Prisoners' Legal Services
A Project of the West Coast Prison Justice Society

Proposed guidelines for medical professionals working in CSC:
Compliance with the *Mandela Rules*

March 4, 2019

In 2015, the United Nations adopted the revised *Standard Minimum Rules for the Treatment of Prisoners*, known as the *Mandela Rules*, which include provisions related to health care professionals working in prisons.[1]

The World Medical Association has called on medical groups to provide clear guidance for physicians working in prisons to protest violations of human rights. It calls on "individuals and organized medical groups worldwide to encourage doctors to resist torture or any pressure to act contrary to ethical principles. It calls upon individual doctors to speak out against maltreatment and urges national and international medical organizations to support doctors who resist such pressure."[2]

Prisoners' Legal Services (PLS) makes the following recommendations to the Correctional Service Canada for the adoption of policies that incorporate the *Mandela Rules* that apply to health care providers.

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[1] *United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules)*. Adopted 17 December 2015. Online: https://undocs.org/A/RES/70/175. [*Mandela Rules*]. The Mandela Rules are substantially the same as the *Standard Minimum Rules for the Treatment of Prisoners,* Adopted by the First United Nations Congress on the Prevention of Crime and the Treatment of Offenders, held at Geneva in 1955, and approved by the Economic and Social Council by its resolution 663 C (XXIV) of 31 July 1957 and 2076 (LXII) of 13 May 1977. In 1975, Canada endorsed the *Standard Minimum Rules* and committed itself to full compliance and implementation.

[2] Office of the United Nations High Commissioner for Human Rights. Geneva. Professional Training Series No. 8/Rev. 1. *Istanbul Protocol. Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (2004) [*Istanbul Protocol*] at 12.

The United Nations has called for guidelines concerning the prohibition against torture or cruel treatment of prisoners as far back as 1975. Article 5 of the 1975 *Declaration on the Protection of All Persons from Being Subjected to Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* prohibits torture and other cruel, inhuman or degrading treatment or punishment, and requires the prohibition to "be included in such general rules or instructions as are issued in regard to the duties and functions of anyone who may be involved in the custody or treatment of [persons deprived of their liberty]."

PLS urges CSC to adopt these proposed *Mandela Rules* guidelines, as they inform the existing domestic ethical rules that apply to medical professionals, such as the Canadian Medical Association's 2004 *Code of Ethics*. These guidelines are intended to empower medical professionals to be able to "consider first the well-being of the patient"[3] while working in the security-focused prison context, which can present conflicting pressures. They provide specific guidance on how to "treat the patient with dignity and as a person worthy of respect", "resist any influence or interference that could undermine…professional integrity" and "refuse to participate in or support practices that violate basic human rights"[4] in a context in which patients have almost no control over their living conditions, the food they eat, their access to the outdoors or their contact with other people.

1. Independence and the problem of dual loyalty

Prisoners' Legal Services strongly recommends that Canada partner with the provincial ministries of health to provide truly independent health services to federal prisoners.

Bill C-83 acknowledges CSC's obligation to "support professional autonomy and clinical independence of registered health care professionals and their freedom to exercise, without undue influence, their professional judgment in the care and treatment of inmates". However, these are not enforceable standards. While health care professionals are employed or contracted with CSC, it will be impossible for them to resist undue influence. Bill C-83 does not go far enough to comply with international legal standards for independent health services.

Mandela Rule 25(2) provides that "health-care services shall consist of an interdisciplinary team with sufficient qualified personnel acting in <u>full clinical independence</u>". Mandela Rule 24 provides that "[p]risoners should enjoy the same standards of health care that are available in the community" that should be "<u>organized in close relationship to the general public health administration</u> in a way that ensures continuity of treatment and care".

Many of our clients have expressed a mistrust of CSC health care providers. This is especially true of mental health providers. Psychologists who are tasked to provide risk assessments that affect a prisoners' security level or access to conditional release cannot be the same people who provide mental health care to prisoners.

