COUR EUROPÉENNE DES DROITS DE L'HOMME
EUROPEAN COURT OF HUMAN RIGHTS

FOURTH SECTION

FINAL DECISION

AS TO THE ADMISSIBILITY OF

Application no. 23800/06
by John SHELLEY
against the United Kingdom

The European Court of Human Rights (Fourth Section), sitting on 4 January 2008 as a Chamber composed of:

Josep Casadevall, *President,*
Nicolas Bratza,
Giovanni Bonello,
Stanislav Pavlovschi,
Lech Garlicki,
Ján Šikuta,
Päivi Hirvelä, *judges,*
and Lawrence Early, *Section Registrar*,

Having regard to the above application lodged on 11 May 2006,

Having regard to the decision to apply Article 29 § 3 of the Convention and examine the admissibility and merits of the case together,

Having regard to the observations submitted by the respondent Government and the observations in reply submitted by the applicant,

Having regard to the comments submitted by the Irish Penal Reform Trust, with the Canadian HIV/AIDS Legal Network and by the National AIDS Trust, supported by the Prison Reform Trust,

Having deliberated, decides as follows:

THE FACTS

The applicant, a United Kingdom national, born in 1972, is currently serving a sentence of imprisonment in H.M. Prison Whitemoor. He was

represented before the Court by Mr Sean Humber, a solicitor practising in London. The United Kingdom Government ("the Government") are represented by their Agent, Mr J. Grainger of the Foreign and Commonwealth Office, London.

A. The circumstances of the case

The facts of the case, as submitted by the parties, may be summarised as follows.

1. Background information

Drugs use is prohibited in prisons in the United Kingdom. In 1997-1998 the Public Health Laboratory Service carried out an anonymised survey in eight prisons, the results of which indicated that the prevalence of HIV was 0.36%, Hepatitis B was 7.8% and Hepatitis C was 7.5%. 24% of the prisoners surveyed had injected drugs at some stage, 30% of whom had injected whilst in prison. 75% of those who injected in prison shared equipment. The most recent Home Office Study (Research Study 267, July 2003) suggested that 2% of prisoners inject drugs while detained, acknowledging that there may however have been significant under-reporting due to the stigma attached to drugs use. The Department of Health identify Hepatitis B and C and HIV as the most common serious viruses carried in the bloodstream. They can cause serious long-term health problems or be life-threatening. The Department considers Hepatitis C as being the certified cause of death in about 100 people per year and as contributing to a further 5,000 deaths each year from the complications of chronic liver disease. It has also identified the sharing of needles by intravenous drugs users as being responsible for over 91% of cases of Hepatitis C between 1992 and 2002.

Needle exchange programmes, whereby equipment is exchanged for sterile needles and syringes, are generally acknowledged as an important way of reducing the risk of infection from the sharing of needles and syringes. Reports suggest that once-only use of sterile needles and syringes is the most effective measure for preventing infections. There are also a number of studies suggesting that in practice disinfection of needles is less effective at preventing transmission. The Department of Health's statistics suggest that at least 99% of health authorities have needle exchange programmes available to the general public. In prisons there have never been needle exchange programmes.

In 1995 the Prison Service's AIDS Advisory Committee recommended that disinfecting agents be made available to prison inmates in England and Wales as a measure to lessen the risks of spreading infections from shared use of drug injecting equipment. This recommendation was implemented but withdrawn after only a few weeks due to health and safety concerns

surrounding the tablets. Three years later a pilot project was launched, involving 11 prisons, which was evaluated by the London School of Hygiene and Tropical Medicine in a detailed report. It concluded that there were real benefits from reintroducing disinfecting tablets and recommended that tablets be made available throughout prisons. On 1 December 2003 Prison Service Instruction No. 53/2003 issued, introducing a scheme to make tablets available as from 1 April 2004. The scheme is currently being implemented and evaluated.

Tablets have been available in Scottish prisons since 1993, in which jurisdiction a pilot needle exchange programme has been reported to have been recently initiated.

