

## ***Special issue devoted to "Right to health"***

In April of this year, we informed Just News readers that we intended dedicating special issues of Just News to specific economic and social rights. In April we covered the right to housing, and this month we examine the right to health. This edition therefore looks at health issues at the local community level and how adopting a rights based approach or indeed a Bill of Rights could help address these, as well as highlighting international developments in relation to the right to health.

## ***A healthy Bill of Rights?***

**The Forum developing a Bill of Rights for Northern Ireland has created seven working groups, one examining socio-economic rights. At its inception, the group brainstormed about the issues the Bill of Rights should generally and specifically address. Relevant to this context is what the group felt the "right to health" should address.**

Members of the group (which consists of political parties and representatives of civil society) believed that it was important that the final Bill of Rights should reflect the particular circumstances of Northern Ireland. For example, several members emphasised Northern Ireland's legacy of poverty and disadvantage, and indeed the important social and economic inequalities that remain unaddressed. Poor health both compounds a person's disadvantage, but is also a product of disadvantage. Why do Traveller children have a much higher infant mortality rate than children in settled families? How will a Bill of Rights address the problem that Northern Ireland has a higher percentage of long term ill health, and of disability than comparative regions of the UK?

Unsurprisingly the working group often reverted to discuss budgetary constraints. A Bill of Rights cannot, and must not, imply that governments have a duty to provide everyone with Rolls Royce medical care, immediately and on demand – still less that government can ensure everyone has good health! Elected politicians have to make hard decisions about whether to spend money on cancer research, or heart disease, or health promotion. Indeed, resource decisions about housing, education, employment and the broader environment, all have a relevance for good health. No Bill of Rights can take such decisions out of the hands of politicians. Instead it creates the context within which such decisions get taken fairly for all.

Every government (the UK included) is expected to "take steps, to the maximum of its available resources, with a view to achieving progressively the full realization of (economic and social) rights by all appropriate means". This is the standard set out in the Covenant on Economic, Social and Cultural Rights to which the UK is a signatory.

To ensure that this is happening in the field of health, there has to be (a) a plan of action with (b) clear goals to ensure constant improvement and (c) a timetable for forward progression as well as (d) a system for regular monitoring about what is/is not working.

The working group determined that "everyone has the right to the highest attainable standard of physical and mental health and well-being" and then discussed the kinds of measures by which this right could be vindicated.

There seemed to be little disagreement as to the importance of people being consulted about decisions affecting their physical and mental health, and encapsulating the importance of free and informed consent. Nor did people appear to disagree with the need for a floor below which no-one should be allowed to fall – specifically no-one should be refused emergency medical treatment.

The debate is proving fascinating - an exercise in embedding positive government initiatives, and in preventing any diminution of standards, regardless of the government of the day. The result should be a Bill of Rights that is healthy and which sets out our right to health.

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# Debating the Bill of Rights

CAJ – as human rights sector representative on the Bill of Rights Forum - has been keeping Just News readers up to date with regular articles on how the Forum is proceeding. In September's issue, we highlighted the fact that Working Groups had been established and begun work. At the most recent Forum meeting on 14<sup>th</sup> December, the convenors of the Working Groups presented the findings to date of their various groups (which are available in full on the Forum's website – [www.billofrightsforum.org](http://www.billofrightsforum.org)).

## Children and Young People's rights

The Working Group on Children and Young People's Rights Working Groups presented a comprehensive report containing fourteen potential provisions which had a high level of agreement from within the group. These ranged from protection from abuse and exploitation and youth justice provisions to the right to play and leisure and right to education.

## Women's rights

The Working Group on Women's Rights has been delayed somewhat in its work so has not yet been able to draw up recommendations. However in their report they highlighted the issues that had been agreed by the group as being possible for inclusion within a Bill of Rights and thus worthy of further discussion. These include gender-related violence, representation in public life, discrimination and equality and reproductive rights.

## Civil and Political Rights (including equality)

The Working Group on Civil and Political Rights used the European Convention on Human Rights as its starting point and identified a number of gaps that should be included in a Bill of Rights, such as the right to information, the right to a nationality and the right to participation.