When self-harming or suicidal prisoners report their needs to mental health providers, they are placed in an observation cell where they subjected to isolation. They are often deprived of clothing, their belongings and anything that would keep their minds occupied. Our clients describe the conditions in observation as worse than segregation. Cells are often contaminated with blood, feces and pepper spray. Prisoners in observation are put in de-humanizing "baby doll" smocks that barely cover their genitals. Our clients report that they often do not report feeling suicidal because they fear being subjected to these conditions.

PLS is also concerned that medical professionals employed or contracted by CSC feel pressure by operations to follow directions that affect the quality of care they provide to patients.

[3] Canadian Medical Association, *Code of Ethics, Fundamental Responsibilities*, ¶ 1 (2004).
[4] *Ibid*. at ¶ 2, 7 and 9.

For example, PLS recently retained Dr. Wesley Boyd, Associate Professor in psychiatry and medical ethics at Harvard Medical School and staff psychiatrist at Cambridge Health Alliance, to conduct an independent review of a client who has been held in prolonged periods of solitary confinement over the course of many years. This client self-harms regularly and has attempted suicide on more than one occasion. Dr. Boyd diagnosed him with Major Depressive Disorder and Post Traumatic Stress Disorder. Yet CSC's health care providers consider him admissible to segregation. Dr. Boyd's report states:

> Mr. X's major depression and PTSD are so abundantly clear that I have to wonder why these diagnoses do not appear in any of the medical records I have reviewed about [him]. Given that these diagnoses are exclusionary criteria for being placed in solitary confinement in Canada, I cannot help but wonder if mental health clinicians working in the Canadian prison system are asked not to use these diagnoses in their written reports. And if mental health clinicians are not being asked to avoid placing these diagnoses in the record – either explicitly or implicitly – then the quality of care being offered to Mr. X, and possibly many other incarcerated individuals in Canada, is concerning give that these diagnoses do not appear in the medical records that I have seen of Mr. X.

This raises the issue of dual loyalty to patients and prison authorities. According to Jörg Pont, DM, Heino Stöver, PhD, and Hans Wolff, MD, MPH, authors of *Resolving Ethical Conflicts in Practice and Research: Dual Loyalty in Prison Health Care*, published in the American Journal of Public Health, March 2012, "[h]ealth care workers in prison should act exclusively as caregivers".

The authors point to rules, resolutions, declarations and recommendations of the United Nations, the Council of Europe, the World Medical Association, International Council of Nurses and Penal Reform International that reinforce "the sole task of health care professionals working in prisons is the care of physical and mental health of the prisoners". This involves providing free and community equivalent health care, confidentiality, preventative health care, humanitarian assistance, and "complete professional independence". It also involves "advising the prison director on health affairs in prison… and acting as health and hygiene officer by inspecting and reporting on food, hygiene, sanitation, heating, lighting, ventilation, clothing, bedding, and physical exercise. All of these tasks must be performed with complete loyalty to the prisoners…"

The authors note that health care professionals working in prisons are at risk of violating principles of medical ethics, including "subtle, less spectacular situations" than carrying out the death penalty or complicity in torture. They warn that "daily prison life cause health care professionals to forsake loyalty to their patient, often unwittingly or by failure to scrutinize routine procedures, decrees, or laws against the standards of medical ethics and human rights".

The authors warn of the danger of medical providers "try[ing] to accommodate their medical skills to the limitations imposed on them" by "adjust[ing] standards of practice to institutional constraints."

The authors discuss the structures for health services, noting that employment arrangements of health professionals working under operational officials compromises their ability to exercise independent judgment. They may become part of an institutional culture that prioritizes operations over the patient's interests.

The authors warn that when health care professionals are employed by the agency in command of prisons, they are at a higher risk of demands for dual loyalty and limitations of medical independence and confidentiality. They warn that even private health care professionals employed by the prison

authority can experience pressure from threat of dismissal. Medical decisions can be influenced by communication about budgetary constraints. “Dual loyalty is least likely to arise where health care services are organized independently of the prison authorities.”

