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*Judgment: approved by the court for handing down (subject to editorial corrections)**	*Delivered:*	**11/06/2026**

IN HIS MAJESTY'S COURT OF APPEAL IN NORTHERN IRELAND

ON APPEAL FROM THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND KING'S BENCH DIVISION (JUDICIAL REVIEW)

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

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

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

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Before: Keegan LCJ, Colton LJ and McLaughlin J

KEEGAN LCJ ***(delivering the judgment of the court)***

Introduction

[1] This appeal arises from a decision of McAlinden J ("the judge") in September 2024. A subsequent decision on relief issued in September 2025. However, this appeal is only concerned with the finding that there had been a breach of Mr Pollins' and Mr Clarke's Convention rights and the Declarations to that effect. Subsequently, the judge awarded damages of £5,000 to Pollins and £2,000 to Clarke. Pollins has issued a cross appeal in relation to that decision.

[2] The South-Eastern Health and Social Care Trust ("the Trust") as a respondent and the Department of Health ("DoH") as a notice party, both now appeal on the basis that the judge's findings that the judicial review applications should be granted were wrong.

[3] In this judgment we refer to Pollins and Clarke as "applicants." Both of the applicants were prisoners with drug addictions at the relevant time. They challenge the delay which they experienced in securing an assessment to determine their suitability for Opiate Substitution Therapy ("OST") through prison healthcare service, for which the Trust is responsible. In summary, Pollins argued that the prolonged delay by the Trust in assessing his suitability for OST and the subsequent provisions of the therapy amounted to breaches of his rights under articles 3 and 8 of the European Convention on Human Rights ("ECHR"). He also claimed that it constituted unlawful discrimination under article 14 when read with articles 3 and 8. Clarke's case was narrower. He claimed that the delay in assessing him for OST amounted to discrimination under article 14, when his treatment as a prisoner was compared to that of community patients who receive timely OST assessments. His claim originally relied on article 14 read with article 8, but during the hearing he was permitted to add article 14 read with article 3. He did not allege freestanding breaches of articles 3 or 8.

[4] The judge held:

> "(a) There had been a breach of Pollins' right not to be subjected to torture, inhuman or degrading treatment pursuant to article 3 ECHR – he issued a declaration and awarded £5,000 damages (to include £2,000 for a breach of article 14)
>
> (b) There had been a breach of Pollins' article 8 ECHR right to private and family life – he issued a declaration
>
> (c) There was unjustified and therefore unlawful discrimination against Pollins, contrary to article 14 ECHR read with article 3 ECHR and article 8 ECHR – he issued a declaration and indicated that he would have awarded £2,000 for a breach of article 14.
>
> (d) There was unjustified and therefore unlawful discrimination against Clarke, contrary to article 14 ECHR read with article 3 ECHR and article 8

ECHR – he issued a declaration and awarded £2,000 damages."

Background facts

[5] The facts are comprehensively set out by the judge and so we only refer to the salient aspects as follows. Both men have long-standing drug addictions which pre-dated their sentences of imprisonment. The relevant aspects of their medical history and their interactions with the prison medical authorities are addressed in more detail below. At the time of admission to prison, neither applicant had been assessed for, nor were they being treated with OST. While in custody, they experienced withdrawal symptoms and requested access to OST. This required an initial assessment to determine suitability. The undisputed evidence was that, although community patients are generally assessed for OST within a relatively short number of weeks, prisoners faced significant delays in obtaining an assessment, sometimes lasting years. However, prisoners who were being treated with OST in the community at the time of admission to prison, would receive priority access and their treatment would generally continue uninterrupted within the prison. In other words, for prisoners seeking OST who had not previously been prescribed in the community, there was a delay in being assessed.

[6] It is common case that Clarke was recommended for OST assessment by the Parole Commissioners but waited over two years without ever receiving an assessment. He claims unlawful discrimination under article 14, read with articles 3 and 8, comparing himself to community patients who receive timely access to an assessment.

[7] Also uncontentious is the fact that Pollins waited more than three years on the OST waiting list, during which time he continued using illicit drugs and experienced some measure of withdrawal, mental deterioration, and distress. After release, he was assessed and commenced on OST within six weeks. He alleges breaches of articles 3, 8, and 14 ECHR.

[8] We are grateful to the judge for highlighting the contextual backdrop to this case and reciting the evidence. We gratefully borrow from his judgment in the following material respects.

[9] In 2008, the Trust assumed day-to-day responsibility for the provision of healthcare services in all prisons in Northern Ireland. The Trust was provided with a specific annual budget to enable it to fulfil its responsibilities in providing prison healthcare. A partnership agreement was entered into between the Northern Ireland Prison Service and the DoH in February 2009.

[10] As has been stressed by the applicants, one of the primary goals of this partnership agreement was to ensure that prisoners had access to the same range and quality of healthcare services as individuals at liberty in the community.

[11] Also of relevance is the NICE Guidance on Drug Misuse and Dependency: UK Guidelines on Clinical Management (2009 updated in 2017). These guidelines contain a section dealing with "Prisons and other secure environments" at 5.4.1 onwards which includes the following:

> "5.4.1 The purpose of healthcare in prison, including care for drug and alcohol problems, is to provide an excellent, safe and effective service to all prisoners, equivalent to that in the community.
>
> 5.4.5.1 The principle of equivalence: the provision to individuals in prison of care equivalent to that provided to individuals in the community (including evidence based and clinically effective interventions and pathways), should always be appropriately applied."

[12] In addition, we note that the Regulation and Quality Improvement Authority ("RQIA") conducted a detailed review of the provision of healthcare in prisons in Northern Ireland and in its report entitled: "Review of Services of Vulnerable Persons Detained in Northern Ireland" which was published in October 2021, it concluded that prison healthcare was:

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

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

> "In assessing our budget, it is important to recognise the challenges NIPS face in managing an increasingly complex population. 50% of those entering our prisons have addictions, 32% have mental health issues, and 54% are at risk of suicide and self-harm.
>
> As prison healthcare is, according to the RQIA Review of Services for Vulnerable Persons Detained in

> Northern Ireland Prisons, "significantly underfunded," there is a clear lack of equivalence with healthcare in the community.
>
> Prison staff are consistently required to manage the shortfall in healthcare provision. There is a clear impact for community healthcare, which is being given additional funding, if the Prison Service is not able to address the complex needs of many prisoners during their time in custody."

[14] Without doubt the evidence exposed chronic underfunding of prison healthcare, including a £4 million annual shortfall, vastly higher OST demand among prisoners, and insufficient staffing. In addition, it pointed to the fact that as priority is given to prisoners who arrive already on OST, others had to wait for 1–2 years or more, with OST waiting lists commonly exceeding 100 prisoners.

The progress of these cases

[15] Both applicants filed judicial review challenges against the Trust's failure to assess them for OST. Extensive affidavit evidence was filed by both sides, including medical records, reports from psychiatrists and psychologists, official prison inspection reports, waiting-list and resource data.

[16] Hearings were held across four days before the judge: 15 May, 20–21 June, and 24 June 2024. Additional submissions on article 3 were filed in July and August 2024.

[17] On 19 January 2024, the application for leave to bring judicial review proceedings by Clarke was granted in part as the application against the DoH was dismissed. The court granted the DoH notice party status, against whom relief was no longer sought. Coincidentally, the application for leave by Pollins was listed on the same day as the judgment in respect of leave in Clarke. Pollins did not seek leave to bring judicial review proceedings against the DoH. Leave was granted against the Trust. As the DoH had been named as a notice party in Clarke's application, it was thereafter added as notice party in Pollins' application.

The judge's decision

[18] The judge found that articles 3 and 8 ECHR impose clear duties on the state to address the healthcare needs of prisoners. Article 3 requires the State to protect the physical wellbeing of those it detains, which includes providing the medical care they need. A failure to provide appropriate healthcare may amount to inhuman or degrading treatment in breach of article 3 and also a failure to respect private life, in breach of article 8.

[19] The judge reiterated that article 3 ECHR places a positive obligation on the state to ensure prisoners are detained in conditions that respect human dignity, which includes securing their health and wellbeing through the provision of necessary medical treatment. Crucially, it required that prisoners with serious illnesses must receive an adequate specialist assessment, and because detainees are especially vulnerable, the state must provide credible evidence that they received comprehensive and appropriate medical care.

[20] The judge also found that denial of access to certain medical treatments can fall within the scope of article 8 ECHR and may amount to interferences with private life and personal autonomy.

[21] The judge found that both articles 3 and 8 were engaged on the facts of these cases regarding the adequacy of healthcare provision and the treatment which they received while in prison. However, only Mr Pollins claimed substantive breaches of these articles. Mr Clarke relied on them only in connection with article 14 discrimination.

[22] Hence, in respect of Pollins' article 3 claim, the judge found that it was "abundantly clear" that the state failed to provide appropriate medical healthcare. That was on the basis that he did not undergo an assessment for OST and the failure not to provide him with same "clearly represents a level of healthcare which is not comparable to that which the state has committed itself to provide to the population as a whole." The court was "clearly satisfied" there had been an actual breach of article 3 as it found that if he had received OST, he would not have suffered regular opiate withdrawal symptoms including pain and the interruption in the supply of illicit drugs in prison and he would not have suffered the level of anxiety and distress which he experienced.

[23] Para [161] of the judgment specifically addressed article 3 as follows:

> "In the opinion of the court, the nature, extent and duration of these symptoms do cross the level of severity necessary to give rise to a breach of article 3 and they clearly and manifestly mean that the second applicant was detained in conditions which were not compatible with human dignity … the severe level of hardship and distress flowed from the deliberate and intentional implementation of a decision in respect of the provision of healthcare rather than flowing from negligent medical treatment."

[24] Following from his determination on the alleged breach of article 3 the judge found that there had been an interference with both applicant's physical and psychological integrity sufficient to contravene the protections set out in article 8(1).

