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

FOURTH SECTION

DECISION

Application no. 37546/06
Rodions FEDOSEJEVS
against Latvia

The European Court of Human Rights (Fourth Section), sitting on 19 November 2013 as a Chamber composed of:

Päivi Hirvelä, President,
Ineta Ziemele,
George Nicolaou,
Zdravka Kalaydjieva,
Vincent A. De Gaetano,
Paul Mahoney,
Krzysztof Wojtyczek, *judges*,

and Françoise Elens-Passos, *Section Registrar,*

Having regard to the above application lodged on 12 September 2006,

Having regard to the observations submitted by the respondent Government and the observations in reply submitted by the applicant,

Having deliberated, decides as follows:

THE FACTS

1. The applicant, Mr Rodions Fedosejevs, is a permanently resident "non-citizen" of the Republic of Latvia who was born in 1974 and is currently serving a prison sentence in Riga. The applicant, who had been granted legal aid, was represented before the Court by Ms J. Kvjatkovska, a lawyer practising in Riga.

2. The Latvian Government ("the Government") were represented by their Agent at the time, Mrs I. Reine, and subsequently by Mrs K. Līce.

A. The circumstances of the case

3. The facts of the case, as submitted by the parties, may be summarised as follows.

1. The applicant's state of health before imprisonment

4. It appears that since 9 August 2001 the applicant has been registered on the register of HIV/AIDS patients at the Latvian Infectious Diseases Centre (*Latvijas Infektoloģijas Centrs*) as having the following diagnosis: HIV infection and infection with hepatitis C virus (HCV).

2. The applicant's pre-trial detention and imprisonment

5. On 30 August 2005 the applicant was transferred to Brasa Prison (*Brasas cietums*).

6. On 12 January 2006 the applicant was transferred to Matīsa Prison (*Matīsa cietums*).

7. On 7 April 2006 the applicant was convicted of an unspecified crime and sentenced to an unspecified term of imprisonment.

8. On 1 November 2008 Matīsa Prison and Central Prison merged to become Rīga Central Prison (*Rīgas centrālcietums*). The applicant continued the serving of his sentence in that prison.

3. The applicant's medical care in prison

9. On 5 September 2005 the applicant underwent a medical examination; it appears that the applicant himself told a doctor that he was infected with HIV and HCV. His medical record contained the following diagnosis: "HIV infection; HCV." A further examination (chest roentgenoscopy) and immunological testing were ordered.

10. On 21 September 2005 the applicant complained of stomach pain. He was prescribed a further examination (roentgenoscopy) and medication. The applicant was later found to have problems in the duodenum and, on 27 October 2005, was diagnosed with chronic gastritis. He received a course of medication for it on at least four occasions.

11. On 4 October 2005 the results of the immunological testing were received. They showed the applicant's HIV infection as being at the A-I clinical stage (HIV-1 A-I), which meant that the CD4 cell count was more than 500 cells per mm^3, and that the applicant had HCV.

12. On 28 December 2005, following further immunological testing, the Latvian Infectious Diseases Centre informed the Medical Unit of the Prisons Administration that the applicant's HIV infection remained at the A-I clinical stage and he had HCV.

13. On 6 January 2006 the applicant was diagnosed with acute bronchitis. He received a course of medication on three subsequent

occasions and, on 18 January 2006, a note was made that his state of health was satisfactory and he had no further complaints.

14. On 19 April 2006, following the next immunological monitoring tests, the applicant's HIV infection was found to be at clinical stage A-II (HIV-1 A-II), which meant that the CD4 cell count was between 200 and 499 cells per mm^3. He also had HCV. In all subsequent tests the CD4 cell count remained between 200 and 499 cells per mm^3. On each occasion further monitoring tests within the next three to four months were advised.

15. According to the Government, during his pre-trial detention and imprisonment the applicant consulted various specialist doctors (internists, psychiatrists, radiologists and dentists) on seventy-seven occasions. On several occasions in December 2005, January 2006, February, March, April and May 2008 and November 2009 he received vitamins. As regards the HIV infection, the prison doctors examined the applicant on nineteen occasions. Blood samples were taken in the prison at two- to six-month intervals and sent for examination to the Latvian Infectious Diseases Centre so that his state of health could be monitored. On one occasion (23 August 2008) the applicant refused to give a blood sample. In connection with the HCV, the prison doctors gave the applicant treatment for his symptoms and treatment to enhance liver functioning. The applicant received hepatoprotectives on six occasions (ten- to fifteen-day courses in 2005, 2008 and 2009) and vitamin courses on seven occasions (seven- to thirty-day courses in 2005, 2006, 2008 and 2009).

