoxification), mental

health in-reach, on-site dentistry, blood-borne virus screening, sexual health, immunisations, suicide prevention, emergency care are all considered to be necessary provisions in the secure setting. Pharmacy services have evolved to provide on-site access to clinical pharmacist and/or wider pharmacy services in order to help address poly-pharmacy and develop safer prescribing practices.

The requirement for the integrity of security of an establishment is not the direct responsibility of the health care provider, that is largely for the establishment authority. However, inevitably, there will be areas where health care provision has an impact upon security decisions.

Therefore, health care providers have a duty to understand and acknowledge the potential impact of their actions and thus work with their security colleagues to find appropriate solutions. Some examples where security and health care provision may conflict with one another include prescribed medications (which may be diverted or misused) and the availability and access for detainees requiring care outside of the secure establishment. These constraints may be further compounded by other regime elements including heightened security levels or the need to need remove a person from association (sometimes known as segregation).

Ultimately, the goal of providing 'equivalent' care requires partnership working between the healthcare providers and security authorities and where possible, by integration with community services. This multidisciplinary, integrative working is seen as the optimum way for achieving equivalent care and managing the relevant risks, but must also be considered within the context of maintaining patient confidentiality.

Development of a working definition of 'equivalence' is a necessary starting point for us as stakeholders so that we can further set out evidence-based strategic aims, development of guidance and objectives for health outcomes.

4. Health Service provision in prisons in the UK

In 1996, Her Majesty's Inspectorate of Prisons for Her Majesty's Chief Inspector of Prisons, Sir David Ramsbotham published his paper *Patient or Prisoner?*¹ in which his terms of reference were: *'to consider health care arrangements in Prison Service establishments in England and Wales with a view to ensuring that prisoners are given access to the same quality and range of health care services as the general public receives from the National Health Service.'* The key recommendation made in this paper was that: *'the National Health Service should assume responsibility for the delivery of all health care... only in this way can consistency of delivery to everyone in the community, in or out of prison, be ensured.'* Sir David highlighted in his introduction that *failure to provide the same level of health care whilst in prison could 'put society at risk.'*

In 1999, in the report by the Joint Prison Service and National Health Service Executive Working Group: *The Future Organisation of Prison Health Care*,² Sir David's recommendation was considered and endorsed *'to give prisoners access to the same quality and range of health care services as the general public receives from the National Health Service.'* In chapter 3 of this paper, equivalence of care is considered in more detail, but is not fully defined:



What exactly does equivalence mean? The European Prison rules – drawing on the UN Standard Minimum Rules for the Treatment of Prisoners – state that 'The [prison] medical services should be organised in close relation with the health administration of the community or nation. This clearly implies that in the UK provision of prison health services should be closely aligned with the NHS. The HAC [Health Advisory Committee] has in 'The Provision of Mental Health Care in Prisons' examined the concept of equivalence as it applies to mental health care in prisons. Their view is that equivalence means equivalent health policy, equivalent standards and equivalent delivery of health care. Government White Papers about health care in England and Wales consider the health of the population as a whole and do not do not make a distinction between prisoners and the rest of the community. Being in prison therefore should not remove the rights of prisoners to receive good health care. ...

... Prisons should not, either by acts of omission or commission, make it more likely that people become ill, experience a deterioration in their health status, or have access to substandard health care services in comparison to those available in the community. For this reason the principle of equivalence in health care policy, standards and delivery described by the HAC underpins the work presented in this report and is the basis for all its recommendations. ”

The NHS Constitution for England Principle 1: The NHS provides a comprehensive service available to all³

“

The NHS provides a comprehensive service, available to all irrespective of gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity, or marital or civil partnership status. The service is designed to improve, prevent, diagnose and treat both physical and mental health problems with equal regard. It has a duty to each and every individual that it serves and must respect their human rights. At the same time, it has a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population... Legal duties require NHS England and each clinical commissioning group to have regard to the need to reduce inequalities in access to health services and the outcomes achieved for patients. This principle is mindful of the NHS' integral role in alleviating health inequalities, which can be defined as 'differences in health status or in the distribution of health determinants between different population groups.' The Principle makes clear that the NHS has a 'wider social duty to promote equality through the services it provides. ”

The NHS Constitution Principle 5: The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population



This principle makes clear that patient interest comes before institutional interest, and that organisations involved in delivering NHS services (including local authority public health services) must work with each other and with other organisations if they are to achieve genuine improvements in the population's health and wellbeing... The NHS should also work with other public sector organisations, for example, the police and criminal justice system, as well as private and voluntary sector organisations. ”