Medical staff cannot perform tasks with “complete loyalty” to their prisoner patients while they are employed or contracted by CSC.

2. Prohibition against participating in torture or cruel, inhuman or degrading treatment or punishment

Rule 32 of the *Mandela Rules* establishes for physicians and other health care professionals an “absolute prohibition on engaging, actively or passively, in acts that may constitute torture or other cruel, inhuman or degrading treatment or punishment…”

Mandela Rule 32 is a restatement of Principle 2 of the UN *Principles of Medical Ethics*[5], adopted in 1982, which states:

> It is a gross contravention of medical ethics, as well as an offence under applicable international instruments, for health personnel, particularly physicians, to engage, actively or passively, in acts which constitute participation in, complicity in, incitement to or attempts to commit torture or other cruel, inhuman or degrading treatment or punishment.

Rule 43 of the *Mandela Rules* prohibits indefinite solitary confinement and prolonged solitary confinement, which are considered “torture or other cruel, inhuman or degrading treatment or punishment”. Solitary confinement is defined as “the confinement of prisoners for 22 hours or more a day without meaningful human contact”. Prolonged solitary confinement is defined as “solitary confinement for a time period in excess of 15 consecutive days” (Rule 44).

Rule 45 of the *Mandela Rules* prohibits the use of solitary confinement for prisoners who have mental or physical disabilities when their conditions would be exacerbated by its use. The UN Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment considers the imposition of solitary confinement on people with mental disabilities for any amount of time to constitute cruel, inhuman or degrading treatment in violation of Article 7 of the *International Covenant on Civil and Political Rights* and Article 16 of the *Convention Against Torture*.[6]

Viewed together, these provisions prohibit health care providers from participating, actively or passively, in the solitary confinement of prisoners if they have disabilities that would be exacerbated by its use, or in any case for more than 15 days.

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[5] The United Nations *Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, Adopted by the General Assembly resolution 37/194 on December 18, 1982 [UN *Principles of Medical Ethics*].

[6] *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment,* Juan E. Méndez, UNGAOR, 66th Sess, UN Doc A/66/268 (5 August 2011) [*Méndez Report*] at ¶ 78.

Rule 46(1) of the *Mandela Rules* further clarifies that "Health-care personnel shall not have any role in the imposition of disciplinary sanctions or other restrictive measures."

Research demonstrates that the negative health effects of solitary confinement occur after only a few days.[7] The psychological effects of solitary confinement can include anxiety, depression, anger, cognitive disturbances, perceptual distortions, paranoia, psychosis and self-harm. Some of the negative health effects are long term, leading to a decline in brain activity that may not be reversible if the person was isolated for more than seven days.[8] Other long term effects may include sleep disturbances, depression, anxiety, phobias, emotional dependence, confusion, and impaired memory and concentration. People who have experienced solitary confinement may also experience lasting personality changes, such as withdrawal, anger and fearfulness in social interactions which can prevent them from successfully reintegrating into regular prison units and into society after release from prison.[9]

Research also shows that "solitary confinement often results in severe exacerbation of a previously existing mental condition" and increases the risk of self-harm and suicide.[10]

Solitary confinement can also cause physical health problems, including heart palpitations, sudden excessive sweating, insomnia, back and joint pains, deteriorating eyesight, poor appetite, weight loss, lethargy, weakness, shaking, feeling cold and aggravation of pre-existing medical problems.[11]

The Essex Group[12] notes that Rule 46 of the *Mandela Rules*, prohibiting medical staff from playing any role in imposing disciplinary sanctions or other restrictive measures, is "in line with the UN *Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*. Similar provisions are included in the World Medical Association *Statement on Body Searches of Prisoners*, the *International Council of Nurses Position Statement*, and the *Dual Loyalty Guidelines.*"[13]

The Essex Group clarifies that Rule 46 "means that [health care providers] must not assess whether a prisoner is medically 'fit' for the imposition of a sanction such as isolation".

