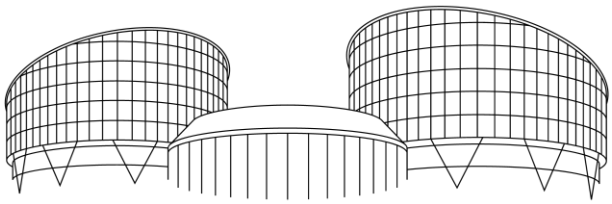

EUROPEAN COURT OF HUMAN RIGHTS
COUR EUROPÉENNE DES DROITS DE L'HOMME

FIRST SECTION

CASE OF VASYUKOV v. RUSSIA

(Application no. 2974/05)

JUDGMENT

STRASBOURG

5 April 2011

FINAL

15/09/2011

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

In the case of Vasyukov v. Russia**,**

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

Nina Vajić, *President,*
Anatoly Kovler,
Elisabeth Steiner,
Khanlar Hajiyev,
George Nicolaou,
Mirjana Lazarova Trajkovska,
Julia Laffranque, *judges,*
and Søren Nielsen, *Section Registrar,*

Having deliberated in private on 15 March 2011,

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

PROCEDURE

1. The case originated in an application (no. 2974/05) 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 a Russian national, Mr Aleksandr Mikhaylovich Vasyukov ("the applicant"), on 28 December 2004.

2. The applicant, who had been granted legal aid, was represented by Ms Y. Yefremova and Mr M. Rachkovskiy, lawyers practising in Moscow. The Russian Government ("the Government") were represented by Mrs V. Milinchuk, former Representative of the Russian Federation at the European Court of Human Rights, and subsequently by their Representative, Mr G. Matyushkin.

3. The applicant alleged, in particular, that he had contracted tuberculosis and had been denied adequate medical assistance in detention.

4. On 16 November 2007 the President of the First Section decided to give notice of the application to the Government. It was also decided to rule on the admissibility and merits of the application at the same time (Article 29 § 1).

5. The Government objected to the joint examination of the admissibility and merits of the application. Having examined the Government's objection, the Court dismissed it.

THE FACTS

I. THE CIRCUMSTANCES OF THE CASE

6. The applicant was born in 1973 and lives in the town of Oryol.

A. Criminal proceedings against the applicant

7. On 14 February 1997 the applicant was arrested on suspicion of manslaughter. He was allegedly severely beaten up after police officers took him to a police station.

8. On 31 October 1997 the Sovetskiy District Court of the Oryol Region found the applicant guilty of murder and sentenced him to twelve years' imprisonment. The judgment was upheld on appeal and became final on 16 December 1997. Ten days later the applicant was sent to serve his sentence in correctional colony no. 2, Oryol Region.

B. The applicant's state of health and the quality of the medical assistance afforded to him in detention

9. Relying on a copy of the applicant's medical record and certificates issued in December 2007 by the acting head of temporary detention facility no. IZ-57/1 in Oryol ("facility no. 1"), the Government argued that on 25 February 1997, on admission to facility no. 1, the applicant had undergone a chest fluorography examination, which revealed no signs of tuberculosis. The Government further submitted that every six months the applicant had been examined by medical specialists and had been subjected to chest fluorography examinations for the purpose of tuberculosis screening. The examinations revealed no presence of the illness. As follows from the list of X-ray examinations enclosed with the applicant's medical record, between March 1997 and 30 October 2001 the applicant received seven fluorography examinations. The authorities had fully complied with the schedule of one exam every six months at the beginning of the applicant's detention. However, almost a year passed between the chest fluorography examinations in 2000 and 2001.

10. On 29 October 1998 a tuberculosis specialist at correctional colony no. 2 made the following entry in the applicant's medical record:

> "[The applicant] is assigned to the 4th [group] of tuberculosis regular medical supervision as [he] has been in contact with inmate A. who suffers from tuberculosis...
>
> [The applicant is prescribed] izoniazid 0.6 [mg] once,... [multivitamins] [and] diet for two months."

The applicant's medical history (record no. 3607/415) drawn up in the tuberculosis hospital of facility no. 1 identified the applicant's detention with inmate A. in October 1998 as the cause of his tuberculosis.

11. According to the applicant, in September 2000 he had been detained for several days in a punishment cell with an inmate, Mr Ye., who was suffering from an active form of tuberculosis. Mr Ye. had been constantly coughing up blood. The applicant's requests for a transfer to another cell received no response from the colony administration. Soon after release from the punishment cell the applicant had fallen ill. However, his numerous complaints to the colony medical division had been to no avail. Relying on a certificate issued by the Oryol Regional police department, the applicant further argued that in March 2001 Mr Ye. had died from tuberculosis. The Government averred that the applicant had never been detained with the late Mr Ye. However, he had been detained with a person bearing the same last name as Mr Ye. The applicant's cellmate at the time had not been suffering from an active form of tuberculosis and therefore had not presented a danger to other detainees.

12. On 30 October 2001 the applicant was once again subjected to a fluorography examination, which detected tuberculosis changes in the form of dense foci and local fibrosis in his left lung.

13. According to the Government, on 15 November 2001 the applicant was transferred to the tuberculosis hospital in facility no. 1 for treatment. However, it appears from the applicant's medical record and certificates issued by the acting head of facility no. 1 and the director of correctional colony no. 2, it was not until 7 December 2001 that the applicant was admitted to the facility's tuberculosis hospital. Following a number of tests doctors diagnosed the applicant with "focal pulmonary tuberculosis, [type] 1A, [smear-negative results for] mycobacterium tuberculosis ("MBT")". Between 17 December 2001 and 14 February 2002 the applicant was subjected to an intensive chemotherapy regimen, comprising a number of drugs: isoniazid, rifampicin, ethambutol and tisamid. During the initial stage of the treatment the applicant adhered to a strict medication regime and received sixty doses of anti-bacteriological medicines. On 15 February 2002 the continuation phase of the therapy commenced, comprising treatment with 120 doses of isoniazid and rifampicin ("HR regimen"). The chemotherapy regimen was accompanied by pathogenetic and general health-improving therapy with a daily special dietary food ration. The intake of every dose was observed by the hospital staff. As follows from the applicant's medical record, clinical blood and urine analyses, sputum monitoring, as well as regular chest radiography examinations, were conducted regularly during the applicant's treatment in the hospital.

14. On 26 June 2002 the applicant was discharged from the tuberculosis hospital with a final diagnosis of "focal tuberculosis of the left lung in the resolution phase" and recommendations to continue treatment with isoniazid

and ethambutol ("HE regimen") accompanied by a daily special dietary food ration. The doctors also indicated that the next X-ray examination should be carried out within three months and that clinical blood and urine analysis and sputum monitoring should be performed once in three months.

15. Between 27 June and 25 October 2002 the applicant was detained in correctional colony no. 2. His medical record shows that on 28 June 2002 the colony doctor made a note that the applicant was to receive special dietary food. On 9 October 2002 the applicant was examined for the first time by a colony doctor, who once again confirmed that the applicant was suffering from focal tuberculosis of the left lung. The doctor authorised a chest X-ray exam and sputum testing. On 22 October 2002 the applicant was sent to Oryol town tuberculosis hospital to undergo prescribed examinations.