The National Partnership Agreement between between the Department of Health and the Home Office for the accountability and commissioning of health services for prisoners in public sector prisons in England, January 2007⁴



The National Partnership Agreement (NPA) is an over-arching agreement between the Secretary of State for Health and the Home Secretary for and on behalf of Her Majesty's Prison Service (HMPS). It is intended to underpin and complement the local partnership arrangements between NHS Primary Care Trusts (PCTs) and public sector prisons within the Prison Service (HMPS). In September 2002, Ministers announced the decision to transfer the budgetary responsibility for prison health from HM Prison Service, an executive agency of the Home Office, to the Department of Health. From April 2003, the Secretary of State for Health assumed responsibility from the Home Secretary for securing a full range of health services for prisoners under Section 3 of the NHS Act 1977. The Secretary of State for Health delegated responsibility for commissioning health services to NHS Primary Care Trusts on a rolling programme starting from April 2004 with full devolution of commissioning responsibility to PCTs by April 2006. This document is intended to cover accountability and commissioning for health services for prisoners from April 2006, when transfer of commissioning responsibility for services from HMPS to NHS Primary Care Trusts will be complete... ”

The National Partnership Agreement: The National Offender Management Service, NHS England and Public Health England for the Co-Commissioning and Delivery of Healthcare Services in Prisons in England 2015–2016⁵



This is an update of the tripartite agreement first published in October 2013. It sets out the shared strategic intentions, joint corporate commitments and mutually agreed developmental priorities for the National Offender Management Service (NOMS), NHS England and Public Health England (PHE) in relation to commissioning and delivering healthcare services in adult prisons in England to April 2016

...

2.2. Prisoners should receive an equivalent health and wellbeing service to that available to the general population with access to services based on need. ”

The National Partnership Agreement: National Partnership Agreement for Prison Healthcare in England — Ministry of Justice, Her Majesty’s Prison and Probation Service, Public Health England, the Department of Health & Social Care, and NHS England — 2018–2021⁶



We recognise our respective statutory responsibilities and independence, but we must work together to ensure safe, legal, decent and effective care that improves health outcomes for prisoners, reduces health inequalities (particularly for those with protected characteristics), protects the public and reduces reoffending. We commit to collaborate and cooperate at all levels within our organisations to achieve our shared priorities and deliver our joint workplan... ”

The Care Quality Commission's document on how CQC regulates Health and social care in prisons and young offender institutions, and health care in immigration removal centres, July 2015⁷



CQC's role in monitoring, inspecting and regulating health care in secure settings is important. People who use services in secure settings are generally more vulnerable because they rely on authorities for their safety, care and wellbeing, and they are unable to choose their place of care. It is our responsibility, working with Her Majesty's Inspectorate of Prisons (HMIP), to ensure that detainees are safeguarded against ill treatment and receive the same quality of care as the rest of the population. Our new approach to regulating care in prisons, young offender institutions and immigration removal centres will support CQC and HMIP to develop a holistic and coherent view of health within these settings. CQC will hold providers to account but we will also work together with HMIP to identify wider health issues within secure settings. This will be facilitated by the strong working relationship we have with HMIP in this sector... ”

— Foreword from CQC's Chief Inspector of Primary Medical Services and Integrated Care, Professor Steve Field



Good healthcare that is equivalent to that available in the community is important not just in caring for people while they are detained but also in helping promote constructive, healthy lifestyles after release that benefit the whole community...

The promotion of equality and human rights, and the prevention of ill treatment, are at the core of both CQC's and HMIP's approaches to inspection. The nature of detention means that it is largely out of sight of the public. This puts detainees in a more vulnerable situation where they rely on authorities for their safety, care and wellbeing. Detainees may be subject to the use of restraint or force whilst in a secure setting for the safety of themselves and others, and these decisions need to be made carefully and with transparent justification. It also means that, unlike the general population, they are unable to choose their place of care. All of this makes monitoring, inspection and regulation even more important, guaranteeing them care at a level that is equivalent to the rest of the population. ”

— Supporting statement from HMIP's Chief Inspector of Prisons, Nick Hardwick CBE [page 6]

Physical Health of People in Prison NICE Guideline 57, November 2016⁸



In April 2013 NHS England became responsible for commissioning all health services for people in prison in England. Healthcare in prison has a very important role in identifying significant health needs, maintaining health and detecting chronic conditions. This guideline supports equivalence of healthcare in prisons, a principle whereby health services for people in prisons are provided to the same standard, quality and specification as for patients in the wider NHS. Providing equivalence of care aims to address health needs, reduce health inequalities, prevent deterioration, reduce deaths from natural causes and ultimately assist rehabilitation and reduce reoffending. ”

5. Ethical Principles

The World Health Organisation's Good Governance for prison health in the 21st century, 2013,⁹ sets out:

Chapter 1 — Prison health is public health

Prisons are closely linked to communities. Prisoners go on leave, receive visitors and sometimes attend outside work placements or health care facilities. The vast majority of prisoners will eventually leave prison and reintegrate into society...

