EuroPak

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EVIDENCE-BASED HEALTH AND HUMAN RIGHTS ASSESSMENT

Detention Conditions, Medical Neglect, and Cumulative Harm

SUBJECT OF ASSESSMENT

Imran Ahmed Khan Niazi

Former Prime Minister, Islamic Republic of Pakistan

Chairman, Pakistan Tehreek-e-Insaf (PTI)

Report Date	Author	Affiliation
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ABOUT EUROPAK

In a global context where social, political, and economic challenges know no borders, the Pakistani diaspora needs organized and strong structures to represent it before European institutions and work to guarantee its dignity, participation, and rights.

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Dr. Nadia Arshad is a Clinical Epidemiologist at the Faculty of Medicine, University of Bergen, Norway. She received her formal education and training in Public Health Epidemiology from Karolinska Institute Medical University, Stockholm, Sweden, and later completed a PhD in Clinical Epidemiology with a focus on venous thromboembolism at the Department of Clinical Medicine, UiT-The Arctic University of Norway.

She subsequently completed Postdoctoral research on women's reproductive health and its long-term implications for chronic disease and mortality at the University of Bergen, and on mental health and gambling addiction at Karolinska Institute Medical University. In addition to her formal education and training in clinical epidemiology, she is a clinical psychologist.

Dr. Arshad's research experience spans multiple areas in clinical epidemiology, including venous thrombosis, stroke, women's health, mental health, and infectious diseases. She specialises in clinical epidemiology, quantitative research methods in health and medical sciences, clinical research, adult psychiatry, evidence synthesis, scientific medical writing, and the assessment of health risks in complex or vulnerable populations, including those in custodial settings.

Dr. Arshad is a prestigious member of EuroPak and prepared this report in her capacity as an independent researcher.

EXECUTIVE SUMMARY

! *Prolonged solitary confinement, absence of family and legal contact for months, and documented deficiencies in prison cell conditions including lack of access to clean drinking water have led to a quantifiable deterioration in Mr Khan's physical and mental health, and clearly represent a violation of the UN Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules).*

Repeated delays in medical evaluation culminated in a belated diagnosis of central retinal vein occlusion (CRVO) with approximately 85% vision loss in his right eye a clear illustration of how custodial neglect may transform a potentially treatable condition into irreversible damage. The detention environment continues to place Mr Khan at risk of infection, dehydration, exacerbation of chronic vascular disease, thrombotic events, and rapid physical deconditioning, any of which may endanger the survival of the other eye or cause stroke or myocardial infarction (heart attack).

Immediate needs:

- Prompt, independent, and unbiased specialist evaluation, including ophthalmology
- Comprehensive vascular and coagulation testing
- Access to treatment by a qualified specialist, including, where feasible, a physician of the family's choice
- Provision of basic hygiene and safe drinking water
- Immediate restoration of regular family and legal contact
- Documentation of all delays and refusals of medical care
- Independent medical and human rights review to prevent further cumulative damage
- Family participation in medical decision-making with Mr Khan's free and informed consent

PURPOSE

This report is a scientific and evidence-based human rights assessment that draws on epidemiological, psychological, and public health research to evaluate the health risks and harms associated with Mr Imran Khan's conditions of detention. The purpose is to provide a clear and evidence-based assessment of the health implications of the circumstances under which the former Prime Minister has been held.

According to publicly available international reporting, he has been held in prolonged solitary confinement and repeatedly denied contact with his family including his sons and sisters and restricted from receiving timely and adequate medical care. Multiple independent news outlets have documented that Pakistani authorities have blocked family visits, restricted access to legal counsel, and maintained extended periods of complete isolation (references 1–5).

These circumstances raise serious concerns under the UN Nelson Mandela Rules (references 6, 7), which prohibit prolonged solitary confinement, require access to meaningful human contact, and guarantee healthcare equivalent to that available in the community. This report aims to inform the European Union, international human rights organisations, and other relevant bodies of the potential health consequences, promote accountability, and encourage timely action to ensure Mr Khan receives humane treatment in accordance with international human rights standards, including access to essential healthcare.

