

COMMENTARY

Prison systems must embrace disability rights as a human rights imperative

SHRUTI TRIPATHI, SHREYA TRIPATHI, SATENDRA SINGH

Abstract

For decades, India has been a staunch supporter of the human rights regime. However, lately, its positive role has been jeopardised by glaring instances of human rights violations against prisoners, especially those with disabilities. Since the edifice of the Convention on the Rights of Persons with Disabilities and the subsequent Rights of Persons with Disabilities Act emphasises non-discrimination and reasonable accommodation, our policies, laws, and procedures need to be aligned with the human rights model of disability. We offer insights into the current challenges and propose disability-inclusive prison reforms, advocating for data disaggregation, legislative amendments, accessibility measures, and decision-making autonomy support. Upholding ethical healthcare standards is vital. Adhering to human rights principles and legal mandates in policymaking is crucial to combat systemic injustices and ensure equitable access to justice for all.

Keywords: incarceration; prisoners with disabilities; human rights; correctional facilities

Introduction

"When authorities detain persons with disabilities, they cannot use the particular needs of the specific body as an instrument of torture."

— Amita Dhanda [1]

According to the latest report on Prison Statistics India (PSI) 2022, from the National Crime Records Bureau (NCRB), India currently detains 573,220 prisoners, with three out of four being undertrials [2]. Among them, two-thirds belong to

marginalised caste groups such as the Scheduled Caste (SC), Scheduled Tribe (ST), and Other Backward Caste (OBC) communities — a percentage that has remained consistent at over 60% for the past 25 years, as the India Spend portal on Prison Watch indicates [3]. However, none of these statistics captures information on prisoners with disabilities. In contrast to this, the United States (US) Survey of Prison Inmates revealed that nearly 2 in 5 (38%) state and federal prisoners had at least one disability in 2016, with an overall disability prevalence of 66% of incarcerated individuals [4]. Women with disabilities exhibited a higher prevalence rate (79.5%) among incarcerated inmates. Furthermore, cognitive disability emerged as the most prevalent form, affecting approximately 2 in 10 prisoners and 3 in 10 jail inmates. The World Health Organization's Global Report on Health Equity for Persons with Disabilities reveals that approximately 16% of the global population, or 1 in 6 individuals, experience some form of disability, making this demographic the largest minority [5]. Yet, this community continues to be overlooked in policy reforms and data collection efforts. Although the NCRB recently added a transgender category to its gender classification of prisoners in PSI statistics [2], the collection of disability statistics remains neglected despite international conventions mandating such data gathering for sustainable development goals.

Injustice compounded in incarceration: the plight of disabled prisoners in India

As we lack official statistics on the number of individuals in this population protected by law, we rely solely on case studies to document the systemic challenges encountered by prisoners with disabilities.

The recent case of former Delhi University Professor GN Saibaba, who is also a wheelchair user with 90% physical disability, underscores the systemic barriers faced by prisoners with disabilities. He was arrested by the Maharashtra Police in May 2014 on allegations of terrorism, and was sentenced to life imprisonment in 2017. However, he was acquitted of the charges by the Nagpur bench of the Bombay High Court (HC) in October 2022. The Supreme Court (SC) later suspended this acquittal for reevaluation. On March 5, 2024, Saibaba was acquitted again by the Nagpur bench, with the HC criticising the state's case and calling the trial court's verdict a "failure of justice." Once more, the state challenged the acquittal in the SC, on the same day. However, the SC rejected the Government's plea for a stay of acquittal, emphasising that it was a well-reasoned judgment

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and stressing, "It's a hard-earned acquittal. How many years has the [paraplegic] man spent in jail?" [6]

"I was in the Anda cell, for eight and a half years without a wheelchair. It was a daily struggle to use the toilet, take a bath, or even fetch myself a glass of water. The prison doesn't have a single ramp for people like me. Now my heart is functioning at 55 percent capacity due to hypertrophic cardiomyopathy. I am facing syncope attacks and fall unconscious. I suffered two attacks of COVID-19 and one of swine flu in prison but was not provided emergency medical treatment. A doctor had recommended a sleep study for me seven years ago, but it was never conducted. I was provided medicines sent by my family following my 10-day hunger strike inside the jail. I was refused permission to meet my dying mother or perform her last rites. Is the state's role to serve people or crush humanity? In jail, I was treated like the biggest terrorist in the world."