Chapter 2.1 — Prisoners' right to health

Imprisonment is never only about safety, security and discipline but, as the Council of Europe laid down in its 2006 Prison Rules, is always also about “... *ensuring prison conditions which do not infringe human dignity and which offer meaningful occupational activities and treatment programmes to inmates, thus preparing them for their reintegration into society*” (20). Therefore, one of the most important principles that guide the deprivation of liberty is that prisoners remain bearers of all human rights insofar as they are not lawfully restricted or limited to an extent demonstrably necessitated by the fact of incarceration (20,21). This also applies to their right to health, which is established on various foundations of fundamental human rights (22). Most important is Article 12 of the International Covenant on Economic, Social and Cultural Rights (23). In its General Comment No. 14 to give guidance to states, the United Nations Committee on Economic, Social and Cultural Rights laid out the scope and content of the right to health. With regard to its scope, the Committee states that “... *the right to health must be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health*” (24). According to the Committee, the necessary public health and health care facilities, goods and services have to meet the following qualities (24):

availability: facilities, services and goods have to be available in sufficient quantity, including the underlying determinants of health, such as safe and potable drinking-water as well as adequate sanitation facilities, hospitals, clinics and other health-related buildings, trained medical and professional personnel and essential drugs;

accessibility: facilities, services and goods and health-related information have to be physically and economically accessible (affordable) without discrimination, especially to vulnerable or marginalized populations;

acceptability: facilities, services and goods must respect medical ethics, respect confidentiality and improve the health status of those concerned;

quality: facilities, services and goods must be scientifically and medically appropriate and of good quality which, according to the Committee, requires (among other things) skilled health care staff, scientifically approved and unexpired drugs and equipment, safe and potable water and adequate sanitation

Chapter 2.3 — The mission of prison health staff and the need for independence

The relationship between health care providers and patients is a crucial factor for the success of any health system. According to the CPT, a trustful doctor–patient relationship “*is a major factor in safeguarding the health and well-being of prisoners*” (31). The states’ special duty of care for prisoners has three fundamental implications for the role, mission, duty and alignment of prison health personnel.

The first is a single duty of care. All relevant prison rules state that the sole mission of health personnel in prisons is to care for and advocate the health and well-being of prisoners. This includes making arrangements for continuity of care after release, inspecting and reporting to prison directors about the conditions of imprisonment relevant to health, and identifying and reporting any sign of ill treatment of prisoners to the relevant authorities (20).

The second is the highest claims to professional ethics. The relationship between health personnel and patients in prisons is not based on free will. The patient cannot choose the doctor, nor can the doctor choose the patient.

This places the highest demands on the professional ethics of prison health personnel.

Thus, most international prison rules contain provisions on medical ethics relating to prison health personnel (32). Most prison rules reflect the ethical dilemma of dual loyalty, which may represent a particularly characteristic challenge for prison health staff (33,34), and which the CPT describes as follows: “*The health-care staff in any*

prison is potentially a staff at risk. Their duty to care for their patients (sick prisoners) may often enter into conflict with considerations of prison management and security. This can give rise to difficult ethical questions and choices” (35). To avoid any such conflict, Principle 3 of the United Nations resolution on the principles of medical ethics relevant to health personnel, particularly physicians, in the protection of prisoners and detainees against torture and other cruel, inhuman or degrading treatment or punishment states that “it is a contravention of medical ethics for health personnel, particularly physicians, to be involved in any professional relationship with prisoners or detainees the purpose of which is not solely to evaluate, protect or improve their physical and mental health” (36).

Third, professional independence is essential. An organizational prerequisite for the undivided loyalty of prison health staff to their patients is full professional independence. Thus, for example, the Committee of Ministers of the Council of Europe states in paragraph 20 of its Recommendation No. R(98)7 Concerning the Ethical and Organisational Aspects of Health Care in Prison: *“Clinical decisions and any other assessments regarding the health of detained persons should be governed only by medical criteria. Health care personnel should operate with complete independence within the bounds of their qualifications and competence...”*

Chapter 2.4 – Principle of equivalence and integration

Based on the above requirements for prison health – prisoners retain their right to health, states have a legally enforceable duty of care for the health of prisoners, the single mission of health personnel in prisons is to care for their patients’ health, and health personnel should operate with complete independence from prison authorities – there follow two interrelated further principles of prison health that are widely represented in international prison rules:

- **the principle of equivalence**
- **the principle of integration**

Since the latter is an institutional consequence of the former, and since the two cannot be clearly separated in legal texts, it is suggested to refer to them as one single principle of equivalence and integration.