While the judge recognised that these were qualified rights, he did not accept that the lack of provision of OST was rationally connected to the aim of providing healthcare in prison in the context of having to operate under a seriously inadequate budget. The judge was also "adamant in [his] view that a less intrusive measure could and should have been devised and implemented ..."

[25] The judge was not persuaded that the measure (delay in the assessment for and provision of OST) was proportionate or struck a fair balance between the rights of the individual and the rights of the community (based in part on the article 3 findings) and was therefore not justified under article 8(2).

[26] At para [167] of his judgment the judge stated that:

> "… bearing in mind the individual and societal benefits to be reaped from the successful induction and maintenance of a patient on OST, the individual's rights and the community's interests coincide and both are, in effect harmed by this measure."

[27] Following on from the article 3 and article 8 findings summarised above, the court held that on the facts of the case and relevant to the article 14 claim, it was "patently obvious that the difference in treatment is on the applicant's status as a prisoner who seeks to be assessed in relation to his suitability for commencement on OST as a treatment." The court further found that the difference in treatment between the delays in assessment and access to medical provision experienced by a prisoner compared with those experienced by a person in the community seeking an assessment for OST could not be objectively justified. The article 14 claim, with reference to article 3 and 8, was accepted (para [169] (relying on findings between paras [136]-[138]).

[28] The judge found that Clarke was similarly able to establish difference in treatment by reason of his status as a prisoner and that the respondent could not justify the difference in treatment (paras [171]-[174]).

Grounds of appeal

[29] The grounds of appeal traverse four core aspects of the judge's decision: the article 3 findings, the article 8 findings, the article 14 findings and the remedy granted. As we have said, the question of remedy is for another day. The grounds of appeal in relation to the article 14 findings are common to the appeals in respect of both respondents. There is also considerable overlap between the grounds of appeal advanced by the first and second appellants.

[30] Therefore, we distil the main points advanced as follows:

(a) In respect of article 3, the judge erred in his approach to article 3 insofar as he found that the minimum threshold of seriousness had been surpassed or that the matters complained of were properly within the scope of article 3 rights.

(b) In respect of the judge's finding the Trust breached Mr Pollins' article 3 rights, the judge failed to take due account of the cause of the alleged distress or anxiety, flowing from the underlying addiction rather than any positive action taken by the Trust and failed to consider whether it had taken reasonable steps to prevent a breach of article 3.

(c) In declaring that the Trust had breached Pollins' article 3 rights, the judge erred in finding his treatment by reason of the delay in a suitability assessment for OST and subsequent provision of the treatment amounted to a breach of article 3.

(d) In declaring that the Trust breached Pollins' article 8 rights, the judge erred in finding that the provision of medical treatment in prison amounted to an interference with his article 8 rights.

(e) In declaring that the Trust had breached Pollins' article 8 rights, the court erred in considering that it involved a positive decision not to provide assessment or treatment rather than a delay in the provision of that assessment or treatment.

(f) In declaring that the Trust had breached Pollins' article 8 rights, the judge erred in finding that the measure complained of was not rationally connected to the objective.

(g) In declaring that the Trust had breached Pollins' article 8 rights, the judge erred in finding that a less intrusive means should have been applied in the form of further funding.

(h) In declaring that the Trust had breached Pollins' article 8 rights, the judge erred in considering that a breach of article 3 required a finding that there had been a breach of article 8.

(i) In reaching the conclusion that there had been a breach of article 14 read with article 3 and/or article 8 the judge failed to apply the guidance contained in the Supreme Court judgment of *Re SC* [2021] UKSC 26.

(j) In declaring that the Trust breached the respondents' article 14 rights (read together with article 3 and article 8) the judge erred in finding that a patient in the community seeking assessment of suitability for OST was in an analogous position to a patient in prison seeking an assessment of suitability for OST

and failed to give due account to the fact that demand in prison exceeded greatly the demand in the community.

Relevant legal principles

[31] We begin with article 3 of the ECHR:

> "**Prohibition of torture**
>
> No one shall be subjected to torture or to inhuman or degrading treatment or punishment."

[32] Numerous Strasbourg decisions emphasise that article 3 encapsulates fundamental values. The prohibition on torture, inhuman or degrading treatment is a value of civilisation closely bound up with respect for human dignity. Article 3 is not a qualified right. The prohibition is absolute and no derogation is permissible under article 15 of the ECHR even in the event of a public emergency threatening the life of the nation or in the most difficult circumstances including terrorism, organised crime or influx of migrants and asylum seekers irrespective of the conduct of the person concerned.

[33] The case of *Blokhin v Russia* (Grand Chamber, 23 March 2016) sets out the general principles which are applicable as follows;

> "**General principles**
>
> 135. The court reiterates that Article 3 of the Convention enshrines one of the fundamental values of democratic society, prohibiting in absolute terms torture or inhuman or degrading treatment or punishment (see, among other authorities, *Stanev v Bulgaria* [GC], no. 36760/06, § 201, ECHR 2012). However, to come within the scope of the prohibition contained in Article 3, the treatment inflicted on or endured by the victim must reach a minimum level of severity. The assessment of this minimum level of severity is a relative one, depending on all the circumstances of the case, such as the duration of the treatment, its physical and mental effects and, in some cases, the sex, age and state of health of the victim (see *M.S. v the United Kingdom*, no. 24527/08, § 38, 3 May 2012, and *Price v the United Kingdom*, no. 33394/96, § 24, ECHR 2001-VII)."

[34] Article 3 also requires the state to safeguard the physical wellbeing of people in custody, including by providing the necessary and appropriate medical care.

Depending upon the circumstances and the consequences for the prisoner, failure to make an adequate assessment of medical needs or to provide the necessary medical care can amount to "treatment" falling within the scope of the Article 3 prohibition. An important factor which will be relevant to any assessment of the severity of the treatment will be a comparison between the medical care and treatment provided and that which is generally available to persons in the community. Cases such as *Blokhin v Russia* make clear that simply being seen by a doctor or given some treatment does not automatically mean that the care is adequate. Medical treatment in prison must be appropriate and broadly equivalent to that available to the general population, though article 3 does not require that prisoners receive the best possible treatment, nor does a lack of equivalence, without more, amount to a breach of article 3.

[35] Specifically, the ECtHR in *Blokhin* stated at para [137]:

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

> detainee must be guaranteed the same level of medical treatment that is available in the best health establishments outside prison facilities (see *Cara-Damiani v Italy*, no. 2447/05, § 66, 7 February 2012).

[36] Para [138] of *Blokhin* highlights the fact sensitive case by case analysis which is required and the flexibility allowed to an adjudicating court:

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

[37] The current Case Law Guide published by the European Court of Human Rights ("ECtHR") on article 3 updated 31 August 2025 is also instructive. It reads as follows:

> "… In order to determine whether the threshold of severity has been reached, other factors may be taken into consideration, in particular:
>
> (a) the purpose for which the ill-treatment was inflicted, together with the intention or motivation behind it, although the absence of an intention to humiliate or debase the victim cannot conclusively rule out a finding of a violation of Article 3 of the Convention;
>
> (b) the context in which the ill-treatment was inflicted, such as an atmosphere of heightened tension and emotions; and
>
> (c) whether the victim is in a vulnerable situation (*Khlaifia and Others v Italy* [GC], 2016, § 160) …"

[38] A Strasbourg decision directly on point is *Wenner v Germany* (1 December 2016). This is a decision of Grand Chamber of the ECtHR which deals with withdrawal of OST from a prisoner. The applicable principles are found in the following paragraphs of the ruling:

"**Recapitulation of the relevant principles**

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

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

56. The court has clarified in this context that it was essential for a prisoner suffering from a serious illness to undergo an adequate assessment of his or her current state of health, by a specialist in the disease in question, in order to be provided with appropriate treatment (compare *Keenan v the United Kingdom*, no. 27229/95, §§

115-116, ECHR 2001-III, concerning a mentally ill prisoner; *Khudobin v Russia*, no. 59696/00, §§ 95-96, ECHR 2006-XII (extracts), concerning a prisoner suffering from several chronic diseases including hepatitis C and HIV; and *Testa v Croatia*, no. 20877/04, §§ 51-52, 12 July 2007, concerning a prisoner suffering from chronic hepatitis C).

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

[39] *Wenner* and *Blokhin* should also be read in light of the subsequent decision in *Cosovan v Moldova* (22 June 2022) in which the ECtHR highlighted the threshold which must be crossed to establish a breach of article 3.

"73. The court reiterates that ill-treatment must attain a minimum level of severity if it is to fall within the scope of Article 3. The assessment of this minimum level of severity is relative; it depends on all the circumstances of the case, such as the duration of the treatment, its physical and mental effects and, in some cases, the applicant's sex, age and state of health (see, among other authorities, Dorneanu, cited above, § 75, with further references).

[40] The ECHR Guide on case-law of the Convention – Prisoners' Rights European Court of Human Rights 32/106 (last updated on 28 February 2026) refers:

"120. The "adequacy" of medical assistance remains the most difficult element to determine. In its assessment of

this issue, the Court is guided by the due diligence test, since the State's obligation to cure a seriously ill detainee is one of means, not of result. In particular, the mere fact of a deterioration of the applicant's state of health, albeit capable of raising at an initial stage certain doubts concerning the adequacy of the treatment in prison, could not suffice, as such, for a finding of a violation of the State's positive obligations under Article 3 of the Convention, if it can be established that the relevant domestic authorities have in timely fashion resorted to all reasonably possible medical measures in a conscientious effort to hinder development of the disease in question (*Goginashvili v. Georgia*, 2011, § 71). The mere fact that a detainee is seen by a doctor and prescribed a certain form of treatment cannot automatically lead to the conclusion that the medical assistance was adequate (*Hummatov v. Azerbaijan*, 2007, § 116). The authorities must also ensure that a comprehensive medical record is kept concerning the detainee's state of health and his or her treatment while in detention (*Khudobin v. Russia*, 2006, § 83; *Eldar Hasanov v. Azerbaijan*, 2024, § 104), that diagnosis and care are prompt and accurate (*Melnik v. Ukraine*, 2006, §§ 104-106), and that where necessitated by the nature of a medical condition supervision is regular and systematic and involves a comprehensive therapeutic strategy aimed at adequately treating the detainee's health problems or preventing their aggravation, rather than addressing them on a symptomatic basis (*Amirov v. Russia*, 2014, § 93). *Moldova*, 2006, § 117). The prison authorities must offer the prisoner the treatment corresponding to the disease(s) with which the prisoner was diagnosed.