## Social and Economic Rights (including equality)

The Working Group on Social and Economic Rights (as reported on page 1) has 'brainstormed' the specific issues that could be reflected in a Bill of Rights (related to health, education, standard of living etc) as well identifying general cross-cutting issues that need to be considered, such as progressive realisation, the approach to be adopted towards specific 'vulnerable' groups etc. While they have drafted wording in relation to specific rights, they have indicated that they require more time to discuss these and the general issues.

## Criminal Justice and Victim's Rights

While the Working Group on Criminal Justice and Victims has identified a number of issues in relation to victim's rights, it has decided not to proceed any further in making recommendations until it has engaged the views of victims themselves. It has also still to deliberate fully on a number of issues it has identified in relation to criminal justice, so is likely to require more time to do this.

## Culture, Identity and Language Rights

The Working Group on Culture, Identity and Language Rights has also been delayed somewhat in its deliberations and in its progress report to the Forum highlighted a number of areas where discussion has taken place, such as a general right to cultural identity, a right to self-identification, how to give effect to the Framework Convention. However the Group has indicated that it also requires more time for further deliberations.

## Preamble, Enforceability and Implementation

CAJ's representative on the Forum, Aideen Gilmore, convenes this Working Group and reported to the Forum that the Group has made significant progress and developed recommendations on a number of issues such as limitation clauses, standing, application and implementation. However, in many cases the Group can only go so far in its discussions since final decisions and recommendations, in relation for example to enforcement mechanisms, will have to await proposals from other Working Groups.

It was clear from the presentation of these reports from the Working Groups and the discussions that ensued that the Forum is making good progress and the Working Groups are proceeding well with all participants – from political parties and civil society - actively engaged in learning about and debating the various rights within their remit.

It was also clear however that the Groups are at different stages, with some convenors expressing doubt as to whether they would realistically be able to meet the deadline of mid January for final reports. Added to this were concerns expressed right across the Forum membership that there was inadequate time remaining to sufficiently engage in outreach and consultation around the Forum's work generally and any specific recommendations that it might make. It was therefore agreed that the Chair should write to the Secretary of State to highlight these concerns and that we would revisit the issue at the next meeting in early February. We will continue to keep readers up to date.

## Using Human Rights to Measure Impact

### “Rights in Action: Changing Mental Health Services”

Since October 2006 the Participation and Practice of Rights (PPR) Project has been working with a number of individuals from two suicide/self harm support groups in North Belfast – PIPS (Public Initiative on the Prevention of Suicide) and RAYS (Reaching Across to prevent Your risk of Suicide).

This group – known as the PIPS/RAYS rights group - is made up of family members bereaved by suicide and workers who are the first point of contact for people in the community who are in crisis. The group has been working on a development programme to enable them to use a human rights based approach to improve mental health services and to monitor if the Department of Health is living up to its obligation to progressively realize the right to the highest attainable standard of mental health.

#### Recent Mental Health Developments

Recent years have seen much attention and expertise being focused on mental health services in Northern Ireland.

In October 2002 the Department of Health initiated an independent review of the law, policy and provision affecting people with mental health needs or a learning disability in Northern Ireland (Bamford Review).

The Bamford Review was completed in August 2007 after a process involving ten working groups who among them produced over 700 recommendations. Attention has now turned to how the recommendations will be implemented, particularly in light of scant consideration given to the mental health budget in the recent Programme for Government, which was denounced by the Chair of the Bamford Review as ‘derisory’.

In addition, members of both PIPS and RAYS were instrumental to the achievement of the ‘Protect Life’ strategy, the Northern Ireland Suicide Prevention Strategy and Action Plan 2006-2010. The stated aim of Protect Life is to ‘reduce the Northern Ireland rate of suicide, particularly among young people and those most at risk’.

Questions remain on how the most vulnerable groups will be reached. Despite highlighting that suicide rates in deprived areas in Northern Ireland were twice that in non-deprived areas, and that age, sexuality and marital status were significant factors in suicide, the Protect Life strategy did not undergo a full equality impact assessment.

