



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

GRAND CHAMBER

CASE OF N. v. THE UNITED KINGDOM

(Application no. 26565/05)

JUDGMENT

STRASBOURG

27 May 2008

In the case of N. v. the United Kingdom,

The European Court of Human Rights, sitting as a Grand Chamber composed of:

Jean-Paul Costa, *President*,
Nicolas Bratza,
Peer Lorenzen,
Françoise Tulkens,
Josep Casadevall,
Giovanni Bonello,
Ireneu Cabral Barreto,
Boštjan M. Zupančič,
Rait Maruste,
Snejana Botoucharova,
Javier Borrego Borrego,
Khanlar Hajiyeu,
Ljiljana Mijović,
Dean Spielmann,
Renate Jaeger,
Ján Šikuta,
Mark Villiger, *judges*,

and Michael O'Boyle, *Deputy Registrar*,

Having deliberated in private on 26 September 2007 and on 23 April 2008,

Delivers the following judgment, which was adopted on the last-mentioned date:

PROCEDURE

1. The case originated in an application (no. 26565/05) against the United Kingdom of Great Britain and Northern Ireland lodged with the Court under Article 34 of the Convention for the Protection of Human Rights and Fundamental Freedoms ("the Convention") by a Ugandan national, Ms N. ("the applicant"), on 22 July 2005. The President of the Grand Chamber acceded to the applicant's request not to have her name disclosed (Rule 47 § 3 of the Rules of Court).

2. The applicant, who had been granted legal aid, was represented by Mr J. Luqmani, a lawyer practising in London. The United Kingdom Government ("the Government") were represented by their Agent, Mr J. Grainger of the Foreign and Commonwealth Office.

3. The applicant, who is HIV-positive, alleged that if she were returned to Uganda she would not have access to the medical treatment she required

and that this would give rise to violations of Articles 3 and 8 of the Convention.

4. The application was allocated to the Fourth Section of the Court (Rule 52 § 1). On 22 May 2007 a Chamber of that Section, composed of Josep Casadevall, Nicolas Bratza, Giovanni Bonello, Kristaq Traja, Stanislav Pavlovski, Ljiljana Mijović, Ján Šikuta, judges, and also of Lawrence Early, Section Registrar, relinquished jurisdiction in favour of the Grand Chamber, neither of the parties having objected to relinquishment (Article 30 of the Convention and Rule 72).

5. The composition of the Grand Chamber was determined according to the provisions of Article 27 §§ 2 and 3 of the Convention and Rule 24.

6. The applicant and the Government each filed observations on the admissibility and merits. In addition, third-party comments were received from the Helsinki Foundation for Human Rights, which had been given leave by the President to intervene in the written procedure (Article 36 § 2 of the Convention and Rule 44 § 2).

7. A hearing took place in public in the Human Rights Building, Strasbourg, on 26 September 2007 (Rule 59 § 3).

There appeared before the Court:

(a) *for the Government*

Mr J. GRAINGER,
Ms M. CARSS-FRISK QC,
Mr T. EICKE,
Ms C. ADAMS,
Mr P. DELLER,
Ms L. STOWE,

*Agent,
Counsel,*

Advisers;

(b) *for the applicant*

Mr D. PANNICK QC,
Mr R. SCANNELL,
Mr J. LUQMANI,

*Counsel,
Solicitor.*

The Court heard addresses by Ms Carss-Frisk and Mr Pannick, and also their replies to questions put by Judges Borrego Borrego and Mijović.

THE FACTS

I. THE CIRCUMSTANCES OF THE CASE

8. The applicant was born in Uganda in 1974. She currently lives in London.

9. The applicant entered the United Kingdom on 28 March 1998 under an assumed name. She was seriously ill and was admitted to hospital, where she was diagnosed as HIV-positive with “considerable immunosuppression and ... disseminated mycobacterium TB”.

10. On 31 March 1998 solicitors lodged an asylum application on her behalf, claiming that she had been ill-treated and raped by the National Resistance Movement in Uganda because of her association with the Lord’s Resistance Army, and asserting that she was in fear of her life and safety if she were returned.

11. In August 1998 the applicant developed a second Aids-defining illness, Kaposi’s sarcoma. Her CD4 count was down to 10 (that of a healthy person is over 500). After treatment with antiretroviral drugs and frequent monitoring, her condition began to stabilise so that by 2005, when the House of Lords examined the case, her CD4 count had risen to 414.

12. In March 2001 a consultant physician prepared an expert report, at the request of the applicant’s solicitor, which expressed the view that without continuing regular antiretroviral treatment to improve and maintain her CD4 count, and monitoring to ensure that the correct combination of drugs was used, the applicant’s life expectancy would be less than one year, due to the disseminated Kaposi’s sarcoma and the risk of infections. The medication she needed would be available in Uganda, but only at considerable expense and in limited supply in the applicant’s home town of Masaka. Moreover, the author of the report pointed out that in Uganda there was no provision for publicly funded blood monitoring, basic nursing care, social security, food or housing.

13. The Secretary of State refused the asylum claim on 28 March 2001 on grounds of credibility, and also because it was not accepted that the Ugandan authorities were interested in the applicant. The applicant’s Article 3 claim was also rejected, the Secretary of State noting that treatment of Aids in Uganda was comparable to that in any other African country, and that all the major antiretroviral drugs were available in Uganda at highly subsidised prices.

14. An adjudicator determined the applicant’s appeal on 10 July 2002. He dismissed the appeal against the asylum refusal, but allowed the appeal on Article 3 grounds by reference to the case of *D. v. the United Kingdom* (2 May 1997, *Reports of Judgments and Decisions* 1997-III). He found that the applicant’s case fell within the scope of the Asylum Directorate

Instructions which provide that exceptional leave to remain in or enter the United Kingdom must be given:

“... where there is *credible* medical evidence that return, due to the medical facilities in the country concerned, would reduce the applicant’s life expectancy and subject him to acute physical and mental suffering, in circumstances where the UK [United Kingdom] can be regarded as having assumed responsibility for his care. ...”

15. The Secretary of State appealed against the Article 3 finding, contending that all the Aids drugs available under the National Health Service in the United Kingdom could also be obtained locally, and most were also available at a reduced price through the United Nations’ funded projects and from bilateral Aids donor-funded programmes. The applicant’s return would not, therefore, be to a “complete absence of medical treatment”, and so would not subject her to “acute physical and mental suffering”. The Immigration Appeal Tribunal allowed the appeal on 29 November 2002. It found as follows:

“Medical treatment is available in Uganda for the [applicant’s] condition even though the Tribunal accept that the level of medical provision in Uganda falls below that in the United Kingdom and will continue to lag behind the advance of continuing drug advances which inevitably first become available in highly developed countries. Nonetheless, extensive efforts are being made in Uganda to tackle the Aids situation – Aids-treating drugs are available, refined forms of drug are being supplied (albeit with time lags) and it would not be until the [applicant’s] specific and varying needs became known that her needs could be assessed and the then availability of appropriate treatment decided.”

16. Leave to appeal to the Court of Appeal was granted on 26 June 2003, and on 16 October 2003 the applicant’s appeal to the Court of Appeal was dismissed by a majority of two to one ([2003] EWCA Civ 1369). With reference to the case of *D. v. the United Kingdom* (cited above), Lord Justice Laws (with whom Lord Justice Dyson concurred) stated:

“The contrast between the relative well-being accorded in a signatory State to a very sick person who, for a while, even a long while, is accommodated there, and the scarcities and hardships which (without any violation of international law) he would face if he were returned home, is to my mind – even if the contrast is very great – an extremely fragile basis upon which to erect a legal duty upon the State to confer or extend a right to remain in its territory, a duty unsupported by any decision or policy adopted by the democratic arm, executive or legislature, of the State’s government. The elaboration of immigration policy ... is a paradigm of the responsibility of elected government. One readily understands that such a responsibility may be qualified by a supervening legal obligation arising under the ECHR [the Convention] where the person in question claims to be protected from torture or other mistreatment in his home country in violation of the Article 3 standards, especially if it would be meted out to him at the hands of the State. But a claim to be protected from the harsh effects of a want of resources, albeit made harsher by its contrast with the facilities available in the host country, is to my mind something else altogether.

... I would hold that the application of Article 3 where the complaint in essence is of want of resources in the applicant’s home country (in contrast to what has been

available in the country from which he is to be removed) is only justified where the humanitarian appeal of the case is so powerful that it could not in reason be resisted by the authorities of a civilised State. That does not, I acknowledge, amount to a sharp legal test ... an Article 3 case of this kind must be based on facts which are not only exceptional, but extreme; extreme, that is, judged in the context of cases all or many of which (like this one) demand one's sympathy on pressing grounds ..."

Lord Justice Carnwath, dissenting, was unable to say that the facts of the case were so clear that the only reasonable conclusion was that Article 3 did not apply. Given the stark contrast between the applicant's position in the United Kingdom and the practical certainty of a dramatically reduced life expectancy if returned to Uganda with no effective family support, he would have remitted the case to the fact-finding body in the case, the Immigration Appeal Tribunal.