The World Health Organisation's *Prisons and Health*, 2014¹⁰

The World Health Organisation's *Prisons and Health*, 2014 sets out key points within their chapter on human rights and medical ethics, some of these are outlined below:

- The state has a special duty of care for those in places of detention which should cover safety, basic needs and recognition of human rights, including the right to health.
- A primary health care service in prisons must be provided with staff, resources and facilities of at least the same standard as those available in the community. This principle of equivalence is an important measure of the adequacy of health care provision in places of detention.
- All health staff should have complete professional independence and should preferably be employed by a health authority. Their right to practise their profession within their professional codes of conduct and ethical rules should be clearly understood and accepted.
- It is important that all staff working in prisons accept that to the health team, prisoners are patients and must be treated as such. The duty of care placed on professional staff is the same whether the patient is at liberty or in prison.
- The prisoner as patient has the right to confidentiality and to treatment and care that is subject to informed consent.
- Continuity of care is a crucial element of a sustainable prison health service. Prison health staff should make arrangements for continuous access to care on transfer or on release, which should be facilitated by prison management.
- A prison health service should be seen as helping to build a healthier society. An element of this is to support, where possible, the work of the prison staff in encouraging changes in attitude and behaviour with the objective of a crime-free society.
- Prison health services should not be isolated but should be integrated into regional and national health systems

Duty of care



There are several unique factors pertaining to people remanded in custody by a judicial authority or deprived of their liberty following conviction. The first is that the detaining authority has to assume a duty of care for them, that is, a comprehensive obligation to meet at least their basic needs. The second is that prisoners are entirely dependent on the staff of prisons and detention centres for all aspects of their daily lives, as well as for protection and safety. This dependence must be understood by the staff since they share the duty of care with their employing authority, which should influence their attitude and approach. The third factor is that detainees retain all human rights other than their freedom. Their right to health is in no way diminished by their detention. ”

Why prison health is important



There are two other compelling reasons for providing health care in prisons. First is the importance of prison health to public health in general. Prison populations contain a high prevalence of people with serious and often life-threatening conditions. Sooner or later most prisoners will return to the community, carrying back with them new diseases and untreated conditions that may pose a threat to community health and add to the burden of disease in the community. Thus there is a compelling interest on the part of society that this vulnerable group receive health protection and treatment for any ill health.

The second reason is society's commitment to social justice. Healthy societies have a strong sense of fair play: those involved in the provision of health care are committed to reducing health inequalities as a significant contribution to health for all...

All this underlines the need for governments to give a degree of priority to health in prisons. First, they should meet their duty of care for those deprived of their liberty. Second, they should respect prisoners' human rights, aid the protection of their health and contribute to public health as a whole, thus making a major contribution towards reducing health inequalities in a vulnerable part of the population while society awaits the effects of action on the broader social determinants of health. ”

6. The Law

There are a number of mechanisms within the legal systems within the UK where the level of care provision to people within detained settings are considered. The purpose of this position statement is to draw together the relevant national and international guidance underpinning the care provided in secure environments and thereby should further act as a framework for practitioners, commissioners and those scrutinising the care in these settings.

International Law

A number of international treaties and instruments address the issue of equivalence in healthcare for prisoners. These include:

The United Nations International Covenant on Economic Social and Cultural Rights (ICESCR) 1966

Article 12(1) of which provides for:

“

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

”

The UN International Covenant on Civil and Political Rights (ICCPR)1996

General Comment 21(2) of which provides that:

“

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. ”

”

United Nations General Assembly Resolution 37/194 in 1982¹³

United Nations General Assembly Resolution 37/194 in 1982 states:

“

...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 afforded to those who are not imprisoned or detained. ”

The UN ‘Basic Principles for the Treatment of Prisoners’, General Assembly resolution 45/111 of 14 December 1990¹⁴

Which states that: which states that:

“

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

The United Nations Standard Minimum Rules for the Treatment of Prisoners 70/175 (the Nelson Mandela Rules), 2015¹⁵

This document comprises a comprehensive set of 122 rules set out in the Resolution adopted by the General Assembly in 2015, of which many rules 24 – 35 refer directly to the healthcare and treatment of prisoners:

Rule 1 states that:

“

All prisoners shall be treated with the respect due to their inherent dignity and 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 states that:

“

The provision of health care for 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. ”

Chapter III of the 3rd report of the European Committee on Prevention of Torture¹⁶

Which stresses the importance of equivalence without discrimination on the basis of legal status.