122. Furthermore, medical treatment provided within prison facilities must be appropriate, that is, at a level comparable to that which the State authorities have committed themselves to provide to the population as a whole. This does not mean that every detainee must be guaranteed the same level of medical treatment that is available in the best health establishments outside prison facilities (*Blokhin v. Russia* [GC], 2016, § 137; *Cara-Damiani v. Italy*, 2012, § 66). 123. On the whole, as the Court explained, it reserves sufficient flexibility in defining the required standard of health care, deciding it on a case-by-case basis. That standard should be "compatible with the human dignity" of a detainee but should also

> take into account "the practical demands of imprisonment" (*Blokhin v. Russia* [GC], 2016, § 137; *Aleksanyan v. Russia*, 2008, § 140; *Patranin v. Russia*, 2015, § 69)."

[41] In relation to equivalence in prison healthcare we were referred to various international instruments:

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

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

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

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

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

> "Those charged with the medical care of prisoners and detainees have a duty to provide them with protection of their physical and mental health and treatment of disease of the same quality and standard as is affordable to those who are not imprisoned or detained."

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

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

(v) UN Standard Minimum Rules for the Treatment of Prisoners 70/175 of 2015:

Rule 1:

> "All prisoners shall be treated with the respect due to their inherent dignity as value as human beings. No prisoner shall be subjected to, and all prisoners shall be protected from, torture and other cruel, inhuman, or

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

Rule 24:

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

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

(vii) European Prison Rules:

Rule 39:

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

Rule 40.1:

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

Rule 40.3:

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

[42] We also mention *Bouyid v Belgium* [2015] ECHR 23380/09, in which the Grand Chamber clarified the principles governing the requirement that treatment by state authorities must reach a minimum level of severity in order to fall within the prohibition in Article 3. It reiterated that the assessment of severity must include all of the circumstances of the case including the duration of the treatment, its effect (physical and mental), the context in which it takes place and, in some cases, the age, gender and health of the person. It may include the intention of those responsible

for the treatment. While ill-treatment will usually involve the infliction of actual bodily injury or result in intense physical pain, "degrading" treatment may still fall within the prohibition in the absence of those features. It can reach the necessary level of severity if it humiliates or debases an individual, showing a lack of respect for or diminishing his or her human dignity, or arouses feelings of fear, anguish or inferiority capable of breaking an individual's moral and physical resistance. The Grand Chamber also made clear that in the case of a person in custody or who is confronted with law enforcement officers, the use of physical force, which was not necessitated by the individual's own conduct, will in principle diminish the human dignity of the person and is thus capable of falling within article 3, even if the treatment did not result in serious or intense physical or psychological injury. The court emphasised the close link between the concepts of "degrading treatment" and respect for human dignity, which forms part of the very essence of the Convention (*Bouyid v Belgium*, at [86]–[90]). Thus, any conduct which diminishes the human dignity of a person can amount to degrading treatment and will fall within the Article 3 prohibition (see [101]). In *Bouyid*, an unnecessary slap in the face by police officers which resulted in light bruising was degrading treatment and amounted to a breach of Article 3, but in the absence of more serious physical or psychological injury, did not amount to inhuman treatment or torture (see [111]-[112]).

[43] The principles explained by the Grand Chamber in *Bouyid v Belgium* mean that in a case of the use of force against a person who is under the control of state agents or who is confronted by law enforcement officers, the court's examination of whether there has been degrading treatment will focus upon the necessity of the use of force, rather than the severity of the effects upon the individual. If the use of physical force is not considered strictly necessary as a result of the individual's conduct, it is likely to amount to degrading treatment and, thus, a violation of Article 3 of the Convention (§§ 111 and 112; see also *Perkov v Croatia*, Application no. 33754/16, 20 September 2022, § 31).

[44] Domestically, the standard of proof in establishing a breach of article 3, particularly for individuals in custody, was discussed in *R (ASK) v Secretary of State for the Home Department* [2019] EWCA Civ 1239 at [72], where the court observed that the individual complainant holds the burden of proving a breach of article 3 to the following standard:

> "… For a violation of art 3 to arise from an applicant's conditions of detention, the suffering and humiliation involved must go beyond that inevitable element of suffering or humiliation connected with a given form of legitimate treatment or punishment. Measures depriving a person of his liberty may often involve an element of suffering or humiliation. However, the state must ensure that a person is detained under conditions which are compatible with respect for his human dignity, that the

> manner and method of the execution of the measure do not subject him to distress or hardship exceeding the unavoidable level of suffering inherent in detention and that, given the practical demands of imprisonment, his health and well-being are adequately secured … When assessing conditions of detention, account has to be taken of the cumulative effects of these conditions, as well as of specific allegations made by the applicant. The length of the period during which a person is detained in the particular conditions also has to be considered."

[45] In the context of complaints about ill-treatment and inadequate medical care for detained persons, the Strasbourg jurisprudence suggests that article 3 is the *lex specialis* (eg *Wenner, Blokhin* and *Cosovan* were all determined by reference to Article 3). However, article 8 may also be engaged in cases of this nature on the basis that this article may protect physical and psychological integrity. This is a qualified right:

> "**Right to respect for private and family life**
>
> 1. Everyone has the right to respect for his private and family life, his home and his correspondence.
>
> 2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others."

[46] Only one Strasbourg decision has been referred to us on the ambit of article 8 in the area of delays in medical treatment namely *Passannante v Italy* (1 July 1998) where the Commission considered that: "… where the State has an obligation to provide medical care, an excessive delay of the public health service in providing a medical service to which the patient is entitled and the fact that such delay has, or is likely to have, a serious impact on the patient's health could raise an issue under article 8(1) of the Convention."

[47] This case is discussed in *Wilson & Kitchen* [2023] NICA 54, which concerned hospital waiting lists in Northern Ireland and examined whether a breach of article 8 could be established due to delays in medical treatment. Within para [70] of that decision the court observed that:

"The single Strasbourg decision on which this aspect of the appellants' cases is promoted is *Passannante v Italy* [1998] 26 EHRR CD 153. This is an admissibility decision of the European Commission. It related to a complaint entailing the contention that the applicant's rights under article 8(1) ECHR had been infringed in consequence of a delay of five months in securing a neurological appointment in the state system. A chamber of the Commission held that the application was inadmissible. The terms of this dismissal must be considered:

> '… The Commission considers that the circumstances of the present case are not such as to warrant the conclusion that the delay of the public authorities raises a serious issue under Article 8 of the Convention and that the present application is manifestly ill founded within the meaning of Article 27(1) of the Convention.'

Close attention must be paid to another passage:

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

[71] This court will make three assumptions favourable to the appellants, namely: (a) that theirs are "physical integrity" article 8(1) cases (b) positive obligations on the part of the respondents within the compass of article 8(1) could be in play and (c) the test formulated by the Commission is correct. Given our analysis of the factual matrix of each case above, the conclusion that each appellant's case falls demonstrably short of satisfying the Commission's test follows inexorably."

[48] *Wilson & Kitchen* also addresses the concern that in this context, a court may become drawn into matters of socio-economic policy and resource allocation. At paras [78] and [79], the court observed as follows:

> "[78] The forum for debate, inquiry, investigation and proposals for improvement and resolution of the issues raised in these proceedings – fundamentally, the single issue of hospital waiting lists in Northern Ireland and its offshoots – belongs to government Ministers, politicians, economists, sociologists, doctors, academics and doubtless other experts and many interested persons and agencies. The subject is one of much controversy and obviously broad and substantial dimensions. It is manifestly inappropriate for judicial intervention.
>
> [79] This court of supervisory superintendence does not possess the traits or credentials, expert or otherwise, of the members of the aforementioned forum. Furthermore, it is evident that the evidence assembled before this court provides but a snapshot of the subject concerned, while the DoH affidavit evidence demonstrates that it is a divisive and contentious one. This subject is, par excellence, unsuitable for assessment in a judicial forum."

[49] Article 14 is the final ECHR article for consideration. This article reads as follows:

> "**Prohibition of discrimination**
>
> The enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status."

[50] The Court of Appeal in *Stach v Department for Communities* [2020] NICA 4 at para [67], set out the series of questions which the court is required to ask itself when considering an article 14 challenge as follows:

(i) What is the status of the applicant?

(ii) Can the applicant lay claim to an "other status" within the embrace of article 14 ECHR? (recognising the overlap of (i) and (ii))?

(iii) If the "other status" hurdle is overcome, is the applicant the victim of differential treatment when compared with others in an analogous situation?

(iv) Does the applicant's case fall within the ambit of any of the substantive Convention rights invoked?

(v) If the above hurdles are overcome, is such differential treatment on the ground of the applicant's article 14 protected status?

(vi) If all the foregoing hurdles are overcome, is the differential treatment justified: more specifically, has the public authority concerned discharged its burden of establishing justification? And does the application of the test of proportionality to the professed legitimate aim satisfy the benchmark of manifestly without reasonable foundation?