— GN Saibaba after release in his first press conference [7]

As noted above, people with disabilities are often dehumanised because of their impairments, but our understanding is now evolving as we transition from the medical model to the social and human rights models of disability as heralded by the United Nations Convention on the Rights of Persons with Disabilities (CRPD). This new understanding, reflected in General Comment No. 6 of 2018, emphasises that disability is a social construct and impairments should not justify the denial or restriction of human rights. It acknowledges disability as one of several layers of identity, asserting the importance of considering the diversity of persons with disabilities in crafting disability laws and policies [8]. In this case, accessibility within the built environment, even if prison, is crucial for fulfilling all human rights. A UN Special Rapporteur on human rights defenders condemned the cruel detention conditions faced by Dr Saibaba, stating that the "anda" cell was unsuitable for a wheelchair user like him [9]. Dr Saibaba was confined in a cramped 8x10 feet cell with no window, and one wall made of iron bars, leaving him exposed to harsh weather conditions, particularly the scorching summer heat.

Our understanding regarding invisible disabilities began with the case of *Veena Sethi v State of Bihar*, in the SC, when a lawyer from the Legal Aid Committee, Jamshedpur, successfully argued for the release of 16 prisoners held in Hazaribagh jail for over 25 years due to their mental illness [10]. The SC stressed the need for adequate mental health institutions and deplored the practice of incarcerating individuals with mental illness, stating that jail was not suitable for their treatment. In 1984, a prisoner at Bangalore jail wrote to the HC about prisoners' grievances (*Rama Murthy v State of Karnataka*). The court then ordered a District Court Judge to visit the jail and investigate [11]. The resulting report highlighted the lack of proper medical care for inmates with mental illness, recommending that the National Institute of Mental Health and Neurosciences (NIMHANS) be requested to treat prisoners

with mental illness as in-patients until their condition improves, without referring them back to prison. However, this suggestion was unfortunately not included in the court's final judgment. The guidelines for prisoners with mental illness were established following *Charanjit Singh v State and Ors*. National Human Rights Commission (NHRC) filed a petition after a 2002 news report exposed the plight of Charanjit, a prisoner with mental illness whose trial was suspended due to his condition [12]. As no family member was willing to stand surety for him, he was sent back to prison. The Court dismissed Charanjit's chargesheet and tasked the NHRC with suggesting systemic changes, detailed in the judgment. The NHRC's recommendations are thorough but we still struggle with implementation.

In 2016, India enacted the Rights of Persons with Disabilities Act, 2016 (RPDA), as a legal mandate to align all existing laws and policies with the CRPD, expanding the number of recognised disabilities to 21. Awareness about these newer disabilities remains limited, but they are afforded legal protection and affirmative action, even within correctional facilities.

In 2020, numerous disability and human rights organisations began sending straws and sippers to the National Investigation Agency's Mumbai office and the Taloja jail outside Mumbai [13]. This action was prompted by the imprisonment of 84-year-old Jesuit priest and tribal rights activist Father Stan Swamy, who lived with Parkinson's disease, a condition newly recognised under the RPDA. Stan Swamy required a sipper and straw to drink water due to tremors associated with Parkinson's disease, as well as a walker, wheelchair, or personal care attendant due to multiple falls in prison resulting from the unsteady gait associated with his condition. Despite his medical needs, he was repeatedly denied bail on medical grounds in the Bhima Koregaon case. Tragically, he passed away on July 5, 2021, the day his bail hearing was scheduled.