17. Leave to appeal to the House of Lords was granted, and on 5 May 2005 the House of Lords unanimously dismissed the applicant's appeal ([2005] UKHL 31).

Lord Nicholls of Birkenhead summarised the applicant's prognosis as follows:

"... In August 1998 [the applicant] developed a second Aids-defining illness, Kaposi's sarcoma. The CD4 cell count of a normal healthy person is over 500. Hers was down to 10.

As a result of modern drugs and skilled medical treatment over a lengthy period, including a prolonged course of systematic chemotherapy, the [applicant] is now much better. Her CD4 count has risen [from 10] to 414. Her condition is stable. Her doctors say that if she continues to have access to the drugs and medical facilities available in the United Kingdom she should remain well for 'decades'. But without these drugs and facilities the prognosis is 'appalling': she will suffer ill health, discomfort, pain and death within a year or two. This is because the highly active antiretroviral medication she is currently receiving does not cure her disease. It does not restore her to her pre-disease state. The medication replicates the functions of her compromised immune system and protects her from the consequences of her immune deficiency while, and only while, she continues to receive it.

The cruel reality is that if the [applicant] returns to Uganda her ability to obtain the necessary medication is problematic. So if she returns to Uganda and cannot obtain the medical assistance she needs to keep her illness under control, her position will be similar to having a life-support machine turned off."

Lord Hope of Craighead, with whom Lord Nicholls, Lord Brown of Eaton-under-Heywood and Lord Walker of Gestingthorpe agreed, referred in detail to the Court's case-law (see paragraphs 32-41 below), and held as follows:

"... that Strasbourg has adhered throughout to two basic principles. On the one hand, the fundamental nature of the Article 3 guarantees applies irrespective of the reprehensible conduct of the applicant. ... On the other hand, aliens who are subject to expulsion cannot claim any entitlement to remain in the territory of a Contracting State in order to continue to benefit from medical, social or other forms of assistance provided by the expelling State. For an exception to be made where expulsion is

resisted on medical grounds the circumstances must be exceptional ... The question on which the Court has to concentrate is whether the present state of the applicant's health is such that, on humanitarian grounds, he ought not to be expelled unless it can [be] shown that the medical and social facilities that he so obviously needs are actually available to him in the receiving State. The only cases where this test has been found to be satisfied are *D. v. the United Kingdom* ... and *B.B. v. France* ... [T]he Strasbourg Court has been at pains in its decisions to avoid any further extension of the exceptional category of case which *D. v. the United Kingdom* represents.

It may be that the Court has not really faced up to the consequences of developments in medical techniques since the cases of *D. v. the United Kingdom* and *B.B. v. France* were decided. The position today is that HIV infections can be controlled effectively and indefinitely by the administration of retroviral drugs. In almost all cases where this treatment is being delivered successfully it will be found that at present the patient is in good health. But in almost all these cases stopping the treatment will lead in a very short time to a revival of all the symptoms from which the patient was originally suffering and to an early death. The antiretroviral treatment can be likened to a life-support machine. Although the effects of terminating the treatment are not so immediate, in the longer term they are just as fatal. It appears to be somewhat disingenuous for the Court to concentrate on the applicant's state of health which, on a true analysis, is due entirely to the treatment whose continuation is so much at risk.

But it cannot be said that the Court is unaware of the advances of medical science in this field. All the recent cases since *S.C.C. v. Sweden* have demonstrated this feature. The fact that the Court appears to have been unmoved by them is due, I think, to its adherence to the principle that aliens who are subject to expulsion cannot claim any entitlement to remain in the territory of a Contracting State in order to continue to benefit from medical, social or other forms of assistance provided by the expelling State. The way this principle was referred to and then applied in *Amegnigan v. the Netherlands* ... is, in my opinion, highly significant. What the Court is in effect saying is that the fact that the treatment may be beyond the reach of the applicant in the receiving State is not to be treated as an exceptional circumstance. It might be different if it could be said that it was not available there at all and that the applicant was exposed to an inevitable risk due to its complete absence. But that is increasingly unlikely to be the case in view of the amount of medical aid that is now reaching countries in the Third World, especially those in sub-Saharan Africa. For the circumstances to be, as it was put in *Amegnigan v. the Netherlands*, 'very exceptional' it would need to be shown that the applicant's medical condition had reached such a critical stage that there were compelling humanitarian grounds for not removing him to a place which lacked the medical and social services which he would need to prevent acute suffering while he is dying.

... So long as [the applicant] continues to take the treatment she will remain healthy and she will have several decades of good health to look forward to. Her present condition cannot be said to be critical. She is fit to travel, and will remain fit if and so long as she can obtain the treatment that she needs when she returns to Uganda. The evidence is that the treatment that she needs is available there, albeit at considerable cost. She also still has relatives there, although her position is that none of them would be willing and able to accommodate and take care of her. In my opinion her case falls into the same category as *S.C.C. v. Sweden*, *Arcila Henao v. the Netherlands*, *Ndangoya v. Sweden* and *Amegnigan v. the Netherlands*, where the Court has consistently held that the test of exceptional circumstances has not been satisfied. In

my opinion the Court's jurisprudence leads inevitably to the conclusion that her removal to Uganda would not violate the guarantees of Article 3 of the Convention. ..."

Lord Hope concluded by observing:

"[Any extension of the principles in *D. v. the United Kingdom*] would have the effect of affording all those in the [applicant's] condition a right of asylum in this country until such time as the standard of medical facilities available in their home countries for the treatment of HIV/Aids had reached that which is available in Europe. It would risk drawing into the United Kingdom large numbers of people already suffering from HIV in the hope that they too could remain here indefinitely so that they could take the benefit of the medical resources that are available in this country. This would result in a very great and no doubt unquantifiable commitment of resources which it is, to say the least, highly questionable the States Parties to the Convention would ever have agreed to. The better course, one might have thought, would be for States to continue to concentrate their efforts on the steps which are currently being taken, with the assistance of the drugs companies, to make the necessary medical care universally and freely available in the countries of the third world which are still suffering so much from the relentless scourge of HIV/Aids."

Baroness Hale of Richmond, agreeing that the appeal should be dismissed, reviewed the domestic and Convention authorities and phrased the test to be applied as follows:

"... whether the applicant's illness has reached such a critical stage (i.e. he is dying) that it would be inhuman treatment to deprive him of the care which he is currently receiving and send him home to an early death unless there is care available there to enable him to meet that fate with dignity. ... [The test] is not met on the facts of this case."

II. MEDICAL TREATMENT FOR HIV AND AIDS IN THE UNITED KINGDOM AND UGANDA

18. According to information obtained by the Court of its own motion, HIV is normally treated by antiretroviral drugs. In the United Kingdom, in common with most developed countries, these drugs are provided in combination, a practice known as "highly active antiretroviral therapy" (HAART). The proper administration of antiretroviral drugs depends on regular monitoring of the patient, including blood tests, and the availability of medical personnel to adjust at frequent intervals the level and type of drugs taken. Such treatment is generally available free of charge on the National Health Service.

19. In Uganda, attempts have been made to reduce the country's dependency on imported medication, including producing generic drugs locally. However, in common with most sub-Saharan African countries, the availability of antiretroviral drugs is hampered by limited financial resources and by shortcomings in the health-care infrastructure required to administer them effectively. As a result, according to research carried out by

the World Health Organisation (WHO), approximately only half of those needing antiretroviral therapy in Uganda receive it (WHO, “Progress on Global Access to HIV Antiretroviral Therapy”, March 2006, pp. 9, 11 and 72). The Joint United Nations Programme on HIV/Aids (UNAIDS) and WHO in their 2007 country situation analysis on Uganda also cited major barriers to HIV prevention, treatment, care and support as including limited public investment, limited service coverage and lack of a policy framework. There are also significant disparities in the provision of drugs between urban and rural areas (WHO, “Summary Country Profile for HIV/Aids Treatment Scale-Up: Uganda”, December 2005). In addition, progress in providing medical care has been offset by the ever-increasing number of people requiring treatment (UNAIDS/WHO, “Aids Epidemic Update”, 2006, p. 18) and given the rapid population growth in Uganda, its stable HIV incidence rate means that an increasing number of people acquire HIV each year (UNAIDS/WHO, “Aids Epidemic Update”, December 2007, p. 17).

THE LAW

I. ADMISSIBILITY OF THE COMPLAINTS

20. The applicant complained that, given her illness and the lack of freely available antiretroviral and other necessary medical treatment, social support or nursing care in Uganda, her removal there would cause acute physical and mental suffering, followed by an early death, in breach of Article 3 of the Convention. The Government disagreed.

Article 3 provides:

“No one shall be subjected to torture or to inhuman or degrading treatment or punishment.”

Article 8 provides:

“1. Everyone has the right to respect for his private and family life, his home and his correspondence.

2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.”