#### Measuring impact on the ground

The primary concern of the PIPS/RAYS rights group is the *impact* these policies and programmes are having in their communities, among the people who need the services the most.

On the 28<sup>th</sup> November the PPR Project hosted an event ‘Rights in Action: Changing Mental Health Services’ at the Spires Conference Centre, Belfast.

During the conference the PIPS/RAYS rights group presented the human rights indicators they have chosen to monitor over the period of a year to a panel of international experts on human rights and mental health.

The indicators monitor local issues, but are tied into international human rights standards. In this way, the indicators monitor not only progress on the issue, but also assess if government is fulfilling its human rights obligation to progressively realize the right to health.

For example, the group will monitor the number of patients discharged from hospital after receiving mental health treatment who receive a follow up appointment within a week. During the summer the group carried out action research and found that, contrary to national guidance, 87% of those discharged did not receive a follow up appointment within a week.

During ‘Rights in Action’ the PIPS/RAYS group emphasized the importance of knowing you are still tied into services after discharge and described the follow up appointment as a ‘lifeline’. The group identified that the right to health included the right to ‘equal and timely access to mental health treatment and care’ and selected this indicator to measure the realization of this aspect of the right.

The international panel validated the approach of local groups setting human rights indicators to monitor if governments are progressively realizing the right to health. They also commented on the validity of the particular indicators chosen by the group, with particular reference to the number of low cost changes the group have identified that would make a significant impact on those at risk of suicide and their families. The panel will issue their findings early in the New Year and indicated that they will maintain a watching brief on the progress of the government in meeting these indicators.

The application of human rights standards to the realities of people’s lives is an important tool for groups in achieving accountability for decisions made in their name. Over the next year, the PIPS/RAYS rights group will measure the realization of the right to health in their community – the only place where it can be rendered meaningful.

**Nicola Browne**

**Participation and the Practice of Rights Project**

The health and human rights communities have much in common. Both are animated by the well-being of individuals and populations. In both communities, many have a particular pre-occupation with discrimination and disadvantage. While human rights violations often lead to higher morbidity and mortality, health programmes have a crucial contribution to make towards the realisation of human rights. Increasingly, health and human rights professionals are recognising their common interests and mutually reinforcing goals.

The last few years have seen some remarkable developments in the field of international human rights. For some decades, the international community focussed on classic civil and political rights – the prohibition against torture, the right to a fair trial, freedom of speech, and so on. But, since the late 1990s, the international community has begun to devote more attention to economic, social and cultural rights – the rights to education, food and shelter, as well as the right to the highest attainable standard of physical and mental health.

As the right to the highest attainable standard of health migrates from the margins to the human rights mainstream, it presents human rights and health professionals with a range of new opportunities and challenges.

### **The ‘judicial’ and ‘policy’ approaches**

Broadly speaking, there are two ways of vindicating human rights, including the right to the highest attainable standard of health. One way is via the courts, tribunals and similar processes (the ‘judicial’ approach). Another approach is by bringing human rights to bear upon policy-making processes so that policies and programmes are put in place that promote and protect human rights (the ‘policy’ approach).

Of course, the two approaches are intimately related and mutually reinforcing. Nonetheless, the distinction between them is important because the ‘policy’ approach opens up challenging interdisciplinary possibilities for the operationalisation of human rights – and it is this approach that is the main focus of these remarks.

### **What is the right to the highest attainable standard of health?**

The right to the highest attainable standard of health is codified in numerous legally binding international and regional human rights treaties. These binding treaties are beginning to generate case law and other jurisprudence that shed light on the scope of the right to health. The right is also enshrined in numerous national constitutions: over 100 constitutional provisions include the right to health or health-related rights.

# *The right to the highest attainable standard of health: opportunities and challenges*

Moreover, in some jurisdictions constitutional provisions on the right to the highest attainable standard of health have generated significant jurisprudence. While the right to health includes the right to health care, it goes beyond health care to encompass the underlying determinants of health, such as safe drinking water, adequate sanitation and access to health-related information.