What the jail authorities and Home Ministry failed to accept was that the denial of reasonable accommodation, such as straws and sippers in this case, constitutes discrimination under the RPDA 2016. Similar events unfolded when the Sonipat police unlawfully detained and tortured labour activist Shiv Kumar in January 2021 [14]. Kumar, who had visual impairment (low vision), had his glasses broken during custody. Despite his pleas for a replacement, he was denied one. This concept was highlighted by the apex court in India when they invoked the human rights model of disability by putting emphasis on the inclusive equality model:

As the Committee on the Rights of Persons with Disabilities noted in General Comment 6, reasonable accommodation is a component of the principle of inclusive equality. It is a substantive equality facilitator. The establishment of this linkage between reasonable accommodation and non-discrimination thus creates an obligation of immediate

effect. Under this rights-based and disabled-centric conceptualization of reasonable accommodation, a failure to provide reasonable accommodation constitutes discrimination. (Vikash Kumar v UPSC [15])

The CRPD (article 2) introduces the crucial concept of "reasonable accommodation", which entails the duty to make suitable adjustments in the processes and physical infrastructure of detention facilities to guarantee that individuals with disabilities can enjoy their rights on an equal footing with others [16]. This same principle is now incorporated into the updated Nelson Mandela Rules (Rule 5.2). Both CRPD and RPDA extend and elaborate on the content of equality including an accommodating dimension to make space for difference as a matter of human dignity.

Milestones and missed opportunities: Disability inclusion in India's prison history

The evolution of the modern prison system in India can be traced through various milestones in history [17]. It commenced with TB Macaulay in 1835 and advanced through initiatives such as the Pakwasa Committee in 1949, which focused on wages for prisoner labour. Dr WC Reckless, a UN expert, made significant contributions with a 1952 report advocating for the transformation of jails into reformation centres. Subsequent developments included the formulation of *The Model Prison Manual* in 1960 and recommendations from committees like the Mulla Committee (1980–83) and the Krishna Iyer Committee in 1987, which introduced concepts like after-care, rehabilitation, and the situation of women prisoners in India. Following a Supreme Court directive in 1996 in the case of *Rama Murthy v State of Karnataka* to standardise prison laws, a draft Model Prison Management Bill was prepared in 1999 [11].

Despite the existence of the Disabilities Act of 1995, the idea of disability-inclusive correctional facilities was never integrated into the agendas of these committees. Even internationally, manuals like the Manual on Human Rights Training for Prison Officials by the Office of the United Nations High Commissioner for Human Rights did not address disability issues [18].

However, significant changes occurred with the ratification of the CRPD, a milestone human rights treaty in the 21st century [16]. The CRPD's extensive support and its status as the first legally binding authority to address disability rights globally led to a paradigm shift. This led to the repeal of two existing disability laws in India and the incorporation of human rights principles into the RPDA, 2016 and the Mental Healthcare Act, 2017.

However, despite efforts to align laws with CRPD principles, the subsequent Model Prison Management Bill of 1999, enacted as the Model Prisons and Correctional Services Act 2023, failed to adequately address the rights and needs of prisoners with disabilities [19]. Although chapters were dedicated to women prisoners, pregnant women prisoners,

women prisoners with children, and transgender prisoners, there was no specific provision for prisoners with disabilities.

An unstarred question concerning special infrastructure, adequate standard of care and data on prisoners with physical disability was posed to the Ministry of Social Justice [20]. However, the Ministry evaded responsibility by citing it as a matter under the State List, rendering the attempt futile. Similarly, the Concluding Observations of the UN's Committee on the Rights of Persons with Disabilities on the report from India criticised the feeble efforts toward access to justice and proposed recommendations that were not incorporated into Union law [21].