4. Review of the applicant's complaints

(a) In relation to medical care

16. On 20 September 2006, in reply to a query by the applicant, the Ministry of Heath explained that the Latvian Infectious Diseases Centre was responsible for providing healthcare to persons infected with HIV and AIDS, including inpatient treatment, outpatient consultations, laboratory examinations and monitoring of HIV treatment. As regards medical care in custody, a reference was made to regulation no. 358 (1999). If necessary a prison doctor could consult with an appropriate specialist. At the same time, the prison doctor was responsible for medical care in prison; he/she established diagnoses and prescribed appropriate treatment.

17. In reply to a complaint by the applicant, the Inspectorate of Quality Control for Medical Care and Working Capability ("the MADEKKI") examined the applicant's medical care in prison and assessed its quality.

18. On 6 October 2006 a report was drawn up. The report contained an information note which read as follows:

> "If [the applicant's] security could be ensured during examinations and if the medical council decides to commence treatment, he should spend 1-2 two days in a hospital, during which time treatment could be started and [during which time]

observations would be made as to whether there was [any] reaction to the medication used. A follow-up examination would be required at the Latvian Infectious Diseases Centre once a month.

Currently, [in Latvia] treatment for HCV is compensated in the amount of 75% of the price of the medication, 25% being paid by the patient himself".

19. The report concluded that the applicant's medical care complied with regulation no. 358 (1999). Taking into account that treatment for HIV-infected persons in Latvia was provided only according to certain criteria – that is, when the CD4 cell count had dropped to the (critical) level of 200 cells per mm3 and when there were other symptoms of immunodeficiency – and that the applicant did not have such symptoms, the decision not to provide any treatment for the applicant's infection was found to be justified.

20. On 11 October 2006, on the basis of that report, an expert at the MADEKKI terminated the proceedings that had been opened in relation to the alleged administrative offence in respect of the applicant's medical care in custody.

21. On the same date a letter was sent to the applicant notifying him of the decision to terminate the administrative proceedings. The information note contained in the report (quoted above) was included in that letter.

22. On 7 November 2006 the administration of Matīsa Prison informed the applicant that the treatment for his disease was decided by doctors at the Latvian Infectious Diseases Centre on the basis of immunological monitoring and blood test results. He could apply to the head doctor of that centre to ask why he had not received any treatment.

23. On 7 December 2006, having reviewed the applicant's complaint against the decision to terminate the administrative proceedings, the Head of the MADEKKI upheld that decision.

24. On 12 January 2007 the applicant lodged an application with the Administrative District Court (Administratīvā rajona tiesa) concerning the matter.

25. On 16 January 2007 the judge at the Administrative District Court (Administratīvā rajona tiesa) stayed the proceedings on account of the applicant's failure to comply with the statutory language requirement, since he had not submitted his complaint in the State language. He had also failed to pay the State duty for lodging the application. A time-limit for rectifying the deficiencies was set. It appears that the applicant did not submit the required documents.

(b) In relation to a special diet

26. On 27 October 2006, in response to the applicant's question whether a special diet was necessary for him, the MADEKKI stated that they did not have competence to decide on such matters. The applicant was advised to

consult a prison doctor; in any event, at the current stage of the applicant's disease, a special diet was not necessary.

27. On 7 November 2006 the administration of Matīsa Prison referred to regulation no. 339 (2002), noting that the applicant did not fall into the category of prisoners entitled to receive nutrition plan 4B.

28. On 8 December 2006 the Prisons Administration informed the applicant that his medical care was provided in accordance with regulation no. 358 (199) and that he received nutrition in accordance with regulation no. 339 (2002). According to the prison doctor, the applicant's state of health was satisfactory.

B. Relevant international material

29. The World Health Organization ("WHO") guidelines of 2006 "Antiretroviral therapy for HIV infection in adults and adolescents: recommendations for a public health approach" read as follows:

> **"4.2. Immunological assessment of HIV-infected adults and adolescents**
>
> The optimum time to commence ART [antiretroviral therapy] is before patients become unwell or present with their first opportunistic infection. Immunological monitoring (CD4 testing) is the ideal way to approach this situation. A baseline CD4 cell count not only guides the decision on when to initiate ART but is also essential if CD4 counts are to be used to monitor ART. Table 3 summarizes the immunological criteria for the initiation of ART.
>
> Table 3. CD4 criteria for the initiation of ART in adults and adolescents