21. The Court considers that the application as a whole raises questions of law which are sufficiently serious that their determination should depend on an examination of the merits. No ground for declaring it inadmissible has

been established. The application must therefore be declared admissible. Pursuant to Article 29 § 3 of the Convention, the Court will now consider the merits of the applicant's complaints.

II. ALLEGED VIOLATION OF ARTICLE 3 OF THE CONVENTION

A. The parties' submissions

1. *The Government*

22. The Government submitted that it was clear from the Court's jurisprudence that, in medical cases such as the present, Article 3 applied only in "exceptional", or "very exceptional", circumstances. This restriction of the application of Article 3 was correct as a matter of principle, given that the source of the risk was not in the expelling State and that it stemmed from factors which were not such as to engage the responsibility of the public authorities of the receiving State. The case-law further demonstrated that "exceptional circumstances" would be found only where the applicant's illness had reached a very advanced or terminal stage and where the probable lack of medical care and support, including support from family members, in the receiving State would be such as to deprive him or her of "the most basic human dignity as his illness runs its inevitably painful and fatal course" (see *D. v. the United Kingdom*, 2 May 1997, opinion of the Commission, § 60, *Reports of Judgments and Decisions* 1997-III). In considering whether there were exceptional circumstances, the Court in previous cases had focused primarily on the gravity of the applicant's medical condition at the moment of the intended removal and had not, to date, carried out any detailed consideration of whether the required treatment and care would be available in practice to the applicant in the receiving country.

23. The "exceptional circumstances" threshold was not satisfied in the instant case. While the Government accepted that without antiretroviral drugs the applicant's condition would deteriorate rapidly and she would suffer illness, discomfort, pain and death within a year or two, they maintained that her illness was currently stable and that the treatment she needed was available in Uganda, albeit at considerable cost. She was fit to travel and would remain fit if, and so long as, she could obtain the treatment that she needed when she returned to Uganda. She had family members there, although she maintained that they would not be willing or able to care for her if she was seriously ill. For these reasons, the case was distinguishable from *D. v. the United Kingdom* and fell into the category of

medical cases in which the Court had rejected the claim under Article 3 (see paragraphs 34-39 below).

24. Advances in the treatment of HIV and Aids available in developed States did not affect the above general principle, as set out in the case-law from *D. v. the United Kingdom* onwards, since the focus in those cases was on ensuring a dignified death rather than prolonging life. The interpretation of the Convention, as with any international treaty, was confined by the consent of the Contracting States. The practical effect of extending Article 3 to cover the applicant's case would be to grant her, and countless others afflicted by Aids and other fatal diseases, a right to remain and to continue to benefit from medical treatment within a Contracting State. It was inconceivable that the Contracting States would have agreed to such a provision. The Convention was intended primarily to protect civil and political, rather than economic and social, rights. The protection provided by Article 3 was absolute and fundamental, whereas provisions on health care contained in international instruments such as the European Social Charter and the International Covenant on Economic, Social and Cultural Rights were merely aspirational in character and did not provide the individual with a directly enforceable right. To enable an applicant to claim access to health care by the "back door" of Article 3 would leave the State with no margin of appreciation and would be entirely impractical and contrary to the intention behind the Convention.

2. The applicant

25. The applicant contended that in order to engage the State's responsibility in an expulsion case it was necessary for the applicant to establish, firstly, that it was reasonably foreseeable for the State that the action or inaction would result in harm and, secondly, that the harm would reach the threshold of severity of Article 3 treatment. The analysis by the Court in an expulsion case was no different from that in any other case involving alleged future harm under Article 3; and the analysis in an expulsion case involving Aids or other serious illness was no different from that where the risk of ill-treatment emanated from the public authorities in the receiving country. Moreover, there was no conceptual distinction between acute suffering occasioned by the removal of someone at death's door, who was psychologically prepared for death, and someone who was not so psychologically prepared, having been brought back from the brink of death by treatment which it was proposed to discontinue.

26. In the instant case there was on the evidence a stark contrast between the applicant's current situation and what would befall her if removed. The adjudicator found the foreseeable consequence of the expulsion to be exposure to acute physical and mental suffering, followed by an early death. This finding was not displaced throughout the domestic proceedings and

was also reached expressly in the speech of Lord Hope (see paragraphs 14-17 above).

27. The applicant submitted that five of her six siblings had died of HIV-related illness in Uganda. She had witnessed their deaths and knew from first-hand experience that all Ugandan doctors could do was to attempt to alleviate symptoms. The hospital in her home town was very small and unable to cope with Aids. She was too weak to work and would not be able to support herself or pay for medication if returned to Uganda. Her quality of life would be appalling; she would quickly relapse into very poor health and she had no relatives left alive to look after her. During her years in the United Kingdom she had formed a private life on the basis of her associations and contacts with people and organisations which had helped her to come to terms with her illness and provided the medical, social and psychological support she needed.

3. The third party

28. The Helsinki Foundation for Human Rights, a non-governmental organisation based in Warsaw, Poland, submitted that the standards established by the Court would affect a large number of Aids sufferers and the Court should seize the opportunity to define the factors to be taken into account when deciding on the expulsion of an HIV/Aids-infected person. Such factors should include: the acquired rights of a person who had been admitted to a host country and treated there using antiretroviral therapy; the medical condition of the person to be removed, principally the degree of dependence on antiretroviral therapy; and the availability of medication in the country of origin to the individual in question.

B. The Court's assessment

1. General principles regarding Article 3 and expulsion

29. According to the Court's constant case-law, ill-treatment must attain a minimum level of severity if it is to fall within the scope of Article 3. The assessment of this minimum level of severity is relative; it depends on all the circumstances of the case, such as the duration of the treatment, its physical and mental effects and, in some cases, the sex, age and state of health of the victim (see, among many other authorities, *Jalloh v. Germany* [GC], no. 54810/00, § 67, ECHR 2006-IX. The suffering which flows from naturally occurring illness, physical or mental, may be covered by Article 3, where it is, or risks being, exacerbated by treatment, whether flowing from conditions of detention, expulsion or other measures, for which the authorities can be held responsible (see *Pretty v. the United Kingdom*, no. 2346/02, § 52, ECHR 2002-III; *Kudła v. Poland* [GC], no. 30210/96,

§ 94, ECHR 2000-XI; *Keenan v. the United Kingdom*, no. 27229/95, § 116, ECHR 2001-III; and *Price v. the United Kingdom*, no. 33394/96, § 30, ECHR 2001-VII).

30. It is the Court's settled case-law that as a matter of well-established international law, and subject to their treaty obligations, including those arising from the Convention, Contracting States have the right to control the entry, residence and removal of aliens. However, expulsion by a Contracting State may give rise to an issue under Article 3, and hence engage the responsibility of that State under the Convention, where substantial grounds have been shown for believing that the person concerned, if deported, faces a real risk of being subjected to treatment contrary to Article 3. In such a case, Article 3 implies an obligation not to deport the person in question to that country (see *Saadi v. Italy* [GC], no. 37201/06, §§ 124-25, ECHR 2008).

31. Article 3 principally applies to prevent a deportation or expulsion where the risk of ill-treatment in the receiving country emanates from intentionally inflicted acts of the public authorities there or from non-State bodies when the authorities are unable to afford the applicant appropriate protection (see *H.L.R. v. France*, 29 April 1997, § 32, *Reports* 1997-III, and *Ahmed v. Austria*, 17 December 1996, § 44, *Reports* 1996-VI).

2. *The Court's case-law in respect of Article 3 and the expulsion of the seriously ill*

32. In addition, aside from these situations and given the fundamental importance of Article 3 in the Convention system, the Court in the above-cited *D. v. the United Kingdom* case (§ 49) reserved to itself sufficient flexibility to address the application of Article 3 in other contexts which might arise, where the source of the risk of proscribed treatment in the receiving country stemmed from factors which could not engage either directly or indirectly the responsibility of the public authorities of that country, or which, taken alone, did not in themselves infringe the standards of Article 3.

33. The applicant in *D. v. the United Kingdom* was a national of St Kitts who had been convicted and sentenced in the United Kingdom in connection with a drugs offence. When he had completed his sentence of imprisonment the United Kingdom authorities sought to deport him to St Kitts. He was, however, by that time in the advanced stages of Aids. When the Court examined the case, his CD4 cell count was below 10, he had suffered severe and irreparable damage to his immune system and his prognosis was very poor; it appeared that he was close to death. He had been counselled about dying and had formed bonds with his carers. There was evidence before the Court that the medical facilities in St Kitts did not have the capacity to provide the applicant with the treatment he needed and

he had no family home or close relatives able to look after him there. The Court held (§§ 53-54) as follows:

“In view of these exceptional circumstances and bearing in mind the critical stage now reached in the applicant’s fatal illness, the implementation of the decision to remove him to St Kitts would amount to inhuman treatment by the respondent State in violation of Article 3.