The right includes freedoms, such as the right to be free from discrimination and involuntary medical treatment. It also includes entitlements, such as the right to essential primary health care. The right has numerous elements, including child health, maternal health, and access to essential drugs. Like other human rights, it has a particular concern for the disadvantaged, the vulnerable, and those living in poverty. The right requires an effective, inclusive health system of good quality.

International human rights law is realistic and recognises that the right to the highest attainable standard of health for all cannot be realised overnight. Thus, the right is expressly subject to both progressive realisation and resource availability. Although qualified in this way, nonetheless the right to health imposes some obligations of immediate effect, such as non-discrimination, and the requirement that a State at least prepares a national plan for health care and protection.

The right demands indicators and benchmarks to monitor the progressive realization of the right. It also encompasses the active and informed participation of individuals and communities in health decision-making that affects them. Under international human rights law, developed States have some responsibilities towards the realization of the right to health in poor countries. Crucially, because the right to health gives rise to entitlements and obligations, it demands effective mechanisms of accountability.

At root, the right to the highest attainable standard of health consists of globally legitimised standards; out of these standards derive legal obligations; and these obligations demand effective mechanisms of accountability. The combined effect of these three dimensions - standards, obligations and accountability - is the empowerment of vulnerable individuals and disadvantaged communities.

While the right to the highest attainable standard of health is a powerful campaigning and advocacy tool, it is more than just a slogan, more than just a bumper sticker. Additionally, it has normative depth and something constructive and concise to say to policy makers.

# st attainable standard ities and challenges

## What does the right to health bring to policy making?

In general, abstract terms the right to health brings a set of fundamental principles, such as dignity, well-being, autonomy, and equality.

It places the interests of individuals and communities – their dignity and well-being – at the heart of policy making.

It brings a keen preoccupation with the vulnerable and disadvantaged, including those living in poverty.

The right to health emphasises primary health and it demands effective health systems that are responsive to local priorities.

It places obligations – moral and legal – on states and requires that they be held to account for their conduct.

It insists that rich states have a responsibility to help developing states realise the right to health – in this way responding to the shocking inequality in global health that shames our contemporary world.

One of my responsibilities as UN Special Rapporteur on the right to health is to clarify what, in more *practical* terms, the right to health brings to a particular health problem.

We all know the cliché – ‘the devil is in the detail’. I have come to the view that, in relation to economic, social and cultural rights, such as the right to health, the devil is *not* in the detail, but just the opposite. The devil is in excessively broad generalisations.

In recent years, the international human rights community has collectively made some significant progress towards understanding the broad scope of economic, social and cultural rights. I suggest that we have come just about as far as we can while addressing these rights at an abstract, general level.

If we are to take the next steps in the evolution of these rights, we have to build upon the intellectual progress collectively made in recent years and apply those insights to specific issues in specific countries and specific contexts. This, it seems to me, is one of the lessons to be learnt from the pioneering work on HIV/AIDS and human rights.

Of course, it is very challenging to operationalise the right to health in specific contexts, but we are more likely to make progress in this way than if we confine ourselves to sweeping generalisations of a large and abstract nature. My main point is that the right to health has something precise, practical and constructive to contribute to serious, complex, specific health issues. Of course, it does not bring a magic solution. Also, you could identify policy responses without reference to the right to health. But the right to health can help to identify these responses and, where they already exist, the right can reinforce them.

In recent years, the right to health – as never before - is in a position to shape national and international policy-making. If integrated into policy making, the right to health can help to establish policies that are robust, sustainable, equitable, and meaningful to those living in poverty. In my view, we are at the threshold of a new era for the right to health. Whether we manage to take those crucial steps across the threshold remains to be seen.

## Conclusion

Increasingly, the right to the highest attainable standard of health presents health and human rights professionals with new opportunities and challenges.