16. On 31 October 2002, having studied the applicant's medical records, including the results of an X-ray examination and the three sputum smear tests performed in October 2002, a medical panel comprising a number of medical specialists took into account the positive dynamic of the applicant's treatment and issued the following diagnosis: "focal tuberculosis of the upper lobe of the left lung in the resolution and consolidation phase,... (fading of the tuberculosis process)". On 18 November 2002 the applicant was transferred back to correctional colony no. 2 with a recommendation to continue outpatient treatment on a two-month HE regimen twice a year.

17. During his first medical examination in the colony on 13 January 2003 the applicant complained of fatigue and headache. A chest fluorography exam performed on 5 February 2003 revealed singular small residual patches in the upper lobe of the applicant's left lung. In early March 2003 the applicant was prescribed prophylactic treatment with isoniazid and ethambutol. A subsequent chest fluorography exam, on 29 April 2003, showed numerous firm patches in the left lung. The colony tuberculosis specialist made an entry in the applicant's medical record, noting no reason to amend his diagnosis. A subsequent X-ray exam, on 21 July 2003, led to the applicant being diagnosed with "local fibrosis in the upper lobe of the left lung [and] small firm patches". A month later a colony tuberculosis specialist examined the applicant, recording the absence of complaints and authorising another course of prophylactic treatment on an HE regimen starting from 1 September 2003. Clinical blood and urine tests and a chest fluorography exam performed on completion of the treatment confirmed the diagnosis made on 21 July 2003.

18. In December 2003 colony medical staff developed a schedule showing future medical procedures and their frequency. In particular, the applicant was to undergo a fluorography examination once in three months and to be subjected to blood, urine and smear testing twice a year. The resumption of the prophylactic treatment on an HE regimen every six months was also recommended. That schedule was upheld on 27 February

2004 by a special tuberculosis medical panel which, having studied the applicant's medical records, issued the following diagnosis: "clinical recovery from pulmonary tuberculosis accompanied by residual changes in the form of firm foci in the upper lobe of the left lung".

19. In the beginning of March 2004 the applicant became extremely ill. A chest fluorography exam carried out on 23 March 2004 showed that he had a left-sided spontaneous pneumothorax. On 27 March 2004 the applicant was admitted to the tuberculosis hospital in facility no. 1 in Oryol. On the basis of another X-ray exam, which showed that the applicant had suffered a complete collapse of the left lung and in view of his complaints of severe chest pain and dyspnea (breathlessness) at rest, on 29 March 2004 he was transferred to the surgical department of the Oryol Regional Tuberculosis Hospital where he was immediately subjected to a chest tube drainage of the left pleural cavity. On 13 April 2004, after an X-ray confirmed the re-expansion of the left lung, the chest tube was removed and the applicant was discharged from the Regional Hospital to the tuberculosis hospital in facility no. 1. The discharge was effected with a recommendation that the applicant undergo an intensive two-month chemotherapy regimen with four drugs: isoniazid, rifampicin, pyrazinamide and ethambutol ("2 HRZE regimen"). The applicant remained in the facility tuberculosis hospital until 6 May 2004. A prescription certificate attached to the applicant's medical record shows that he received four anti-bacteriological medicines between 14 April and 6 May 2004.

20. On 19 May 2004 the applicant arrived in correctional colony no. 2. When he was admitted a colony doctor made the following entry in the applicant's medical record: "arrived from [the tuberculosis hospital of facility no. 1] in Oryol with diagnosis of clinical recovery from pulmonary tuberculosis accompanied by residual changes in the form of firm foci in the upper lobe of the left lung. Prophylactic treatment [is to be carried out] twice a year for two months, [and] an X-ray examination [and] clinical blood and urine tests [are to be performed] twice a year. Diet food ration until 1 June 2005".

21. It appears from the applicant's medical record that the schedule of X-ray examinations and clinical testing was fully complied with. However, in August 2004 the applicant lodged a complaint with the Prosecutor General's office alleging inadequate medical assistance. The complaint was readdressed to the Oryol Regional Prosecutor. No response followed.

22. The applicant's medical history contained a number of entries made by attending tuberculosis specialists, recording the applicant's negative attitude towards the treatment. In particular, on 1 September 2004 the colony doctor reported the applicant's refusal to take a two-month prophylactic course of anti-bacteriological drugs. In February 2005 the colony medical staff recorded the applicant's refusals to submit to an X-ray examination and blood, urine and sputum tests. It was also noted that the

applicant did not want to confirm his refusals in writing. Numerous further attempts in March and April 2005 by the colony medical staff to persuade the applicant to submit to medical procedures and to undergo prophylactic treatment were unsuccessful. On 28 June 2005 the applicant was summoned to the colony medical unit where, in the presence of the director of the correctional colony and representatives of the Moscow Human Rights Commission, it was once again explained to him that it was necessary to continue treatment and undergo medical examinations, and he was warned that a relapse was possible. The applicant wrote a statement that he was willing to submit to medical examinations and treatment, on condition that he was admitted to the tuberculosis hospital of facility no. 1 for examinations by independent medical specialists invited by his relatives. When two days later the applicant was made an offer to be sent to Livny Town Hospital he refused it.

23. Early in August 2005 the applicant applied to Livny District Court seeking to be released on parole on health grounds. In particular, the applicant argued that his tuberculosis and the absence of effective treatment made him eligible for release. On 5 August 2005 the District Court stayed the proceedings so that a thorough medical examination of the applicant could be carried out. The examination was to be performed in the tuberculosis hospital in facility no. 1.

24. Between 20 and 25 August 2005 the applicant underwent medical examinations, including an X-ray exam and clinical blood analysis, in the tuberculosis hospital in facility no. 1. He, refused however to submit to urine and sputum smear and culture testing and to undergo an electrocardiogram, citing "personal considerations". Having observed no pathology, the hospital doctors confirmed the applicant's previous diagnosis of clinical recovery from tuberculosis and declared that he was fit to continue serving his sentence in the correctional colony.

25. On 9 February 2006 the District Court dismissed the applicant's request for release, relying on the results of the applicant's medical examination in August 2005 and finding that the applicant's health did not preclude him from serving the sentence. The applicant did not appeal.

26. All entries made by attending doctors in the applicant's medical history between 1 September 2005 and February 2007 recorded that he was refusing to undergo seasonal tuberculosis treatment and/or to submit to medical observations and testing. For instance, on 14 April 2006 the applicant was visited by a representative of the Medical Department of the Oryol Regional Service for Execution of Sentences. The visit was carried out in response to a complaint from the applicant's mother about the authorities' alleged failure to provide the applicant with effective medical assistance. The applicant firmly refused to talk to the representative and protested that he did not wish to have any such contact in the future. In May 2006 the head of the medical department of the correctional colony, assisted

by a physician from the Human Rights Committee, examined the applicant. The latter complained of shortness of breath, fatigue, dizziness and excessive perspiration. An X-ray examination did not reveal any changes in the lungs. The applicant refused a request that he submit to additional clinical examinations. His refusals were attested to by written statements of at least two members of the colony medical staff.

