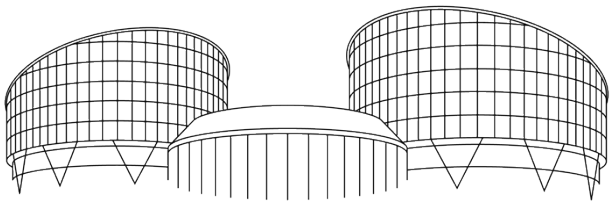

EUROPEAN COURT OF HUMAN RIGHTS
COUR EUROPÉENNE DES DROITS DE L'HOMME

FIRST SECTION

CASE OF E.A. v. RUSSIA

(Application no. 44187/04)

JUDGMENT

STRASBOURG

23 May 2013

FINAL

23/08/2013

This judgment has become final under Article 44 § 2 of the Convention. It may be subject to editorial revision.

In the case of E.A. v. Russia,

The European Court of Human Rights (First Section), sitting as a Chamber composed of:

Isabelle Berro-Lefèvre, *President,*
Khanlar Hajiyev,
Mirjana Lazarova Trajkovska,
Linos-Alexandre Sicilianos,
Erik Møse,
Ksenija Turković,
Dmitry Dedov, *judges,*
and Søren Nielsen, *Section Registrar,*

Having deliberated in private on 30 April 2013,

Delivers the following judgment, which was adopted on that date:

PROCEDURE

1. The case originated in an application (no. 44187/04) against the Russian Federation lodged with the Court under Article 34 of the Convention for the Protection of Human Rights and Fundamental Freedoms ("the Convention") by an Uzbek national, Mr E.A. ("the applicant"), on 9 November 2004. The President of the Section decided that the applicant's name should not be disclosed (Rule 47 § 3 of the Rules of Court).

2. The applicant was represented by Mr Z. Zhulanov, a lawyer practising in Perm. The Russian Government ("the Government") were represented by Mr A. Savenkov and then by Mr G. Matyushkin, acting and current Representatives of the Russian Federation at the European Court of Human Rights respectively.

3. The applicant alleged, *inter alia*, that the deficiencies in his medical care in detention between 2003 and 2006 amounted to a violation of Article 3 of the Convention.

4. Following a preliminary examination of the admissibility of the application, on 16 June 2008 the judge appointed as rapporteur under Rule 49 § 2 of the Rules of Court requested the respondent Government to submit a copy of the applicant's medical file, including information on HIV-related medication and any recent (institutional or, preferably, independent) assessment of his medical conditions, if available. On 28 July 2008 the Government submitted a number of documents from the applicant's medical file.

5. On 30 January 2009 the application was communicated to the Government. It was also decided to rule on the admissibility and merits of the application at the same time (Article 29 § 1).

THE FACTS

I. THE CIRCUMSTANCES OF THE CASE

6. The applicant was born in 1966. After his release from detention in 2008 the applicant resided in the town of Perm.

7. The applicant arrived in Russia from Uzbekistan in 2002 or 2003. He was arrested on 11 August 2003 in the town of Perm in relation to criminal proceedings against him (see paragraph 25 below).

A. Medical care in detention

8. During his admission to Perm detention centre no. 1 in August 2003 the applicant had a check-up and was questioned about his past illnesses. According to the documents submitted by the Government, since the 1990s the applicant had been suffering from pulmonary tuberculosis and had received treatment in Uzbekistan. According to the applicant, in 1995 and 1998 he had pneumonia and had no pulmonary tuberculosis before his arrest in August 2003.

9. The applicant had a chest fluorography examination in the detention centre and was examined by a chest physician who prescribed treatment (such as ethambutol and B6 vitamin) in relation to his tuberculosis. On 18 August 2003 a blood sample from the applicant was submitted for HIV testing (an "enzyme-linked immunosorbent assay"). An additional similar test and a confirmatory test ("western blot") were carried out on 3 and 4 September 2003 respectively.

10. The case file contains a document dated 9 September 2003 which appears to be the record of the HIV-related initial physical examination (involving, *inter alia*, vital signs, lymph nodes, skin, thorax and lungs). The applicant's weight was 73 kg. The reference to the HIV stage is not legible. The next check up was scheduled for February 2004. The Government also submitted the applicant's "epicrisis" record for 2003, which indicates HIV stage 2Б under the domestic classification (see paragraph 29 below). It is indicated in the record that during 2003 the applicant did not request any treatment or medication. Another document entitled "Plan for treatment in 2003" indicated that the applicant was to be examined in February 2004. This document did not specify any treatment, including HIV-related medication.

11. It can be seen from the typed copy of the applicant's medical file that on several occasions in late 2003 and early 2004 he was examined by a chest physician who maintained his medication in relation to tuberculosis.