... [T]he respondent State has assumed responsibility for treating the applicant’s condition since August 1994. He has become reliant on the medical and palliative care which he is at present receiving and is no doubt psychologically prepared for death in an environment which is both familiar and compassionate. Although it cannot be said that the conditions which would confront him in the receiving country are themselves a breach of the standards of Article 3, his removal would expose him to a real risk of dying under most distressing circumstances and would thus amount to inhuman treatment.

...

Against this background the Court emphasises that aliens who have served their prison sentences and are subject to expulsion cannot in principle claim any entitlement to remain in the territory of a Contracting State in order to continue to benefit from medical, social or other forms of assistance provided by the expelling State during their stay in prison.

However, in the very exceptional circumstances of this case and given the compelling humanitarian considerations at stake, it must be concluded that the implementation of the decision to remove the applicant would be a violation of Article 3.”

34. Since the judgment in *D. v. the United Kingdom*, the Court has never found a proposed removal of an alien from a Contracting State to give rise to a violation of Article 3 on grounds of the applicant’s ill health.

35. In *B.B. v. France* (7 September 1998, *Reports* 1998-VI), the applicant, who had been serving a period of imprisonment in France, was suffering from Aids with acute immunosuppression. His condition had reached an advanced stage, requiring repeated hospital stays, but had stabilised as a result of antiretroviral treatment which he claimed would not be available to him in his home country, the Democratic Republic of the Congo. The Commission, in its report on the case, had found that it was highly probable that if the applicant were to be deported he would not have access to treatment designed to inhibit the spread of the virus and that the numerous epidemics raging in his country would increase the risk of infection. To expect him to confront his illness alone, without any support from family members, was likely to make it impossible for him to maintain human dignity as the disease ran its course. It concluded that deporting him would amount to a violation of Article 3. The case was referred to the Court, but before it could examine it the French Government gave an undertaking

that the applicant would not be deported and the case was therefore struck out of the Court's list.

36. In *Karara v. Finland* (no. 40900/98, Commission decision of 29 May 1998, unreported), the applicant, a citizen of Uganda, had been treated in Finland for an HIV infection since 1992. The Commission distinguished the case from *D. v. the United Kingdom* and *B.B. v. France* on the ground that the applicant's illness had not yet reached such an advanced stage that his deportation would amount to treatment proscribed by Article 3 and it declared the application inadmissible.

37. The applicant in *S.C.C. v. Sweden* ((dec.), no. 46553/99, 15 February 2000), was a Zambian national who had been refused leave to enter Sweden, where she had previously lived and where she had been treated for HIV. The applicant submitted medical evidence to the effect that life-prolonging treatment would have a much better success rate if she was given the chance to continue it in Sweden since the standard of care and monitoring possibilities in Zambia were reduced in comparison. The Court declared the application inadmissible, on the basis that, according to a report from the Swedish embassy in Zambia, the same type of Aids treatment was available there, although at considerable cost, and that the applicant's children as well as other family members lived there. Taking into account the applicant's present state of health, her removal to Zambia would not amount to treatment proscribed by Article 3.

38. The following year the Court delivered judgment in *Bensaid v. the United Kingdom* (no. 44599/98, ECHR 2001-I). The applicant, an Algerian national, was a schizophrenic who had been treated for this illness for some years in the United Kingdom. The Court unanimously rejected the complaint under Article 3 and held as follows (§§ 36-40):

"In the present case, the applicant is suffering from a long-term mental illness, schizophrenia. He is currently receiving medication, olanzapine, which assists him in managing his symptoms. If he returns to Algeria, this drug will no longer be available to him free as an outpatient. He does not subscribe to any social insurance fund and cannot claim any reimbursement. It is, however, the case that the drug would be available to him if he was admitted as an inpatient and that it would be potentially available on payment as an outpatient. It is also the case that other medication, used in the management of mental illness, is likely to be available. The nearest hospital for providing treatment is at Blida, some 75 to 80 km from the village where his family live.

The difficulties in obtaining medication and the stress inherent in returning to that part of Algeria, where there is violence and active terrorism, would, according to the applicant, seriously endanger his health. Deterioration in his already existing mental illness could involve relapse into hallucinations and psychotic delusions involving self-harm and harm to others, as well as restrictions in social functioning (such as withdrawal and lack of motivation). The Court considers that the suffering associated with such a relapse could, in principle, fall within the scope of Article 3.

The Court observes, however, that the applicant faces the risk of relapse even if he stays in the United Kingdom as his illness is long term and requires constant management. Removal will arguably increase the risk, as will the differences in available personal support and accessibility of treatment. The applicant has argued, in particular, that other drugs are less likely to be of benefit to his condition, and also that the option of becoming an inpatient should be a last resort. Nonetheless, medical treatment is available to the applicant in Algeria. The fact that the applicant's circumstances in Algeria would be less favourable than those enjoyed by him in the United Kingdom is not decisive from the point of view of Article 3 of the Convention.

The Court finds that the risk that the applicant would suffer a deterioration in his condition if he were returned to Algeria and that, if he did, he would not receive adequate support or care is to a large extent speculative. The arguments concerning the attitude of his family as devout Muslims, the difficulty of travelling to Blida and the effects on his health of these factors are also speculative. The information provided by the parties does not indicate that travel to the hospital is effectively prevented by the situation in the region. The applicant is not himself a likely target of terrorist activity. Even if his family does not have a car, this does not exclude the possibility of other arrangements being made.

The Court accepts the seriousness of the applicant's medical condition. Having regard, however, to the high threshold set by Article 3, particularly where the case does not concern the direct responsibility of the Contracting State for the infliction of harm, the Court does not find that there is a sufficiently real risk that the applicant's removal in these circumstances would be contrary to the standards of Article 3. The case does not disclose the exceptional circumstances of *D. v. the United Kingdom* (cited above), where the applicant was in the final stages of a terminal illness, Aids, and had no prospect of medical care or family support on expulsion to St Kitts."

39. In *Arcila Henao v. the Netherlands* ((dec.), no. 13669/03, 24 June 2003), the applicant was a national of Colombia who, while serving a prison sentence for drug trafficking, was found to be HIV-positive and was thus treated using antiretroviral medication. The Court found that the applicant's present condition was reasonable, but that he might relapse if treatment were discontinued. It noted that the required treatment was "in principle" available in Colombia, where the applicant's father and six siblings resided. The Court distinguished the case from *D. v. the United Kingdom* and *B.B. v. France* (both cited above), on the ground that the applicant's illness had not reached an advanced or terminal stage and that he had a prospect of medical care and family support in his country of origin. It did not, therefore, find that the circumstances of the applicant's situation were of such an exceptional nature that his expulsion would amount to treatment proscribed by the Convention and it therefore declared the application inadmissible.

40. The applicant in *Ndangoya v. Sweden* ((dec.), no. 17868/03, 22 June 2004), was a Tanzanian national who had been treated with antiretroviral medication which been successful in reducing his HIV levels to the point where they were no longer detectable. It was said that the prospects of his receiving that treatment in Tanzania were very slim and that its interruption would lead to a relatively rapid deterioration of his immune system, to the

development of Aids within one to two years and death within three to four years. The application was declared inadmissible, on the grounds that the applicant's illness had not reached an advanced or terminal stage; adequate treatment was to be had in Tanzania, albeit at considerable cost and with limited availability in the rural area from whence the applicant came; and that he maintained some links with relatives who might be able to help him.

41. A similar conclusion was reached in *Amegnigan v. the Netherlands* ((dec.), no. 25629/04, 25 November 2004), where the applicant, who came from Togo, had been treated with antiretroviral treatment in the Netherlands. Medical evidence indicated that as soon as the therapy was stopped he would relapse to the advanced stage of the disease which, given its incurable nature, would entail a direct threat to life. A report on local conditions in Togo indicated that, while the treatment was available there, a person who did not have health insurance would find it difficult to afford it if relatives were unable to provide financial support. The application under Article 3 was declared manifestly ill-founded, on the grounds that the applicant had not reached the stage of full-blown Aids and was not suffering from any HIV-related illness. While acknowledging the assessment of the applicant's treating specialist doctor that the applicant's health condition would relapse if treatment would be discontinued, the Court noted that adequate treatment was in principle available in Togo, albeit at a possibly considerable cost.

3. *The principles to be drawn from the case-law*

42. In summary, the Court observes that since *D. v. the United Kingdom* it has consistently applied the following principles.

Aliens who are subject to expulsion cannot in principle claim any entitlement to remain in the territory of a Contracting State in order to continue to benefit from medical, social or other forms of assistance and services provided by the expelling State. The fact that the applicant's circumstances, including his life expectancy, would be significantly reduced if he were to be removed from the Contracting State is not sufficient in itself to give rise to breach of Article 3. The decision to remove an alien who is suffering from a serious mental or physical illness to a country where the facilities for the treatment of that illness are inferior to those available in the Contracting State may raise an issue under Article 3, but only in a very exceptional case, where the humanitarian grounds against the removal are compelling. In the *D. v. the United Kingdom* case the very exceptional circumstances were that the applicant was critically ill and appeared to be close to death, could not be guaranteed any nursing or medical care in his country of origin and had no family there willing or able to care for him or provide him with even a basic level of food, shelter or social support.