INTRODUCTION

Solitary confinement is a custodial practice in which an individual is held alone in a cell with minimal or no meaningful human interaction for 22–24 hours per day (references 7, 8). Extensive scientific

evidence demonstrates that such levels of isolation carry severe consequences for mental and physical well-being (references 10–15). Social and sensory deprivation interfere with emotional regulation, cognitive processing, sleep patterns, and stress physiology, increasing vulnerability to psychological distress, exacerbations of chronic disease, and morbidity (references 10, 11, 13).

The Mandela Rules (updated 2015) represent a broad international consensus that prisoners must be treated with dignity and protected against cruel, inhuman, or degrading treatment. They require that prisoners have access to medical assessment and continuity of care comparable to community standards, be permitted routine communication with family and counsel, and be protected by independent monitoring (reference 7). Solitary confinement is considered a high-risk strategy permissible only in exceptional circumstances and for the shortest possible period. Scientific and human rights evidence clearly shows that prolonged isolation, denial of meaningful contact, and restricted medical access cause serious harm to both mental and physical health (references 6, 7, 10, 11, 13, 16).

MENTAL HEALTH CONSEQUENCES OF SOLITARY CONFINEMENT

Solitary confinement has been associated with high rates of psychological distress, self-harm, and increased mortality. These effects occur rapidly and can persist after release (references 10, 11). The severe deprivation of social and environmental stimulation disrupts human functioning, producing severe loneliness, anxiety, depression, perceptual disturbances such as hallucinations, and cognitive impairment (references 17, 18).

Empirical evidence from systematic reviews and meta-analyses indicates that prisoners subjected to solitary confinement have significantly higher levels of psychological symptomatology in general mental health, mood, and hostility compared to those in general incarceration, even after controlling for pre-existing mental illness (reference 10). A comprehensive systematic review and meta-analysis of 13 studies ($n \approx 382{,}440$) found moderate associations between solitary confinement and worsening psychological symptoms, increased self-harm, and trends toward higher mortality including suicide (reference 10). A recent meta-analytic review confirmed increased psychological distress with complete isolation compared to less restrictive environments (reference 19).

These effects are biologically and psychologically plausible. Prolonged stress activates the hypothalamic-pituitary-adrenal (HPA) axis and dysregulates circadian rhythms, with resulting sleep disruption further impairing cognition, affective regulation, and physiological homeostasis. Restricted or absent access to medical and psychiatric care in solitary settings allows pre-existing and emergent mental health conditions to worsen, increasing the risk of adverse outcomes (references 10, 20).

CENTRAL RETINAL VEIN OCCLUSION AND MEDICAL NEGLECT

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! *From November 2025 until mid-February 2026, (approximately three months) Mr Khan repeatedly reported blurred vision to prison authorities but received no medical assessment. Only in late February 2026 was he taken to a non-specialist facility, without informing his family. Pakistani authorities subsequently confirmed approximately 85% loss of vision in his right eye. These facts clearly indicate a substantial delay in timely ophthalmic assessment and treatment.*

Stress-Induced Vascular Mechanisms

Severe psychological stress, particularly that caused by extreme isolation, activates the HPA axis and the sympathetic nervous system, resulting in sustained elevation of cortisol and catecholamines. Chronic activation of these pathways may disrupt physiological homeostasis, leading to inflammatory responses, endothelial dysfunction, increased platelet reactivity, elevated fibrinogen levels, and reduced fibrinolysis. The combination of these factors shifts haemostatic balance toward a prothrombotic or hypercoagulable state (references 21–25), increasing the risk of venous thrombosis (reference 26).