12. After the closure of the criminal proceedings against him (see paragraph 25 below), in June 2004 the applicant was transferred to prison

no. 12 in the Perm region. Subsequently, he also spent periods of time in prison no. 9, as well as in the psychiatric and other units of the hospital for detainees (August - October 2004, February - March 2005, July 2005 and several months in 2006 and 2007). The applicant was treated, *inter alia*, for tuberculosis, gonorrhoea, haemorrhoids, hepatitis C, a psychiatric condition, and in relation to acts of self-mutilation.

13. In particular, in September 2004 the applicant was admitted to tuberculosis hospital no. 7 in relation to the progression of his infection with the hepatitis C virus. He had a number of blood tests, such as a full blood count (including leukocytes, erythrocytes, and lymphocytes), a urine test, a chest fluorography, an X-ray and an abdominal ultrasound scan, and was examined by a chest physician and a neurologist. It appears that, although scheduled, a consultation by an infectious disease specialist was not provided. It is indicated in one of the documents submitted by the Government that the applicant's weight dropped to 60.5 kg in September 2004. However, it can be seen from the record of a check-up done on 1 October 2004 that his weight was then 70 kg. This record mentions HIV stage 2 or 3 (not clearly legible). The next check-up was scheduled for April 2005.

14. The Government submitted a handwritten medical document (which appears to relate to 2004) bearing the stamp of prison no. 9 and indicating HIV stage 3A.

15. It appears that in April 2005 the applicant was examined by an infectious disease specialist who prescribed laboratory testing for bilirubin and some laboratory tests in relation to liver function. The record of a check-up of the applicant of 25 July 2005 indicates HIV stage 2Б. The next check-up was scheduled for 25 January 2006.

16. In July 2005 the applicant complained that he was not being provided with adequate medical treatment in relation to his diseases, in particular as regards his HIV infection. The Kizel prosecutor's office in charge of the supervision of prisons examined the applicant's complaint and stated that the applicant had been provided with medical care free of charge, and that he had been regularly admitted to a medical facility and had consultations by infectious disease specialists. The prosecutor's office also mentioned that no funds had been allocated to prison no. 12 for out-patient treatment of HIV-positive detainees in 2005 and thus the relevant medication had not been available there.

17. In March 2006 the applicant was again hospitalised and his discharge certificate refers to HIV stage 3. In July 2006 he had a periodic check-up; the record indicates HIV stage 3 (corrected from "4").

18. In July 2006 the applicant complained about the issue of medical care to the Federal Department for the Execution of Sentences. This authority stated in reply that an infectious disease specialist had concluded that antiretroviral therapy (ART) was not necessary. Another similar

complaint was examined in August 2006 by the Kizel prosecutor's office in charge of the supervision of prisons. Dismissing the applicant's complaint, this authority mentioned that prison hospital no. 9 had facilities for carrying out an immunological assessment, should it be prescribed for the applicant. So far there had been no indications for such an assessment.

19. In September 2006 the Medical Office of the Regional Department for the Execution of Sentences examined and dismissed the applicant's further complaint relating to his HIV treatment. They stated that the applicant had received the necessary testing and medication, as well as consultations by specialist doctors, including an infectious disease specialist. They indicated that a decision on immunological assessment had to be taken by a medical professional. The applicant's illnesses and their staging had not, at the relevant time, required ART.

20. Between October 2006 and May 2007 the applicant was kept in hospital no. 7 in the Perm region, on account, in particular, of the aggravation of his pulmonary tuberculosis. According to the Government, in October 2006 the applicant failed to comply with unspecified recommendations made by the regional centre for the prevention of and fight against AIDS and infectious diseases ("the AIDS centre").

21. The applicant had a check up in January 2007; the record indicates HIV stage 4Б. In March 2007 he underwent an immunological assessment. It appears that he started a highly active antiretroviral therapy (HAART) regimen in April 2007. In early 2008 the regimen was adjusted.

22. The applicant sought early conditional release. By a judgment of 4 September 2008 the Solikamsk Town Court of the Perm Region granted his application and ordered his release, considering that his continued detention was not necessary for the purposes of his "correction". The applicant was released soon thereafter. The court ordered him to report to the supervising authority and not to change his place of residence without prior notice to that authority.

23. According to the applicant, the administration of the detention facility told him that he had fifteen days to leave Russia or he would be deported.

24. According to the Government, in October 2008 and January 2009 the applicant attended the AIDS centre, where he confirmed that he was taking medication.

B. Criminal proceedings against the applicant

25. On 15 April 2004, rejecting the applicant's plea of self-defence, the Leninskiy District Court of Perm convicted the applicant of causing injuries to one person and causing fatal injuries to another person. The court sentenced the applicant to six years and one month of imprisonment. On 25 May 2004 the Perm Regional Court upheld the judgment. The applicant

made submissions through a videoconferencing facility from the remand centre.

26. The applicant served his sentence of imprisonment from June 2004 to September 2008, when he was released (see paragraphs 12 and 22 above).

II. RELEVANT DOMESTIC LAW

A. Decree no. 170 of 16 August 1994

27. By Decree no. 170 of 16 August 1994 the Federal Ministry of Health adopted Guidelines relating to HIV/AIDS Diagnosis and Treatment (section 1) and Dispensary Supervision (section 2). The Guidelines state as follows.