[51] In *Re Sterritt* [2021] NICA 4, the Court of Appeal confirmed that the article 14 discrimination test is cumulative. This means that an applicant must satisfy each stage of the test in their favour; if they fail any one of the required steps, the entire article 14 claim necessarily fails. In advancing his article 14 discrimination claim in respect of article 8, the first applicant draws on the assistance of the decision of *R (on the application of Stott) Secretary of State for Justice* [2018] UKSC 59, and in particular a passage from Lady Black's judgment:

> "8. The approach to an Article 14 claim. In order to establish that different treatment amounts to a violation of Article 14, it is necessary to establish four elements. First, the circumstances must fall within the ambit of a Convention right. Secondly, the difference in treatment must have been on the ground of one of the characteristics listed in Article 14 or "other status." Thirdly, the claimant and the person who has been treated differently must be in analogous situations. Fourthly, objective justification for the different treatment will be lacking. It is not always easy to keep the third and the fourth elements entirely separate, and it is not uncommon to see judgments concentrate upon the question of justification, rather than upon whether the people in question are in analogous situations. Lord Nicholls of Birkenhead captured the point at para 3 of *R (Carson) v Secretary of State for Work and Pensions* [2005] UKHL 37; [2006] 1 AC 173. He observed that once the first two elements are satisfied:
>
> > 'The essential question for the court is whether the alleged discrimination, that is, the difference in treatment of which complaint is made, can withstand scrutiny. Sometimes the answer to this question will be plain. There may be such an obvious, relevant difference

> between the claimant and those with whom he seeks to compare himself that their situations cannot be regarded as analogous. Sometimes, where the position is not so clear, a different approach is called for. Then the court's scrutiny may best be directed at considering whether the differentiation has a legitimate aim and whether the means chosen to achieve the aim is appropriate and not disproportionate in its adverse impact.'
>
> In an Article 14 claim, the issue of status requires careful consideration. Establishment of a precisely defined protected status is not only a fundamental requirement of an Article 14 challenge but is also a prerequisite to consideration of what the appropriate comparator group is, whether those in an analogous situation with whom the applicant compares himself or those in a different situation which he says the respondent has failed to treat differently. Precise definition of the status relied upon is also necessary to assess whether the allegedly discriminatory treatment was on the ground of that protected status. In this respect, it is accepted that the category of 'other status' is broad and being a prisoner is an aspect of personal status and may amount to "other status" for the purposes of Article 14 (*Stummer v Austria* [GC], 2011, § 90; *P.C. v Ireland*, 2022, § 80)."

[52] In determining whether, in an article 14 challenge, groups are in a relevantly analogous situation the court must have regard to the nature of the complaint being advanced: see, for example *Clift v United Kingdom* at [66]. This underscores the need for precision in the way the status and comparator groups are identified. This test does not require the demonstration of exact equivalence. Rather the requirement is one of sufficient similarity: *AL (Serbia) v Secretary of State for the Home Department* [2008] 1 WLR 1434 at [25] per Baroness Hale. Here the applicants contend that they are in an analogous situation to persons in the community who await assessment for OST. This issue is addressed in more detail below.

[53] The appropriate legal test which applies in considering an article 14 claim has most recently been explained in *SC, CB v Secretary of State for Work and Pensions and others* [2021] UKSC 26. At para [37] of SC Lord Reed referred as follows:

> "(1) The court has established in its case law that only differences in treatment based on an identifiable

> characteristic, or 'status', are capable of amounting to discrimination within the meaning of article 14.
>
> (2) Moreover, in order for an issue to arise under article 14 there must be a difference in the treatment of persons in analogous, or relevantly similar, situations.
>
> (3) Such a difference of treatment is discriminatory if it has no objective and reasonable justification; in other words, if it does not pursue a legitimate aim or if there is not a reasonable relationship of proportionality between the means employed and the aim sought to be realised."

[54] Finally, is the question of how we should approach this appeal. This is complicated by the fact that the applicants' claims involve alleged breaches of more than one ECHR right. Article 3 is an absolute right and does not involve any question of justification. Articles 8 and 14 are qualified rights and interferences require justification, including the questions of proportionality. An overarching consideration is that an appellate court should not interfere with findings of fact at first instance save in an exceptional case. This is explained in *DB v Chief Constable of Police Service Northern Ireland* [2017] UKSC 7. Lord Kerr (whom the other Lords agreed with) considered the question of 'review by an appellate court of findings at first instance' at [78]–[80] and concluded as follows:

> "80. The statements in all of these cases and, of course, in *McGraddie* itself were made in relation to trials where oral evidence had been given. On one view, the situation is different where factual findings and the inferences drawn from them are made on the basis of affidavit evidence and consideration of contemporaneous documents. But the vivid expression in *Anderson* that the first instance trial should be seen as the "main event" rather than a "tryout on the road" has resonance even for a case which does not involve oral testimony. A first instance judgment provides a template on which criticisms are focused and the assessment of factual issues by an appellate court can be a very different exercise in the appeal setting than during the trial. Impressions formed by a judge approaching the matter for the first time may be more reliable than a concentration on the inevitable attack on the validity of conclusions that he or she has reached which is a feature of an appeal founded on a challenge to factual findings. The case for reticence on the part of the appellate court, while perhaps not as strong in a case where no oral evidence has been given,

> remains cogent. In the present appeal, I consider that the Court of Appeal should have evinced a greater reluctance in reversing the judge's findings than they appear to have done."

[55] However, in the application of this principle, it is equally important to bear in mind the distinction between findings of fact made at first instance and the inferences or the legal conclusions which may properly be drawn from those facts. In its application of legal principles to the facts found by a trial judge, an appellate court may therefore reach a contrary conclusion, without any departure from the *DB* principles. That is essentially the position in this case where we are dealing with how the judge applied the law to the facts.

[56] When considering article 8, which is a qualified right, recent Supreme Court decisions, *Safe Access Zones* (2022), *JR*123 (2023) and *Shvidler* (2025), provide guidance on how appellate courts should approach proportionality-based appeals. These authorities confirm that an appellate court has two possible approaches when reviewing a proportionality assessment made by a trial judge:

(i) Reviewing whether the judge applied the correct approach, or

(ii) Undertaking its own proportionality assessment afresh.

[57] In *Shvidler*, the Supreme Court revisited the issue, emphasising that while appellate courts require flexibility, this flexibility operates "only up to a point." It identified a multifactorial test to determine whether an appellate court should review the trial judge's proportionality analysis or carry out a fresh assessment itself. The court listed several factors that may justify a fresh proportionality assessment by an appellate court, including:

(i) The importance of the court giving its own opinion on the proportionality of a measure, such as cases involving measures of particular social or political significance, where it is important in providing guidance for other cases or where an issue of general legal principle is at stake.

(ii) The nature of the measure being challenged, especially where the measure is legislative in nature or is of general application, rather than a decision by a public authority in an individual case. In such cases, a full proportionality assessment by an appellate court may only be necessary in a first challenge. In subsequent challenges, the principles may already be clear.

(iii) Whether the case concerns a claim that devolved legislation exceeds legislative competence due to incompatibility with Convention rights.

(iv) Whether the case alleges significant inconsistency between primary legislation and Convention rights.

(v) The need to resolve conflicting case law emerging in the lower courts.

(vi) The high public importance of the issue, creating a public interest in senior court determination.

[58] Whilst comprehensive the above list is not exhaustive, and a fresh proportionality analysis may be required where there is a clear reason to do so and where this is explained by the appellate court.

Our consideration

[59] We begin by commending the judge for the care and attention that he has paid to this complicated case. His judgment denotes a considered understanding of the factual background which he recites in impressive detail. The underlying facts have not been disputed by any party during the appeal. Rather, the focus of the arguments and of this judgment is upon the legal conclusions to be drawn from those facts. The key findings of the judge and his assessment of the legal consequences are contained at paras [154]-[177]. The judge begins with a consideration of article 3 of the Convention as we do.

(i) Article 3 ECHR

[60] The state obligations under article 3 are twofold. First, and most obviously, it imposes a substantive prohibition upon treatment by state authorities which amounts to torture, inhuman or degrading treatment. However, article 3 jurisprudence of the ECtHR has developed in line with that under article 2, with the result that the substantive prohibition can also impose positive obligations to put in place a legislative and regulatory framework of protection. In certain well-defined circumstances there is also an obligation to take operational measures to protect specific individuals against real and immediate risks of treatment, contrary to article 3 (See *X & Ors v Bulgaria* (2021) 50 BHRC, at [181]). Second, article 3 also imposes a procedural obligation to carry out an effective investigation into credible claims of breaches of the substantive obligation. In these proceedings, we are only concerned with claims of a breach of the substantive obligation, namely the treatment of the applicants by reason of the delay experienced in accessing a suitability assessment for and the subsequent provision of OST while in prison.

[61] Article 3 prohibits a range of treatment. At the apex is torture. Then there is also a prohibition on inhuman or degrading treatment. The distinction between torture, inhuman treatment or punishment and degrading treatment or punishment derives principally from a difference in the intensity of the suffering inflicted. What we are concerned about in this case is alleged inhuman and degrading treatment due

to the delay in accessing an OST assessment for both applicants. As explained by the Grand Chamber in cases such as *Bouyid*, inhuman treatment will normally involve the infliction of actual bodily injury involving intense physical or psychological suffering. Treatment will be degrading when it humiliates or debases an individual showing a lack of respect for or diminishing his or her human dignity or arouses feelings of fear, anguish or inferiority capable of breaking an individual's moral and physical resistance. The presence of intent on the part of the person responsible for inflicting the treatment is relevant but is not determinative.

[62] In addition, for any claim under article 3 to succeed, the treatment must involve a minimum level of severity. The test of severity is composite, rather than cumulative – ie includes consideration of both the treatment and the effects on the individual concerned.

[63] The Strasbourg authorities stress that whether an act constitutes torture, inhuman or degrading treatment depends on a range of factors and the individual circumstances of each case. Therefore, the specific context in which the article 3 challenge arises is key.