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[7] *Ibid* at ¶ 62.

[8] *Supra note* 6, *Méndez Report*, at ¶ 64.

[9] *Supra* note 6, *Méndez Report,* ¶ 65.

[10] *Supra* note 6, *Méndez Report,* at ¶ 67.

[11] Sharon A. Shalev, *A sourcebook on solitary confinement* (London: Mannheim Centre for Criminology, London School of Economics and Political Science, 2008) at 15-16. Online: http://solitaryconfinement.org/uploads/sourcebook_web.pdf.

[12] The Essex Group is a group of experts who met on April 7-8, 2016 at the University of Essex in Colchester, UK, organized by Penal Reform International and the Human Rights Centre at the University of Essex.

[13] *Essex Paper 3: Initial guidance on the interpretation and implementation of the UN Nelson Mandela Rules.* Based on deliberations at an expert meeting organized by Penal Reform International and Essex Human Rights Centre at the University of Essex, April 2016. Online: https://s16889.pcdn.co/wp-content/uploads/2016/10/Essex-3-paper.pdf [*Essex Paper 3*].

The Essex Group notes that because solitary confinement is "inherently harmful to a person's health", making a fitness assessment would also violate *Mandela Rules* 43 and 25[14]. It stresses, however, that medical staff "should pay particularly close attention to the health of prisoners" in segregation once it is imposed. Medical staff should visit segregated prisoners daily and provide prompt medical assistance upon request.

The UN *Principles of Medical Ethics* further prohibit any professional relationship with prisoners "the purpose of which is not solely to evaluate, protect or improve their physical and mental health."[15] These principles also establish that it is a contravention of medical ethics for health care professionals to provide fitness assessments for any treatment that "may adversely affect their physical or mental health".[16]

The UN *Principles of Medical Ethics* apply at all times, even during emergencies (principle 6).

The UN *Istanbul Protocol* points to the ethical codes that are so fundamental that they are universal – to alleviate suffering and avoid harm despite other pressures, to provide compassionate care, to do no harm and to respect patients' rights.[17]

The *Istanbul Protocol* states that doctors must refuse to comply with any procedures that may harm patients or leave them vulnerable to harm. They state that assessment of prisoners' health to facilitate punishment or torture is "clearly unethical".[18]

The World Medical Association *Declaration of Tokyo* states: "The physician shall not be present during any procedure during which torture or any other forms of cruel, inhuman or degrading treatment is used or threatened."[19] The *Declaration of Tokyo* also prohibits physicians from condoning or participating in cruel, inhuman or degrading procedures.

The World Health Organization provides guidance to doctors not to "collude in moves to segregation or restrict the movement of prisoners except on purely medical grounds, and they should not certify a prisoner as being fit for solitary confinement or any other form of punishment." The World Health

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[14] *Mandela Rule* 25: 1. Every prison shall have in place a health-care service tasked with evaluating, promoting, protecting and improving the physical and mental health of prisoners, paying particular attention to prisoners with special health-care needs or with health issues that hamper their rehabilitation. 2. The health-care service shall consist of an interdisciplinary team with sufficient qualified personnel acting in full clinical independence and shall encompass sufficient expertise in psychology and psychiatry. The services of a qualified dentist shall be available to every prisoner.

[15] *Supra* note 5, UN *Principles of Medical Ethics,* Principle 3.

[16] *Supra* note 5, UN *Principles of Medical Ethics,* Principle 4.

[17] *Supra* note 2, *Istanbul Protocol*, at 13.

[18] *Ibid.* at 12 and 14.

[19] World Medical Association. *Declaration of Tokyo – Guidelines for Physicians Concerning Torture and Other Cruel, Inhuman or degrading treatment or punishment in relation to detention and imprisonment,* Adopted by the 29th World Medical Assembly, Tokyo, Japan, October 1975, Revised by the 67th WMA General Assembly, Taipei, Taiwan, October 2016, [*Declaration of Tokyo*], ¶ 1, 4 and 6.