28. There is a clear link between the illness's progress and the reduction of CD4 lymphocytes, the latter process being the main feature of HIV pathogenesis (point 1.1.). Staging of HIV should be determined depending on clinical and other relevant considerations listed in the Guidelines (points 1.3. and 1.5.). An HIV-positive person should be subjected to an initial examination confirming the HIV diagnosis and determining the stage of the illness and any concomitant illnesses. The initial examination should include, *inter alia*, HIV serological testing (an enzyme-linked immunosorbent assay test and a western blot test) and a CD4 cell count (point 2.1. of the Guidelines). Subsequent examinations should be carried out in accordance with the gravity of the patient's state of health, or on a periodic basis. A subsequent examination at HIV stage 2 or 3 should be carried out in twelve months for a CD4 cell count of below 500, and in twenty-four months for a CD4 cell count of above 500 or if unknown.

29. Basic therapies include ART and prophylaxis to prevent secondary diseases. Antiretroviral therapy should be prescribed at stages 2A, 3A, 3Б and 3B (under the Russian classification) during periods of clinical activity and with regard to the clinical data (point 1.6.2.1. of the Guidelines). As to periods of remission, sustaining ART should be provided, with regard to clinical and immunological assessment. Depending on the CD4 level, the therapy should be constant or administered in three-month periods with three-month interruptions. If the CD4 level is not known, no sustaining therapy should be provided in certain situations or at stage 3A.

B. Federal Law no. 38-FZ of 30 March 1995

30. Federal Law no 38-FZ on the Prevention of HIV Propagation in Russia provided, in its pre-January 2005 version, that the State guaranteed the availability of the relevant examinations for detecting HIV infection; diagnosis and treatment; and provision of free medical care to HIV-positive Russian citizens (section 4 of the Law).

III. REVELANT INTERNATIONAL DOCUMENTS

A. Patient evaluation and ART

31. In 2004 the World Health Organisation (WHO) published its Guidelines "Scaling up Antiretroviral Therapy in Resource-Limited Settings. Guidelines for a public health approach." They read as follows:

> "WHO recommends that, in resource-limited settings, HIV-infected adults and adolescents should start ARV therapy when the infection has been confirmed and one of the following conditions is present.
>
> *Clinically advanced HIV disease:
>
> -WHO Stage IV HIV disease, irrespective of the CD4 cell count;
>
> -WHO Stage III disease with consideration of using CD4 cell counts <350/mm^3 to assist decision-making.
>
> *WHO Stage I or II HIV disease with CD4 cell counts <200/mm^3...
>
> ... The treatment of patients with WHO Stage IV disease (clinical AIDS) should not be dependent on a CD4 cell count determination. However, where available, this test can be helpful in categorizing patients with Stage III conditions with respect to their need for immediate therapy. For example, pulmonary TB can occur at any CD4 count level and, if the CD4 cell count level is well maintained (i.e. >350/mm^3), it is reasonable to defer therapy and continue to monitor the patient. For Stage III conditions a threshold of 350/mm^3 has been chosen as the level below which immune deficiency is clearly present such that patients are eligible for treatment when their clinical condition portends rapid clinical progression ... For patients with Stage I or Stage II HIV disease the presence of a CD4 cell count <200/mm^3 is an indication for treatment.
>
> In cases where CD4 cell counts cannot be assessed the presence of a total lymphocyte count of 1200/mm^3 or below can be used as a substitute indication for treatment in the presence of symptomatic HIV disease. While the total lymphocyte count correlates relatively poorly with the CD4 cell count in asymptomatic persons, in combination with clinical staging it is a useful marker of prognosis and survival. An assessment of viral load (e.g. using plasma HIV-1 RNA levels) is not considered necessary before starting therapy. Because of the cost and complexity of viral load testing, WHO does not currently recommend its routine use in order to assist with decisions on when to start therapy in severely resource-constrained settings. It is hoped, however, that increasingly affordable methods of determining viral load will become available so that this adjunct to treatment monitoring can be more widely employed.
>
> It should be noted that the current WHO Staging System for HIV Infection and Disease for Adults and Adolescents was developed several years ago and has consequent limitations. Adaptations at the level of national programmes may therefore be appropriate. Nevertheless, it remains a useful tool for assisting in defining

parameters for initiating therapy in resource-limited settings and thus has continued to be applied in this revision."

Under these Guidelines, if CD4 testing was, at the time, not available, it was recommended that ART be offered to patients with: (i) WHO Stage IV disease, irrespective of the total lymphocyte count; (ii) WHO Stage III disease, irrespective of the total lymphocyte count, the recommendation to start ART in all patients with stage III disease without reference to total lymphocyte counts reflecting, in the WHO's opinion, the consensus of expert opinion; and (iii) WHO Stage II disease with a total lymphocyte count $\leq$ 1200/mm^3. A total lymphocyte count of $\leq$ 1200/mm^3 could be substituted for the CD4 count when the latter was unavailable and HIV-related symptoms existed. It was not useful in the asymptomatic patient. Thus, in the absence of CD4 cell testing, asymptomatic HIV-infected patients (WHO Stage I) should not be treated because there was currently no other reliable marker available in severely resource-constrained settings.