The European Prison Rules 1990¹⁷

Rule 39 of which provides that:

“

Prison authorities shall safeguard the health of all prisoners in their care. ”

Rule 40.1 continues that:

“

Medical Services in Prison shall be organised in close relation with the general health administration of the community or nation. ”

and **Rule 40.3**, that:

“

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

These latter European rules are perhaps the most more frequently cited provisions in support of equivalence of care.

Despite this proliferation of international law-making, few if any of these rights are directly enforceable by an individual prisoner against the UK Government. They are not ‘constitutional level’ protection. Instead, these laws and provisions are a way in which the UK government is held accountable by the international community.

Domestic ‘UK’ Law

The question of healthcare equivalence has been considered by the domestic courts. In the 1999 case of *Brooks v Home Office* where it was held that women in prison are entitled to the same standard of obstetric care as those in the community, and *R (on the application of Nathan Brooks) v (1) Secretary of State for Justice (2) Isle of Wight Primary Care Trust* [2010] 1 Prison LR 266, where the High Court held 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. ”

The judge adding that:

“

There are of course, some constraints which are inevitable because of security considerations... ”

Application

The concept of 'equivalence' comes into play, or as lawyers would say, litigated in five principal areas:

Coroners Inquests

In England and Wales: where there is an investigation into a prisoner's death, and the care received in prison is one of the circumstances relevant to death.

Personal Injury

Claims for injury caused by a breach of duty by the person providing the healthcare.

Clinical Negligence

Claims for injury resulting from failures or errors in medical care

Human Rights Act

Where a prisoner claims that his or her medical treatment was so bad that it amounted to inhuman or degrading treatment (Article 3 of the European Convention). Please note that the threshold for inhuman treatment under this Article is very high, and requires the failure to attain a sufficient level of severity.

Judicial Review

Typically, a challenge to the refusal of treatment by prison healthcare

Challenges

The real challenge for practitioners is to communicate the concept of equivalence, and more importantly to communicate the exceptions which apply in a secure environment. This must be done, not simply as a matter of generality (eg. "for reasons of security"), but with specific reference to the logistical hurdles faced in respect of that particular prisoner.

Devolved Nations

Scotland

In Scotland the law requires a Fatal Accident Inquiry (FAI) to take place when someone dies in custody in prison or in a police station. Mandatory FAI categories also include deaths of children in secure care and all cases where the person is arrested or detained by the police at the time of death regardless of where the death takes place. An FAI is a non-adversarial, fact-finding process through which the circumstances of some deaths occurring in Scotland, including but not limited to deaths in custody, are investigated and established. They take place before a Sheriff, who is required to produce a determination setting out time, place and cause of death, and any precautions or defects in the system which could have prevented the death. The sheriff can also make recommendations as part of the FAI process, although these are not required.

Wales

In Wales, healthcare is a devolved matter. The following domestic statutory provisions are relevant to the question of equivalence:

Section 3B of the National Health Service Act 2006 (which applies to England) allows the Secretary of State to make regulations about the commissioning of healthcare in prisons and other places of detention. That power has been exercised to make regulation 10 of the NHS Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012. Regulation 10 requires NHS England to arrange community services, secondary care services and other services specified in the Act for those detained in prisons, secure children's homes, young offender institutions, certain secure training centres and certain immigration removal centres. Primary care services also fall to NHS England to arrange under the NHS Act 2006.

Section 249 of the NHS Act 2006 provides that in exercising their respective functions, NHS bodies and the prison service must co-operate with another with a view to improving the way in which those functions are exercised in relation to securing and maintaining the health of prisoners.

Prison Rule 20 of the Prison Rules 1999 provides that the governor must work in partnership with local health care providers to secure the provision to prisoners of access to the same quality and range of services as the general public receives from the National Health Service. ...

Rule 33 of the Detention Centre Rules 1999 governs healthcare, and provides in particular that (1) every detention centre shall have a medical practitioner, who shall be vocationally trained as a general practitioner and a fully registered person within the meaning of the Medical Act 1983 who holds a licence to practise; (2) Every detention centre shall have a health care team (of which the medical practitioner will be a member), which shall be responsible for the care of the physical and mental health of the detained persons at that centre.

7. References and further reading

Journal articles

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Looking behind the bars: emerging health issues for people in prison, **Stürup-Toft, O’Moore and Plugge**, *British Medical Bulletin* 2018

Health care in secure environments, **Sparrow**, *British Journal of General Practice* 2006

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