CD4 (cells/mm^3)	Treatment recommendation
<200	Treat irrespective of clinical stage
200-350	Consider treatment and initiate before CD4 count drops below 200 cells/mm^3
>350	Do not initiate treatment

> ...
>
> The benchmark threshold marking a substantially increased risk of clinical disease progression is a CD4 cell count of 200 cells/mm^3. Although it is never too late to initiate ART, patients should preferably begin the therapy before the CD4 cell count drops to or below 200 cells/ mm^3. The optimum time to initiate ART with a CD4 cell count of 200−350 cells/mm^3 is unknown. Patients with CD4 cell counts in this range require regular clinical and immunological evaluation.
>
> The treatment of patients with WHO clinical stage 4 disease should not depend on a CD4 cell count determination: all such patients should initiate ART. For WHO clinical stage 3 conditions, a threshold of 350 cells/ mm^3 has been identified as a level below which functional immune deficiency is present and ART should be considered ... For patients with clinical stage 1 or 2 disease, a CD4 count below 200 cells/mm^3 is

a clear indication for treatment. Although there are no randomized trial data on the CD4 cell count level at which to start therapy in asymptomatic persons, data from a number of cohorts have been consistent in demonstrating that disease progression is greater in persons who start antiretroviral therapy with CD4 counts below 200 cells/mm^3 than in those starting therapy above this level. In general these studies have not been able to detect a difference in outcome between persons who start therapy at CD4 counts of 200−350 cells/mm^3 and those who do so at CD4 counts above 350 cells/mm^3. However, if the CD4 count is above 350 cells/mm^3, ART should be delayed ...

Table 4. Recommendations for initiating ART in adults and adolescents in accordance with clinical stages and the availability of immunological markers

WHO clinical staging	CD4 testing not available	CD4 testing available
1	Do not treat	Treat if CD4 count is below 200 cells/mm^3
2	Do not treat	
3	Treat	Consider treatment if CD4 count is below 350 cells/mm^3 and initiate ART before CD4 count drops below 200 cells/mm^3
4	Treat	Treat irrespective of CD4 count

...

4.3. Virological assessment of HIV-infected adults and adolescents

Plasma viral load measurement is not necessary before initiating ART. It rarely informs the clinical decision as to when ART should begin if both CD4 testing and the assessment of clinical staging are performed ...

13. Considerations in hepatitis B or hepatitis C coinfection

...

In the setting of HIV infection the course of HCV [hepatitis C]-associated liver disease is accelerated. Rates of progression of liver disease in HIV/HCV coinfection are greater. ... there is contradictory evidence on the effects of HCV on HIV disease progression. In the Swiss cohort study the presence of HCV was independently associated with an increased risk of progression to AIDS and death. However, the EuroSIDA cohort analysis found that the overall virological and immunological responses to ART were not affected by HCV serostatus... However, the risk of mortality related to liver disease was markedly increased in HCV-seropositive patients ...

Irrespective of whether a patient has HIV infection, the optimal treatment for hepatitis C virus infection is pegylated interferon alpha and ribavirin (RBV)... The initiation of ART in HIV/HCV-coinfected patients should follow the same principles and recommendations as for the initiation of ART in HIV-monoinfected patients. However, the patients should be followed up more closely because of the major risk of drug-related hepatotoxicity and for specific drug interactions of some ARVs with

anti-HCV drugs ... In patients with high CD4 cell counts it is preferable to treat HCV infection before HIV. While concurrent treatment of both infections is feasible, it may be complicated by pill burden ..., drug toxicities and drug interactions. In patients who need ART it may be preferable to initiate ART and delay HCV therapy in order to obtain better anti-HCV response rates after immune recovery ...

15. Clinical and laboratory monitoring

...

Clinical and laboratory monitoring of HIV-infected patients serves two purposes. Firstly, for patients under care who are not yet eligible for ART, regular monitoring is essential for the identification of the point at which they become eligible for ART or for prophylaxis against opportunistic infections... Well-designed monitoring protocols can facilitate the initiation of [opportunistic infections] prophylaxis and ART in the majority of HIV-infected patients before they develop advanced HIV infection.

Secondly, once patients have been initiated on ART, regular monitoring is necessary to assess efficacy, manage side-effects and identify treatment failure ...

Because resources are limited, laboratory testing should generally be directed by signs and symptoms and should be done only when the results can be used to guide management decisions. Exceptions are the recommendations to obtain a CD4 cell count every six months...