32. In 2004 the WHO also published "HIV/AIDS Treatment and Care. WHO Protocols for countries of the Commonwealth of Independent States". The Protocols provide that the initial evaluation of an HIV positive patient must, *inter alia*, include routine laboratory assessments (haemoglobin, white blood cell count and differential, urinalysis, liver function tests, creatinine) and a CD4 cell count. ART should be started at (i) stage IV irrespective of CD4 cell count; (ii) stage III disease if symptoms present (including, but not restricted to, chronic diarrhoea of unknown aetiology, prolonged fever of unknown aetiology, pulmonary tuberculosis, recurrent invasive bacterial infections, or recurrent/persistent mucosal candidiasis), with consideration given to using CD4 cell counts < 350/mm^3 to assist decision making. A CD4 count is advisable to assist with determining the need for immediate therapy. For example, pulmonary TB may occur at any CD4 level and other conditions may be mimicked by non-HIV aetiologies (for example, chronic diarrhoea, prolonged fever); (iii) stage I or II disease with CD4 cell counts = 200/mm^3. The precise CD4 level above 200/mm^3 at which ART treatment should be started is not established. ART is recommended for all patients with TB with a CD4 count < 200 cells/mm^3 and should be considered for patients with CD4 < 350 cells/mm^3.

33. In 2006 the WHO issued revised guidelines: "Antiretroviral therapy for HIV infection in adults and adolescents. Recommendation for a public health approach." (with previous updates from 2003). They read as follows:

"In resource-limited settings the decision to initiate ART in adults and adolescents relies on clinical and immunological assessment. In order to facilitate the rapid scale-up of ART programmes with a view to achieving universal access to this therapy, WHO emphasizes the importance of using clinical parameters in deciding when to initiate it. However, it is recognized that the value of clinical staging in deciding when to initiate and monitor ART is improved by additional information on baseline and subsequent (longitudinal) CD4 cell counts. While WHO continues to advocate wider availability of affordable point-of-care CD4 cell count testing, the lack of a CD4 count

should not delay the initiation of ART if the patient in question is clinically eligible. WHO encourages national programmes to increase access to CD4 measurement technologies ...

Clinical staging is intended for use where HIV infection has been confirmed by HIV antibody testing. It should form part of the baseline assessment (first visit) on entry into a care and treatment programme and is used to guide decisions on when to start co-trimoxazole prophylaxis and when to start and switch ART in situations where CD4 testing is not available ...

ART results in improvement in clinical status and brings about effective reversal of the clinical stage in patients with symptomatic disease. However, the value of clinical staging in monitoring the efficacy of ART, defining ART failure and determining when to switch ART is less clear. Studies are urgently needed to address the use of clinical criteria (clinical stage on treatment) in deciding when to switch ART in the absence of CD4 cell counts or viral load testing.

The optimum time to commence ART 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 ...

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/mm3 [A-III]. 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 [A-III]. 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. This level also conforms to what is indicated in other consensus guideline documents. 4 CD4 cell counts can be helpful in categorizing patients with stage 3 conditions in respect of their need for immediate therapy. For example, pulmonary tuberculosis or severe bacterial infections can occur at any CD4 count level and it is reasonable to delay ART and continue to monitor patients with CD4 cell counts above 350 cells/ mm^3. However, the initiation of ART is recommended for all HIV-infected individuals with pulmonary TB and CD4 counts below 350 cells/ mm^3 ... and also for patients with severe bacterial infections who have CD4 counts below this value."

34. According to the WHO Clinical Protocols on HIV/AIDS Treatment and Care, adopted in 2007, the core component of treating HIV-positive persons is the provision of ART, including HAART, combining three or more drugs. The initial evaluation of a patient should include confirmation of HIV infection status with the potential time of infection established, if possible; a detailed personal, family and medical history; a physical examination; laboratory and other examinations; specialist examinations, as

appropriate; and clinical and immunological staging. Clinical staging (stage 3 or 4) and CD4 counts are the best primary markers and viral load the secondary marker for deciding whether to start ART.

35. In 2010 the WHO issued a revised and updated version of the Guidelines "Antiretroviral therapy for HIV infection in adults and adolescents. Recommendation for a public health approach." The revised text indicates that all adolescents and adults with HIV infection and CD4 counts of or less than 350 cells/mm^3 should start ART, regardless of the presence or absence of clinical symptoms. Those with severe or advanced clinical disease (WHO clinical stage 3 or 4) should start ART irrespective of their CD4 cell count. All patients should have access to CD4 cell-count testing to optimise pre-ART care and ART management. Viral-load testing is recommended to confirm suspected treatment failure. Irrespective of CD4 cell counts, patients co-infected with HIV and tuberculosis should be started on ART as soon as possible after starting TB treatment.