Organization also states that "doctors must follow the prisoner being punished with extreme vigilance", visiting them daily "to assess their physical and mental state and determine any deterioration in their well-being", noting that solitary confinement increases the risk for suicide.[20]

While Bill C-83 purports to eliminate "segregation" and replace this regime with "Structured Intervention Units" (SIUs), the use of solitary confinement is still permitted. Bill C-83 allows prisoners in SIUs to be deprived of meaningful human contact for 22 hours per day. This is still within the UN definition of solitary confinement of 22 or more hour of isolation without meaningful human contact.

Bill C-83's provisions on mental health assessments are not mandatory. Section 37.11 provides that a staff member "may" recommend that a health care professional assess a prisoner's mental health in certain circumstances. The health care professional is not required to recommend changes to the conditions of confinement or removal from an SIU if a prisoner's health is affected by isolation. Again, the language under s 37.2 is permissive ("may, for health reasons, recommend…"). If the warden does not follow a recommendation of a health care provider under s 37.2 a second health care professional is required to review the case and "may, for health reasons, recommend… that the inmate's conditions of confinement in the unit be alter or that the inmate not remain in the unit." This review does not require an in-person assessment of the patient. Bill C-83 also provides for daily visits of prisoners in SIUs (s 37.1).

Without a requirement that the mental health professional recommend removal from separate confinement if the prisoner's physical or mental health is negatively impacted, the above referenced provisions of Bill C-83 amount to fitness assessments of prisoners in solitary confinement.

We have heard many reports from prisoners of health care staff briefly checking on them through the cell door in segregation after they have been in isolation for well more than 15 days, sometimes for several months, often with pre-existing mental disabilities, and sometime when they have been actively engaging in self-harm. Our clients report that they may not speak with health care professionals because they are uncomfortable speaking where other prisoners and prison guards can hear, or they do not trust the health care professionals who routinely rubber stamp their continued solitary confinement.

Recommended policy:

Health care professions must not participate, actively or passively, in acts that may be considered torture or cruel, inhuman or degrading treatment or punishment. This includes playing any role in recommending or approving prisoners for any form of isolation or by determining their medical fitness to continue such measures.

[20] World Health Organization. *Prisons and Health.* Edited by: Stefan Enggist, Lars Møller, Gauden Galea and Caroline Udesen (2014) [*Prisons and Health*] at 13.

3. Duty to document and report ill-treatment

Rule 33 of the *Mandela Rules* provides:

> The physician shall report to the prison director whenever he or she considers that a prisoner's physical or mental health has been or will be injuriously affected by continued imprisonment or by any condition of imprisonment.[21]

Rule 34 of the *Mandela Rules* provides:

> If, in the course of examining a prisoner upon admission or providing medical care to the prisoner thereafter, health-care professionals become aware of any signs of torture or other cruel, inhuman or degrading treatment or punishment, they shall document and report such cases to the competent medical, administrative or judicial authority. Proper procedural safeguards shall be followed in order not to expose the prisoner or associated persons to foreseeable risk of harm.

Rule 46(3) of the *Mandela Rules* provides:

> Health-care personnel shall have the authority to review and recommend changes to the involuntary separation of a prisoner in order to ensure that such separation does not exacerbate the medical condition or mental or physical disability of the prisoner.

As discussed above, the solitary confinement of prisoners for more than 15 days, or for any amount of time for those with mental disabilities that would be exacerbated by its use, is considered torture or cruel treatment. Therefore, medical staff have a duty to report the use of solitary confinement in these circumstances to the warden and to the "competent medical, administrative or judicial authority", and to recommend that it be discontinued.