2. The proceedings brought by the applicant

The applicant is a prisoner. In 2004, he instructed solicitors as he was concerned that the provision of tablets instead of needle exchange programmes failed sufficiently to address the risks caused by the sharing of infected needles. Such risks were not confined to drugs users but also other prisoners or prison staff who could be accidentally infected.

In correspondence with his solicitors, the Department of Health acknowledged that tablets would only disinfect, not reach the clinical standards of sterilization. They stated that there was no plan to introduce a needle exchange programme. In correspondence with his solicitors, the Treasury Solicitor explained that the introduction of tablets was a reasonable and proportionate response as Hepatitis B and C would be inactivated by several moderately potent disinfectants and stated the view that needle exchanges would increase drugs use and the number of needles in circulation. It was stated that it was not always possible to replicate health care provided in the community and that disinfecting tablets provided an effective way of cleaning needles and fell within the range and quality of health services to be provided to prisoners.

On 11 November 2004, the applicant commenced judicial review proceedings arguing that the failure to introduce a trial of needle exchanges into English and Welsh prisons violated Articles 2, 3 and 8 of the Convention. He did not specify whether he was himself an intravenous user of drugs, claiming that other prisoners and staff could be affected by the risks of needle sharing. Permission to pursue such proceedings was refused after consideration of the papers by Mr Justice Harrison. The application was renewed orally and there was a full hearing before Mr Justice Beatson at which the applicant and the Secretary of State were represented by counsel.

The Secretary of State relied on the following grounds:

- the Prison Service was concerned not to increase drugs use and there was no safe way of injecting drugs;

- drugs use was dropping in prison – this might in part be due to a lack of needles and a concern about infectious diseases;
- needle exchanges would increase the number of syringes in prison;
- the introduction of needle exchanges was to be kept under review.

It was accepted that if a prisoner did inject drugs it was safer to use a new syringe rather than a disinfected syringe. Later, in the oral proceedings, counsel for the Secretary of State also alleged that syringes could be used as weapons.

At the conclusion of argument, Mr Justice Beatson refused the applicant's renewed application for permission to apply for judicial review. He found that steps taken by the Secretary of State to protect the health of prisoners were not unreasonable, noting that providing syringes would remove one of the disincentives to prisoners injecting themselves and that the effect of a decision to introduce a policy of distributing disinfecting tablets had yet to be assessed. He also found that the security considerations of managing a prison population in which people lived cheek by jowl meant that it was not realistic to assume that the same regime could apply as in the community. He found no issues arising under Articles 2 or 3 of the Convention.

The applicant's legal representatives obtained new evidence which was submitted in the renewed application to the Court of Appeal. This was a report dated July 2005 from the Addiction Development Officer of the Scottish Prisons Addictions Team which *inter alia* noted that rigorous evaluations in Germany and Switzerland consistently found that needle exchange programmes did not increase drugs use, drugs users or the amount of drugs in circulation; that the provision of bleach was only a partial solution and its use often inadequate; lower transmission rates of HIV and hepatitis had been found to result from needle exchange schemes which had been in operation in 46 prisons in 4 European countries for ten years, without any increase in drugs use, interference with drugs prevention strategies or attacks on either staff or prisoners. It was stated: "... it could be argued that the refusal to make sterile equipment available to prisoners is actually condoning the spread of HIV and HCV among prisoners and, indirectly, to the community at large."

On 29 November 2005, the Court of Appeal refused the renewed application for permission to apply for judicial review. It noted that it was far from clear on the facts of this case that Article 2 was engaged. On the assumption that it was, it was nonsense to suggest that the failure to attempt a trial of needle exchanges amounted to a violation of the positive right to life. The applicant himself had only argued for a trial period which was an indicator in itself that the overall benefits of such a policy had yet to be established. There was no satisfactory evidence as to the difference in the decreased risk to life inherent in a needle exchange programme as opposed to a disinfectant scheme. Also the United Kingdom was far from alone in

refusing to introduce such programmes. It was satisfied that there remained a legitimate concern that a needle exchange programme might increase drugs use and the number of syringes in prison. While in the future the balance might tip in favour of needle exchange programmes this was not inevitable and the Home Office had put in place an effective and sensible policy of assessing such programmes and the results thereof. It was emphasised that the matter should be kept under review.