B. Medical care in detention

36. The United Nations Guidelines on HIV/AIDS and Human Rights, under the heading "Freedom from Cruel, Inhuman or Degrading Treatment or Punishment" state that denial to prisoners of access to HIV-related health care can constitute cruel, inhuman or degrading treatment, whereas prisoners suffering from AIDS should be considered for early release and given proper treatment outside prison.

37. The relevant extracts from the 3rd General Report [CPT/Inf (93) 12] of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment ("the CPT") read as follows:

> 38. A prison health care service should be able to provide medical treatment and nursing care, as well as appropriate diets, physiotherapy, rehabilitation or any other necessary special facility, in conditions comparable to those enjoyed by patients in the outside community. Provision in terms of medical, nursing and technical staff, as well as premises, installations and equipment, should be geared accordingly.
>
> There should be appropriate supervision of the pharmacy and of the distribution of medicines. Further, the preparation of medicines should always be entrusted to qualified staff (pharmacist/nurse, etc.).
>
> 39. A medical file should be compiled for each patient, containing diagnostic information as well as an ongoing record of the patient's evolution and of any special examinations he has undergone. In the event of a transfer, the file should be forwarded to the doctors in the receiving establishment.
>
> Further, daily registers should be kept by health care teams, in which particular incidents relating to the patients should be mentioned. Such registers are useful in that

they provide an overall view of the health care situation in the prison, at the same time as highlighting specific problems which may arise.

40. The smooth operation of a health care service presupposes that doctors and nursing staff are able to meet regularly and to form a working team under the authority of a senior doctor in charge of the service."

THE LAW

I. ALLEGED VIOLATION OF ARTICLE 3 OF THE CONVENTION

38. The applicant complained that the deficiencies in his medical care in detention between 2003 and 2006 amounted to a violation of 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. Admissibility

39. The Government argued that the applicant had not exhausted domestic remedies because he had not complained to the administration of the detention facilities about his medical care. Nor had he lodged a civil claim for compensation in respect of non-pecuniary damage or damage to his health caused to him in this regard. Moreover, he could also have brought a complaint under Chapter 25 of the Code of Civil Procedure, which, as clarified by the Plenary Supreme Court in 2009, enables the courts to deal with health-related issues.

40. The Court observes that the applicant's complaint was first raised in substance before the Court in May 2006 and concerned the continuous situation of absent or inadequate medical care during his detention since 2003. The Court has previously examined and dismissed similar arguments on the part of the Government in relation to a similar situation (see *Koryak v. Russia*, no. 24677/10, §§ 74-95, 13 November 2012, and *Dirdizov v. Russia*, no. 41461/10, §§ 75-91, 27 November 2012). Nothing in the Government's submissions inclines the Court to reach a different conclusion in the present case.

41. The Court notes that this complaint is not manifestly ill-founded within the meaning of Article 35 § 3 (a) of the Convention. It further notes that it is not inadmissible on any other grounds. It must therefore be declared admissible.

A. Merits

1. The parties' submissions

(a) The applicant

42. The applicant alleged that between 2003 and 2006 he had not been provided with adequate medication in respect of his illnesses, in particular HIV and hepatitis C. He argued, with reference to the domestic and international documents, that an immunological assessment was an indispensable element of the medical care of an HIV-positive patient and such an assessment should have been carried out on a regular basis. Between 2003 and 2006 no informed decision as to the necessity for a highly active antiretroviral therapy (HAART) could be taken without a complete immunological assessment, and no such assessment had been carried out until 2007, when the applicant's state of health had already deteriorated significantly. The antiretroviral treatment had been prescribed in 2007 only when his condition had reached stage 4, although the relevant clinical indications had already been noted earlier. In any event, provision of sustaining ART should have been available to the applicant while the disease was in remission. During his detention he had complied with all medical recommendations. In 2009, after his release, however, he had indeed not complied with the medical recommendations, fearing arrest and deportation from Russia.

(b) The Government

43. The Government stated that following HIV testing the applicant had been placed under supervision in the medical unit of the remand centre in 2003. He had received consultations by an ophthalmologist, a dermatologist and a psychiatrist. Under the applicable domestic rules (see paragraph 29 above) antiretroviral treatment could be prescribed where it was clinically indicated and while the disease remained clinically active, until the disappearance of clinical symptoms. The clinical data in 2003-06 had not indicated that antiretroviral treatment was necessary; the applicant had at that time been receiving treatment for concomitant diseases, including tuberculosis. Making their own assessment of the available documentation, the Government affirmed that the presence of tuberculosis was not an element of clinical data which necessitated ART. The Government submitted that the applicant's other illnesses (such as tuberculosis or hepatitis C) were not HIV-related since they had not resulted from his HIV infection and, as such, could not be taken as markers for determining the necessity for ART.