[64] The applicants are both prisoners who have, due to their criminal convictions, lawfully been deprived of their liberty. However, the fact that they are prisoners does not detract from the state's obligation to protect their rights. For prisoners the positive obligation is to ensure that where a person is detained it is under conditions which are compatible with respect for human dignity; that the manner and method of the execution of the measure do not subject the individual to distress or hardship exceeding the unavoidable level of suffering inherent in detention; that, given the practical demands of imprisonment, the person's health and well-being are adequately secured by, among other things, the provision of the requisite medical assessment, assistance and treatment; and treatment must satisfy the principle of equivalence (see: *Wenner* at [55]; *Blokhin* at [136]-[138]; and *Cosovan* at [74]-[78]). The suffering which flows from a natural illness, whether physical or mental, may still fall foul of Article 3, where it is or it risks being exacerbated by the conditions of detention. Accordingly, detaining an ill person in inappropriate material or medical conditions may, in principle, give rise to a breach of Article 3.

[65] Plainly, an evaluation of the facts is required in each case. Also, as article 3 is a fundamental ECHR article, any assessment of whether there has been a violation must involve particularly thorough scrutiny. Care must be taken to relate the facts to the principles underlying article 3. Whilst the right is absolute and proportionality has no part to play, the governing principles which are set out above still leave room for an overall assessment of the treatment of a prisoner and the effects of the conditions of their detention, in light of their medical condition and needs. Those conditions must be appropriate in the sense that they are adequate to meet the medical needs of the prisoner and are comparable to the medical treatments which the state has committed to provide to the population as a whole. In making

that assessment the Court retains a sufficient level of "flexibility", deciding on a case-by-case basis whether the prisoner's treatment was compatible with human dignity (see *Blokhin* at [138]).

[66] The key consideration in this case is how the prison authorities have treated both prisoners in light of their established drug addiction, within the parameters of health care provision in prison, bearing in mind that they had not been assessed as suitable for, nor were they being treated with OST at the time of their admission to prison.

[67] There are a limited number of cases to which we have been referred, which concern the specific issue of the treatment of prisoners with drug addictions and who suffer withdrawal. First is *McGlinchey and others v United Kingdom* [2003] ECHR 50390/99. This case concerned the adequacy of medical care provided by prison authorities to a heroin addict suffering from withdrawal symptoms. The court found that within a week of the applicant's imprisonment, she was suffering from serious weight loss and became dehydrated as a result of continuous vomiting and an inability to hold down food or water. In addition to her manifest distress, these were found to be sufficient indications of severe risks to her health for the domestic authorities to be required to take measures to address her heroin withdrawal symptoms and her condition. There were also gaps in the monitoring of the prisoner and she ultimately died within less than one month of her imprisonment. The court found that the prison authorities had failed to comply with their duty to provide her with the requisite medical care and that her treatment was inhuman and degrading, in violation of article 3 of the Convention.

[68] The other case specifically on point is *Wenner v Germany* [2017] 64 EHRR 19 (Application 62303/19). We have set out the legal principles which derive from this decision above. However, we also make some reference to the facts. The case concerned a complaint by a long-time heroin addict who also suffered from HIV and Hepatitis C and was forcibly denied drug substitution therapy in prison which he had been taking for 17 years prior to his incarceration. After a period of abstinence-based therapy, the medical recommendation (including that of an independent external medical practitioner) was for him to receive substitution therapy to avoid a deterioration in his health, high risk to his life and the spreading of HIV and hepatitis. There were differing medical opinions on the best form of treatment for drug addicts. Substitution therapy was not made available in prison and the authorities declined to make an assessment for suitability, despite independent medical expert advice indicating that it was appropriate treatment. The nature of the suffering experienced by the prisoner as a result of the denial of substitution therapy was particularly marked. Although he did not experience withdrawal symptoms within the prison, he suffered daily chronic pain with deteriorations in his physical and mental health. The court held that there had been a violation of article 3 on the grounds that the authorities, despite their obligation to assess the applicant's state of health and provide appropriate treatment, had failed

to examine with the help of independent and specialist medical expert advice which therapy was to be considered appropriate.

[69] These decisions are examples of factual circumstances which can give rise to a breach of article 3. They are, however, distinguishable from the facts of the cases before us. In *McGlinchey* no treatment at all was provided for the prisoner. Nor did any medical intervention take place, despite clear indications of serious deterioration in her health. The circumstances were stark, with severe effects upon the applicant's health, ultimately resulting in her death in custody. In *Wenner* the authorities withdrew OST when it had been provided in the community for 17 years to the applicant and refused to provide substitute treatment, despite independent medical advice to the contrary and despite deteriorations in the prisoner's health. Neither case deals with the distinct issue we are asked to determine whether the treatment experienced by the applicants as a result of delay in assessment for OST suitability, within the prisons regime amounted to inhuman or degrading treatment.

[70] We also note the admissibility decision of *Shelley v UK* 2008 in a slightly different context. This ruling designated prisoners on the same footing as those in the community in terms of healthcare. However, it also highlighted the importance of context in assessing state obligations. Specifically, the ECtHR declared inadmissible a claim on the basis that prison authorities are not legally required to provide needle exchange programmes to prisoners to prevent disease transmission provided they offer reasonable preventative health measures.

[71] Having considered the relevant legal principles we agree with the judge that these cases both fall within the scope of the article 3 principles. The fact that the applicants were required to wait three years without receiving an assessment for OST calls for scrutiny of their treatment under Article 3. However, the key issue is whether there has been a violation of article 3 based on the effects of delay in accessing a service that would be provided within the community within a matter of weeks, in other words, the absence of an equivalent service and the level of suffering experienced by the applicants during the interim period.

[72] The judge placed much emphasis on equivalence in healthcare for prisoners relative to persons in the community drawing from the Strasbourg authorities and some International Law treaties and instruments that address the issue of equivalence in healthcare for prisoners. We have discussed the ECtHR cases above. We have also considered the international instruments referred to us. Whilst not part of our domestic law, these instruments are a complement to the Strasbourg cases which refer to equivalence. Equivalence is a standard which Council of Europe Member states should try to achieve for prisoners. However, as the Strasbourg cases state equivalence does not mean identical care, and when assessing the impact of this much will depend on the context in which the question arises. In domestic law terms equivalence is not a public law norm. Similarly, while the Strasbourg authorities emphasise the importance of conducting an equivalence

analysis as part of the overall assessment of the adequacy of medical treatment, we do not consider that any of those cases go so far as to find that a lack of equivalence, without more, will amount to ill-treatment falling foul of Article 3. The context is key.

[73] The context is provided by the body of evidence provided by the Trust. Of particular value is the evidence of Dr Margaret Siobhan Flanagan as she is the lead clinician responsible for the assessment and administration of OST within the prison. She is a Consultant Psychiatrist and was in direct charge of Pollins' care while in prison. In her affidavit of 6 June 2024, she avers that:

> "Unlike many areas of medicine where a medicine can be prescribed and the patient's condition treated, leading ultimately to a timely discharge from care, OST treatment will continue for several years or indefinitely. Commencing a patient on OST is only the start of addictions work. Patients on OST often have significant psychiatric and physical comorbidity in addition to various social challenges. Work focuses on addressing associated medical (hepatitis, HIV, cirrhosis, COPD) psychiatric (complex trauma, PTSD, depression, personality disorder) and social problems (family breakdown, homelessness, issues with criminal justice; reducing the risk of relapse and helping the patient move forward with lifestyle change. A holistic approach is taken to give the treatment the greatest possible prospects of success."

[74] Additionally, as Dr Flanagan explains, there is a robust system of regular reviews and personal contact with professionals. In her affidavit Dr Flanagan also states that:

> "Another mistaken view which I repeatedly encounter both with potential patients and other authorities is a belief that OST is a panacea for all drug addiction. It is not. OST is not appropriate for those who are addicted to drugs other than opiates; it is not suitable for those who misuse opiates but are not addicted (in the clinical sense) nor is it even suitable for all patients who are in fact addicted to opiate, OST can be life threatening if incorrectly prescribed and/or administered."

[75] It is uncontroversial that the prevailing conditions in the community versus the prison are different. That is because there is a greater demand for OST within the prison population than in the community on a pro rata basis and there are finite

resources and capacity to provide OST within the prison. This reality on the ground has led to a waiting list for OST assessments among prisoners and an operational decision that those who are already being treated with OST upon admission into the prison, should be prioritised in the interests of safety.

[76] The evidence also highlights the fact that administration of the drug in prison is different in that primary care nurses are required to dispense in prison in the vast majority of cases whereas this is undertaken by pharmacies in the community. Dr Flanagan also explains that this service could not be effectively outsourced to the community. Dr Flanagan makes the point that the staffing issue is exacerbated since body scanners were introduced in the prison to detect drugs since April 2023. She explains that what this means is that all new committals to HMP Maghaberry will have a body scan to ensure that they are not smuggling in drugs or other items with the effect that:

> "This has had an unpredicted and adverse impact on our resource levels. When patients on OST fail a body scan, their OST medication is withheld due to the possibility of accidental death-that risk could manifest if they receive OST while having street drugs within their bodies or secreted on or in their person. They have to be carefully monitored during that period. If they then miss three days of OST treatment, this means we have to stop their OST to re-induct them onto the program. This is a dangerous process because opiate tolerance dissipates quickly, and there is a significantly increased risk of overdose as a result. This is a high-risk area of treatment. It requires careful observation and clinical consideration. This consumes time and resources."

[77] On this issue, Dr Flanagan goes on to state that:

> "In the first 12 months of the body scanner being in place, the addiction team in prison re-inducted 41 patients onto OST as a direct result of the scanner. We had no additional resource to support this. This took away from the time we could have spent seeing patients on OST and new patients. Patients being re-inducted need to be seen on average weekly by nursing staff for at least 6 weeks. This is more instance that the review of a new OST patient or one who is already established on a course. This is a considerable volume of work and has compounded our difficulties in addressing the waiting list."