B. United Kingdom and European materials

Prison Service policy provides as follows:

> Standards: Health Services for Prisoners (May 2004)
>
> “To provide prisoners with access to the same range and quality of services as the general public receives from the National Health Service.”

The Committee for the Prevention of Torture has set out in its general standards the following approach to medical services in prison (Chapter III Health Care Services in Prison):

> “b. Equivalence of care
>
> i) general medicine
>
> 38. A prison health care service should be able to provide medical treatment and nursing care, as well as appropriate diets, physiotherapy, rehabilitation or any other necessary special facility, in conditions comparable to those enjoyed by patients in the outside community. Provision in terms of medical, nursing and technical staff, as well as premises, installations and equipment, should be geared accordingly.
>
> d. Preventive health care
>
> 52. The task of prison health care services should not be limited to treating sick patients. They should also be entrusted with responsibility for social and preventive medicine.
>
> ...ii) transmittable diseases
>
> 54. A prison health care service should ensure that information about transmittable diseases (in particular hepatitis, AIDS, tuberculosis, dermatological infections) is regularly circulated, both to prisoners and to prison staff. Where appropriate, medical control of those with whom a particular prisoner has regular contact (fellow prisoners, prison staff, frequent visitors) should be carried out. ”

Rule 40 of the European Prison Rules

> "Medical services in prison shall be organised in close relation with the general health administration of the community or nation. ...
>
> Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation."

C. Submissions by intervening parties

1. Irish Penal Reform Trust, with the Canadian HIV/AIDS Legal Network

Drug use was common in prison, with most studies reporting prisoners who have used drugs as at 50% or greater. While it was true that some prisoners stopped injecting on entering prison, some continued: a 2002 European Union report showed that 0.3% to 34% of the prison population injected while incarcerated. Elevated risks of HIV and HCV flowed from the prevalence of sharing needles, often home-made (with additional risks of scarring, vein damage and other infections). HIV infection ran from a reported 4% in Russia to 38% in some prison populations in Spain. The vast majority of peer-reviewed studies put HCV infection at between 20-40% of prison populations.

Cleaning syringes with disinfectant such as bleach did not sufficiently reduce the risk of infection. Bleach was not fully effective in reducing HCV transmission. While repeated applications of bleach had been shown to eliminate HIV in syringes, field studies indicated users (amongst those who bothered to avail themselves of available bleach) had trouble following the instructions correctly and thus the method offered no, or little, protection.

Needle exchange programmes (NEPs) had been acknowledged to be the most effective harm reduction method in the community, reducing infection substantially without increasing the initiation, duration or frequency of illicit drug use. NEPs had been in operation in prisons since 1992 and now existed in at least one prison within nine jurisdictions: Armenia, Belarus, Germany, Kyrgyzstan, Luxembourg, Moldova, Scotland, Spain[1] and Switzerland. NEPs were also in development in Belgium, Iran, Portugal, Tajikistan and Ukraine. The evidence and experience from the prison schemes showed that they reduced needle-sharing, reduced drug overdoses and led to a decrease in abscesses and injection-related injections and facilitated referral of users to treatment programmes. It had not been demonstrated that they resulted in an increase in drug consumption, increase in drug injection or in any incidents of intentional use of needles as weapons or accidental needle-stick injuries.

2. The National AIDS Trust, supported by the Prison Reform Trust

HIV prevalence in drug injectors (IDUs) was about 2.1% in England and Wales. 31% of HCV infections occurred in current IDUs and 57% in ex-IDUs as opposed to 12% in non-IDUs. Infection rates were substantially higher amongst the prison population than the general population. The Health Protection Agency identified NEPs as the key to preventing infections amongst IDUs in the community. This was also the established

[1] NEPs were being extended to all prisons.

opinion of the National Health Service. An estimated 90% of IDUs in England and Wales had accessed a needle exchange service. No such facilities were available in prisons. Some eight prisons appeared to be using disinfectant tablets, which were to be made available in all prisons during 2007. The Prison Service nonetheless had the responsibility, under guidelines, to ensure that prisoners had access to health services broadly equivalent to those in the community. The Department of Health did not consider that disinfectant tablets were an adequate response to risks of HIV and HCV transmission for the general public. There was strong evidence from around the world that NEPs in prison did not produce countervailing effects that could outweigh the benefits to prisoners. There had been no instances of needles being used as a weapon, nor any increase in drug use or injections. The only difference was that the possession of needles had ceased to be illegal. The fact that drugs use did drop on entry to prison was probably a consequence not of the absence of clean needles but of the fact that possession and use were illegal in prisons and that prisoners were closely supervised.