44. The Government submitted that the applicant had been under the constant supervision of the medical staff and had had regular check-ups in

the detention facilities and hospitals. Diagnosis and treatment of his illnesses had been provided at the minimum required standard. It did not follow from the prosecutor's reference to the lack of funding in the prison in 2005 (see paragraph 16 above) that the applicant had not been provided with adequate medical care in medical facilities to which he had been admitted on numerous occasions during the relevant period. At times the applicant had refused medication, treatment or medical testing. He had been taken before a medical committee, which had informed him of the necessity of treatment and the adverse consequences of refusing it. Following his release, the applicant had again refused to comply with the medical recommendations and had refused medication.

2. The Court's assessment

(a) General principles

45. The Court reiterates that under Article 3 of the Convention the State must ensure that a person is detained in conditions which are compatible with respect for his human dignity, that the manner and method of the execution of the measure do not subject him to distress or hardship of an intensity exceeding the unavoidable level of suffering inherent in detention and that, given the practical demands of imprisonment, his health and well-being are adequately ensured by, among other things, providing him with the requisite medical assistance (see *Kudła v. Poland* [GC], no. 30210/96, § 94, ECHR 2000-XI).

46. Where complaints are made about a failure to provide necessary medical assistance in detention, it is not indispensable for such a failure to have led to a medical emergency or have otherwise caused severe or prolonged pain in order for the Court to find that a detainee was subjected to treatment incompatible with the guarantees of Article 3 (see *Ashot Harutyunyan v. Armenia*, no. 34334/04, § 114, 15 June 2010). Article 3 cannot be interpreted as laying down a general obligation to release a detainee on health grounds, save for in exceptional cases (see *Papon v. France (no. 1)* (dec.), no. 64666/01, ECHR 2001-VI, and *Priebke v. Italy* (dec.), no. 48799/99, 5 April 2001), or to place him in a civil hospital to enable him to obtain a particular kind of medical treatment. However, a lack of appropriate medical treatment may raise an issue under Article 3 even if the applicant's state of health did not require his immediate release.

47. The national authorities must ensure that diagnosis and care in detention facilities, including prison hospitals, are prompt and accurate, and that, where necessitated by the nature of a medical condition, supervision is regular and systematic, and involves a comprehensive therapeutic strategy aimed at adequately treating the detainee's health problems or preventing their aggravation (see *Dirdizov v. Russia*, no. 41461/10, § 95, 27 November 2012, and *Sakhvadze v. Russia*, no. 15492/09, § 83, 10 January 2012).

48. On the whole, while taking into consideration "the practical demands of imprisonment", the Court reserves a fair degree of flexibility in deciding, on a case-by-case basis, whether any deficiencies in medical care were "compatible with the human dignity" of a detainee (see *Aleksanyan v. Russia*, no. 46468/06, § 140, 22 December 2008).

49. The Court reiterates that an unsubstantiated allegation of no, delayed, or otherwise unsatisfactory medical care is normally not sufficient to disclose an issue under Article 3 of the Convention. A credible complaint should normally include, among other things, sufficient reference to the medical condition in question, medical prescriptions that were sought, made or refused, and some evidence – for instance, expert reports – capable of disclosing serious failings in the applicant's medical care (see *Valeriy Samoylov v. Russia*, no. 57541/09, § 80, 24 January 2012).

50. The Court also reiterates that its task is to determine whether the circumstances of a given case disclose a violation of the Convention in respect of an applicant, rather than to assess *in abstracto* the national legislation of the respondent State, its regulatory schemes or the complaints procedure used by an applicant. Thus, mere reference to the domestic compliance with such legislation or schemes, for instance as regards licensing of medical institutions or qualifications of medical professionals, does not suffice to oppose an alleged violation of Article 3 of the Convention. It is fundamental that the national authorities dealing with such an allegation apply standards which are in conformity with the principles embodied in Article 3 (ibid., § 81).

51. Concerning its own scrutiny, the Court reiterates that, in view of the subsidiary nature of its role, it must be cautious in taking on the role of a first-instance tribunal of fact where this is not rendered unavoidable by the circumstances of a case. The Court has held in various contexts that where domestic proceedings have taken place, it is not the Court's task to substitute its own assessment of the facts for that of the domestic courts and, as a general rule, it is for those courts to assess the evidence before them (see, among others, *Giuliani and Gaggio v. Italy* [GC], no. 23458/02, §§ 179 and 180, 24 March 2011). Although the Court is not bound by the findings of domestic courts, in normal circumstances it requires cogent elements to lead it to depart from the findings of fact reached by those courts (ibid.).

52. In its assessment of issues under Article 3 of the Convention, the Court gives thorough scrutiny to the question of the authorities' compliance with the prescriptions issued by medical professionals, in the light of the specific allegations made by an applicant (see *Vladimir Vasilyev v. Russia*, no. 28370/05, § 59, 10 January 2012).