[78] Dr Flanagan makes the stark observation in her affidavit that:

> "if too many patients are inducted onto OST or are committed on OST, given the current level of resource, the system risks becoming unsafe."

[79] None of the evidence as to the system of OST provision in prison is disputed. Hence, this appeal boils down to how the judge dealt with the body of evidence as to the delay in Pollins being assessed for OST and the effects that had upon him.

(ii) The specifics of the Pollins article 3 appeal

[80] Pollins filed two short affidavits. In the first dated July 2023, he refers to the fact that he is an addict and that he used illicit substances within the prison to manage his addictions. He avers that there are risks with this and that:

> "when I can't get enough, I really struggle both physically and mentally. I will feel sick and in pain. I become extremely depressed and struggle to go out. I turn inwards. I hear voices in my head. I want to kill myself. My mental health really plummets - it is unbearable."

In this affidavit Pollins also states that:

> "I appreciate I have been provided with other types of support with my addiction from prison, for example working with Adept. However, this isn't enough to deal with my issues. I need help to stop me chasing a hit every day."

[81] In his second affidavit of 24 June 2024, Pollins confirms that he started on OST upon release into the community on 21 June 2024.

[82] Within the above context, Pollins relied on two areas of complaint, arising from the delay in assessing him for OST from February 2021 onward and which he contended amounted to inhuman or degrading treatment in breach of article 3 ECHR, namely withdrawal symptoms and distress. This had to be established to a minimum level of severity.

[83] Pollins also relied on evidence from Professor R J Davidson, Consultant Clinical Psychologist, who filed a report dated 25 November 2023. Professor Davidson interviewed the second applicant by video link on 25 September 2023. Summarising his report, he refers to the fact that the applicant has spent much of his life in the care system or prison. He has a diagnosis of ADHD and borderline personality disorder (now more properly described as an emotionally unstable personality disorder) rendering him much less able to cope with adversity and more

difficult to manage in a custodial setting. Anxiety issues were first recorded when he was fifteen years old. There was an impulsive suicide attempt by hanging in 2010 which resulted in an admission to hospital. Drug abuse was an issue at that time and he was already known to the local addiction service.

[84] Having assessed Pollins by video link Professor Davidson expressed the view that he would clearly benefit from a structured OST programme. It is worthy of note that Pollins was able to inform Professor Davidson that those individuals who had been on OST in the community and were then subsequently committed to prison were prioritised in relation to being placed on OST in prison. Pollins provided a history to Professor Davidson of frequently experiencing withdrawal symptoms and regularly experiencing headaches, restlessness, insomnia, cold sweats, diarrhoea and poor appetite. He stated that this made it difficult for him to attend appointments.

[85] Professor Davidson administered the Leeds Dependence Questionnaire and having considered the results concluded that the second applicant had a serious "polydrug problem." He stated that:

> "Essentially, his life in prison is characterised by sourcing drugs, paying for drugs and using drugs."

[86] The results of psychometric assessments were interpreted by Professor Davidson as being consistent with the description in the GP Notes and Records of a lifetime of mild depression but with significant anxiety.

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

[88] In summary, Professor Davidson found in relation to Pollins:

- Unenthusiastic about mental health services.

- Suffers ADHD and does not have coping mechanisms in the community.

- Significant withdrawal symptoms have become a regular feature of mental and physical state. Complaining of suffering twice per week.

- Self-medication is producing dependence and withdrawal symptomatology which impacts mental and physical health. He believes OST would break the cycle.

- He would be suitable but may lack motivation in the community. Will experience withdrawal symptomatology in the prison and is at risk of OD on release, due to changes in tolerance levels.

[89] However, the evidence presented by Pollins as to the impact of delay in assessing him for OST was disputed by the Trust which highlighted inconsistencies in his prison notes and records which it was said undermined his claims. Mr Henry highlighted a complex presentation of comorbidities, aggression towards staff, self-harm attempts and a repeating pattern of non-attendance and refusal of services over years in and out of prison between 2008-2024.

[90] We note the following references to OST/Clinical Addictions Team which have been highlighted to us although in doing so we stress this is not a complete account of the lengthy prison records:

3/10/18 "28-year-old man, currently not suitable for OST and declined same, not keen to engage, states he has seen ADEPT, and has completed naxalone treatment, offered Naltrexone treatment and declined this option, encouraged to consider same but was clear he was not keen for support in prison."

24/5/19 Mental health screening, requests consideration of OST.

24/5/19 Drug misuse review; drug history taken, declined ADEPT, referred to Clinical Addictions Team.

17/2/20 Refused to attend Clinical Addictions Team appointment with Dr Flanagan, Addictions Consultant; she offers to see him again.

18/2/20 Attended Clinical Addictions Team review with nurse; said he is off all drugs and does not require OST; but keen to commence on Naltrexone; advised in respect of drugs; further appointment made for him to see Dr Flannagan on 2/3/20.

14/3/21 Self-inflicted injury, reluctant to speak with medical staff but agrees, wounds treated, refers to taking drugs, no signs of withdrawal, SPAR opened.

20/4/21 Seen by Clinical Addictions Team; will speak with ADEPT to request increased contact with ADEPT key worker.

24/8/21 Mental health review; said he self-harmed because of delay and he could continue to do so until he was seen by addictions; he was advised this would not cause him to be seen sooner; he was praised for seeking help.

3/9/21 He attended appointment with CPN; in good humour; things are going well; thinks he would be seen sooner by Clinical Addictions Team if he had a better ADEPT key worker, but he was assured that individuals cannot move him up the waiting list like that.

2/3/23 Failed to attend appointment with Dr Flanagan; she had called him on the telephone to his landing to remind him of the appointment; landing staff now said he was refusing to attend; Dr wishes to speak to him again about reduced tolerances and OST, Naltexone and Naloxene and happy to see him again if he is agreeable.

27/4/23 Prison and Probation requested a referral to mental health; nurse met with the applicant; he did not think it was necessary; his issues are drug related but knows he can request mental health assistance at any time.

18/5/23 Timeline for OST request by prison officer for parole hearing; Clinical Addictions Team not able to provide a timescale, but he is on waiting list.

7/8/23 Nurse met with him to review the Commissioners recommendations.

8/8/23 Meet to discuss Commissioners recommendations; applicant feels he was misdiagnosed as a child with anti-social personality disorder and EUPD; discussed a mental health referral to explore this; applicant happy with this; no other mental health complaints.

17/8/23 Contact with NIPS prison psychology.

31/8/23 MDT; mental health referral will be offered.

[91] On any reading, the medical records do not offer strong support for Pollin's claims. Properly analysed, Pollins' medical history is complicated and multi-faceted. His difficulties arise not only from opiate drug addiction. In addition, we can see long periods of non-engagement or problematic engagement with professionals including Dr Flanagan although we acknowledge Pollin's position that some of this is attributable to the delay in being assessed.

[92] Dr Flanagan has filed an expert report in these proceedings which contains her opinion on the potential benefits of OST for Pollins and the distress caused by not having access to OST. Again, this is not a particularly helpful report for Pollins. Her opinion also differs markedly from that of Professor Davidson. Of most relevance for present purposes are extracts from para 8 of Dr Flanagan's report which read as follows:

> "8.3 There are four entries in Mr Pollins' EMIS records documenting formal requests for symptomatic relief medication for opiate withdrawal July 2012, May 2019, February and November 2022. Mr Pollins received Mebeverine and Loperamide to alleviate opiate withdrawal symptoms in February and November 2022. He received cyclizine to alleviate sickness due to opiate withdrawal in May 2019 and Lofexidine to alleviate opiate withdrawal in June symptoms in July 2012. I note that Mr Pollins reported to Professor Davidson that he is experiencing withdrawal symptoms approximately twice weekly. Whilst I cannot ascertain from the EMIS records how often Mr Pollins has sought medication informally from the house nurse, regular twice weekly requests for opiate withdrawal medication would lead to a referral to or a discussion with medical staff. No such concern is documented in Mr Pollins' EMIS record.
>
> 8.4 Any additional medication the patient is prescribed may also alleviate opiate withdrawal symptoms. Mr Pollins was prescribed Olazapine from January to May 2012, Diazepine from May to June 2019 and co-codamol an opiate in December 2020 and again in January 2023.
>
> 8.5 It is difficult to say if OST would alleviate Mr Pollins' distress as he presents with co-morbid difficulties with emotional instability and his poor coping skills. If he were to commence OST and continue to use Pregabalin and/or other drugs on top to manage emotional dysregulation, he may still experience daily withdrawal symptoms in the stress of sourcing drugs. Having said that, if he were opiate dependent and did stabilise on OST, this would remove the stress and financial burden of seeking opiates and other drugs daily and allow him the opportunity to progress within the prison and again to address his mental health difficulties.

> 8.6 Mr Pollins remains at risk of overdose and release if he continues to use drugs in prison. My understanding is that he has engaged superficially with ADEPT and has not to date shown any motivation to stop using drugs completely and the focus of their work has thus been harm reduction. Most drug deaths now involve several drugs. Mr Pollins is at risk of overdosing not only on opiates but also Pregabalin, cocaine and other street drugs he may take. If he is not opiate dependent and continued to use drugs on top of OST his risk of overdose on release would remain heightened."

[93] Dr Flanagan opines that Pollins requires "a thorough comprehensive assessment of his physical and mental health, his motivation to change and engage safely in treatment and his degree of dependence on the drugs he is taking to ascertain if he is suitable for OST. The suitability for OST at this stage remains unclear (that is on 14 March 2024). He was offered the opportunity to avail of the assessment in February and March 2020, but he declined to attend." Dr Flanagan finishes by saying that he is currently on a waiting list.

[94] Having considered the competing evidence, the judge reached core conclusions which are challenged on appeal as follows;

(i) The nature, extent and duration of his symptoms crossed the level of severity to give rise to a breach of article 3, and they resulted in Pollins being detained in conditions which were not compatible with human dignity (para [161]).