The traditional techniques and skills that have served the human rights community so well for many years – ‘naming and shaming’, letter-writing campaigns, taking test cases to court, and so on – will not be sufficient to ensure that the right to health is integrated into national and international health policy making. Quite apart from expertise in the field of health, additional techniques and skills are needed. For example, selecting priorities and making trade-offs are part of the inescapable reality of policy making. So human rights proponents will have to clarify how to select priorities in a way that is respectful of the right to health. They will have to clarify how to identify which trade-offs are permissible and which are not from the human rights point of view. They will also have to develop and use new tools, like human rights impact assessments and human rights indicators and benchmarks.

Of course, the traditional human rights techniques - naming and shaming and so on - remain vitally important. But they are no longer enough. Additional skills are needed. Crucially, these new techniques and skills will have to be developed in close cooperation with health professionals. The right to the highest attainable standard of health cannot be realised without their active engagement. In short, with the maturing of human rights, health professionals have become an integral and indispensable element in the global human rights movement.

**Paul Hunt, UN Special Rapporteur on the Right to the highest attainable standard of physical and mental health** (Adapted from comments made in a lecture at University of New South Wales)

## Health at community level

**The Community Development and Health Network (CDHN) is a regional voluntary organisation with a mission to end health inequalities using a community development approach. By this we mean campaigning, influencing policy and developing best practice work which show that communities can define their own health needs and design and implement preventative and radical solutions.**

CDHN support their member organisations that are, through community development projects, tackling a wide range of local community health issues. CDHN and their members believe that health is a human right and that it is affected by more than individual lifestyle choices and access to services. We promote and support the social model of health, which carefully considers the wider determinants of health and acknowledges that a person's health is affected by a range of social, economic, cultural, political and environmental factors.

Our members work at 'grass roots' level on local health projects addressing needs and issues including working with carers, people with disabilities, men or women's issues as well as more wide ranging issues within a geographical community for example on housing or education.

The right to participate in decision making is both a guiding principle of human rights and one of the underlying principles of community development. It is the more vulnerable members of our society who find it most difficult to access services and who have been most disadvantaged by our past. Society's focus on political conflict has meant that these people have suffered even greater marginalisation than they may have in a more stable society.

CDHN believes that a strong and inclusive Bill of Rights for Northern Ireland would help its members to protect their social and economic rights and to address health inequalities at local level. For example:

The Belfast Carers Centre works with and for carers from the greater Belfast area. They provide comprehensive information and support services for carers dealing with a range of issues such as benefits, accessing services and financial support. They organise support groups and social activities to give carers the opportunity to meet, share experiences and support and to reduce isolation. They recognise that being a carer is rarely easy and that although rewarding and fulfilling, it is often isolating, physically and emotionally draining, financially crippling and can come to dominate every aspect of life.

The centre works at a policy level and is actively involved in ensuring that the recent legislative changes, the Carers Strategy and the Carers and Direct Payments legislation, make a real and positive change to the lives of carers. A Bill of Rights could guarantee carers the right to adequate support from health authorities and if carers' rights were more clearly defined in legislation service providers would be more proactive in ensuring that carers get the help that they need.

The Rural Health Partnership (RHP) is based in the WALD Centre, Cullyhanna, South Armagh, an area that has been particularly isolated during the troubles and where people have had, and continue to have, difficulty accessing

services. It is also an area with very strong community networks, again as a result of isolation and the need to come together for the benefit of all. RHP is a community based initiative which assists people to recover from mental illness and promotes positive mental health. In one particular project they work with young women experiencing stress and anxiety. The project has utilised a number of approaches including a pharmacy information session and offering one-to-one support. The project links up

with other initiatives in the area to bring in expertise on issues such as depression and parenting. A Bill of Rights could help these women in a number of ways from accessing services for mental illness to issues around the provision of childcare. If a Bill of Rights included a right to good quality, affordable childcare for pre-school children, some mothers, who would otherwise be denied the opportunity, could return to work or education.