The resurgence of protests against the torture on Dr Saibaba by disability rights organisations and human rights defenders prompts a revisiting of the question as to why India has yet to ratify the UN Convention Against Torture (UNCAT). In the case of *DK Basu v State of West Bengal*, the SC noted that torture has not been explicitly defined in the Constitution or in other criminal statutes [22]. Torture and inflicted injuries, as in extrajudicial punishments can also lead to disability. From 1970 to 1980, law enforcement officers in Bhagalpur, Bihar, subjected 33 undertrials and convicts to the inhuman act of pouring acid into their eyes, resulting in the infamous Bhagalpur blindings — a symbol of police brutality [23]. This incident marked a pivotal moment in criminal justice history, as it led to the Indian Supreme Court mandating compensation for the violation of fundamental human rights. Four decades later, similar extrajudicial practices continue, as seen in the alarming injuries inflicted by the use of pellet guns in Kashmir. The international community, including the Office of the UN High Commissioner for Human Rights, has criticised the use of pellet guns, urging India to cease their use for crowd control purposes [24]. India's delay in ratifying UNCAT and its reluctance to enact legislation prohibiting torture raise concerns regarding its adherence to the doctrine of sovereign immunity, as seen in British jurisprudence's "the King can do no wrong" maxim.

Medical ethics in detention: Upholding human rights in prisons

There are certain protections against torture outlined in Indian legislation. For instance, section 54 of the Code of Criminal Procedure provides safeguards against custodial torture and violence by permitting the examination of arrested individuals by a medical officer. However, when doctors, who are considered the standard-bearers of medical ethics, engage in activities that contradict the essence of their profession, it raises questions about the entire concept of medical ethics. This was starkly demonstrated in the case of visually impaired labor activist Shiv Kumar, who was unlawfully detained and tortured in police custody. A judicial probe revealed that he underwent five medical examinations, but none of the doctors either at

Sonipat General Hospital or the jail facility, fulfilled their responsibilities; instead, as per the judge's report, they "apparently danced to the tune of the police officials" [14]. This incident particularly underscores the doctors' dereliction of duty, as they compromised one of the fundamental pillars of medical ethics: justice.

A similar *Lancet* review disclosed that medical professionals at Abu Ghraib prison not only falsified death certificates to hide detainee killings and covered up evidence of physical abuse but also revived a prisoner for subsequent torture [25]. Additionally, physicians and other healthcare professionals have been implicated in aiding, concealing, or passively observing incidents of humiliation, degrading treatment, and physical abuses [25].

The literature shows that Prison Activities of Daily Living was associated with a higher likelihood of depression and suicidal ideation in older prisoners [26]. This risk may be heightened among prisoners with disabilities who often find their conditions aggravated because of "segregation" in prisons and also due to lack of specific health requirements linked to their impairments. Although solitary confinement can be used as a disciplinary measure to maintain order and security, to investigate or question, prolonged tenures of confinement have been documented to cause serious psychological, psychiatric, and physiological effects, many a time including the risks of self-harm and suicide [27]. Aligned with the adverse effects of solitary confinement, the World Medical Association has advised that it should be utilised sparingly and only in extraordinary circumstances, as a final option [28]. Furthermore, it should undergo independent evaluation and should be limited to the shortest duration feasible, not exceeding 15 consecutive days.

The UN has also adopted the World Health Organization (WHO) codes of medical ethics prepared by the Council for International Organizations of Medical Sciences. These codes are entitled "Principles of medical ethics relevant to the role of health personnel in the protection of persons against torture and other cruel, inhuman, or degrading treatment or punishment" [29]. They lay down the six key principles (See Table 1), which should be the guiding mantra for all physicians.