COMPLAINTS

The applicant complained under Article 2 of the Convention that the authorities were failing to take preventive steps in respect of a known real and immediate risk to life through the spread of viruses in prison. The authorities had also failed in their positive obligation under Article 3 to adequately secure his health and well-being and under Article 8 to protect his safety from bodily threats from others or from the transmission of disease. He relied *inter alia* on the reports of the European Committee for the Prevention of Torture which state that prisoners are entitled to health care of the same standard as that available to those in the community.

The applicant also contended that there had been a breach of Article 14 on the basis that prisoners in England and Wales, as a group, were treated without proper justification, less favourably than people in the community.

THE LAW

1. The applicant complained under Article 2 (respect for the right to life), Article 3 (prohibition of torture and inhuman or degrading treatment or punishment) and Article 8 of the Convention (respect for private life) that the authorities had failed to take steps to prevent a risk to his life and his health and well-being through their refusal to introduce needle exchange schemes in prison.

A. The parties’ submissions

1. The Government

The Government pointed out that the applicant had not claimed to be an intravenous drugs user himself, nor had he adduced any evidence as to any persons becoming infected as a result of coming into contact with drugs users. They submitted therefore that he could not claim to be a victim of any violation of the Convention, otherwise anyone in contact with the prison system could so claim and every prison in every Contracting State would be required to have NEPs.

As concerned their policy, they submitted that they had given most careful consideration in the prison context to the misuse of drugs that were injected. The policy of introducing disinfecting tablets remained under review as further study and research became available. The scheme introduced in April 2004 was too early in its life for concluded views to be reached and required time and careful evaluation. They submitted that a properly cautious approach was appropriate in the prison context.

As regarded the applicant’s arguments on NEPs, they pointed out that prison policy was designed to reduce drugs use in prison. Misuse of drugs was a serious matter, causing damage to health (there being no safe way to inject banned drugs) and raising serious concerns as to the maintenance of good order and discipline in prisons, as well as the commission of criminal offences. There was powerful evidence that the vast majority of drugs users ceased to inject when they entered prison, and although the reason was open to doubt, one factor was likely to be the lack of needles, and the fact that it was well-known that sharing needles carried a significant risk of infection. These incentives would not operate so powerfully if injecting drugs was made easier and less risky. They submitted that disinfectant tablets were an effective way of significantly reducing the risks associated with injecting, as shown by the report of the London School of Hygiene and Tropical Medicine, while the security concerns were less than those attaching to needles. They also emphasised that there was a difference between the prison and external community: there were different pressures on prisoners, there were greater numbers of dangerous people grouped together in prisons, some had mental difficulties or disorders likely to be exacerbated by the taking of drugs and the injection of drugs created more serious risks in this context.

As concerned the comparative position, the Government were not aware that any Contracting State had introduced NEPS throughout their prison system and only limited pilot schemes had been taken up in a few Contracting States, indicating no common or consistent approach.

Consequently, concerning the applicant’s Article 8 complaints, the Government considered that there had been no lack of respect for the applicant’s rights. Facilitating the injection of drugs by providing new

needles could not be a component part of the right to respect for private life as concerned health. Even if NEPs were in operation in the community, this did not indicate any right, merely that health authorities sought to use this method to manage the problem. Security reasons clearly justified any interference, and the current policy pursued the legitimate aims of safeguarding the health of users and those who came into contact with them. Seeking to encourage individuals entering prison to stop the highly dangerous practice of injecting was the most effective method of minimising risks to all. Although it would have been a legitimate policy response not to provide any equipment, they considered that the introduction of disinfecting tablets took into account the relevant concerns in an effective way.