27. In August 2007 the director of correctional colony no. 2 lodged an application with the Livny District Court of the Oryol Region requesting that the applicant be compulsorily admitted to Special Medical Tuberculosis Establishment no. 3 in the Tula Region for an in-depth medical examination and prophylactic treatment for tuberculosis. The colony director argued that since August 2004 the applicant had on a number of occasions refused to submit to prophylactic and clinical examinations, which violated sanitary and anti-epidemic regulations. The applicant's refusals made it impossible for the colony medical personnel to observe the dynamic development of the illness and to effectively control and treat it if necessary. The colony director insisted that the applicant's behaviour presented a danger to a large number of detainees and colony staff members who were in contact with the applicant.

28. The applicant and his representatives objected, arguing that the District Court lacked jurisdiction to authorise the applicant's admission to a hospital against his will, as he did not suffer from the contagious form of tuberculosis. In any event, the applicant was ready to submit to medical observations if they were to be carried out by specialists from medical establishments other than those in correctional colony no. 2 or detention facility no. 1. He insisted that the medical assistance afforded to him in those two facilities had been inadequate and ineffective.

29. On 14 August 2007 the District Court adjourned the proceedings, having authorised a forensic medical examination of the applicant by specialists from the Oryol Regional Forensic Medical Expert Bureau to determine the form of tuberculosis from which the applicant suffered. The District Court held, in so far as relevant, as follows:

> "By virtue of Article 10 § 2 of the Russian law "On Prevention of Dissemination of Tuberculosis in the Russian Federation" individuals suffering from contagious forms of tuberculosis who... intentionally avoid medical examinations aimed at detecting tuberculosis, or avoid treating it, shall be admitted, by court decision, to specialised medical anti-tuberculosis establishments for mandatory examinations and treatment.
>
> By virtue of Article 18 § 3 of the Russian Penitentiary Code individuals sentenced to imprisonment who are suffering from contagious forms of tuberculosis shall be admitted for mandatory treatment by the detention facility administration following a decision by a medical panel.
>
> The case file materials do not contain any information on the form of tuberculosis from which [the applicant] is suffering... The colony representative also did not provide such information in court hearings. The court therefore considers that special

knowledge in the field of medicine is required for the correct decision in the present case, and that it is necessary to perform a complex forensic medical examination to determine the state of [the applicant's] health".

30. On 11 September 2007 the applicant was transferred to facility no. 1 to receive the expert examination. He was sent back to the correctional colony on 19 October 2007. On 25 September 2007 the Expert Bureau issued a report, noting that it was impossible to determine the form of tuberculosis from which the applicant was suffering because of the latter's refusal to submit to medical examinations, and given the absence of any recent information in the applicant's medical record describing the state of his health. On 20 December 2007 the Livny District Court, finding that in 2006 and 2007 the applicant had repeatedly refused to undergo medical examinations, testing and seasonal prophylactic treatment and that the possibility of a relapse could thus not be excluded, ordered the applicant's placement in Special Medical Tuberculosis Establishment no. 3 in the Tula Region. That decision was upheld on appeal by the Oryol Regional Court on 13 February 2008.

31. The applicant's medical record shows that while detained in the correctional colony between 19 October and 28 December 2007 the applicant continued refusing to submit to medical examination, X-ray exams, clinical testing and seasonal prophylactic treatment. Each time, in response to the applicant's refusal, colony staff members drew up reports recording the refusal and describing the applicant's behaviour.

32. The most recent medical certificate, dated 28 December 2007, issued in correctional colony no. 2 and submitted to the Court by the Government, reads as follows:

"[The applicant's skin and visible mucous membrane are clean. Normosthenic [athletic] type; satisfactory nutrition; the osteoarticular skeleton is without deformations; movements are entirely preserved. [The applicant] refused to submit to an objective examination (palpation, percussion, auscultation, anthropometric measuring). [He] has no complaints; the state of his health is satisfactory. At present [his] diagnosis is: clinical recovery from pulmonary tuberculosis, [Supervision Group Type] 3 until February 2007; the tuberculosis control was not cancelled as [he] is refusing to undergo medical examinations and treatment."

33. In the meantime, in 2007 the applicant lodged an action against the Russian Ministry of Justice, the Oryol Regional Service for Execution of Sentences and correctional colony no. 2, seeking, *inter alia*, compensation for damage caused to his health as a result of his having contracted tuberculosis in detention and inability to receive effective medical assistance.

34. On 3 June 2008 the Livny District Court dismissed the applicant's claim for damages, finding no evidence of fault in the authorities' actions and no causal link between their actions and the damage caused to the applicant's health as a result of his having contracted tuberculosis. While issuing the judgment, the District Court rejected as unreliable statements by

a number of applicant's former inmates, who had argued in open court that inmates suffering from contagious forms of tuberculosis had frequently been detained with healthy inmates in correctional colony no. 2 and that many of them had contracted tuberculosis during their detention in that facility. The District Court's judgment became final on 17 September 2008 when the Oryol Regional Court upheld it on appeal.

35. The applicant was released in 2009, having served his entire sentence.

II. RELEVANT DOMESTIC LAW

Health care of detainees

1. Federal Law of 18 June 2001 no. 77-FZ "On Prevention of Dissemination of Tuberculosis in the Russian Federation"

Section 7. Organisation of anti-tuberculosis aid

"1. Provision of anti-tuberculosis aid to individuals suffering from tuberculosis is guaranteed by the State and is performed on the basis of the principles of legality, compliance with the rights of the individual and citizen, [and] general accessibility in the amount determined by the programme of State guarantees for provision of medical assistance to citizens of the Russian Federation, free of charge.

2. Anti-tuberculosis aid shall be provided to citizens when they voluntarily apply [for such aid] or when they consent [to such aid], save for cases indicated in Sections 9 and 10 of the present federal law and other federal laws..."

Section 8. Provision of anti-tuberculosis aid

"1. Individuals suffering from tuberculosis who are in need of anti-tuberculosis aid shall receive such aid in medical anti-tuberculosis facilities licensed to provide [it].

2. Individuals who are or have been in contact with an individual suffering from tuberculosis shall undergo an examination for the detection of tuberculosis in compliance with the laws of the Russian Federation..."

Section 9. Regular medical examinations

"1. Regular medical examinations of persons suffering from tuberculosis shall be performed in compliance with the procedure laid down by a competent federal executive body...

2. Regular medical examinations of persons suffering from tuberculosis shall be performed irrespective of the patients' or their representatives' consent.

3. A medical commission appointed by the head of a medical anti-tuberculosis facility... shall take decisions authorising regular medical examinations or terminating them and record such decisions in medical documents...; an individual in respect of whom such a decision has been issued, shall be informed in writing about the decision taken."

Section 10. Mandatory examinations and treatment of persons suffering from tuberculosis

"2. Individuals suffering from contagious forms of tuberculosis who... intentionally avoid medical examinations aimed at detecting tuberculosis, or avoid treating it, shall be admitted, by court decision, to specialised medical anti-tuberculosis establishments for mandatory examinations and treatment."

Section 12. Rights of individuals.... suffering from tuberculosis

"2. Individuals admitted to medical anti-tuberculosis facilities for examinations and (or) treatment, shall have a right to:

receive information from the administration of the medical anti-tuberculosis facilities on the progress of treatment, examinations...

have meetings with lawyers and clergy in private;

take part in religious ceremonies, if they do not have a damaging impact on the state of their health;

continue their education...