Pathophysiology of CRVO

Central retinal vein occlusion is a thrombotic condition of the retinal venous system occurring within the framework of Virchow's triad: venous stasis, endothelial dysfunction, and hypercoagulability. CRVO is multifactorial and may be associated with classical atherosclerotic risk factors hypertension, diabetes mellitus, hyperlipidaemia, glaucoma, and advanced age as well as other systemic processes increasing hypercoagulability (reference 27). Stress-induced physiological dysregulation represents a biologically plausible contributor to CRVO in Mr Khan's case, particularly in combination with delayed medical care and potentially untreated vascular risk factors. A complete investigation of ophthalmological and systemic manifestations including blood pressure, glucose, lipid profile, and thrombophilia/coagulation studies is necessary to establish clinical causation.

PHYSICAL HEALTH CONSEQUENCES

Under international human rights standards and basic medical care obligations, Mr Khan should not be deprived of specialist medical access for timely treatment. Delay in specialist care following a CRVO diagnosis may lead to persistent macular oedema, irreversible retinal ischaemia, neovascularisation with secondary glaucoma, and permanent visual loss in the affected eye (reference 27). Delayed treatment also increases the risk to the fellow eye, particularly where systemic risk factors hypertension, diabetes, hyperlipidaemia, dehydration, or thrombophilia are present and inadequately controlled (references 27, 28).

Urgent ophthalmological assessment, retinal imaging, and treatment of ocular complications must be combined with systemic evaluation including blood pressure, glucose, lipids, hydration status, and targeted coagulation tests as untreated risk factors raise the probability of further ocular and systemic thrombotic events. Early specialist intervention reduces the likelihood of bilateral involvement and other serious complications (reference 29).

The reported denial of clean drinking water and placement in a poorly maintained cell (reference 30), combined with repeated delays in specialist assessment, substantially increased Mr Khan's risk of infection and general physical health decline (references 31, 32). Prolonged isolation with restricted medical access can also worsen chronic diseases such as cardiovascular disease and diabetes, precipitate acute vascular events including myocardial infarction and stroke, interrupt essential medications, and cause muscle wasting.

Immediate actions required:

- Documentation of all delays in medical assessment and treatment
- Urgent, independent, and unbiased specialist medical assessment, with priority given to ophthalmology
- Prompt vascular and coagulation blood investigations
- Access to treatment by a qualified specialist, including, where feasible, a physician of the family’s choice
- Family participation in medical decision-making with Mr Khan’s free and informed consent
- Immediate restoration of regular family and legal contact

CUMULATIVE IMPACT

Overall, prolonged solitary confinement, repeated delays in medical examination and treatment, and cell conditions including lack of clean drinking water contribute to a gradual and accelerating deterioration in Mr Khan's health. These factors interact and compound one another:

Stress + untreated vascular risk	Increased risk of thrombosis and vascular occlusion
Poor cell hygiene, unsafe water, no medical care	Elevated risk of infection, dehydration, and systemic decline
Prolonged immobility and isolation	Progressive loss of strength, fitness, and functional capacity
Repeated delays in specialist review	Treatable conditions converted to irreversible damage

> ! *Mr Khan has lost approximately 85% of vision in his right eye, damage that appears irreversible. The immediate concern is to protect his remaining vision and overall vascular health. Untreated systemic risk factors and continued delays in specialist care increase the likelihood that the fellow eye will be affected and raise the risk of other serious vascular events, including heart attack and stroke.*

Immediate independent documentation, urgent and unbiased specialist assessment and treatment, and prompt systemic blood testing are therefore essential to limit further cumulative harm.

RECOMMENDATIONS

1. Specialist Medical Review	Immediate, independent, and unbiased ophthalmological examination including retinal imaging and evaluation for treatment
2. Systemic Investigation	Comprehensive medical workup: blood pressure, blood glucose, lipid profile, renal function, full coagulation and thrombophilia screening
3. Safe Living Conditions	Immediate provision of clean drinking water and maintenance of basic cell hygiene per the Mandela Rules
4. End Solitary Confinement	Immediate cessation of prolonged isolation; restoration of meaningful family and legal contact
5. Documentation	Full independent documentation of all instances of delayed or denied medical care for accountability
6. International Monitoring	Engagement of an independent international medical and human rights body for ongoing monitoring of detention conditions

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