The Foyle Haven Centre in Derry is a damp drop in (i.e. allows street and homeless drinkers who have consumed alcohol that day on to the premises). The users of the centre do not access broader state services that are available to them. This project delivers an integrated programme for the promotion of self worth and self esteem and raises awareness of the many health issues associated with the usually chaotic lifestyle of the street drinker. Involvement in activities arranged by the centre enables participants to accept personal responsibility for their physical and psychological health. A Bill of Rights could transform the lives of these people if it included a right to adequate housing and a right to access to services. This group of people represent some of the most vulnerable and socially excluded members of our society whose rights are not adequately considered.



COMMUNITY DEVELOPMENT  
AND HEALTH NETWORK

**Kathy Martin**  
**Network Development Manager (CDHN)**

# The Right to Health and the Bill of Rights

**The right to health, as defined in Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) imposes positive obligations upon the state, requiring it to make available factors necessary for health, requiring it to ensure equal access to those factors and to protect the freedom of the individual in relation to those factors. These obligations do not require the state to provide an infinite level of resources to address a perceived infinite level of need, but rather are obligations in law stipulating 'equality' and the acknowledgement that what is attainable in health includes factors which are beyond the control of the state and the individual.**

The reality, acknowledged within the language of the right is that resources may be limited and a state may be working to achieve full implementation of the right in the context of current poor health status indicators.

Although there is acceptance of a degree of state discretion in respect of resources, the obligation is still imposed upon the state to make progress in health and to ensure all individuals are given an equal opportunity to access the benefits of that progress. In other words all have a right to 'the highest attainable standard of health'.

There has been a growing body of work on the implementation and meaning of the right to health which in recent years has been supplemented with jurisprudence on the right, such as that from South Africa where the right is protected under the Constitution. This developing body of work makes it clear that it is possible to have a right to health in domestic law which is open to judicial enforcement in a way that does not infringe the domain of policy or politics or limit other mechanisms of implementation. "What we learn from the SA transition and constitutional process is that it is possible and valuable to embed protections for the

right to health. Such a lesson should not be lost on policy makers in Northern Ireland. Despite acknowledgement that a right to health may be enforceable in domestic law, criticisms continue to arise against making the right to health enforceable in the courts.

Two key criticisms include the assertion that the right is vaguely worded, and that the right's dependence on state allocation of resources means that it is an issue more properly dealt with in the context of governance than rights.

These general criticisms have also been made in relation to the development of a right to health in the Northern Ireland Bill of Rights. This has resulted in the Northern Ireland Human Rights Commission in the 2004 consultation document *'Progress towards a Bill of Rights in NI: An update'* identifying three potential versions of a right to health for further consultation, one of which was simply a combination of two of the versions.

These versions ranged from a simple statement that 'everyone has a right of access to health care' to a more detailed right focusing on the State 'public duties'. The latter embedded not only the definition from Article 12 of the ICESCR 'the right to the highest attainable standard of health' but also the approach of the South African Constitutional Court in the 'concept of reasonableness'.

A further important aspect of the CESC and South African Constitutional Court approach is that of equality. Equality is a central principle in the implementation of the right to health in both approaches.

The CESC approach to equality is to question the position of the most vulnerable in society in relation to access to health and require states to provide information on how they will correct such inequality.

The Constitutional Court in South Africa has embedded the equality principle within the right to health through its interpretative approach. The Court indicates that in considering equality it looks to the aim of the Constitution which is to deal with historical inequality. In doing this the South African Court deals with the issue of resource allocation in the context of equality as a legal obligation and whether the decision of the health care authority was reasonable and acknowledged that inequality in its decision making.

Such an approach provides that those who are most 'vulnerable' are given special consideration in order to achieve equal opportunity to health. It also allows that the process of how the decision was made is reviewed providing that aspects of the right to health such as 'participation in decision making' can also be enforced.

In the UK, government policy has long acknowledged the reduction of health inequality as a central policy aim. This is reflected in the *Northern Ireland Department of Health, Social Services and Public Safety's 2002 'Investing in Health Strategy'* which clearly states that 'policies should actively pursue equality of opportunity' and goes further stating that 'health is a fundamental right'.