43. The Court does not exclude that there may be other very exceptional cases where the humanitarian considerations are equally compelling.

However, it considers that it should maintain the high threshold set in *D. v. the United Kingdom* and applied in its subsequent case-law, which it regards as correct in principle, given that in such cases the alleged future harm would emanate not from the intentional acts or omissions of public authorities or non-State bodies, but instead from a naturally occurring illness and the lack of sufficient resources to deal with it in the receiving country.

44. Although many of the rights it contains have implications of a social or economic nature, the Convention is essentially directed at the protection of civil and political rights (see *Airey v. Ireland*, 9 October 1979, § 26, Series A no. 32). Furthermore, inherent in the whole of the Convention is a search for a fair balance between the demands of the general interest of the community and the requirements of the protection of the individual's fundamental rights (see *Soering v. the United Kingdom*, 7 July 1989, § 89, Series A no. 161). Advances in medical science, together with social and economic differences between countries, entail that the level of treatment available in the Contracting State and the country of origin may vary considerably. While it is necessary, given the fundamental importance of Article 3 in the Convention system, for the Court to retain a degree of flexibility to prevent expulsion in very exceptional cases, Article 3 does not place an obligation on the Contracting State to alleviate such disparities through the provision of free and unlimited health care to all aliens without a right to stay within its jurisdiction. A finding to the contrary would place too great a burden on the Contracting States.

45. Finally, the Court observes that, although the present application, in common with most of those referred to above, is concerned with the expulsion of a person with an HIV and Aids-related condition, the same principles must apply in relation to the expulsion of any person afflicted with any serious, naturally occurring physical or mental illness which may cause suffering, pain and reduced life expectancy and require specialised medical treatment which may not be so readily available in the applicant's country of origin or which may be available only at substantial cost.

4. Application of the above principles to the present case

46. The Court observes at the outset that, although the applicant applied for, and was refused, asylum in the United Kingdom, she does not complain before the Court that her removal to Uganda would put her at risk of deliberate, politically motivated, ill-treatment. Her claim under Article 3 is based solely on her serious medical condition and the lack of sufficient treatment available for it in her home country.

47. In 1998 the applicant was diagnosed as having two Aids-defining illnesses and a high level of immunosuppression. As a result of the medical treatment she has received in the United Kingdom her condition is now stable. She is fit to travel and will remain fit as long as she continues to

receive the basic treatment she needs. The evidence before the national courts indicated, however, that if the applicant were to be deprived of her present medication her condition would rapidly deteriorate and she would suffer ill health, discomfort, pain and death within a few years (see paragraphs 14-17 above).

48. According to information collated by WHO (see paragraph 19 above), antiretroviral medication is available in Uganda, although through lack of resources it is received by only half of those in need. The applicant claims that she would be unable to afford the treatment and that it would not be available to her in the rural area from which she comes. It appears that she has family members in Uganda, although she claims that they would not be willing or able to care for her if she were seriously ill.

49. The United Kingdom authorities have provided the applicant with medical and social assistance at public expense during the nine-year period it has taken for her asylum application and claims under Articles 3 and 8 of the Convention to be determined by the domestic courts and this Court. However, this does not in itself entail a duty on the part of the respondent State to continue to provide for her.

50. The Court accepts that the quality of the applicant's life, and her life expectancy, would be affected if she were returned to Uganda. The applicant is not, however, at the present time critically ill. The rapidity of the deterioration which she would suffer and the extent to which she would be able to obtain access to medical treatment, support and care, including help from relatives, must involve a certain degree of speculation, particularly in view of the constantly evolving situation as regards the treatment of HIV and Aids worldwide.

51. In the Court's view, the applicant's case cannot be distinguished from those cited in paragraphs 36-41 above. It does not disclose very exceptional circumstances, such as in *D. v. the United Kingdom* (cited above), and the implementation of the decision to remove the applicant to Uganda would not give rise to a violation of Article 3 of the Convention.

III. ALLEGED VIOLATION OF ARTICLE 8 OF THE CONVENTION

52. The applicant argued under Article 8 that the circumstances facing her on return to Uganda would engage her right to respect for her private life.

53. The Court does not consider that any separate issue arises under Article 8 of the Convention. It is not necessary, therefore, to examine this complaint.

FOR THESE REASONS, THE COURT

1. *Declares*, unanimously, the application admissible;
2. *Holds* by fourteen votes to three that there would be no violation of Article 3 of the Convention in the event of the applicant being removed to Uganda;
3. *Holds* by fourteen votes to three that it is not necessary to examine the complaint under Article 8 of the Convention.

Done in English and in French, and delivered at a public hearing in the Human Rights Building, Strasbourg, on 27 May 2008.

Michael O'Boyle
Deputy Registrar

Jean-Paul Costa
President

In accordance with Article 45 § 2 of the Convention and Rule 74 § 2 of the Rules of Court, the following joint dissenting opinion of Judges Tulkens, Bonello and Spielmann is annexed to this judgment.

J.-P.C.
M.O'B.

JOINT DISSENTING OPINION OF JUDGES TULKENS, BONELLO AND SPIELMANN

1. We do not agree with the Court’s finding that there would be no violation of Article 3 of the Convention in the event of the applicant’s removal to Uganda.

2. In those circumstances, nor can we agree that it is not necessary to examine the complaint under Article 8 of the Convention.

I. Article 3 of the Convention

3. A thorough analysis of the domestic courts’ decisions leads us to the conclusion that there are substantial grounds for believing that the applicant faces a real risk of prohibited treatment in her home country. Moreover, this case is indeed one of exceptional gravity meeting the “very exceptional circumstances” test as laid down in *D. v. the United Kingdom* (2 May 1997, *Reports of Judgments and Decisions* 1997-III).

4. But before turning to the facts of the case, we would like to make four remarks as to the general principles of the Court’s case-law which, in our view, have been wrongly appraised by the majority. We would then like to propose our alternative dissenting view.

A. As to the general principles

5. Firstly, we would stress that we cannot share the view expressed by the majority that the Court should maintain its high threshold “given that in such cases the alleged future harm would emanate not from the intentional acts or omissions of public authorities or non-State bodies, but instead from a naturally occurring illness and the lack of adequate resources to deal with it in the receiving country” (see paragraph 43 of the judgment).

The Court emphasised as early as 1997 in the *H.L.R. v. France* case (29 April 1997, *Reports* 1997-III) the potential danger emanating from non-State bodies:

“40. Owing to the absolute character of the right guaranteed, the Court does not rule out the possibility that Article 3 of the Convention (art. 3) may also apply where the danger emanates from persons or groups of persons who are not public officials. However, it must be shown that the risk is real and that the authorities of the receiving State are not able to obviate the risk by providing appropriate protection.”

Concerning, in particular, the suffering which flows from naturally occurring illness, physical or mental, the Court has elaborated the so-called “*Pretty* threshold” (see *Pretty v. the United Kingdom*, no. 2346/02, ECHR 2002-III):

“52. As regards the types of ‘treatment’ which fall within the scope of Article 3 of the Convention, the Court’s case-law refers to ‘ill-treatment’ that attains a minimum

level of severity and involves actual bodily injury or intense physical or mental suffering (see *Ireland v. the United Kingdom*, cited above, § 167, and *V. v. the United Kingdom* [GC], no. 24888/94, § 71, ECHR 1999-IX). Where treatment humiliates or debases an individual, showing a lack of respect for, or diminishing, his or her human dignity, or arouses feelings of fear, anguish or inferiority capable of breaking an individual's moral and physical resistance, it may be characterised as degrading and also fall within the prohibition of Article 3 (see amongst recent authorities, *Price v. the United Kingdom*, no. 33394/96, §§ 24-30, ECHR 2001-VII, and *Valašinas v. Lithuania*, no. 44558/98, § 117, ECHR 2001-VIII). *The suffering which flows from naturally occurring illness, physical or mental, may be covered by Article 3*, where it is, or risks being, exacerbated by treatment, whether flowing from conditions of detention, expulsion or other measures, for which the authorities can be held responsible (see *D. v. the United Kingdom* and *Keenan*, both cited above; and *Bensaid v. the United Kingdom*, no. 44599/98, ECHR 2000-I)." (emphasis added)

This principle should therefore equally apply where the harm stems from a naturally occurring illness and a lack of adequate resources to deal with it in the receiving country, if the minimum level of severity, in the given circumstances, is attained. Where a rigorous examination reveals substantial grounds for believing that expulsion will expose the person to a real risk of suffering inhuman or degrading treatment, removal would engage the removing State's responsibility under Article 3 of the Convention.