2. The applicant

The applicant submitted that there had been no dispute in the domestic proceedings as to his victim status, arguing that irrespective of whether he was an intravenous drugs user, he was a prisoner directly at risk from the use of infected needles, a risk acknowledged by prison policy in making tablets available. Prisoners lived in close proximity with each other; restrictions in force meant that prisoners hid needles, increasing the risk that a prisoner could accidentally injure himself with a hidden needle. As using drugs was a disciplinary and criminal offence he had no intention of confirming or denying drugs use. In any event, he drew an analogy with secret surveillance cases where applicants did not need to prove that they had been the subject of measures; similarly the State's actions in penalising drugs use should not be allowed to prevent complaints being made to the Court.

The applicant submitted that the Court's case-law showed that inadequate medical care could potentially violate Article 8 even if insufficiently serious to engage Article 3. Article 8 also gave rise to a positive duty to protect the environment in which persons lived. The failure to provide NEPs resulted in prisoners living in an unsafe environment. The applicant rejected the Government's extravagant claim that his case required the immediate introduction of NEPs throughout the United Kingdom, suggesting the sensible course of introducing a trial scheme as a logical first step. He accepted that he could demand no more at this stage. The applicant argued that many of the Government's arguments against NEPs could also apply equally to drugs users in the community, where a lack of needles could also act as a disincentive. The provision of tablets showed that the Prison Service knew that a balance had to be struck and that risks had to be reduced. There was no reason why the balance should be struck differently inside prison. Where the healthcare of a vulnerable group of people, such as prisoners, was concerned, he argued that the margin of appreciation was reduced and any failure to provide equivalent healthcare should be closely

scrutinised, in particular as it was acknowledged that prisoners should be provided with the same medical services as were provided in the community (Rule 40 of the European Prison Rules, and the Prison Service's own regulations).

The Government had, in his view, failed to provide the weighty justification necessary to explain the lack of NEPs. There was no direct evidence of any problems from the needles already in circulation in prisons and no instance of any assault had been provided. Conversely the applicant had considerable evidence to support the positive aspects of NEPs. A significant number of prisoners did continue to inject when in prison, while some started to inject. No evidence had been produced to indicate that the prisoners who gave up on entering prison did so due to lack of needles. The evidence of NEPs elsewhere showed no increase of use which indicated that lack of needles did not operate as a disincentive, nor did the fear of contamination from shared needles. Further there was no evidence to indicate how effective tablets were or that they were as effective as needle exchanges. Indeed WHO and the Department of Health stated that tablets were not as effective. Nor in any event was it apparent when the tablets had been introduced and in which prisons.

B. The Court's assessment

The Court would note at the outset that the applicant has not specified that, due to his own personal circumstances, he is at any real or immediate risk of becoming infected through unclean or shared needles. Nor, in particular, has the applicant claimed to use drugs himself. His complaint must therefore be regarded as concerning the general situation within the prison system. While the Court notes the information provided concerning the higher levels of infection of HIV and HCV within prison populations, it is not satisfied that the general unspecified risk, or fear, of infection as a prisoner is sufficiently severe as to raise issues under Articles 2 or 3 of the Convention. It has however given consideration to the extent to which Article 8, which in its private life aspect protects physical and moral integrity, may require the authorities to take particular preventive measures to counter infection rates in prisons. In this context the Court is prepared to accept for the purposes of this case that the applicant, detained in prison where there is a significantly higher risk of infection of HIV and HCV, may claim to be affected by the health policy implemented in that regard by the prison authorities. It therefore rejects the Government's argument as regards victim status. It remains to be examined whether the impugned health policy fails to comply with the requirements of Article 8.