3. Individuals... suffering from tuberculosis shall have other rights provided for by the laws of the Russian Federation on health care..."

Section 13. Obligations of individuals... suffering from tuberculosis

"Individuals... suffering from tuberculosis shall;

submit to medical procedures authorised by medical personnel;

comply with the internal regulations of medical anti-tuberculosis facilities when they stay at those facilities;

comply with sanitary and hygiene conditions established for public places when persons not suffering from tuberculosis [visit them]."

Section 14. Social support for individuals... suffering from tuberculosis

"4. Individuals... suffering from tuberculosis shall be provided with medication free of charge for out-patient treatment of tuberculosis by federal specialised medical facilities in compliance with the procedure established by the Government of the Russian Federation..."

2. Regulation on Medical Assistance to Detainees

36. Russian law gives detailed guidelines for the provision of medical assistance to detained individuals. These guidelines, found in joint Decree no. 640/190 of the Ministry of Health and Social Development and the Ministry of Justice, on Organisation of Medical Assistance to Individuals Serving Sentences or Detained ("the Regulation"), enacted on 17 October 2005, are applicable to all detainees without exception. In particular, section III of the Regulation sets out the procedure for initial steps to be taken by medical personnel of a detention facility on admission of a detainee. On arrival at a temporary detention facility all detainees must be subjected to preliminary medical examination before they are placed in cells shared by other inmates. The examination is performed with the aim of identifying individuals suffering from contagious diseases or in need of urgent medical assistance. Particular attention must be paid to individuals suffering from contagious conditions. No later than three days after the detainee's arrival at the detention facility, he should receive an in-depth medical examination, including fluorography. During the in-depth examination a prison doctor should record the detainee's complaints, study his medical and personal history, record injuries if present, and recent tattoos, and schedule additional medical procedures if necessary. A prison doctor should also authorise laboratory analyses to identify sexually transmitted diseases, HIV, tuberculosis and other illnesses.

37. Subsequent medical examinations of detainees are performed at least twice a year or at a detainee's request. If a detainee's state of health has deteriorated, medical examinations and assistance should be provided by medical personnel of the detention facility. In such cases a medical examination should include a general medical check-up and additional methods of testing, if necessary, with the participation of particular medical specialists. The results of the examinations should be recorded in the detainee's medical history. The detainee should be fully informed of the results of the medical examinations.

38. Section III of the Regulation also sets out the procedure for cases of refusal by detainees to undergo medical examination or treatment. In each case of refusal, a corresponding entry should be made in the detainee's medical record. A prison doctor should fully explain to the detainee the consequences of his refusal to undergo the medical procedure.

39. Detainees take prescribed medicines in the presence of a doctor. In a limited number of cases the head of the medical department of the detention facility may authorise his medical personnel to hand over a daily dose of medicines to the detainee for unobserved intake.

40. Section X of the Regulation regulates medical examinations, monitoring and treatment of detainees suffering from tuberculosis. It lays down a detailed account of medical procedures to be employed, establishes their frequency, and regulates courses of treatment for new tuberculosis

patients and previously treated ones (relapsing or defaulting detainees). In particular, it provides that when a detainee exhibits signs of a relapse of tuberculosis, he or she should immediately be removed to designated premises (infectious unit of the medical department of the facility) and should be sent for treatment to an anti-tuberculosis establishment. Prophylactic and anti-relapse treatment of tuberculosis patients should be carried out by a tuberculosis specialist. Rigorous checking of the intake of anti-tuberculosis drugs by the detainee should be put in place. Each dose should be recorded in the detainee's medical history. A refusal to take anti-tuberculosis medicine should also be noted in the medical record. A discussion of the negative effects of the refusal should follow. Detainees suffering from tuberculosis should also be put on a special dietary ration.

3. Anti-Tuberculosis Decree

41. On 21 March 2003 the Ministry of Health adopted Decree no. 109 on Improvement of Anti-Tuberculosis Measures in the Russian Federation ("the Anti-Tuberculosis Decree" or "the Decree"). Having acknowledged a difficult epidemic situation in the Russian Federation in connection with a drastic increase in the number of individuals suffering from tuberculosis, particularly among children and detainees, and a substantial rise in the number of tuberculosis-related deaths, the Decree laid down guidelines and recommendations for country-wide prevention, detection and therapy in respect of tuberculosis, in conformity with international standards, identifying forms and types of tuberculosis and categories of patients suffering from them, establishing types of necessary medical examinations, analyses and testing to be performed in each case, and giving extremely detailed instructions on their performance and assessment; it also laid down rules on vaccination, determined courses and regimens of therapy for particular categories of patients, etc.

42. In particular, Addendum 6 to the Decree contains an Instruction on chemotherapy for tuberculosis patients. The aims of treatment, essential anti-tuberculosis drugs and their dose combinations, as well as standard regimens of chemotherapy laid down by the Instruction for Russian tuberculosis patients, conformed to those recommended by the World Health Organisation in *Treatment of Tuberculosis: Guidelines for National Programs* (see below).

III. RELEVANT INTERNATIONAL REPORTS AND DOCUMENTS

A. General health care issues

1. *Recommendation Rec(2006)2 of the Committee of Ministers to member states on the European Prison Rules, adopted on 11 January 2006 at the 952nd meeting of the Ministers' Deputies ("the European Prison Rules")*

43. The European Prison Rules provide a framework of guiding principles for health services. The relevant extracts from the Rules read as follows:

"*Health care*

39. Prison authorities shall safeguard the health of all prisoners in their care.

Organisation of prison health care

40.1 Medical services in prison shall be organised in close relation with the general health administration of the community or nation.

40.2 Health policy in prisons shall be integrated into, and compatible with, national health policy.

40.3 Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation.

40.4 Medical services in prison shall seek to detect and treat physical or mental illnesses or defects from which prisoners may suffer.

40.5 All necessary medical, surgical and psychiatric services including those available in the community shall be provided to the prisoner for that purpose.

Medical and health care personnel

41.1 Every prison shall have the services of at least one qualified general medical practitioner.

41.2 Arrangements shall be made to ensure at all times that a qualified medical practitioner is available without delay in cases of urgency.

...

41.4 Every prison shall have personnel suitably trained in health care.

Duties of the medical practitioner

42.1 The medical practitioner or a qualified nurse reporting to such a medical practitioner shall see every prisoner as soon as possible after admission, and shall examine them unless this is obviously unnecessary.

...

42.3 When examining a prisoner the medical practitioner or a qualified nurse reporting to such a medical practitioner shall pay particular attention to:

...

b. diagnosing physical or mental illness and taking all measures necessary for its treatment and for the continuation of existing medical treatment;

...

f. isolating prisoners suspected of infectious or contagious conditions for the period of infection and providing them with proper treatment;

...

43.1 The medical practitioner shall have the care of the physical and mental health of the prisoners and shall see, under the conditions and with a frequency consistent with health care standards in the community, all sick prisoners, all who report illness or injury and any prisoner to whom attention is specially directed.

...