The World Medical Association *Declaration of Tokyo* states that physicians have an ethical obligation to report abuses.[22]

Guidance on the application of the *Mandela Rules* by Penal Reform International and the OSCE Office for Democratic Institutions and Human Rights states that health care providers have an "ethical and professional obligation to document and report any instance of torture and other ill-treatment that they become aware of," noting that obligations to third parties cannot override that duty.[23]

This Guidance Document provides that documentation of any physical injuries should be timely because they may be visible only for a short period of time. It provides guidance on what to record in the event of a health professional witnessing ill-treatment or an allegation of ill-treatment by a patient, and

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[21] Rule 33 of the *Mandela Rules* is identical to Rule 25(2) of the 1955 UN *Standard Minimum Rules for the Treatment of Prisoners*, endorsed by Canada in 1975.

[22] *Supra* note 19, *Declaration of Tokyo*, ¶ 4.

[23] Penal Reform International and OSCE Office for Democratic Institutions and Human Rights (ODIHR), *Guidance Document on the Nelson Mandela Rules,* (Warsaw and London: 2018) [*Guidance Document*] at page 158. Citing WMA Declaration of Tokyo Guidelines for physicians concerning torture and other cruel, inhuman, or degrading treatment or punishment in relation to detention and imprisonment, 29th WMA October 1975, Article 1.

recommends that the patient be provided with immediate psychological support and counselling, as well as follow-up care to address therapeutic and other needs.[24]

The Guidance Document recommends that the health provider keep a trauma register to record all types of injuries so that the health care service can compile periodic statistics of injuries observed in prison for prison management and the relevant ministries.[25]

Similarly, the Essex Group notes that health care providers must record all signs of ill-treatment in the prisoner's medical file and to compile periodic statistics on the types of injuries observed for submission to the prison administration and ministry of justice.[26]

The Essex Group interprets *Mandela Rule* 46(3) as providing health care staff with the authority to recommend discontinuation of solitary confinement to ensure that physical or mental disabilities are not exacerbated, noting that it "provides a route for the health care staff to advise the prison administration on a harmful practice for so long as it persists and until it is phased out".[27]

The UN *Istanbul Protocol* provides further guidance on the investigation of torture and cruel treatment in prison, noting that effective documentation is one of the most fundamental ways to protect individuals from torture and cruel treatment.[28]

The *Istanbul Protocol* lists the following among torture methods (all of which have been reported to PLS by prisoners in BC Corrections' custody):

- solitary confinement;
- unhygienic conditions;
- irregular or contaminated food; and
- manipulation of brightness of the cell.[29]

The *Istanbul Protocol* provides guidance on the duty of individual health care professionals to speak out against mistreatment and for their bodies to provide clear guidance to protest human rights violations:

> Health professionals also have a duty to support colleagues who speak out against human rights violations. Failure to do so risks not only an infringement of patient rights and a contravention of the declarations listed above but also brings the health professions into disrepute. Tarnishing the honour of the profession is considered to be serious professional misconduct. The World Medical Association's resolution on human rights calls on all national medical associations to review the human rights situation in their own countries and ensure that doctors do not conceal evidence of abuse even where they fear

[24] *Ibid* at page 161.

[25] *Supra* note 5, UN *Principles of Medical Ethics,* at page 161.

[26] *Supra* note 13, *Essex Paper 3*, at page 273-274.

[27] *Supra* note 13, *Essex Paper 3,* at 74-75.

[28] *Supra* note 2, *Istanbul Protocol*, at 1.

[29] *Supra* note 2, *Istanbul Protocol*, at 29.

> reprisal. It requires national bodies to provide clear guidance, especially for doctors working in the prison system, to protest alleged violations of human rights and provide effective machinery for investigating doctors' unethical activities in the human rights sphere. It also requires that they support individual doctors who call attention to human rights abuses. The World Medical Association's subsequent Declaration of Hamburg reaffirms the responsibility of individuals and organized medical groups worldwide to encourage doctors to resist torture or any pressure to act contrary to ethical principles. It calls upon individual doctors to speak out against maltreatment and urges national and international medical organizations to support doctors who resist such pressure.[30]

The *Istanbul Protocol* further provides that:

> Doctors have a duty to monitor and speak out when services in which they are involved are unethical, abusive, inadequate or pose a potential threat to patients' health. In such cases, they have an ethical duty to take prompt action as failure to take an immediate stand makes protest at a later stage more difficult. They should report the matter to appropriate authorities or international agencies who can investigate, but without exposing patients, their families or themselves to foreseeable serious risk of harm. Doctors and professional associations should support colleagues who take action on the basis of reasonable evidence.[31]

The World Medical Association *Resolution on the Responsibility of Physicians in the Documentation and Denunciation of Acts of Torture or Cruel or Inhuman or Degrading Treatment* provides further guidance for medical professionals working in prisons. This resolution recognizes "[t]hat careful and consistent documentation and denunciation by physicians of cases of torture and of those responsible contributes to the protection of the physical and mental integrity of victims and in a general way to the struggle against a major affront to human dignity".[32] The resolution further recognizes that physicians are "privileged witnesses" of violations of human rights and that victims are often unable to bring complaints on their own behalves.[33]

The resolution recommends that national medical associations attempt to ensure that physicians assess and document symptoms of torture or ill-treatment in the patient's medical records, promote awareness of the *Istanbul Protocol*, promote training for doctors on identifying symptoms of specific forms of torture and in using the documentation techniques set out in the *Istanbul Protocol*, promote

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[30] *Supra* note 2, *Istanbul Protocol*, at 12.

[31] *Supra* note 2, *Istanbul Protocol*, at 15. The *Istanbul Protocol* provides the following direction concerning confidentiality of the patient's information: "[Prison] doctors must bear in mind the best interests of the patient and their duties of confidentiality to that person, but the moral arguments for the doctor to denounce evident maltreatment are strong, since prisoners themselves are often unable to do so effectively. Where prisoners agree to disclosure, no conflict arises and the moral obligation is clear. If a prisoner refuses to allow disclosure, doctors must weigh the risk and potential danger to that individual patient against the benefits to the general prison population and the interests of society in preventing the perpetration of abuse."

[32] World Medical Association. *Resolution on the Responsibility of Physicians in the Documentation and Denunciation of Acts of Torture or Cruel or Inhuman or Degrading Treatment*. Adopted by the 54th WMA General Assembly, Helsinki (September 2003) and amended by the 58th WMA General Assembly, Copenhagen (October 2007) at ¶ 16.

[33] *Ibid.* at ¶ 17 and 18.

awareness of the correlation between examination findings, understanding torture methods and the patient's reporting of abuse, and facilitate production of medical reports for submission to judicial and administrative bodies.

The resolution also recommends that national medical associations support the adoption of rules and legislation that affirms the ethical obligations of doctors to report or denounce acts of torture or cruel treatment to medical, legal, national or international authorities, or to non-governmental organizations.

In the context of prisoners held in CSC custody in any form of isolation, medical professionals have a duty to record the effects of isolation on the patient in their medical files and recommend to the warden that the isolation end if health deteriorates or if the isolation lasts for more than 15 days. If the isolation is continued, medical professionals have an ethical duty to report the treatment to outside authorities, including the Office of the Correctional Investigator, the Canadian Human Rights Commission, PLS and the Ministries of Public Safety and Health.

Medical professionals also have a duty to perform complete medical assessments of prisoners who have been subject to uses of force or other incidents that cause harm. These assessments should occur in private, should be thorough, and should attend to both the physical and psychological needs of the patient.

Recommended policy:

All staff must record all observations of signs of ill-treatment of patients by correctional staff in the patient's medical file. This may include any injuries or psychological trauma suffered from uses of force or restraints, or any physical or psychological effects of isolation including observation or SIUs.

The record of signs of ill-treatment should include:

- A statement by the patient after interviewing them, including their description of their state of health and any allegations of ill-treatment;
- A full account of objective medical findings based on a thorough medical examination and psychological interview, including a record of traumatic injuries on a form for this purpose (with body charts for marking injuries);
- Photographs of any visible injuries (taken as soon as possible and within 24 hours);
- The health care professional's observations in light of the above, indicating the consistency between any allegations made and the objective medical or psychological findings;
- The results of additional examinations, detailed conclusions of specialists consulted; and
- A description of the treatment given and any procedures performed.