15.2. Monitoring of patients who are not yet eligible for ART

Patients who are not yet eligible for ART should be monitored for clinical progression and by CD4 count measurement every six months. Clinical evaluation should include the same parameters as are used in baseline evaluations, including weight gain or loss and development of clinical signs and symptoms of progressive HIV disease. These clinical parameters and the CD4 cell count should be used to update the WHO disease stage at each visit and to determine whether patients have become eligible for [opportunistic infections] prophylaxis or ART. Clinical evaluation and CD4 counts can be obtained more frequently as the clinical or immunological threshold for initiating ART approaches (Table 4) ..."

30. On 30 November 2009 the WHO published a document entitled "Rapid Advice: Antiretroviral Therapy for HIV Infection in Adults and Adolescents". It revised the previous recommendations concerning the commencement of antiretroviral treatment contained in the 2006 guidelines. It strongly recommended that antiretroviral treatment be started in all patients with HIV who had a CD4 count below 350 cells per mm^3 irrespective of clinical symptoms. It stressed the necessity of CD4 testing to identify whether HIV-positive patients at WHO clinical stage 1 or 2 of the disease needed to start antiretroviral treatment. Furthermore, it strongly recommended that antiretroviral treatment be started in all patients with HIV at WHO clinical stage 3 or 4 irrespective of CD4 count.

31. The same recommendations are contained in the WHO's 2010 guidelines "Antiretroviral therapy for HIV infection in adults and adolescents: recommendations for a public health approach".

C. Relevant domestic law

1. Medical care in custody

32. Section 10 of the Medical Treatment Law (*Ārstniecības likums*), as in force at the material time, provided that the MADEKKI was responsible for monitoring the professional quality of medical care in healthcare establishments. With legislative amendments effective from 5 October 2007 onwards that task was entrusted to the Health Inspectorate (*Veselības inspekcija*).

33. Regulation of the Cabinet of Ministers no. 358 (1999), in force at the material time and effective until 28 March 2007, provided as follows:

> "2. Convicted persons shall receive the minimum standard of health care free of charge up to the amount established by the Cabinet of Ministers. In addition, the Prisons Administration, within its budgetary means, shall provide convicted persons with:
>
> 2.1. primary, secondary and tertiary (in part) medical care;
>
> 2.2. emergency dental care;
>
> 2.3. medical examinations/check-ups;
>
> 2.4. preventive and anti-epidemic measures;
>
> 2.5. medication and injections prescribed by a (prison) doctor; and
>
> 2.6. medical equipment.
>
> 3. Detainees shall receive medical care in accordance with Article 2 of these Regulations, excluding planned inpatient treatment ... Detainees shall be sent for inpatient treatment only in acute circumstances. ...
>
> 12. The prison authorities may agree with [a civilian hospital or medical centre] that the latter is to provide consultation and treatment at convicted prisoners' ... own expense if they so wish."

34. The relevant part of Regulation of the Cabinet of Ministers no. 199 (2007), effective from 28 March 2007, provides as follows:

> "2. Convicted persons in prison shall receive free of charge:
>
> 2.1. primary medical care, but not scheduled/planned dental care,
>
> 2.2. emergency dental care,
>
> 2.3. secondary medical assistance in emergency situations, as well as secondary medical assistance, which is provided by prison doctors in so far as it is within their field of expertise,
>
> 2.4. the most effective and affordable medicine, prescribed by the prison medical practitioner. ...
>
> 15. Upon application by a convicted person, and with the approval of a prison doctor, the prison authorities may agree with a civilian hospital or medical centre that the latter is to provide consultations and treatment outside the prison premises. Such consultations and treatment are to be paid for by the convicted person, including transport and security-related expenses."

35. Regulation of the Cabinet of Ministers no. 1046 (2006), effective from 1 January 2007, stipulates that laboratory tests and medicine for HIV/AIDS treatment must be financed by the State.

2. Nutrition in custody

36. Regulation of the Cabinet of Ministers no. 339 (2002), in force at the material time and effective until 20 June 2008, laid down nutrition guidelines for detainees held in pre-trial detention facilities. It provided that detainees who were ill should receive nutrition plan 4A. More specifically, detainees suffering from certain serious illnesses, including tuberculosis in the active phase, cancer and AIDS (but not HIV or hepatitis C) were to receive nutrition plan 4B. The difference between nutrition plans 4A and 4B was that under the latter the detainees received 10 extra grams of pasta products (30 instead of 20 grams), 45 extra grams of meat products (125 instead of 80 grams), twice as much milk (500 instead of 250 ml) and butter (40 instead of 20 grams), half an egg (instead of none) and 50 extra grams of vegetables (350 instead of 300 grams). Under nutrition plan 4B, detainees also received less animal fat (10 instead of 15 grams).