Health care provision

46.1 Sick prisoners who require specialist treatment shall be transferred to specialised institutions or to civil hospitals when such treatment is not available in prison.

46.2 Where a prison service has its own hospital facilities, they shall be adequately staffed and equipped to provide the prisoners referred to them with appropriate care and treatment."

2. 3rd General Report of the European Committee for the Prevention of Torture ("the CPT Report")

44. The complexity and importance of health care services in detention facilities was discussed by the European Committee for the Prevention of Torture in its *3rd General Report* (CPT/Inf (93) 12 - Publication Date: 4 June 1993). The following are the extracts from the Report:

"33. When entering prison, all prisoners should without delay be seen by a member of the establishment's health care service. In its reports to date the CPT has recommended that every newly arrived prisoner be properly interviewed and, if necessary, physically examined by a medical doctor as soon as possible after his

admission. It should be added that in some countries, medical screening on arrival is carried out by a fully qualified nurse, who reports to a doctor. This latter approach could be considered as a more efficient use of available resources.

It is also desirable that a leaflet or booklet be handed to prisoners on their arrival, informing them of the existence and operation of the health care service and reminding them of basic measures of hygiene.

34. While in custody, prisoners should be able to have access to a doctor at any time, irrespective of their detention regime... The health care service should be so organised as to enable requests to consult a doctor to be met without undue delay...

35. A prison's health care service should at least be able to provide regular out-patient consultations and emergency treatment (of course, in addition there may often be a hospital-type unit with beds)... Further, prison doctors should be able to call upon the services of specialists.

As regards emergency treatment, a doctor should always be on call. Further, someone competent to provide first aid should always be present on prison premises, preferably someone with a recognised nursing qualification.

Out-patient treatment should be supervised, as appropriate, by health care staff; in many cases it is not sufficient for the provision of follow-up care to depend upon the initiative being taken by the prisoner.

36. The direct support of a fully-equipped hospital service should be available, in either a civil or prison hospital...

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. ...

> 54. A prison health care service should ensure that information about transmittable diseases (in particular hepatitis, AIDS, tuberculosis, dermatological infections) is regularly circulated, both to prisoners and to prison staff. Where appropriate, medical control of those with whom a particular prisoner has regular contact (fellow prisoners, prison staff, frequent visitors) should be carried out."

3. Committee of Ministers Recommendation No. R (98) 7 on Health care in Prisons

45. A further elaboration of European expectations as regards health care in prisons is found in the appendix to Recommendation no. R (98) 7 of the Committee of Ministers to Member States on the ethical and organisational aspects of health care in prison (adopted on 8 April 1998 at the 627th meeting of the Ministers' Deputies). Primarily restating the European Prison Rules and CPT standards, the Recommendation went beyond reiteration of the principles in some aspects to include more specific discussion of the management of certain common problems including transmissible diseases. In particular, in respect of cases of tuberculosis, the Committee of Ministers stressed that all necessary measures should be applied to prevent the propagation of this infection, in accordance with relevant legislation in this area. Therapeutic intervention should be of a standard equal to that outside prison. The medical services of the local chest physician should be requested in order to obtain the long-term advice that is required for this condition, as is practised in the community, in accordance with relevant legislation (Section 41).

B. Health care issues related to transmissible diseases

1. Committee of Ministers Recommendation no. R (93) 6 on Control of Transmissible Diseases in Prisons

46. The fact that transmissible diseases in European prisons have become an issue of considerable concern prompted a recommendation of the Committee of Ministers to Member States concerning prison and criminological aspects of the control of transmissible diseases and related health problems in prison (adopted on 18 October 1993 at the 500th meeting of the Ministers' Deputies). The relevant extracts from the Recommendation read as follows:

> "2. The systematic medical examination carried out on entry into prison should include measures to detect intercurrent diseases, including treatable infectious diseases, in particular tuberculosis. The examination also gives the opportunity to provide health education and to give prisoners a greater sense of responsibility for their own health....

15. Adequate financial and human resources should be made available within the prison health system to meet not only the problems of transmissible diseases and HIV/Aids but also all health problems affecting prisoners."

2. 11th General Report of activities of the European Committee for the Prevention of Torture

47. An expanded coverage of the issue related to transmissible diseases in detention facilities was given by the European Committee for the Prevention of Torture in its *11th General Report* (CPT/INF (2001) 16 published on 3 September 2001), a discussion prompted by findings of serious inadequacies in health provision and poor material conditions of detention which were exacerbating the transmission of the diseases. Addressing the issue, the CPT reported as follows:

"31. The spread of transmissible diseases and, in particular, of tuberculosis, hepatitis and HIV/AIDS has become a major public health concern in a number of European countries. Although affecting the population at large, these diseases have emerged as a dramatic problem in certain prison systems. In this connection the CPT has, on a number of occasions, been obliged to express serious concerns about the inadequacy of the measures taken to tackle this problem. Further, material conditions under which prisoners are held have often been found to be such that they can only favour the spread of these diseases.

The CPT is aware that in periods of economic difficulties - such as those encountered today in many countries visited by the CPT - sacrifices have to be made, including in penitentiary establishments. However, regardless of the difficulties faced at any given time, the act of depriving a person of his liberty always entails a duty of care which calls for effective methods of prevention, screening, and treatment. Compliance with this duty by public authorities is all the more important when it is a question of care required to treat life-threatening diseases.

The use of up-to date methods for screening, the regular supply of medication and related materials, the availability of staff ensuring that prisoners take the prescribed medicines in the right doses and at the right intervals, and the provision when appropriate of special diets, constitute essential elements of an effective strategy to combat the above-mentioned diseases and to provide appropriate care to the prisoners concerned. Similarly, material conditions in accommodation for prisoners with transmissible diseases must be conducive to the improvement of their health; in addition to natural light and good ventilation, there must be satisfactory hygiene as well as an absence of overcrowding.

Further, the prisoners concerned should not be segregated from the rest of the prison population unless this is strictly necessary on medical or other grounds...

In order to dispel misconceptions on these matters, it is incumbent on national authorities to ensure that there is a full educational programme about transmissible diseases for both prisoners and prison staff. Such a programme should address methods of transmission and means of protection as well as the application of adequate preventive measures.

It must also be stressed that appropriate information and counselling should be provided before and - in the case of a positive result - after any screening test. Further, it is axiomatic that patient-related information should be protected by medical confidentiality. As a matter of principle, any interventions in this area should be based on the informed consent of the persons concerned.

Moreover, for control of the above-mentioned diseases to be effective, all the ministries and agencies working in this field in a given country must ensure that they co-ordinate their efforts in the best possible way. In this respect the CPT wishes to stress that the continuation of treatment after release from prison must be guaranteed."

C. Health care reports on the Russian Federation

1. The CPT Report on Russia

48. The CPT report on the visit to the Russian Federation carried out from 2 to 17 December 2001 (CPT/INF (2003) 30) provides as follows:

"102. The CPT is also seriously concerned by the practice of transferring back from SIZO [temporary detention facility] to IVS [temporary detention ward in police departments] facilities prisoners diagnosed to have BK+ tuberculosis (and hence highly contagious), as well as by the interruption of TB treatment while at the IVS. An interruption of the treatment also appeared to occur during transfers between penitentiary establishments.