(ii) The symptoms caused prolonged hardship and distress which were clearly in excess of the unavoidable level of suffering inherent in detention (para 161]).

(iii) Other medical resources available to Pollins did not reduce his suffering below the relevant level (para [162]).

[95] The Trust maintains that the judgment from first instance cannot stand for three core reasons. First, that the judge placed the minimum level of severity threshold at substantially too low a level. Second, that the judge failed to identify or apply the different legal analysis which operates when the ill-treatment alleged is related to an underlying illness and as opposed to one inflicted directly by the actions of a public authority (ie avoiding exacerbation of the pre-existing condition due to the conditions of detention for which the state is responsible). The applicants contend that this is particularly important in the context of a delay case. Third, that the judge also erred when he concluded that the Trust failed to provide care to address the underlying problem which was polydrug addiction which the Trust said was tackled through a specialist ADEPT programme. This is all within a context

where Pollins had been offered an OST assessment previously in March 2020 when the demand for the service was at a lower level, but he refused to attend for the appointments, despite encouragement from the OST team.

[96] The judge did not hear oral evidence from either expert. He reached a conclusion on paper as is the normal approach in judicial review. We acknowledge that his was a difficult determination given the competing evidence in a specialist area. However, in judicial review, if there is such a conflict it is usually resolved on behalf of the respondent on the basis that an applicant cannot satisfy the burden of proof. The judge does not acknowledge this principle. It follows that given the contested expert evidence; para [161] of the judge's ruling sits uneasily and begs the question whether the evidence provided in this case establishes a violation of article 3.

[97] We have carefully considered all of Mr Hutton's well-crafted submissions on this point. The main source of the evidence on withdrawal symptoms was Pollins himself. He said he normally suffered withdrawal twice a week. However, the objective evidence was more limited. There was one entry referring to mild withdrawal in 2012 and two entries of mild withdrawal in May 2019 after he entered prison from the community, several years prior to the relevant period. There was very little evidence of withdrawal in his medical notes and records for the relevant period, despite him being seen regularly by medical professionals and prison officers throughout and knowing that he could have ready access to medication from medical staff to ease withdrawal if required.

[98] Regarding distress and anxiety – the Trust accepted that Pollins would have suffered some distress because of the delay in assessing him for OST. However, the question is whether this amounted to torture, inhuman or degrading treatment, either in its own right or when combined with any withdrawal he may have suffered. Mr Henry stressed that Pollins is a polydrug user and that ADEPT is a global addictions service, not limited to opiates.

[99] No one disputed the fact that ADEPT is a valuable and specialist service provided throughout the prison estate in Northern Ireland and which has been commended by the inspectorate. It was offered and provided to Pollins, along with other care.

[100] The State's obligation to provide appropriate medical treatment to a seriously ill detainee is not an obligation to cure the illness, nor is it an obligation to avoid suffering associated with the illness. In particular, the mere fact of a deterioration of the applicant's state of health is not, on its own, sufficient to amount to inhuman or degrading treatment, even where, at an initial stage, there may be certain doubts concerning the adequacy of the treatment in prison. The article 3 caselaw discussed above requires a flexible focus upon the adequacy of the treatment, which was provided to a prisoner, in light of his condition and whether it involves unnecessary

suffering, degradation or avoidable exacerbation. If, bearing in mind the specific context, it can be established that the relevant domestic authorities have provided appropriate medical treatment in a timely fashion to treat the medical condition presented by a prisoner and if it has resorted to all reasonably possible medical measures in a conscientious effort to hinder development of the disease in question and to avoid unnecessary suffering or exacerbation, it is open to a court, on a case by case basis, to find that the necessary threshold of severity for inhuman and degrading treatment has not been reached.

[101] Assessed through this prism we consider that, on the facts of this case, the judge was wrong to find fault on the part of the Trust which, as a service provider with limited resources, was acting conscientiously to assist prisoners in the management of drug withdrawal symptoms. We also consider that he underestimated the importance and propriety of the other interventions which were available to Pollins, particularly ADEPT. These were reasonable preventative health measures whilst the applicants were on the waiting list for OST assessment.

[102] Furthermore, we agree with the Trust that, whilst Pollins claimed to be suffering frequent withdrawal, this did not accord with the objective evidence which was reflected in the Trust medical records or the opinion of the clinician who was responsible for his care, while in prison. The only contrary account of the extent of effects was provided by Pollins himself and repeated by Professor Davidson based on Pollins' self-report. There were also limitations with Professor Davidson's report in that he simply offered the view that Pollins "would likely benefit" from OST. However, that is not the test. When assessing article 3 compliance the issue is the adequacy of the treatment offered in all of the circumstances, including the effects upon Pollins and the level of suffering he has endured.

[103] Thus, in this case we reach a different view about the legal consequences of the facts found by the judge. We also have reservations about the approach followed by the judge in arriving at the conclusions which he did. On an overall view of all of the circumstances of this case and notwithstanding the difference in assessment waiting times, we do not consider that the treatment provided to the applicant could be described as inadequate, particularly in light of his pre-existing polydrug addiction, the fact that Pollins was not receiving OST treatment upon admission to prison, his regular medical review while in prison, the provision of medication as prescribed by clinicians, his access to the ADEPT programme and his prior refusal of OST assessment. Bearing in mind those circumstances, we do not consider that the level of distress and/or anxiety which he undoubtedly experienced, coupled with any withdrawal, reach the minimum level of severity to constitute inhuman treatment, nor was his treatment or the conditions in which he was kept incompatible with human dignity such that they amounted to degrading treatment.

[104] Furthermore, the treatment provided to Pollins and the suffering endured by him are markedly different to *McGlinchey* and *Wenner* cases. Pollins was also treated

with professionalism by the prison authorities and by Dr Flanagan. He suffered no degradation or humiliation. There is no suggestion in this case that medical advice was ignored. Rather this was a case of delayed provision, with appropriate interim care. Accordingly, we disagree with the judge that there was any breach of article 3 ECHR.

[105] We also agree with Mr Henry that the judge placed too great an emphasis on equivalence when determining whether there had been a breach of article 3. The positive obligation is to provide "requisite" medical care. The care must be appropriate. That is what the court will look for within the context that pertains. However, a lack of equivalence cannot mean an automatic breach of article 3. The test is broader. Whilst equivalence could be taken into account as a factor, a failure to provide treatment in the prison on terms equivalent to the community because of delay, in a case where the alleged harm was primarily caused by an underlying illness, does not significantly inform whether there has been ill-treatment amounting to torture, inhuman or degrading treatment in the circumstances of this case, considering the care that was in fact provided and the fact that by necessity the prison had to manage a waiting list by way of prioritising those already on OST.

[106] The evidence of Dr Richard Kirk, Medical Doctor and Clinical Director of Health Care in Prisons, is persuasive on this point. He deals with the issue of equivalence, but he does say that providing health care in prison is not exactly the same as providing it in the community. The provision of health care can be constrained or altered by the existence of the prison regime, its processes and factors which could have an impact on care delivery. In relation to the key question, which is the limited numbers who can avail themselves of OST, Dr Kirk states in his evidence that this is not something the Trust wants to do for the following reasons:

> "It is a purely resources driven requirement. Once admitted onto an OST programme, following assessment, the OST must follow up and review in accordance with the Orange Guidelines. In the prison, based on the funding available at present, once the number passes 180 patients in OST, it becomes difficult to safely adhere to these guidelines and there are responsibilities for follow-up and review. There is a risk of death on OST. The General Medical Council Good Medical Practice Guidelines are implicit about non-malfeasance and their first do no harm principle is clear. It is also clear that patient safety is the responsibility of the Treating Clinician. In the prison system, given the inability to review patients in a timely fashion it is safer to not start OST medication than to start and not be able to follow up."

[107] We find the above explanation compelling and the hallmark of a conscientious healthcare provider. In his evidence, Dr Kirk also goes on to say:

> "We have also been surprised by the rapid escalation in demand for OST. Demand has grown at a rate unseen in our experience of addiction services. Demand for OST is extraordinarily high among the prison population."

[108] Thus, for a combination of reasons we find that in all of the circumstances, neither the treatment provided, nor the effects upon Pollins reach the requisite level of seriousness for a violation of article 3. The judge's conclusion was plainly wrong. Moreover, we are bound to say that in light of the requirement under section 6 of the Human Rights Act that the conduct of public authorities is examined individually (rather than the conduct of the "state" to be considered collectively), a claim against the Trust for breach of article 3 was going to be challenging. That is because the Trust was the designated health care provider for prisons and could only operate within resources made available to it. There was no dispute between the parties, that the clinical priorities developed by the Trust to allocate those resources were appropriate and that they were based upon the sound clinical principles explained by Dr Kirk. In the circumstances, it seems to us that any finding of inadequate treatment and a breach of Article 3 by the Trust is particularly harsh. This also raises the question whether the claims made may have been directed against the wrong target insofar as it may have been founded upon the consequences of the unavoidable budgetary constraints placed upon the Trust, which was unable to divert the resources allocated for community healthcare provision into prison healthcare.

(iii) Article 8 ECHR

[109] There is an alternative claim made by the applicants based on article 8 of the ECHR. We have our reservations as to the applicability of this article where article 3 is the *lex specialis*. The ECtHR has found breaches of article 8 in some cases where the minimum level of severity necessary for article 3 has not been reached. However, as far as we can see these cases do not concern delays in medical treatment generally or to prisoners in particular. In our view, it is a stretch to engage article 8 and find an interference in this context.

[110] We favour the analysis in *Wilson and Kitchen* and repeat the observation of the Court of Appeal that the single Strasbourg decision on which this aspect of the applicants' cases is promoted is *Passannante v Italy* [1998] 26 EHRR CD 153 which is an admissibility decision of the European Commission. As summarised above, this is also framed in a qualified way, namely that delay which has a serious impact on the patient's health could raise an issue under article 8(1) of the Convention. It is telling that no other cases are cited in support of the article 8 claim.