6. Secondly, and most regrettably, in paragraph 44 of the judgment the Court adds worrying policy considerations based on an incomplete statement that the Convention is essentially directed at the protection of civil and political rights, thus ignoring the social dimension of the integrated approach adopted by the Court, specifically in *Airey v. Ireland* (9 October 1979, Series A no. 32) and in more recent case-law (see, most notably, *Sidabras and Džiautas v. Lithuania*, nos. 55480/00 and 59330/00, ECHR 2004-VIII¹):

In *Airey* the Court held:

"26. The Court is aware that the further realisation of social and economic rights is largely dependent on the situation – notably financial – reigning in the State in question. On the other hand, the Convention must be interpreted in the light of present-day conditions (see *Marckx*, cited above, § 41) and it is designed to safeguard the individual in a real and practical way as regards those areas with which it deals (see paragraph 24 above). Whilst the Convention sets forth what are essentially civil and political rights, many of them have implications of a social or economic nature. The Court therefore considers, like the Commission, that the mere fact that an interpretation of the Convention may extend into the sphere of social and economic rights should not be a decisive factor against such an *interpretation*; *there is no water-*

1. For an analysis of this judgment and as to the "permeability" of human rights norms, see Virginia Mantouvalou, *European Law Review*, vol. 30, 2005, pp. 573-85. For an analysis of the moral justification for protection of socio-economic rights, see J. Waldron, "Liberal Rights: Two Sides of the Coin", in Waldron, *Liberal Rights – Collected Papers 1981-1991* (Cambridge: Cambridge University Press), 1993, p. 1 at pp. 4-17, quoted by Mantouvalou, *op. cit.*

tight division separating that sphere from the field covered by the Convention.”
(emphasis added)

We are minded to draw attention to the incomplete and thus misleading quotation from the *Airey* judgment made by the majority in paragraph 44 of the judgment, for the sake of clarity and completeness and not because we are of the opinion that this case is about social and economic rights. It is a case about one of the core fundamental *civil* rights guaranteed under the Convention, namely that of Article 3.

7. Thirdly, we also strongly disagree with the highly controversial statement made by the majority in paragraph 44 of the judgment in the context of the non-derogable right of Article 3 that “... inherent in the whole of the Convention is a search for a fair balance between the demands of the general interest of the community and the requirements of the protection of the individual’s fundamental rights”.

Even though certain “proportionalist errings”, severely criticised in legal writings, existed at one time, particularly in the case-law of the old Commission¹, the balancing exercise in the context of Article 3 was clearly rejected by the Court in its recent *Saadi v. Italy* judgment ([GC], no. 37201/06, ECHR 2008), confirming the *Chahal v. the United Kingdom* judgment (15 November 1996, *Reports* 1996-V), in the following terms:

“130. In order to determine whether there is a risk of ill-treatment, the Court must examine the foreseeable consequences of sending the applicant to the receiving country, bearing in mind the general situation there and his personal circumstances ...

...

138. ... *Since protection against the treatment prohibited by Article 3 is absolute, that provision imposes an obligation not to ... expel any person who, in the receiving country, would run the real risk of being subjected to such treatment. As the Court has repeatedly held, there can be no derogation from that rule ...*”² (emphasis added)

1. S. van Drooghenbroeck, *La Proportionnalité dans le Droit de la Convention Européenne des Droits de l’Homme. Prendre l’Idée Simple au Sérieux* (Brussels: Bruylant, Publications des Facultés Universitaires Saint-Louis), 2001, pp. 125 et seq.

2. A similar approach has been adopted by Lord Hope in the case of *Limbuela*, concerning destitution, decided by the House of Lords on 5 November 2005 (*Regina v. Secretary of State for the Home Department, ex parte Limbuela*, [2005] UKHL 66): “55. So the exercise of judgment is required in order to determine whether in any given case the treatment or punishment has attained the necessary degree of severity. It is here that it is open to the court to consider whether, taking all the facts into account, this test has been satisfied. But it would be wrong to lend any encouragement to the idea that the test is more exacting where the treatment or punishment which would otherwise be found to be inhuman or degrading is the result of what Laws LJ refers to as legitimate government policy. That would be to introduce into the absolute prohibition, by the backdoor, considerations of proportionality. They are relevant when an obligation to do something is implied into the Convention. In that case the obligation of the State is not absolute and unqualified. But proportionality, which gives a margin of appreciation to States, has no part

8. Fourthly, and in contrast with what the majority say, we would like to add that in this case the claim has not been articulated that Article 3 does “place an obligation on the Contracting State to alleviate such disparities through the provision of free and unlimited health care to all aliens without a right to stay within its jurisdiction” (see paragraph 44).

However, the view expressed by the majority that such a finding “would place too great a burden on the Contracting States” (see paragraph 44 *in fine*), reflects the real concern that they had in mind: if the applicant were allowed to remain in the United Kingdom to benefit from the care that her survival requires, then the resources of the State would be overstretched. Such a consideration runs counter to the absolute nature of Article 3 of the Convention and the very nature of the rights guaranteed by the Convention that would be completely negated if their enjoyment were to be restricted on the basis of policy considerations such as budgetary constraints. So does the implicit acceptance by the majority of the allegation that finding a breach of Article 3 in the present case would open up the floodgates to medical immigration and make Europe vulnerable to becoming the “sickbay” of the world. A glance at the Court’s Rule 39 statistics concerning the United Kingdom shows that, when one compares the total number of requests received (and those refused and accepted) as against the number of HIV cases, the so-called “floodgate” argument is totally misconceived¹.

to play when conduct for which it is directly responsible results in inhuman or degrading treatment or punishment. The obligation to refrain from such conduct is absolute.”

Admittedly, Lord Hope’s dictum in *Limbuela* concerned the question “whether the state is properly to be regarded as responsible for the harm”. See the analysis of Ellie Palmer, “Socio-Economic Rights and the Human Rights Act”, *Judicial Review* (Oxford: Hart Publishing), 2007, p. 266.

1. – *June to December 2005*: 15 requests: 13 refused, 1 accepted (namely *N. v. the United Kingdom*).

– *2006*: 88 requests: 83 refused, 5 accepted (2 of these 5 were HIV cases).

– *2007*: 951 requests: 217 refused, 182 accepted (19 were HIV cases, 14 accepted, 0 refused; in one of the cases, the Rule 39 indication was lifted and the applicant has withdrawn her application because of fresh domestic proceedings).

– *1 January 2007 to 22 April 2008*: 969 requests: 174 refused, 176 accepted (19 were HIV cases, 13 accepted and 0 refused).

Those statistics beg the following explanation. The system now records all cases where interim measures are requested, whether a decision is taken by a judge or not. This explains why there is a large disparity between the fact that there are 969 recorded requests for January-April 2008 but only 176 when Rule 39 has been applied and 174 when it has been refused. The rest would be either out of scope or not submitted because there were no documents.

For the HIV cases there are a number of explanations which may account for the fact that 19 were registered as HIV cases in each year but only 14 and 13 decisions were taken each year to apply Rule 39. For example, the Government have given undertakings in some cases and in others the applicants may have withdrawn their applications because they have been given leave to remain on other grounds.

B. As to the facts of this case

9. The undisputed facts are set out eloquently in paragraph 73 of the House of Lords’ judgment. We would like to repeat them here, as it follows from those facts that substantial grounds are shown for believing that the person faces a real risk of prohibited treatment in the country of proposed removal. That is what makes this case very exceptional.

Paragraph 73 of the House of Lords’ judgment reads as follows:

“73. This appellant, a Ugandan national, is a case in point. Seven years ago, then aged 23, she arrived on a flight from Entebbe and the following day, seriously ill, was admitted to Guy’s Hospital where she was diagnosed HIV-positive with severe damage to the immune system (a CD4 count of ten) and disseminated TB. Following a long initial stay in hospital she developed a second Aids-defining illness, Kaposi’s sarcoma, a particularly aggressive form of cancer. She was readmitted to hospital and started a prolonged course of chemotherapy. By 2002, after some years of treatment with antiretroviral drugs and many setbacks, her CD4 count had risen to 414 and she was well. In October 2002, the date of the latest medical evidence in the case, she was described by Dr Meadway as ‘stable and free of any significant illness’ and, were she to remain in the United Kingdom, ‘likely to remain well for decades’. Were she, however, to be returned to Uganda, her prospects would deteriorate dramatically. In this event it was Dr Meadway’s view that:

‘[T]he formulation of antiretroviral drugs Ms N is currently taking are not available in Uganda. Ms N’s HIV virus already has some resistance and in the future she will require a change of antiretrovirals which is likely to include other drugs not available in Uganda. If she returns to Uganda although antiretrovirals are available in parts of the country she would not have the full treatment required and would suffer ill health, pain, discomfort and an early death as a result.’

By an ‘early death’ it appears that Dr Meadway was suggesting death within a year or at most two. Dr Larbalestier, a Consultant Physician at Guy’s, also reporting in October 2002, said:

‘I have no doubt at all that if she is forced to return to Uganda her lifespan will be dramatically shortened from potentially decades of high-quality life to almost certainly less than two years.’”