In the interest of combating the spread of tuberculosis within the law-enforcement and penitentiary system and in society in general, the CPT recommends that immediate measures be taken to put an end to the above-mentioned practice."

2. The World Bank Report on Tuberculosis and Aids Control Project in Russia

49. On 23 December 2009 the World Bank published the *Implementation Completion and Results Report* (Report no. ICR00001281, Volume I) on a loan granted to the Russian Federation for its Tuberculosis and Aids Control Project. The relevant part of the Report read as follows:

"According to the World Health Organization (WHO), Russia was one of the 22 high-burden countries for TB in the world (WHO, Global Tuberculosis control: Surveillance, Planning, Financing, Geneva, 2002). The incidence of TB increased throughout the 1990s. This was due to a combination of factors, including: (i) increased poverty, (ii) under-funding of TB services and health services in general, (iii) diagnostic and therapeutic approaches that were designed for a centralized command-and-control TB system, but were unable to cope with the social mobility and relative freedom of the post-Soviet era, and (iv) technical inadequacies and outdated equipment. Migration of populations from ex-Soviet republics with high TB burdens also increased the problem. Prevalence rates were many times higher in the prison system than in the general population. Treatment included lengthy hospitalizations, variations among clinicians and patients in the therapeutic regimen, and frequent recourse to surgery. A shrinking health budget resulted in an erratic

supply of anti-TB drugs and laboratory supplies, reduced quality control in TB dispensaries and laboratories, and inadequate treatment. The social conditions favouring the spread of TB, combined with inadequate systems for diagnosis, treatment, and surveillance, as well as increased drug resistance, produced a serious public health problem.

TB control in the former Union of Soviet Socialist Republics (USSR) and in most of Russia in the 1990s was heavily centralized, with separate hospitals (TB dispensaries), TB sanatoriums, TB research institutes and TB specialists. The system was designed in the 1920s to address the challenges of the TB epidemic. Case detection relied strongly on active mass screening by X-ray (fluorography). Specificity, sensitivity, and cost-effectiveness considerations were not features of this approach. Bacille Calmette-Guerin (BCG) immunization was a key feature of the TB control system...

By 2000, there was more than a two-fold increase in TB incidence, and mortality from TB increased 3 times, compared with 1990. The lowered treatment effectiveness of the recent years resulted in an increase in the number of TB chronic patients, creating a permanent 'breeding ground' for the infection. At that moment, the share of pulmonary TB cases confirmed by bacterioscopy did not exceed 25%, and the share of such cases confirmed by culture testing was no more than 41% due to suboptimal effectiveness of laboratory diagnosis, which led to poor detection of smear-positive TB cases. Being a social disease, TB affected the most socially and economically marginalized populations in Russia."

D. General guidelines for tuberculosis therapy

50. The following are the extracts from *Treatment of Tuberculosis: Guidelines for National Programmes*, World Health Organisation, 1997, pp. 27, 33 and 41:

"Treatment regimens have an initial (intensive) phase lasting 2 months and a continuation phase usually lasting 4-6 months. During the initial phase, consisting usually of 4 drugs, there is rapid killing of tubercle bacilli. Infectious patients become non-infectious within about 2 weeks. Symptoms improve. The vast majority of patients with sputum smear-positive TB become smear-negative within 2 months. In the continuation phase fewer drugs are necessary but for a longer time. The sterilizing effect of the drugs eliminates remaining bacilli and prevents subsequent relapse.

In patients with smear positive pulmonary TB, there is a risk of selecting resistant bacilli, since these patients harbour and excrete a large number of bacilli. Short-course chemotherapy regimens consisting of 4 drugs during the initial phase, and 2 drugs during the continuation phase, reduce this risk of selecting resistant bacilli. These regimens are practically as effective in patients with initially resistant organisms as in those with sensitive organisms.

In patients with smear negative pulmonary or extra-pulmonary TB there is little risk of selecting resistant bacilli since these patients harbour fewer bacilli in their lesions. Short-course chemotherapy regimens with three drugs during the initial phase, and two drugs in the continuation phase, are of proven efficacy...

Patients with sputum smear-positive pulmonary TB should be monitored by sputum smear examination. This is the only group of TB patients for whom bacteriological monitoring is possible. It is unnecessary and wasteful of resources to monitor the patient by chest radiography. For patients with sputum smear-negative pulmonary TB and extra-pulmonary TB, clinical monitoring is the usual way of assessing response to treatment. Under programme conditions in high TB incidence countries, routine monitoring by sputum culture is not feasible or recommended. Where facilities are available, culture surveys can be useful as part of quality control of diagnosis by smear microscopy...

Directly observed treatment is one element of the DOTS strategy, i.e. the WHO recommended policy package for TB control. Direct observation of treatment means that a supervisor watches the patient swallowing the tablets. This ensures that a TB patient takes the right drugs, in the right doses, at the right intervals...

Many patients receiving self-administered treatment will not adhere to treatment. It is impossible to predict who will or will not comply, therefore directly observed treatment is necessary at least in the initial phase to ensure adherence. If a TB patient misses one attendance to receive treatment, it is necessary to find that patient and continue treatment."

THE LAW

I. ALLEGED VIOLATION OF ARTICLE 3 OF THE CONVENTION

51. The applicant complained under Article 3 of the Convention that he had contracted tuberculosis during his detention and that the authorities had not taken steps to safeguard his health and well-being, having delayed diagnosing him with tuberculosis and failed to provide him with adequate medical assistance in the correctional colony. Article 3 of the Convention reads as follows:

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

A. Submissions by the parties

52. The Government firstly argued that it was impossible to establish "beyond reasonable doubt" that the applicant had contracted tuberculosis in detention. They reasoned that according to medical specialists and research, the majority of the Russian adult population and, consequently, the majority of individuals entering the Russian prison system, are already infected with mycobacterium tuberculosis ("MBT"). They cited statistical data, arguing that out of 100,000 persons infected with the bacteria only eighty-nine will

develop an active form of the illness. The Government stressed that detection of dormant MBT cannot be made through ordinary radiological methods of screening and a period of several years may pass between the date when a person contracts the illness and the date when the illness fully develops. They drew the Court's attention to the fact that modern science did not clearly identify the factors which led to the reactivation of the tuberculosis process. It is, however, established that persons with a weak immune system are prone to the infection. Hereditary factors should also be taken into account. The Government disputed the possibility of detaining individuals suffering from contagious forms of tuberculosis alongside healthy inmates in Russian detention facilities. They accepted that in September 2000 during detention in the correctional colony the applicant had shared a cell with a person suffering from a non-contagious form of tuberculosis. Therefore, the applicant's contact with that person could not have been a factor in the development of the illness.

53. Relying on a copy of the applicant's medical record, the Government further submitted that the applicant had been under effective medical supervision throughout his detention. That supervision involved regular medical check-ups prior to diagnosis with tuberculosis and a prompt and effective response to any health grievances the applicant had, as well as effective medical treatment to the point of clinical cure after the illness revealed itself. The treatment the applicant had received complied with the requirements laid down by Russian law and international medical standards.