(b) Application of the principles in the present case

53. Both before and after his arrest the applicant was diagnosed with, and treated for, a number of illnesses. After his arrest in 2003 he tested positive for HIV infection. It can be seen from the available documents that in 2003 the applicant's HIV was at stage 2. It appears that in 2004 it progressed to stage 3 and remained at that stage until 2006. At least one official report submitted by the applicant indicated that the prison at that time had no funding to supply prisoners with HIV-related medication (see paragraph 16 above). An immunological assessment was carried out in March 2007. The applicant started receiving antiretroviral treatment in April 2007.

54. The Court observes that the main thrust of the applicant's complaint in the present case relates to the alleged failings of the prison authorities in relation to his HIV infection. In particular, the applicant argued that the authorities failed, between 2003 and 2006, to carry out a proper immunological assessment and to put in place an (HA)ART regimen.

55. Having regard to the nature of the applicant's medical conditions, his submissions and the documents available (see paragraphs 27-37 above), the Court is satisfied that the applicant made out a credible complaint which was capable of disclosing serious failings in his medical care (see *Valeriy Samoylov*, cited above, § 80).

56. The Government submitted in response that the authorities had rightly decided on the basis of the relevant test results that between 2003 and 2006 the applicant required no specific medical treatment, including antiretroviral treatment.

57. Thus, the main dispute between the parties is whether (HA)ART for HIV should have been administered to the applicant in 2003 to 2006. The Court has not been provided with any authoritative, for instance expert and/or judicial, assessment in this connection. As a rule, in its assessment of issues under Article 3 of the Convention, the Court gives thorough scrutiny to the question of the authorities' compliance with the prescriptions issued by medical professionals, in the light of the specific allegations made by an applicant (see *Vladimir Vasilyev*, cited above, § 59). For this reason, it is not the Court's task to rule on matters lying exclusively within the field of expertise of medical specialists and to establish whether the applicant in fact required such treatment during the relevant period.

58. Rather, 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 sufficient medical supervision capable of effectively assessing his condition and setting up an adequate course of treatment for his diseases (see *Kozhokar v. Russia*, no. 33099/08, § 108, 16 December 2010). It considers that, given the nature and seriousness of his ailments, the applicant's condition required, *inter alia*, regular and specialised medical supervision for the monitoring of the

progression rate of his HIV infection and timely diagnosis and treatment of possible opportunistic or concomitant infections (ibid.).

59. The Court notes that the complex medical issues arising in the present case were not subject to any prior and thorough scrutiny at the national level. Although the applicant's complaints relating to medical care were examined and dismissed by various public authorities, it appears that they did not have recourse to the requisite expertise or any specialist opinion (see paragraphs 16, 18 and 19 above). Neither the authorities nor the respondent Government in the present case specified a sufficient factual basis for their conclusions as to the adequacy of the medical care and supervision provided to the applicant during the relevant period.

60. Thus, it falls to the Court to determine, in the light of the parties' submissions and the available materials, including those obtained by it *proprio motu* (see *A.B. v. Russia*, no. 1439/06, § 131, 14 October 2010), whether the factual and legal elements of the case disclose a violation of Article 3 of the Convention. Indeed, this is not the first time that the Court has had to deal with allegations of inadequate HIV-related medical care in respect of detainees in Russia (see *Aleksanyan*, cited above, §§ 145-158; *A.B. v. Russia*, no. 1439/06, §§ 132-135, 14 October 2010; *Kozhokar v. Russia*, no. 33099/08, §§ 108-116, 16 December 2010; *Shchebetov v. Russia*, no. 21731/02, §§ 73-77, 10 April 2012; and *Koryak v. Russia*, no. 24677/10, §§ 102-108, 13 November 2012).

61. The Court notes that the WHO stipulated, both at the relevant time and, even more clearly, in subsequent reports (see paragraph 31 above), that in the case of an HIV infection an initial patient evaluation should include, *inter alia*, laboratory and other examinations, as well as clinical and immunological staging. Laboratory HIV-related testing includes HIV serological testing and a CD4 cell count to determine the severity of the immunodeficiency. Similar requirements also clearly arise from the applicable domestic regulations (see paragraphs 27-29 above).

62. The Court observes that in September 2003 the applicant underwent HIV serological testing, which included two enzyme-linked immunosorbent assays and a confirmatory test (see paragraph 9 above). Having tested HIV positive, the applicant was given an initial physical examination. Similar examinations were carried out, albeit at varying intervals, later (see paragraphs 10-21 above).