Embedding a fundamental right to health in a Bill of Rights would be an acknowledgement of this basic principle and allow for a more effective implementation of that right. More importantly it would increase the role of the individual in the implementation and enforcement of that right in the context of a right which has undivided meaning and value to all members of our society.

**Jacinta Miller**  
**University of Ulster,**  
**Magee**

## Civil Liberties Diary

### 5<sup>th</sup> November

The panel established to examine how Northern Ireland can address the legacy of the Troubles, meets with relatives of those killed in the 1974 Dublin and Monaghan bombs.

### 6<sup>th</sup> November

Former Northern Ireland police oversight commissioner Al Hutchinson takes over the post of Police Ombudsman from Nuala O'Loan who stands down after seven years service.

### 7<sup>th</sup> November

The Parades Commission criticises the Garvaghy Road Residents Group for its failure to respond to mediation offers from the Orange Order over the march at Drumcree.

### 15<sup>th</sup> November

PSNI steps up security for its officers after recent murder bids in Derry and Dungannon.

### 16<sup>th</sup> November

Freedom of Information Act ruling tells the PSNI that it was wrong to withhold material on the grounds of health and safety and to protect the identities of senior staff named in documents. The dispute involved concerns over a shotgun licence.

Announcement that Daphne Trimble, wife of David Trimble, is to serve on the Northern Ireland Human Rights Commission alongside new member Colm Larkin. The two commissioners standing down are Christine Eames and Kevin McLaughlin.

The Parades Commission places restrictions on a loyalist march in Belfast. The march which has planned to pass down Donegall Pass was criticised as racially intimidating.

The family of former Sinn Féin official Denis Donaldson have made a complaint to the Garda Ombudsman over concerns into the investigation into his murder.

### 20<sup>th</sup> November

A District Policing Partnership meeting in the Markets area of Belfast is cancelled after dissent republican protesters disrupt proceedings.

High Court in Belfast is told that the smacking of children is a violation of their human rights. The claim was made at the opening of a judicial review aimed at overturning new legislation which does not prevent parents from assaulting their children while discipline them. The judicial review was brought, the NI Commissioner for Children and Young People, and the application



CAJ wishes everyone  
Season's Greetings  
and a peaceful 2008

was backed by the Childrens Law Centre, the Parents Advice Centre and the Save the Children Fund.

### 21<sup>st</sup> November

In the High Court Mr Justice Ronald Weatherup issues a declaration that the Chief Constable had failed to furnish all the available information at three inquests more than 20 years ago. Police will now have to give coroners all documents they have about the murders of Danny Doherty, Francis Bradley and Gerard Casey if the Attorney General orders new inquests.

Children's Commissioner Patricia Lewsley accompanies a march of children to Stormont to call on MLAs to take their views into account.

### 23<sup>rd</sup> November

In the Court of Appeal two former IRA prisoners challenge an employment tribunal's upholding of the Simon Community's refusal to employ them because of their terrorist convictions.

The Fair Employment Tribunal said in 2005 that the two men had been discriminated against on grounds of their political opinion. However, the case was lost because of the impact of the Fair Employment and Treatment (NI) Order 1998.

Police have referred CCTV footage of a sectarian attack in Portadown to the Police Ombudsman after claims that officers failed to intervene as Catholic youths were assaulted.

### 26<sup>th</sup> November

DUP MLA Jeffrey Donaldson calls for the law on religious hatred to be repealed as it "curtails religious freedom". The law, which applies only in Northern Ireland, criminalises incitement to religious hatred but no person has been successfully prosecuted under the Act since its inception in 1987.

### 29<sup>th</sup> November

The European Court of Human Rights finds the United Kingdom in breach of its obligations under the European Convention by failing to properly investigate allegations of security force collusion in the murders of eight Co. Armagh men during the 1970s.

*Compiled by Mark Bassett from various*

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Human Rights in Northern Ireland

*newspapers.*

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*The views expressed in Just News are not necessarily those of CAJ.*

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***The right to the highest attainable  
standard of health: opportunities and  
challenges***