54. The Government concluded by arguing that the applicant had made it impossible for the Russian authorities to provide him with the medical services he required, as since September 2004 he had exhibited a negative attitude towards any medical procedures or treatment offered by the authorities. Relying on the applicant's medical history and written statements by members of the colony medical staff, the Government stressed that on at least twenty-five occasions between September 2004 and December 2007 the applicant had refused to submit to medical observations and testing and had not taken seasonal prophylactic treatment. That behaviour led to a court decision authorising the applicant's placement, against his will, in a tuberculosis hospital in an attempt to establish whether he had suffered a relapse and presented a danger to other inmates and warders.

55. The applicant averred that he had not been suffering from tuberculosis before his arrest in February 1997 and that he had acquired his illness in detention. He stressed that the first eight fluorography tests performed in facility no. 1 and correctional colony no. 2 did not show any symptoms of tuberculosis. It was more than four years after his arrest that his illness was discovered. The applicant insisted that the Government had provided no evidence in support of their assertion that he had already been infected with MBT before his arrest or, for that matter, that he had received

the necessary medical assistance in detention. Relying on statements by his inmates made in open court within the tort proceedings, he argued that it was more than probable that his detention alongside inmates suffering from TB was the cause of his illness.

56. The applicant continued by arguing that the authorities' reaction to his health complaints had been belated and inadequate. In particular, it was almost two months after the infection had revealed itself that he had been admitted to hospital for treatment. The medical services rendered to the applicant had had a large number of defects. The treatment had been sporadic and incomplete. A serious deterioration of his health in March 2004 resulting in his suffering a spontaneous pneumothorax had been a firm evidence of inadequate quality of the medical services. The applicant further disputed the Government's assertion that he had refused to cooperate with the authorities. He explained that his refusals to submit to medical observations and testing in the correctional colony had pursued the single purpose of forcing the colony administration to transfer him to a "proper" medical establishment. His behaviour had been a mere attempt to obtain adequate and effective medical services. In the applicant's opinion, it was indisputable that he wanted to become healthy but that aim was impossible to achieve in a prison hospital.

B. The Court's assessment

1. Admissibility

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

2. Merits

(a) General principles

58. The Court reiterates that Article 3 of the Convention enshrines one of the most fundamental values of democratic society. It prohibits in absolute terms torture or inhuman or degrading treatment or punishment, irrespective of the circumstances and the victim's behaviour (see, for example, *Labita v. Italy* [GC], no. 26772/95, § 119, ECHR 2000-IV). 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 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 other authorities, *Ireland v. the United Kingdom*, 18 January 1978, § 162, Series A no. 25).

59. Ill-treatment that attains such a minimum level of severity usually involves actual bodily injury or intense physical or mental suffering. However, even in the absence of these, 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 *Pretty v. the United Kingdom*, no. 2346/02, § 52, ECHR 2002-III, with further references).

60. In the context of deprivation of liberty the Court has consistently stressed that, to fall under Article 3, the suffering and humiliation involved must in any event go beyond that inevitable element of suffering and humiliation connected with the detention (see, *mutatis mutandis*, *Tyrer v. the United Kingdom*, 25 April 1978, § 30, Series A no. 26, and *Soering v. the United Kingdom*, 7 July 1989, § 100, Series A no. 161).

61. The State must ensure that a person is detained in conditions which are compatible with respect for 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 secured (see *Kudła v. Poland* [GC], no. 30210/96, §§ 92-94, ECHR 2000-XI, and *Popov v. Russia*, no. 26853/04, § 208, 13 July 2006). In most of the cases concerning the detention of people who are ill, the Court has examined whether or not the applicant received adequate medical assistance in prison. The Court reiterates in this respect that even if Article 3 does not entitle a detainee to be released "on compassionate grounds", it has always interpreted the requirement to secure the health and well-being of detainees, among other things, as an obligation on the part of the State to provide detainees with the requisite medical assistance (see *Kudła,* cited above, § 94; *Kalashnikov v. Russia*, no. 47095/99, §§ 95 and 100, ECHR 2002-VI; and *Khudobin v. Russia*, no. 59696/00, § 96, ECHR 2006-XII (extracts)).

62. The "adequacy" of medical assistance remains the most difficult element to determine. The CPT proclaimed the principle of the equivalence of health care in prison with that in the outside community (see paragraph 44 above). The Court insists that, in particular, authorities must ensure that the diagnosis and care are prompt and accurate (see *Hummatov v. Azerbaijan*, nos. 9852/03 and 13413/04, § 115, 29 November 2007; *Melnik v. Ukraine*, no. 72286/01, §§ 104-106, 28 March 2006; and, *mutatis mutandis, Holomiov v. Moldova*, no. 30649/05, § 121, 7 November 2006), and that where necessitated by the nature of a medical condition, supervision is regular and systematic and involves a comprehensive therapeutic strategy aimed at curing the detainee's health problems or preventing their aggravation (see *Hummatov*, cited above, §§ 109, 114;

Sarban v. Moldova, no. 3456/05, § 79, 4 October 2005; and *Popov v. Russia*, cited above, § 211). However, the Court has also held that Article 3 of the Convention cannot be interpreted as securing for every detained person medical assistance at the same level as "in the best civilian clinics" (see *Mirilashivili v. Russia* (dec.), no. 6293/04, 10 July 2007). In another case the Court went further, holding that it was "prepared to accept that in principle the resources of medical facilities within the penitentiary system are limited compared to those of civil clinics" (see *Grishin v. Russia*, no. 30983/02, § 76, 15 November 2007).

63. On the whole, the Court reserves sufficient flexibility in defining the required standard of health care, deciding it on a case-by-case basis. That standard should be "compatible with the human dignity" of a detainee, but should also take into account "the practical demands of imprisonment" (see *Aleksanyan v. Russia*, no. 46468/06, § 140, 22 December 2008).

(b) Application of the above principles to the present case

64. Turning to the circumstances of the present case, the Court observes that following a fluorography test on 30 October 2001, more than four years after the arrest in February 1997, the applicant was diagnosed as having tuberculosis, which, according to him, he had not suffered from prior to his arrest. In fact, the medical certificates submitted by the parties show that he had no history of tuberculosis before his placement in detention facility no. 1 in Oryol. Likewise, no symptoms of tuberculosis were discovered in the period from 25 February 1997, when the applicant underwent his first fluorography exam in detention, to 30 October 2001, when the disease was diagnosed. The eight fluorography tests performed during that period revealed no signs of infection.