Promising practices

The Supreme Court, following the release of a handbook and sensitisation module aimed at combating gender stereotypes and promoting inclusivity for the LGBTIQ+ community within the judiciary, has initiated consultations for a similar handbook targeting stereotypes against individuals with disabilities. Additionally, the apex court's E-Committee has developed a standard operating procedure for creating accessible court documents. Building upon a previous SC ruling that expanded the definition of "vulnerable witness" to include people with disabilities (*Smruti Tukaram Badade v*

State of Maharashtra [30], the Delhi High Court upheld the rights of a speech and hearing impaired petitioner who argued against sound-based trial proceedings, deeming them contrary to principles of natural justice [31]. The court directed all authorities to implement suitable arrangements to ensure accessibility of the criminal justice system for persons with disabilities, whether as accused individuals or victims, suggesting the use of assistive technology and the establishment of special courtrooms. Furthermore, the court instructed the Delhi State Legal Services Authority (DSLISA) to develop a comprehensive scheme to address these accessibility issues.

The United Kingdom's prison service, in collaboration with the NGO Prison Reform Trust, has introduced an information package tailored for incarcerated individuals with disabilities [32]. This resource is distributed to all inmates with disabilities upon their admission to the facility. In the Netherlands, specific protocols have been established for all staff members outlining procedures for preventing suicides, responding to completed suicides, and managing post-suicide situations. These policies are seamlessly integrated into the overall communication framework of institutions and their foundational training [33]. Australia leads the way in peer support programmes aim to prevent suicide and self-harm. In Mount Gambier prison, South Australia, specially trained prisoners provide 24/7 support to their peers, while in Western Australia, regular meetings are held between prison administrators and peer support inmates [34].

In guardianship, a court-appointed guardian assumes decision-making authority for an individual deemed incapable, stripping them of their decision-making rights. People with intellectual and psychosocial disabilities, as well as the elderly with dementia, are commonly placed under guardianship. The CRPD effectively eliminates guardianship, leading to increased recognition of alternative decision-making approaches. A few progressive nations are also taking steps to eliminate substitute decision-making in favour of supported decision-making for individuals with cognitive disabilities. For instance, Germany discontinued full guardianship applications in 1992, while in Sweden, a "legal mentor" serves as the person's representative with their consent. The individual retains the ability to terminate the mentorship, ensuring their preferences are respected throughout the decision-making process [35].

Efforts were also witnessed during the Covid-19 pandemic, such as in the UK, where prisoners with less than two months left of their sentences were released, along with similar releases in the US, Iran, Turkey, and Indonesia [36]. Additionally, Brazil's National Justice Council recommended reviewing and releasing prisoners with disabilities, including those in the juvenile criminal system [36].

Table 1: 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 (Reproduced from reference 28)

Principle 1: Health personnel, particularly physicians, charged with the medical care of prisoners and detainees have a duty to provide them with protection of their physical and mental health and treatment of disease of the same quality and standard as is afforded to those who are not imprisoned or detained.
Principle 2: 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.
Principle 3: It is a contravention of medical ethics for health personnel, particularly physicians, to be involved in any professional relationship with prisoners or detainees the purpose of which is not solely to evaluate, protect or improve their physical and mental health.
Principle 4: It is a contravention of medical ethics for health personnel, particularly physicians: <ol style="list-style-type: none"> a) To apply their knowledge and skills in order to assist in the interrogation of prisoners and detainees in a manner that may adversely affect the physical or mental health or condition of such prisoners or detainees and which is not in accordance with the relevant international instruments; b) To certify, or to participate in the certification of, the fitness of prisoners or detainees for any form of treatment or punishment that may adversely affect their physical or mental health and which is not in accordance with the relevant international instruments, or to participate in any way in the infliction of any such treatment or punishment which is not in accordance with the relevant international instruments.
Principle 5: It is a contravention of medical ethics for health personnel, particularly physicians, to participate in any procedure for restraining a prisoner or detainee unless such a procedure is determined in accordance with purely medical criteria as being necessary for the protection of the physical or mental health or the safety of the prisoner or detainee himself, of his fellow prisoners or detainees, or of his guardians, and presents no hazard to his physical or mental health.
Principle 6: There may be no derogation from the foregoing principles on any ground whatsoever, including public emergency.