37. Regulation of the Cabinet of Ministers no. 155 (2002), in force at the material time and effective until 23 December 2006, laid down nutrition guidelines for convicted persons. It provided that inmates who were ill should receive nutrition plan 4A. More specifically, inmates suffering from certain serious illnesses, including tuberculosis in the active phase, cancer and AIDS (but not HIV or hepatitis C) were to receive nutrition plan 4B. The difference between nutrition plans 4A and 4B was as described above.

38. Regulation of the Cabinet of Ministers no. 1022 (2006), effective from 23 December 2006, specifies in more detail the nutrition plan for convicted persons. Only convicts who are ill and are being treated in a prison hospital or a prison medical unit are entitled to a special nutrition plan (no. 3). The same nutrition plan (no. 3) is provided to those suffering from serious illnesses, including tuberculosis in the active phase, cancer and AIDS (but not HIV or hepatitis C).

COMPLAINTS

39. The applicant complained that he had not been provided with adequate medical care for his HIV infection, the hepatitis C virus (HCV) and chronic gastritis.

THE LAW

40. The applicant submitted that he had not received adequate medical care in prison. Since the Court is master of the characterisation to be given in law to the facts of the case, it considers that the applicant's complaint falls to be examined under Article 3 of the Convention, which reads as follows:

> "No one shall be subjected to torture or to inhuman or degrading treatment or punishment."

A. The parties' submissions

41. The Government raised a preliminary objection of non-exhaustion of domestic remedies. They submitted that the relevant authority to lodge a complaint with was the MADEKKI or the Health Inspectorate, which took over the MADEKKI's functions in 2007. The Government pointed out that these authorities were responsible for monitoring the professional quality of health care provided in health-care institutions, including medical units in prisons; its conclusions were authoritative and binding. They could issue "binding decisions and instructions" concerning the further course of medical treatment. An appeal could be lodged against their decision, first with the head of that authority and then with the administrative courts.

42. The Government pointed out that the applicant had in fact exercised his right to lodge a complaint with the MADEKKI, and then he had further complained to the head of the MADEKKI and to the Administrative District Court. The Government emphasised that the applicant had not lodged an appeal against the decision of 16 January 2007 staying the administrative proceedings and that he had not completed his application. They concluded that he had failed to proceed with the exhaustion of the relevant domestic remedy.

43. The Government further submitted that medical examinations and treatment for HIV/AIDS patients in Latvia, including detainees and convicted persons, were financed by the State. In particular, according to the guidelines of the Latvian Infectious Diseases Centre and in line with the approach adapted by other European States, antiretroviral therapy was started when the CD4 cell count dropped to 200 cells per mm^3, or when the CD4 cell count was higher if the patient was suffering from serious opportunistic infections. As to the treatment of hepatitis C in prison, the Government argued that under the minimum standard of healthcare State-financed hepatitis C treatment was available in cases of acute hepatitis C or aggravated chronic hepatitis C.

44. The Government insisted that the applicant was under constant supervision by prison doctors and had been provided with the necessary examinations and treatment (in total 77 times) whenever his condition

required medical intervention, including the prescription of medication to promote enhanced liver functioning and vitamins for the improvement of his immune system. The Government argued that the applicant's state of health was satisfactory; it had not deteriorated during his imprisonment. Nor was there any record of the applicant's chronic HCV having progressed. As to the HIV infection, blood samples were taken and sent for specific examinations on a regular basis. The results showed that the applicant's condition had been stable throughout his imprisonment – his CD4 cell count had remained very high (according to the last test results it was 523 cells per mm^3). Accordingly, there were no clinical indications for antiretroviral therapy.

45. The applicant did not submit any response to the Government's preliminary objection. He disagreed with the Government and maintained that he had received only the strict minimum of medical care to keep him alive; he had not received any treatment in relation to his infection with HIV and hepatitis C. He alleged that he had been guaranteed no special care to ensure detention conditions corresponding to his special needs. In illustration of the generally poor level of medical care in the Latvian prison system, he referred to the results of an inquiry carried out by the Ombudsman.

B. The Court's assessment

46. The Court notes the Government's objection as to the non-exhaustion by the applicant of the domestic remedies. However, it does not consider it necessary to deal with that objection as, in any event, it finds the present complaint inadmissible for the following reasons.