10. The Convention guarantees should not be understood outside the context of prevailing practical realities. These are usefully described in the extracts of the speeches of the Law Lords and adjudicator set out below:

Lord Hope of Craighead:

“20. The decision which your Lordships have been asked to take in this case will have profound consequences for the appellant. *The prospects of her surviving for more than a year or two if she is returned to Uganda are bleak.* It is highly likely that the advanced medical care which has stabilised her condition by suppressing the HIV virus and would sustain her in good health were she to remain in this country for decades will no longer be available to her. If it is not, her condition is likely to reactivate and to deteriorate rapidly. There is no doubt that if that happens she will face an early death after a period of acute physical and mental suffering ...” (emphasis added)

Baroness Hale of Richmond:

“59. ... The issue is when it is permissible to expel a person who is suffering from an illness which can be treated here but whose prospects of receiving such treatment in her home country do not look good.

...

67. ... None of us wishes to send a young woman, who has already suffered so much but is now well cared for and with a future ahead of her, *home to the likelihood of an early death* in a much less favourable environment ...” (emphasis added)

Lord Brown of Eaton-under-Heywood:

“73. ... Were [the applicant], however, to be returned to Uganda, *her prospects would deteriorate dramatically*.” (emphasis added)

11. The adjudicator, Mr P.H. Norris, found on 3 July 2002 as follows:

“10. ... I accept that [the applicant] came to this country to escape from those who had harassed and ill-treated her. I also find that when she came to this country she did not know that she was suffering from a life-threatening illness and that she did not come here to obtain medical treatment. I find that the condition from which she now suffers is indeed Aids and that without the sophisticated treatment which she is now receiving she would die within a matter of months. I find that the treatment she needs would not be available to her in Uganda. In making these findings as to her state of health, I take into account and accept the medical evidence contained within the appellant’s bundle. There is no need for me to refer to any specific medical report: all the reports are in my view consistent with each other. I do however find the three reports by Dr Jeanette Meadway, medical director of Mildmay Hospital, ... to be particularly impressive. I note that Mildmay Hospital operates at least one hospice in Uganda, and I see no reason why I should not accept the opinions of Dr Meadway in their entirety. One of her conclusions ... *is that to compel the appellant to return to Uganda would cause suffering and early death and would amount to inhuman and degrading treatment*. I accept this conclusion on the evidence which I have heard and seen.” (emphasis added)

12. We would like to add that concerning the situation in Uganda, a so-called “high prevalence” country, the progress made in providing medical care is offset by the spread of the epidemic (more medical treatment but ever-increasing numbers of people requiring treatment)¹. Concerning the treatment, and, in particular, “highly active antiretroviral therapy” (HAART), the quality of medical care will depend not just on the availability of the drugs but on the availability of doctors to manage and adjust the doses, since HAART is a cocktail of drugs which requires constant monitoring. The medical reports submitted in the domestic proceedings in the present case indicate that the applicant would have a life expectancy of two years if the treatment she is receiving in the United Kingdom were to be withdrawn. The problem in assessing what kind of

1. UNAIDS/WHO, “Aids Epidemic Update”, December 2006, pp. 17-18:
http://data.unaids.org/pub/EpiReport/2006/2006_EpiUpdate_en.pdf

medical care she would receive on return is that if she does not receive antiretroviral therapy, she is likely to die from what are called “opportunistic infections” (which the body cannot fight because of the weakened immune system, the reason for her life expectancy of two years).

13. It is against this factual background and practical realities that the Grand Chamber had to decide the present case.

C. As to the potential violation of Article 3 of the Convention

14. Lord Hope expressly asked our Court to give a clear answer, saying:

“[I]t is not for [the House of Lords] to search for a solution to [the applicant’s] problem which is not to be found in the Strasbourg case-law. *It is for the Strasbourg Court, not for us, to decide* whether its case-law is out of touch with modern conditions and to determine what further extensions, if any, are needed to the rights guaranteed by the Convention. We must take its case-law as we find it, not as we would like it to be.”¹ (emphasis added)

15. Admittedly, the Court has never found a violation in cases decided since *D. v. the United Kingdom* (cited above). However, all the cases have been decided on facts distinguishable from those in that case and also from those of the present case. We refer in this respect to the very accurate summary of the case-law provided in paragraphs 34 to 41 of the judgment².

16. We would like, however, to emphasise that in *B.B. v. France* (7 September 1998, *Reports* 1998-VI), a case settled and consequently struck out of the Court’s list, the European Commission of Human Rights, in its opinion, as expressed in the Article 31 report of 9 March 1998, found,

1. Compare with Baroness Hale in *R (on the application of Animal Defenders International) v. Secretary of State for Culture, Media and Sport* [2008] UKHL 15 in paragraph 53: “I do not believe that, when Parliament gave us those novel and important powers, it was giving us the power to leap ahead of Strasbourg in our interpretation of the Convention rights. Nor do I believe that it was expecting us to lag behind. ...”

2. See *B.B. v. France*, 7 September 1998, *Reports* 1998-VI; *Karara v. Finland*, no. 40900/98, Commission decision of 29 May 1998: illness had not yet reached an advanced stage; *S.C.C. v. Sweden* (dec.), no. 46553/99, 15 February 2000: same type of Aids treatment as in Sweden was available in Zambia, although at a considerable cost, but the applicant’s children and family members lived there; *Bensaid v. the United Kingdom*, no. 44599/98, ECHR 2001-I: medical treatment available in Algeria, not receiving support or care to a large extent speculative; *Arcila Henao v. the Netherlands* (dec.), no. 13669/03, 24 June 2003: applicant’s illness had not reached an advanced or terminal stage and he had a prospect of medical care and family support in his country of origin; *Ndangoya v. Sweden* (dec.), no. 17868/03, 22 June 2004: applicant’s illness had not reached an advanced or terminal stage and adequate treatment was to be found in Tanzania, albeit at considerable cost and with limited availability in the rural area from where the applicant came, and he maintained some links with relatives who might be able to help him; *Amegnigan v. the Netherlands* (dec.), no. 25629/04, 25 November 2004: applicant had not reached the stage of full-blown Aids and was not suffering from any HIV-related illnesses and adequate treatment was in principle available in Togo albeit at a possibly considerable cost; see also *Tatete v. Switzerland* (friendly settlement), no. 41874/98, 6 July 2000; and *M.M. v. Switzerland* (dec.), no. 43348/98, 14 September 1998.

by twenty-nine votes to two, that deporting the applicant to the Democratic Republic of the Congo would amount to a violation of Article 3 of the Convention. The Commission based its opinion on the following reasoning:

“53. In the Commission’s opinion, a finding that such a risk exists need not necessarily imply that the receiving country or the public authorities there are responsible for it. Given the fundamental importance of Article 3 in the Convention system, the Commission and the Court have already recognised that they were not prevented from scrutinising an applicant’s claim under Article 3 where the source of the risk of his or her suffering proscribed treatment in the receiving country stems from factors which cannot engage either directly or indirectly the responsibility of the public authorities of that country or which, taken alone, do not in themselves infringe the standards of that Article. It is therefore important to examine the application of Article 3 in the light of all the circumstances which could entail a violation of it (see *Ahmed v. Austria*, 17 December 1996, *Reports* 1996-VI, opinion of the Commission, p. 2207, § 44; *H.L.R. v. France*, 29 April 1997, *Reports* 1997-III, opinion of the Commission, p. 792, § 49).

54. Given that the object and purpose of the Convention as an instrument for the protection of individual human beings require that its provisions be interpreted and applied so as to make its safeguards practical and effective (see *Soering*, cited above, § 87), the Commission considers that exposing a person to a real and substantiated risk to his health which is so serious as to amount to a violation of Article 3 on account of other factors in the receiving country, such as the lack of medical care and services, as well as social and environmental factors, are capable of engaging the responsibility of the State intending to expel the person (see, *inter alia*, *Tanko v. Finland*, no. 23634/94, Commission decision of 19 May 1994, *Decisions and Reports* 77-A, p. 133; *Nasri v. France*, 13 July 1995, Series A no. 320-B, opinion of the Commission, p. 36, § 61; and *D. v. the United Kingdom*, cited above, §§ 49 et seq.).

55. The Commission is of the view that, if the applicant is deported to his native country, it is highly probable that he will not have access to treatment designed to inhibit the spread of the virus and delay the appearance of opportunistic infections, to which Aids sufferers are extremely vulnerable. The numerous epidemics raging in his country, causing a high degree of mortality, would increase this risk of infection. Furthermore, the Commission considers that, on the facts, expecting the applicant to confront an illness such as advanced Aids alone, without any support from his family, is likely to make it impossible for him to maintain human dignity as the disease runs its – inevitably painful and fatal – course.”¹

1. In his separate opinion, Judge Cabral Barreto, then a member of the Commission, even went a step further: “... where the applicant is obliged to travel to hospital for treatment and needs peace and tranquillity to ‘cope with’ his serious illness, condemning him to remain an illegal alien for the rest of his life constitutes in itself treatment contrary to Article 3 of the Convention.

...