To date the Court's case-law has been limited to holding that the acts and omissions of the authorities in the field of health care policy may in certain circumstances engage their responsibility under the positive limb of

Article 2. This has so far imposed systemic and structural obligations, such as to make regulations compelling hospitals, whether public or private, to adopt appropriate measures for the protection of their patients' lives, and to provide for an effective independent judicial system to be set up so that the cause of death of patients in the care of the medical profession, whether in the public or the private sector, can be determined and those responsible made accountable (*Calvelli and Ciglio v. Italy* [GC], no. 32967/96, § 49, ECHR 2002-I; *Byrzykowski v. Poland*, no. 11562/05, § 104, 27 June 2006; *Silih v. Slovenia*, no. 71463/01, § 117, 28 June 2007).

So far as preventive health is concerned, there is no authority that places any obligation under Article 8 on a Contracting State to pursue any particular preventive health policy. The case-law discloses that complaints have been more commonly brought against preventive measures taken by States to safeguard general health (such as the obligation to use safety helmets, pedestrian crossings or subways, and compulsory seatbelts *e.g.* 8707/79, (Dec.) 13.12.79 DR 18 p. 255 (contrast cases where the complaint was about the requirement to undergo medical treatment such as vaccinations: *e.g*. 7154/75, (Dec.) July 12, 1978, 14 D.R. 31). While it is not excluded that a positive obligation might arise to eradicate or prevent the spread of a particular disease or infection, the Court is not persuaded that any potential threat to health that fell short of the standards of Articles 2 or 3 would necessarily impose a duty on the State to take specific preventive steps. Matters of health care policy, in particular as regards general preventive measures, are in principle within the margin of appreciation of the domestic authorities who are best placed to assess priorities, use of resources and social needs (*mutatis mutandis*, *Osman v. the United Kingdom*, judgment of 28 October 1998, *Reports of Judgments and Decisions* 1998-VIII, § 116.

The applicant cannot point to any directly negative effect on his private life (*mutatis mutandis*, *Benito v. Spain*, no. 36150/03, (dec.) 13 November 2006 concerning passive smoking in prisons). Nor is he being denied any information or assistance concerning a threat to his health for which the authorities are directly or indirectly responsible (see environmental cases where individuals can claim access to information, or protection, where they are affected by dangerous industrial or mining operations licensed or condoned by the authorities *e.g. Guerra and Others v. Italy*, judgment of 19 February 1998, *Reports* 1998-I, *Taşkın and Others v. Turkey*, no. 46117/99, ECHR 2004-X, *Giacomelli v. Italy*, no. 59909/00, ECHR 2006-...). Giving due leeway to decisions about resources and priorities and to a legitimate policy to try to reduce drug use in prisons, and taking account of the fact that some preventive steps have been taken (disinfecting tablets) and that the authorities are monitoring developments in needle exchange programmes elsewhere, the Court concludes that the respondent Government have not failed to respect the applicant's private life.

It follows that this part of the application must be rejected as being manifestly ill-founded pursuant to Article 35 §§ 3 and 4 of the Convention.

2. The applicant complained that he was discriminated against since those in prison in England and Wales were treated less favourably than those in the community. Article 14 of the Convention provides that:

> “The enjoyment of the rights and freedoms set forth in [the] 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.”

1. The parties’ submissions

The Government submitted that the applicant had not exhausted domestic remedies as regarded Article 14 of the Convention which provision had not been raised in the judicial review proceedings. In any event they argued that being a prisoner was not a "status" or personal characteristic capable of disclosing the existence of discrimination. Also prisoners were not in an analogous position for the purpose of comparing alleged differences in treatment. The prison context was different and required a different policy approach to the issues. Comparison of injectors in prison with those in the community was misconceived. In any event, any difference in treatment would be justified as pursuing a legitimate aim and proportionate.

The applicant argued that he had exhausted domestic remedies. The facts relied on in his application had been presented to the courts who had had the opportunity to address the substance of his complaints, relying on *Azinas v. Cyprus* ([GC], no. 56679/00, § 38, ECHR 2004-III). He submitted that the relevant "other status" for the purposes of Article 14 was that of a prisoner. Prisoners were treated differently due to their status as such. While in many contexts prisoners would not be in an analogous position to those at liberty, in this context they were, as it was acknowledged that they were entitled to the same standards of health care. He noted that many police authorities now operated needle exchanges for those in police custody.