47. The Court reiterates that when assessing the adequacy of medical care in prison, it must reserve, in general, sufficient flexibility in defining the required standard of health care, which must accommodate the legitimate demands of imprisonment but remain compatible with human dignity and the due discharge of its positive obligations by the State. In this regard, it is incumbent upon the relevant domestic authorities to ensure, in particular, that diagnosis and care are prompt and accurate, and that supervision by proficient medical personnel is regular and systematic and involves a comprehensive therapeutic strategy. The mere fact of a deterioration in an applicant's state of health, albeit capable of raising, at an initial stage, certain doubts concerning the adequacy of the applicant's treatment in prison, cannot suffice, by itself, for a finding of a violation of the State's positive obligations under Article 3 of the Convention, if, on the other hand, it can be established that the relevant domestic authorities have in a timely fashion provided all reasonably available medical care in a conscientious effort to hinder development of the disease in question (see, among many others, *Jashi v. Georgia*, no. 10799/06, § 61, 8 January 2013).

48. The Court observes, first of all, that in the present case it is undisputed between the parties that the applicant became infected with HIV and HVC prior to his detention unlike in the *Jashi* case (ibid., § 31). It is likewise undisputed that upon admission to Brasa Prison the applicant informed a prison doctor that he had those viruses and the doctor ensured that an immunological test was carried out by the Latvian Infectious Diseases Centre to establish an exact diagnosis and to monitor his state of health.

49. The applicant's dissatisfaction with the medical care afforded to him in detention largely lies in the fact that he did not receive adequate treatment for his HIV infection. However, the Court cannot establish whether the applicant in fact required any particular treatment (for example, antiretroviral treatment), since it is not its task to rule on matters lying exclusively within the field of expertise of medical specialists. Instead, in order to determine whether Article 3 of the Convention has been complied with, the Court will focus on determining whether the domestic authorities provided the applicant with medical supervision capable of effectively assessing his condition and setting up an adequate course of treatment for his diseases. It considers that, given the nature and seriousness of the applicant's ailments, his condition required regular and specialised medical supervision for the monitoring of the progression rate of his diseases, timely prescription of the requisite HIV and hepatitis C therapies, and timely diagnosis and treatment of possible opportunistic infections (see *Kozhokar v. Russia*, no. 33099/08, § 108, 16 December 2010).

50. The facts in the case disclose that the applicant was subjected to a specific blood test – the CD4 cell count – which according to the 2006 WHO recommendations is the test that is required to identify if patients with HIV clinical stage 1 or 2 disease need to start antiretroviral treatment (see paragraph 29 above). It can be seen from the case-file materials that this test was carried out every two to six months by doctors at a specialised centre for infectious diseases. On every occasion the doctors recorded that the applicant's HIV infection was at either clinical stage 1 or 2, that is, that the CD4 cell count had not yet dropped below the relevant threshold for commencement of antiretroviral treatment (see also the 2006 WHO recommendations, paragraph 29 above). The Court notes that the MADEKKI, following their assessment of the applicant's medical care in detention, came to a similar conclusion. In such circumstances, and in the absence of any medical evidence to the contrary, the Court cannot conclude that the national authorities did not ensure proper medical supervision of the applicant's HIV infection (see, by contrast, the case of *E.A. v. Russia*, no. 44187/04, §§ 63, 65, 23 May 2013, where the specific CD4 cell count test was not carried out in due time).

51. As concerns the applicant's infection with the hepatitis C virus, the Court takes note of the Government's submission, supported by the

applicant's prison medical record, that the applicant received symptomatic therapy and therapy, including hepatoprotectives and vitamins, aimed at enhancing his liver functioning. The Court notes that the applicant failed to explain in a detailed and convincing manner why he considered that the medical treatment he received in relation to the HCV was inadequate or in any other way in breach of the guarantees provided for in Article 3 of the Convention. The Court is unable to detect any shortcomings in the applicant's medical care in detention in this respect from the case-file materials.

52. Finally, the Court is unable to identify any deficiency in the medical care afforded to the applicant in respect of his chronic gastritis. The applicant's prison medical record indicates that his illness was attended to by the prison medical staff and that he received courses of medication in connection with it on several occasions.

53. It follows from the foregoing that the application is manifestly ill-founded and must be rejected in accordance with Article 35 §§ 3 and 4 of the Convention.

For these reasons, the Court unanimously

Declares the application inadmissible.

Françoise Elens-Passos	Päivi Hirvelä
Registrar	President