For my part, I consider that a seriously ill foreigner living in a country as a kind of illegal alien, unable to benefit fully and as of right from the social security regime, is in a situation which fails to meet the requirement of Article 3 of the Convention.

Finally, given the importance of this factor, I consider that it should have been expressly mentioned in the Commission’s report.”

17. Compared to this humane but reasonable approach, the Grand Chamber decision constitutes a clear setback.

18. By inviting our Court to expand (or restrict) the scope of the “very exceptional circumstances” test, Lord Hope seems to have taken as the starting point of his reasoning that this case is distinguishable from *D. v. the United Kingdom*.

19. We believe that it is not. We are not convinced that the facts in this case are so different from *D. v. the United Kingdom* as to call for a different solution. Admittedly, it is true that in *D. v. the United Kingdom* the applicant’s fatal illness had already reached a *critical stage*¹. And it is equally true that the Court, in its judgment of 2 May 1997, quite rightly decided that, in the “exceptional circumstances” of that case, removing the applicant to St Kitts would amount to inhuman treatment by the respondent State in violation of Article 3². The Court’s majority, in paragraph 42 of this Grand Chamber judgment, heavily relied on that particular feature of *D. v. the United Kingdom*, stating as follows:

“In the *D. v. the United Kingdom* case the very exceptional circumstances were that the applicant was critically ill and appeared to be close to death, could not be guaranteed any nursing or medical care in his country of origin and had no family there willing or able to care for him or provide him with even a basic level of food, shelter or social support.”

The majority explained, however, in the following paragraph that it:

“[did] not exclude that there [might] be other very exceptional cases where the humanitarian considerations [were] equally compelling.”

20. Indeed, deportation of an “applicant on his or her death bed” would *in itself* be inconsistent with the absolute provision of Article 3 of the Convention. Or to put it differently, and as Lord Brown has rightly pointed

This visionary separate opinion anticipated, more than seven years earlier, the House of Lords’ judgment of 5 November 2005 in *Regina v. Secretary of State for the Home Department, ex parte Limbuela*, [2005] UKHL 66.

1. Lord Hope emphasised as follows in paragraph 36 of the House of Lords’ judgment, commenting on *D. v. the United Kingdom*: “It was the fact that [*D.*] was already terminally ill while still present in the territory of the expelling state that made his case exceptional”.

A recent and lucid comment, describing the restrictive view of the House of Lords’ judgment in *N.* reads as follows: “... the House of Lords in *N.* concluded that the inference to be drawn from Strasbourg jurisprudence is that it is not necessarily a violation of Article 3 ECHR [the Convention] to return an Aids patient, unless the facts are on all fours either with those in *D. v. the United Kingdom* (in other words, if the applicant’s condition is advanced or at terminal stage) or with those in the HIV/Aids cases that had been found admissible (in other words, if there will be a complete absence of palliative care or family support after deportation).” See Ellie Palmer, “Socio-Economic Rights and the Human Rights Act”, *Judicial Review* (Oxford: Hart Publishing), 2007, p. 273.

2. *D. v. the United Kingdom*, 2 May 1997, § 53, *Reports* 1997-III: “In view of these exceptional circumstances and bearing in mind the critical stage now reached in the applicant’s fatal illness, the implementation of the decision to remove him to St Kitts would amount to inhuman treatment by the respondent State in violation of Article 3.”

out: “[t]he mere fact that the applicant is fit to travel, however, is not in itself sufficient to preclude his removal being characterised as Article 3 ill-treatment” (paragraph 80 of the House of Lords’ judgment).

21. We understand, however, that the additional grounds advanced by the Court in *D. v. the United Kingdom* and related to a lack of medical and palliative care as well as a lack of psychological support, in the home country, might be equally relevant to the finding of a *separate* potential violation of Article 3 of the Convention¹.

22. On the basis of this principle, and above all on the basis of the facts, the Court should also have found in this case a potential violation of Article 3 of the Convention, precisely because there are substantial grounds to believe that the applicant faces a real risk of prohibited treatment in the country of proposed removal².

23. There is no doubt that in the event of removal to Uganda the applicant will face an early death after a period of acute physical and mental suffering. In this case we are satisfied of the existence of such extreme facts with equally compelling humanitarian considerations. After all, the highest judicial authorities in the United Kingdom were almost unanimous in holding that the applicant, if returned to Uganda, would have to face an early death. The expelling State’s responsibility, because substantial grounds are thus shown for believing that the applicant almost certainly faces a risk of prohibited treatment in Uganda, is engaged.

24. Without interpreting the scope of Article 3 of the Convention differently from our Court in the case of *D. v. the United Kingdom*, a violation could therefore have been found in the light of the very extreme facts of this case³. In other words, finding a potential violation of Article 3

1. Or as Baroness Hale rightly put it: “There may, of course be other exceptional cases, with other extreme facts, where the humanitarian considerations are equally compelling. The law must be sufficiently flexible to accommodate them ...” (paragraph 70 of the House of Lords’ judgment).

2. We would also like to add that all the criteria identified by the Helsinki Foundation for Human Rights in its written comments lodged with the Court on 6 September 2007 are met:

– *Continuation of the therapy*

If the HIV/Aids-infected person has been officially admitted in the host country to start the antiretroviral therapy, it should be expected he/she has a chance of continuation.

– *Medical situation of the HIV/Aids-infected person*

If ceasing the therapy causes an almost immediate result (death within a very short time) this factor should be considered as being a compelling factor.

– *Availability of medication in the country of origin allowing for the continuation of the therapy in this country*

– *Possibility for continuing treatment abroad, but on the basis of financial support from the expelling country*

In this case all three factors are applicable, making it a “very exceptional case”.

3. Facts which concern, after all, what one commentator has considered to be “a life and death issue”. See Ellie Palmer, “Socio-Economic Rights and the Human Rights Act”, *Judicial Review* (Oxford: Hart Publishing), 2007, p. 270.

in this case would not have been an extension of the exceptional category of cases which is represented by *D. v. the United Kingdom*.

25. The distinguishing of the present case from that of *D. v. the United Kingdom* is thus, in our opinion, misconceived.

II. Article 8 of the Convention

26. While it is understandable that the Court, in its case-law, has refrained from examining a second complaint – concerning the same facts – when the first has given rise to a finding of a violation, it is certainly strange for the Court to be using the laconic form of words “it is not necessary to examine the complaint under Article 8 of the Convention” after finding that there was *no* violation of Article 3 of the Convention. While the Court considered that the present case lacked very exceptional circumstances and that the threshold of seriousness for the purposes of Article 3 was thus not satisfied, it should nevertheless, in our opinion, have examined closely and carefully the situation of the applicant and of her illness under Article 8 of the Convention, which guarantees, in particular, a person’s right to physical and psychological integrity. Faced with the situation of a person who will, without doubt, be sent to certain death, we think that the Court could neither legally¹ nor morally confine itself to saying “[no] separate issue arises under Article 8 of the Convention”.

1. In *Bensaid v. the United Kingdom* (no. 44599/98, ECHR 2001-I), a case concerning deportation of a schizophrenic to a country where adequate medical treatment was allegedly not available, the Court found a violation of Article 8 of the Convention:

“47. ‘Private life’ is a broad term not susceptible to exhaustive definition. The Court has already held that elements such as gender identification, name and sexual orientation and sexual life are important elements of the personal sphere protected by Article 8 (see, for example, *Dudgeon v. the United Kingdom*, 22 October 1981, § 41, Series A no. 45; *B. v. France*, 25 March 1992, § 63, Series A no. 232-C; *Burghartz v. Switzerland*, 22 February 1994, § 24, Series A no. 280-B; and *Laskey, Jaggard and Brown v. the United Kingdom*, 19 February 1997, § 36, *Reports* 1997-I). Mental health must also be regarded as a crucial part of private life associated with the aspect of moral integrity. Article 8 protects a right to identity and personal development, and the right to establish and develop relationships with other human beings and the outside world (see, for example, *Burghartz*, cited above, opinion of the Commission, p. 37, § 47, and *Friedl v. Austria*, 31 January 1995, § 45, Series A no. 305-B). The preservation of mental stability is in that context an indispensable precondition to effective enjoyment of the right to respect for private life.

48. Turning to the present case, the Court recalls that it has found above that the risk of damage to the applicant’s health from return to his country of origin was based on largely hypothetical factors and that it was not substantiated that he would suffer inhuman and degrading treatment. Nor in the circumstances has it been established that his moral integrity would be substantially affected to a degree falling within the scope of Article 8 of the Convention. Even assuming that the dislocation caused to the applicant by removal from the United Kingdom where he has lived for the last eleven years was to be considered by itself as affecting his private life, in the context of the relationships and support framework which he enjoyed there, the Court considers that such interference may be

regarded as complying with the requirements of the second paragraph of Article 8, namely as a measure ‘in accordance with the law’, pursuing the aims of the protection of the economic well-being of the country and the prevention of disorder and crime, as well as being ‘necessary in a democratic society’ for those aims.”