In all cases of ill-treatment the patient should be immediately provided with appropriate, professional and confidential psychological support and counselling. A follow up care plan should be developed to evaluate the patient's therapeutic and other needs and to monitor the patient for signs of post-traumatic stress disorder.

Health care managers will compile periodic statistics of injuries observed in prison, for the attention of prison management and the Office of the Correctional Investigator, the Canadian Human Rights Commission, PLS and the Ministries of Public Safety and Health.

In every case in which a health care provider observes mental or physical health deterioration as a result of treatment or a condition of confinement, including the use of segregation, SIUs, observation, or other forms of isolation, the health care provider must recommend to the warden that the treatment or condition of confinement be terminated. Health care providers must also report any use of isolation on prisoners who suffer from a mental or physical disability that would be exacerbated by isolation for any amount of time, or the use of isolation on any prisoner for more than 15 days. If the treatment or condition of confinement is not terminated, the health care provider must report the treatment to the Assistant Commissioner for Health Services, who must report the treatment to the Office of the Correctional Investigator, the Canadian Human Rights Commission, PLS and the Ministries of Public Safety and Health.

4. Duty to Inspect and advise on conditions of confinement

Mandela Rule 35 provides:

1. The physician or competent public health body shall regularly inspect and advise the prison director on:

   (a) The quantity, quality, preparation and service of food;
   (b) The hygiene and cleanliness of the institution and the prisoners;
   (c) The sanitation, temperature, lighting and ventilation of the prison;
   (d) The suitability and cleanliness of the prisoners' clothing and bedding;
   (e) The observance of the rules concerning physical education and sports, in cases where there is no technical personnel in charge of these activities.[34]

2. The prison director shall take into consideration the advice and reports provided in accordance with paragraph 1 of this rule and rule 33 and shall take immediate steps to give effect to the advice and the recommendation in the reports. If the advice and the recommendations do not fall within the prison director's competence or if he or she does not concur with them, the director shall immediately submit to a higher authority his or her own report and the advice or recommendations of the physician or competent public health body.

PLS' clients have reported concerns about many of the issues listed above, including the quality and quantity of food, denial of clean clothes following the use of OC spray, cells and mattresses contaminated with blood and feces, cold temperatures, and being denied an hour of outdoor exercise each day while in segregation.

CSC should ensure that its policies include delegation to a specific physician of the responsibility to inspect these conditions of confinement in all areas where people are detained, including in SIUs and observation cells.

Recommended policy:

A designated centre physician shall inspect the following in all areas of the centre where prisoners are detained, including in segregation and observation cells, on a weekly basis:

[34] *Mandela Rule* 35(1) is virtually identical to Rule 26(1) of the 1955 UN *Standard Minimum Rules for the Treatment of Prisoners*, endorsed by Canada in 1975.

(a) The quantity, quality, preparation and service of food;
(b) The hygiene and cleanliness of the institution and the prisoners;
(c) The sanitation, temperature, lighting and ventilation of the prison;
(d) The suitability and cleanliness of the prisoners' clothing and bedding;
(e) The observance of the rule for a daily outdoor exercise;
(f) That each cell has a view to the outside world; and
(g) The provision of adequate daily meaningful activities and meaningful human contact, including access to radio, television, reading materials, games and counselling.

The designated physician shall report their findings and recommendations to the warden of the institution, the Assistant Commissioner for Health Services and the Commissioner of CSC. If any unsatisfactory conditions of confinement are not addressed, the designated physician shall advise the Assistant Commissioner for Health Services who shall report the findings and recommendations to the competent public health body, the Office of the Correctional Investigator, the Canadian Human Rights Commission, PLS and the Ministries of Public Safety and Health.