The way forward for disability: reforms for inclusive prisons

In order to provide an inclusive road towards reform, we offer the following recommendations for collective advocacy towards disability-inclusive prison reforms:

At the international level

- 1) Address the recommendations outlined in the Concluding Observations of the Committee on the Rights of Persons with Disabilities regarding India's country report on the CRPD [21].
- 2) Extend the adoption of the Health In Prisons European Database (HIPED) surveys to improve the performance of the prison health system in the WHO South East Asian Region. [37].
- 3) Accelerate the process of ratifying the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment and its optional protocol.
- 4) Ensure that all forms of mistreatment inflicted upon individuals with disabilities are recognised as criminal offences, in accordance with the definition of torture provided in international law.

At the national level

- 1) Ensure that the NCRB disaggregates data based on all 21 disabilities in its classification of prisoners and in PSI statistics [2].
- 2) Amend the Model Prisons and Correctional Services Act 2023 to align with the UNCRPD [16,19].
- 3) Ensure full accessibility of courts, police stations, and other legal services and documents for persons with disabilities within a designated timeline, budget, and monitoring and evaluation mechanism. Conduct all access audits in consultation with Organisations of Persons with Disabilities [21].
- 4) Enhance and standardise the support available for providing reasonable accommodation in correctional facilities by involving incarcerated individuals with disabilities.
- 5) Incorporate disability training on the human rights model of disability into judicial academies or National Legal Services Authority/State Legal Services Authority, involving facilitators with disabilities to emphasise the importance of lived experience.

- 6) Encourage the NHRC and Indian Council of Medical Research to promote studies on factors contributing to the unmet need for legal services and healthcare among persons with disabilities.
- 7) Promote supported decision-making and legal support services for persons with disabilities.
- 8) Reassess punitive sentencing policies for individuals with disabilities with high support needs and introduce sentencing alternatives for offenders with mental disabilities. Avoid using solitary confinement for prisoners with disabilities, especially cognitive disabilities [28,29].
- 9) Establish independent monitoring mechanisms reporting to independent bodies.
- 10) Assign the Chief Commissioner for Persons with Disabilities with the responsibility of monitoring equal opportunity policies within central prison and law enforcement agencies administration.
- 11) Implement a post-release support plan following release from prison, similar to the Open Jail concept used in Hoshangabad, Madhya Pradesh.

At the state level

- 1) As prisons, disability, and health fall under the jurisdiction of states, they should align all their laws and policies with the CRPD.
- 2) Prison authorities must guarantee that prisoners with disabilities are not subjected to discrimination, ensure accessibility and offer reasonable accommodation.
- 3) The majority of states/union territories lack a sanctioned post for a psychiatrist or psychologist. The standards and procedures for mental health services in prisons must adhere to Rule 11 of the Mental Healthcare Rules, 2018

For medical associations and health professionals

- 1) The principles of medical ethics pertaining to the responsibility of health personnel, particularly physicians, in safeguarding prisoners and detainees against torture and other forms of cruel, inhuman, or degrading treatment or punishment should be integrated into health professions education [29].
- 2) National and state medical associations should endorse the World Medical Association statement on this matter, and State Medical Councils should promote continuing medical education programmes to raise awareness.
- 3) Physicians entrusted with the medical care of prisoners and detainees are obligated to ensure the protection of their physical and mental health, providing treatment of diseases at a level consistent with the care given to those who are not incarcerated or detained.

- 4) They should maintain a publicly accessible database containing all research involving prisoners.

This commentary endeavours to contemplate disability through the lens of the human rights model of disability, aligning with the legal mandate of the CRPD to meet our constitutional obligations of nondiscrimination, accommodation, integration, and inclusion. Failure to adhere to these principles will render the concept of access to justice elusive for prisoners with disabilities.

Note: To honour disability culture, we have utilised both person-first and identity-first language throughout this paper. One of the authors identifies as a person with lived experience of disability

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