2. The Court’s assessment

As regards the Government’s submission that the applicant had not exhausted domestic remedies as he had not invoked Article 14 in the judicial review proceedings, the Court would recall the principles of flexibility and avoidance of undue formalism developed in its case-law on Article 35, in particular that it is sufficient if the applicant has raised the substance of his Convention complaint before the domestic authorities (see *e.g. Cardot v. France*, judgment of 19 March 1991, Series A no. 200, § 34). It observes that the applicant’s argument that he was being denied preventive treatment as a prisoner which was available in the community had been raised before the domestic courts which gave reasons for

dismissing it. This is, in essence, his complaint before the Court, which therefore rejects the Government's objection on the point.

Insofar as the Government argued that the applicant could not claim that being a prisoner was a status for the purposes of attracting the prohibition against discriminatory treatment, the Court would observe that being a convicted prisoner may be regarded as placing the individual in a distinct legal situation, which even though it may be imposed involuntarily and generally for a temporary period, is inextricably bound up with the individual's personal circumstances and existence, as may be said, variously, of those born out of wedlock or married. Prisoners' complaints do not therefore fall outside the scope of Article 14 on this ground. The legal status of a prisoner is, however, very relevant to the assessment of compliance with the other requirements of Article 14.

For the purposes of Article 14, a difference in treatment between persons in analogous or relevantly similar positions is discriminatory if it has no objective and reasonable justification, that is if it does not pursue a legitimate aim or if there is not a reasonable relationship of proportionality between the means employed and the aim sought to be realised. Moreover, the Contracting States enjoy a margin of appreciation in assessing whether and to what extent differences in otherwise similar situations justify a different treatment (see *Camp and Bourimi v. the Netherlands*, no. 28369/95, § 37, ECHR 2000-X).

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

the provision of health care (see also *Mathew v. the Netherlands*, no. 24919/03, §§ 186, 193, ECHR 2005-...).

The issue remains to be determined whether the difference in preventive policy applied in prisons where NEPs are not available as they are in the community may be justified in terms of the principles above. The Court would note first and foremost that the margin of appreciation must be particularly wide in the area of preventive measures in which considerations such as of priorities, resources and social policies will come into play. It may be observed that while the CPT advocates equivalence in the provision of general medical treatment in prison, it deals separately with preventive care and gives no attention to the issue of NEPs. The Court also recalls that the authorities take the view that, as many individuals give up drugs use on entering prison, the best policy is to encourage this opportunity rather than to put the emphasis on ensuring access for such prisoners to clean needles. It is not for the Court to substitute its own opinion as to the wisdom of this choice. The authorities are nonetheless not insensible to the problems of infection for those who continue to use, or take up use, and are providing disinfectants, which although arguably not the optimal method, have some support as decreasing the risk.

Nor is it without relevance in this context that the risk of infection primarily flows from conduct by the prisoners themselves which they know, or should know, is dangerous to their own health, a situation that can be contrasted with damage to health flowing from conditions for which the authorities themselves are directly responsible (*e.g. Kalashnikov v. Russia*, no. 47095/99, § 102, ECHR 2002-VI) and are under an obligation to bring up to the appropriate standards. Furthermore, while it is true that there is no evidence from the studies so far that the provision of needles either increases needlestick injuries or drugs use within the prison, the Court considers that the authorities are entitled to give careful consideration to extending such schemes in such a context and to proceed with requisite caution as concerns their implementation. The domestic courts noted that the prison authorities were monitoring the progress of NEPs elsewhere and warned that they should keep the matter under review. It would appear that the first such programme is in fact being implemented within the United Kingdom, though in the Scottish prison system, not in England and Wales where this applicant is held.

In the circumstances therefore, the Court finds that the difference in treatment falls within the margin of appreciation and considers that it may be regarded, at the current time, as being proportionate and supported by objective and reasonable justification. This part of the application must also be rejected as manifestly ill-founded pursuant to Article 35 §§ 3 and 4 of the Convention.

3. Having regard to the above conclusions, the application of Article 29 § 3 of the Convention to the case should be discontinued.

For these reasons, the Court, by a majority,

Declares the application inadmissible.

Lawrence Early	Josep Casadevall
Registrar	President