[111] We remain sceptical that article 8 is properly engaged in cases concerning delay in medical treatment. In any event, even if article 8 can be engaged and an interference can be established based on delayed treatment, we consider that any interference is justified and that the claim fails upon application of article 8(2). We reach this conclusion having reviewed the judge's findings but also having conducted the proportionality balance ourselves as per *Shivdler* out of an abundance of caution.

[112] The argument advanced by the applicants is that the judge erred in determining that the measures employed were not rationally connected with the legitimate aim. We have sympathy with the judge insofar as the legitimate aim was not articulated with clarity at the lower court. However, Mr Henry has now provided much needed definition to this aspect of the article 8 analysis by saying that the legitimate aim was to provide adequate healthcare. In addition, and allied to this legitimate aim, Mr Henry makes the fair point that the judge failed to identify what the measures complained of were when obviously there was a scheme of prioritisation introduced to deal with demand exceeding supply. The scheme of prioritisation was based on clinical judgment and best practice, grounded on national guidelines. This was plainly and rationally connected to the legitimate aim.

[113] We also consider that the judge erred when determining that there was a less intrusive means available to the Trust of achieving the legitimate aim. He explained that the underlying problem was inadequate funding and the solution was a complete overhaul of the budgetary methodology and more money from the state. However, this course was clearly outside the control of the Trust as provider of services. Therefore, the judge has erred in finding against the Trust on this basis.

[114] Insofar as the article 8 challenge does relate to the availability of resources, we consider that in matters of socio-economic policy and resource allocation a wide margin must be available to the state. There was little or no evidence before the judge or this court about the choices which were available or which were made as between competing priorities. Insofar as the impugned measure does touch upon the issue of resource allocation, we consider that it falls within the available margin.

[115] Furthermore, the judge erred when determining the "balancing exercise" component of the article 8 proportionality test, which weighs the interests of the individual against the interests of the general public. He relied on his adverse finding against the Trust on the (earlier) "rational connection" component of the proportionality test as a reason why there was not a fair balance between the interests of the individual and the broader interests of the community. That was an error of reasoning. We agree with Mr Henry that when addressing the balance, the judge took an unduly narrow view of the public interest, which includes the broader interests in the safe treatment of prisoners and continuation of treatment for those already on OST which is part and parcel of the prioritisation structure.

[116] Hence, having conducted a review of the judge's analysis and having conducted the proportionality balance ourselves we reach the same conclusion. We find that any interference with article 8 rights in both Pollins' and Clarke's case was objectively justified and proportionate.

(iv) Article 14 ECHR

[117] The remaining aspect of the challenge invoking article 14 is difficult for both applicants given we do not consider there has been a breach of either article 3 or 8. Whilst this finding is not determinative it would, in our view, be highly unusual if not unprecedented for a discrimination claim to succeed without a breach. In any event, we are not satisfied that an article 14 discrimination claim can be established for the following reasons following the steps that are required for article 14 claims set out above. In summary this involves consideration of ambit, status, analogous situation, objective justification and proportionality.

[118] The article 14 discrimination test is cumulative. An applicant must satisfy each stage of the test in their favour; if they fail any one of the required steps, the entire article 14 claim necessarily fails.

[119] The Trust accepts that the issues raised do come within the ambit of articles 3 and 8 albeit this is not accepted by the DoH. However, ambit is a wider concept than that of interference. We are inclined to proceed on the basis that the issues are within ambit.

[120] However, the establishment of a precisely defined protected status is not only a fundamental requirement of an article 14 challenge but is also a prerequisite to consideration of what the appropriate comparator group is, whether those in an analogous situation with whom the applicant compares himself or those in a different situation which the respondent has failed to treat differently. Precise definition of the status relied upon is also necessary to assess whether the allegedly discriminatory treatment was on the ground of that protected status. In this respect, it is accepted that the category of 'other status' is broad and being a prisoner is an aspect of personal status and may amount to "other status" for the purposes of article 14 (see *Stummer v Austria [GC], 2011, § 90; P.C. v Ireland, 2022, § 80).*

[121] In determining whether, in an article 14 challenge, groups are in a relevantly analogous situation the court must regard the nature of the complaint being advanced: see, for example *Clift v United Kingdom* at [66]. This underscores the need for precision in the way the status and comparator groups are identified. This has not been well defined on paper although we got better oral argument. This test does not require the demonstration of exact equivalence. Rather the requirement is one of sufficient similarity: see *AL (Serbia) v Secretary of State for the Home Department* [2008] 1 WLR 1434 at [25] per Baroness Hale.

[122] Thereafter, the establishment of a precisely defined protected status is obviously a pre-requisite because it is the foundation for consideration of what the appropriate comparator group is and whether those in an analogous situation with whom the applicants compare themselves or those in a different situation which they say the respondent has treated differently. In determining this, the courts must look at what is actually in issue with some clarity.

[123] This is important because as Lord Reed said at para 145 of *SC*:

> "In domestic law, as at the Strasbourg level, one would expect closer scrutiny where the case concerns discrimination on a ground such as sex or race, rather than a difference in treatment on less sensitive grounds, especially if it is simply a by-product of a legitimate policy. Distinctions drawn on "suspect" grounds are inherently appropriate for close judicial scrutiny, notwithstanding the respect due to the judgment of the executive or the legislature."

[124] Upon consideration, the question of status was not fully analysed at the lower court. The status appears to have been identified as a prisoner. However, such a categorisation is not an accurate reflection of the facts. Within the prison regime, prisoners are treated differently. Those on OST when they enter prison remain on the treatment. Therefore, the status of each applicant is a prisoner who is alleging he is entitled to OST.

[125] It follows that the analogy is made with individuals in the community who are seeking OST treatment. Whilst the DoH challenged this proposition there seems to be sufficient authority to the effect that prisoners can claim to be on a similar footing to those in the community as regards the provision of healthcare. This means that on balance the argument that there is a difference in treatment between those in analogous positions is sustainable in principle.

[126] That said, we acknowledge the argument made by Mr McGleenan that if the applicants have status, they are at the outer end of the range that is protected. This assessment is relevant in relation to the assessment of justification. Even if a person in an analogous situation is treated differently, an article 14 discrimination claim can only succeed if there is no objective justification for the treatment. The objective justification given for the difference of treatment is ostensibly the provision of a safe system of OST provision within resource.

[127] As we are dealing with an area of prison policy, the state is afforded a wide margin of appreciation. In this regard, we are reminded of what Lord Reed said in *SC* at para [160] that:

> "It may also be helpful to observe that the phrase "manifestly without reasonable foundation", as used by the European court, is merely a way of describing a wide margin of appreciation. A wide margin has also been recognised by the ECtHR in numerous other areas where that phrase has not been used, such as national security, penal policy and matters raising sensitive moral or ethical issues."

[128] The proportionality of the response by the state authority also falls to be examined. The ordinary approach to proportionality gives appropriate weight to the judgment of the primary decision-maker: a degree of weight which will normally be substantial in fields such as economic and social policy, national security, penal policy, and matters raising sensitive moral or ethical issues. *SC* determined at para 161 that the ordinary approach to proportionality will accord the same margin to the decision-maker as the "manifestly without reasonable foundation" formulation in circumstances where a particularly wide margin is appropriate. This is such a case arising as it does in the policy arena.

[129] When determining this issue, the judge did consider the competing interests, however, he focused on the resource position as a reason for rejecting the objective justification provided. We can understand how the judge was drawn into this position given the way the case was argued. Specifically, the judge was urged to follow *R (Steinfeld) v Secretary of State for International Development* [2018] UKSC 32 and *R (Coll) v Secretary of State for Justice* [2017] UKSC 40.

[130] Therefore, he relied on the judgment of Lady Hale in *Coll,* particularly para [40] wherein she stated:

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

[131] Reliance on this line of authority is misplaced. That is because the *Steinfeld* and *Coll* cases arise in an entirely different context. They were cases concerned with direct discrimination as part of statutory schemes. In such circumstances resource

arguments cannot succeed. However, we are dealing with potential indirect discrimination as a result of the application of a prioritisation of prisoners for OST. When deciding on that question resources can come into the proportionality balance along with other factors. The judge has therefore erred in his consideration of objective justification and been distracted by the resource argument when in reality the Trust had to prioritise prisoners within resource in the provision of OST. This is an objective justification to differential treatment of prisoners versus those seeking to be assessed for OST in the community.

[132] Thus, even if some of the foundational hurdles for an article 14 claim are overcome (about which we have reservations) the differential treatment is justified. Furthermore, the application of the test of proportionality to the professed legitimate aim could not be said to be manifestly without reasonable foundation as refined by the Supreme Court in *SC* particularly given the wide margin of appreciation afforded in what is a policy area. Therefore, the judge was wrong to find discrimination under article 14 in each applicant's case.

(v) Conclusion

[133] Accordingly, for the reasons given we allow the appeals. In our view, the Trust has acted lawfully as a provider of services within the prison with the legitimate aim of managing a safe system. No relief was sought against the DoH or any other state agency responsible for prisoners. We find no breach of human rights in either prisoner's case against the Trust.

[134] That said, we are cognisant that the DoH have committed to seek further funding for OST in Northern Ireland prisons. This is welcome considering the number of prisoners with opioid addiction who will struggle to rehabilitate without treatment such as OST, a point raised by the Parole Commissioners in these cases.

[135] Finally, we point out that even though we disagree with the outcome reached at first instance, we can see that there is a pressing need for constructive debate at governmental level in relation to delays in the assessment for OST in our prisons just as there is a need to debate hospital waiting lists for people in the community. These are social policy issues which engender a range of views. The judge was right to highlight the problem. However, our role differs from that of the policy makers. Any deficit in this area is best raised in the political sphere with the benefit of debate and a wide range of expertise.

[136] We will hear from the parties as to any remaining issues that arise.