63. The Court finds it regrettable that the reference to the applicant's HIV staging is not legible in the initial check-up record and that, despite a request from the Court, the parties submitted no specific information giving the exact data of the initial HIV testing. In particular, neither the available documents nor the Government's submissions indicate how the staging of the applicant's HIV was determined. Nor does it appear that the applicant had a consultation by an infectious diseases specialist in 2003 or 2004. Significantly, despite the applicant's specific arguments, the respondent

Government have omitted to clarify whether the domestic authorities took any measures to determine the severity of the applicant's immunodeficiency by way of a CD4 cell count or another equivalent measure which was sufficient and current at the time. It has not been argued that a CD4 cell count, as envisaged by the 2004 WHO guidelines, was not available at the time (see paragraph 31 above). To the contrary, the domestic regulations in force at the relevant time did provide for this type of testing (see paragraphs 27 and 28 above). The collection of this data had a certain importance in view of the presence of tuberculosis, in particular in so far as management of the compounding effect of the co-infection was concerned. Furthermore, the applicant had also tested positive for the hepatitis C virus, which was among the relevant factors to be taken into consideration when planning the applicant's HIV-related treatment.

64. The Government's submissions are limited to stating that following the initial HIV testing the applicant was placed under supervision in the medical unit of the remand centre or a hospital for detainees. Their assertions before the Court relating to the timeliness of the decision to initiate ART only in 2007 are not substantiated by reference to any medical assessment of the applicant's situation and thus cannot be accepted by the Court as based on verified medical evidence.

65. The Court has been unable to assess on the basis of the available information whether the applicant's HIV status in 2003 to 2006 required (HA)ART or whether some other form of medical care was appropriate and afforded to him. The fact remains, however, that for several years there was no proper immunological assessment to determine the appropriate time to initiate antiretroviral therapy. It was not until 2007, that is, nearly four years after the authorities had learned of the applicant's illness, that he was enabled to commence the therapy.

66. These considerations are sufficient for the Court to conclude that in the circumstances of the present case the authorities failed to comply with their responsibility to ensure the provision of adequate medical care to the applicant (see *A.B. v. Russia*, §§ 132-135, and *Koryak*, § 102, both cited above).

67. In view of the gravity of the applicant's medical condition and the respondent Government's omission to substantiate their position regarding the absence of any need for medical care in relation to the applicant's HIV between 2003 and 2006, the case discloses a failure on the part of the respondent State leading to a situation in which the applicant can be said to have been subject to distress or hardship of an intensity exceeding the unavoidable level of suffering inherent in detention. The Court thus considers that the authorities' failure amounted to inhuman and degrading treatment within the meaning of Article 3 of the Convention.

68. There has therefore been a violation of this provision.

II. OTHER ALLEGED VIOLATIONS OF THE CONVENTION

69. Lastly, the applicant complained about the conditions of his detention, ill-treatment by prison officials, unlawful detention and unfair criminal proceedings.

70. The Court has examined these complaints as submitted by the applicant. However, in the light of all the material in its possession, and in so far as the matters complained of are within its competence, the Court finds that they do not disclose any appearance of a violation of the rights and freedoms set out in the Convention or its Protocols. It follows that this part of the application is manifestly ill-founded and must be rejected in accordance with Article 35 §§ 3 (a) and 4 of the Convention.

III. APPLICATION OF ARTICLE 41 OF THE CONVENTION

71. Article 41 of the Convention provides:

> "If the Court finds that there has been a violation of the Convention or the Protocols thereto, and if the internal law of the High Contracting Party concerned allows only partial reparation to be made, the Court shall, if necessary, afford just satisfaction to the injured party."

A. Damage

72. The applicant claimed compensation in respect of non-pecuniary damage, leaving the amount to the Court's discretion.

73. The Government considered that a finding of a violation should suffice.

74. The Court observes that it is undeniable that the applicant suffered physical pain and mental anguish in relation to his serious medical conditions. It also accepts that he must have suffered distress, frustration and anxiety related to his inadequate health care, as established by the Court. Having regard to the nature of the violation and making assessment on an equitable basis, the Court awards the applicant 7,500 euros (EUR) in respect of non-pecuniary damage, plus any tax that may be chargeable on this amount.

B. Costs and expenses

75. Since the applicant made no claim, the Court does not find it necessary to make any award under this head.

C. Default interest

76. The Court considers it appropriate that the default interest rate should be based on the marginal lending rate of the European Central Bank, to which should be added three percentage points.

FOR THESE REASONS, THE COURT UNANIMOUSLY

1. *Declares* the complaint concerning medical care in detention admissible and the remainder of the application inadmissible;

2. *Holds* that there has been a violation of Article 3 of the Convention;

3. *Holds*
   (a) that the respondent State is to pay the applicant, within three months of the date on which the judgment becomes final in accordance with Article 44 § 2 of the Convention, EUR 7,500 (seven thousand five hundred euros) in respect of non-pecuniary damage, to be converted into the currency of the respondent State at the rate applicable at the date of settlement, plus any tax that may be chargeable;
   (b) that from the expiry of the above-mentioned three months until settlement simple interest shall be payable on the above amount at a rate equal to the marginal lending rate of the European Central Bank during the default period plus three percentage points.

Done in English, and notified in writing on 23 May 2013, pursuant to Rule 77 §§ 2 and 3 of the Rules of Court.

Søren Nielsen
Registrar

Isabelle Berro-Lefèvre
President