65. In this respect, the Court is mindful of the Government's opinion that Mycobacterium tuberculosis, also known as Koch's bacillus, may lie dormant in the body for some time without exhibiting any clinical signs of the illness. At the same time, for the Government to effectively argue that the applicant was infected with Koch's bacillus even before his arrest, it would have been necessary for the authorities to perform on the applicant, upon his admission to the detention facility and in addition to a fluorography examination, the Mantoux test or a special tuberculosis blood test which would have indicated the presence of the latent infection. However, as follows from the parties' submissions, apart from fluorography examinations, the Russian penitentiary institutions did not employ any other methods to check for TB at the moment of detainees' admission to detention facilities. It is therefore possible to conclude that the applicant was never exposed to the infection prior to his arrest and that he only contracted tuberculosis in detention, particularly taking into account that in October 1998 he had been placed in a cell with an individual suffering from the contagious form of tuberculosis (see paragraph 10 above). In this respect,

the Court attributes particular weight to the conclusion recorded in the applicant's medical history and finding the roots of the applicant's tuberculosis in his detention with the sick inmate (ibid). The Court also does not lose sight of the statistical estimations that place Russia among one of the twenty-two highest-burden countries for tuberculosis in the world, recording a drastic increase in the incidence of tuberculosis in the 1990s, with some reports indicating that TB is many times more prevalent in Russian prisons than in civilian life (see paragraph 49 above). With all these considerations in mind and also adding to them the fact that the first eight fluorography tests performed between the applicant's arrest and October 2001 showed no pathology in the applicant's lungs, the Court considers it most probable that the applicant contracted tuberculosis in detention facility no. 1 (see *Staykov v. Bulgaria*, no. 49438/99, § 81, 12 October 2006; *Yakovenko v. Ukraine*, no. 15825/06, §§ 28 and 95, 25 October 2007; *Hummatov*, cited above, §§ 108 and 111; and *Ghavtadz, v. Georgia*, no. 23204/07, § 86, 3 March 2009). In these circumstances, the Court does not consider it necessary to establish the veracity of the applicant's argument regarding another alleged instance of his detention with an inmate with TB in September 2000 (see paragraph 11 above).

66. While finding it particularly disturbing that the applicant's infection with tuberculosis occurred in a penitentiary institution within the State's control, the Court reiterates its constant approach that even if an applicant had contracted tuberculosis while in detention, this in itself would not imply a violation of Article 3, provided that he received treatment for it (see *Alver v. Estonia*, no. 64812/01, § 54, 8 November 2005, and *Pitalev v. Russia*, no. 34393/03, § 53, 30 July 2009, with further references). However, the State does have a responsibility to ensure treatment for prisoners in its charge, and a lack of adequate medical assistance for serious health problems not suffered from prior to detention may amount to a violation of Article 3 (see *Hummatov*, cited above, § 108 et seq.). Absent or inadequate treatment for tuberculosis, particularly when the disease has been contracted in detention, is most certainly a subject of the Court's concern. It is therefore bound to assess the quality of medical services the applicant was provided with in the present case and to determine whether he was deprived of adequate medical assistance as he claims, and if so whether this amounted to inhuman and degrading treatment contrary to Article 3 of the Convention (see *Sarban v. Moldova*, no. 3456/05, § 78, 4 October 2005).

67. In this respect, the Court reiterates the Government's description of the applicant's attitude towards the treatment and medical assistance afforded to him in detention. In particular, they argued that after September 2004 the applicant had refused to submit to medical procedures, including X-ray examinations and clinical tests, and had declined prophylactic treatment for his illness. Given the fact that the applicant did not dispute his refusal to follow medical recommendations of the detention authorities,

albeit for quite different reasons than those implied by the Government, the Court will assess the quality of the medical care during the two periods of the applicant's detention, accepting September 2004 as the dividing point.

i. Medical assistance from October 1998 to September 2004

68. The Court reiterates that the applicant opened his line of arguments by complaining that the authorities' response to his health grievances aired already in the end of September 2000 was belated (see paragraph 11 above) and about delayed diagnosis of the illness. In this connection, while observing no entries in the applicant's medical history recording health complaints before the discovery of the disease in October 2001, the Court still finds strong evidence before it in support of the applicant's claims as to the belated screening of the illness. In particular, it does not escape the Court's attention that almost a year passed between the chest fluorography examinations in 2000 and 2001 (see paragraph 9 above). The Court is troubled by that delay, given the fact that at the time the applicant was, most probably, a carrier of the latent tuberculosis infection following his detention alongside an inmate ill with active tuberculosis, he was in detention, a recognised setting for the transmission and development of tuberculosis (see *Ghavtadze*, cited above, § 86, and, most recently, *Pakhomov v. Russia*, no. 44917/08, 30 September 2009, § 64), and there is no indication that following his contact with the inmate who was ill the applicant received the full course of preventive treatment to reduce the risk of the latent infection progressing to active TB later in his life. The Court believes that in these circumstances the Russian authorities were under an obligation to closely monitor the applicant's health to be able to respond promptly to any reactivation of the latent infection, an obligation which they failed to comply with.

69. The Court further observes that more than a month passed between the discovery of the illness during a fluorography examination on 30 October 2001 and the applicant's admission to the tuberculosis hospital in facility no. 1 on 7 December 2001. The Government did not provide any explanation for the delay, nor did it indicate whether the authorities had ever considered that the delay in the applicant's admission to the hospital could have worsened his untreated condition, as well as made him a source of a secondary spread of infection throughout the prison population and facility staff, should the applicant turn out to be sputum smear positive. Noting that delayed treatment is particularly detrimental to patients suffering from tuberculosis, the Court also finds it striking that it was not until 17 December 2001 that the applicant started receiving antibacterial treatment (see paragraph 13 above). While acknowledging the necessity to perform clinical tests for proper diagnosis, case definition and choice of standard treatment regimen, the Court is concerned that the testing delayed the initiation of the applicant's treatment. It is therefore not convinced that

the authorities acted promptly and diligently in identifying the illness and initiating effective therapy, the key measures in the modern strategy of tuberculosis control and treatment.

70. The Court reiterates that the applicant remained in the tuberculosis hospital until 26 June 2002. Although he did not make any complaints pertaining to the quality of the medical services rendered to him in the hospital, the Court still considers it necessary to emphasise that the quality of the hospital care following the initiation of the anti-tuberculosis therapy on 17 December 2001 appears to be adequate. In particular, the evidence placed before the Court shows that, having been placed on a strict medication regime necessary for the tuberculosis therapy when the initial stage of the treatment was followed by the continuation stage, as recommended by the WHO, the applicant received a number of anti-tuberculosis medicines and concomitant antihistamine drugs, which were administered to him in the requisite dosage, at the right intervals and for the appropriate duration. During the entire period of his treatment the applicant was subjected to regular and systematic clinical and radiological assessment and bacteriological monitoring, which formed part of the comprehensive therapeutic strategy aimed at curing the disease. The authorities also effectively implemented the doctors' recommendations in respect of a special dietary ration necessary for the applicant to improve his health (contrast *Gorodnitchev v. Russia*, no. 52058/99, § 91, 24 May 2007).

71. Furthermore, the Court attributes particular weight to the fact that the facility administration not only ensured that the applicant was attended to by doctors, that his complaints were heard and that he was prescribed a trial of anti-tuberculosis medication, they also created the necessary conditions for the prescribed treatment to be actually followed through (see *Hummatov*, cited above, § 116). The Court notes that the intake of medicines by the applicant was supervised and directly observed by the facility medical personnel throughout the whole treatment regimen, as required by the DOTS strategy. The authorities' actions guaranteed the applicant's adherence to the treatment and compliance with the prescribed regimen, this being a key factor in the treatment's success.

72. The applicant's medical history containing his diagnosis following the completion of the treatment in the tuberculosis hospital in the summer of 2002 as "focal tuberculosis of the left lung in the resolution phase" showed positive dynamics in the applicant's treatment, meaning that he was recovering. The applicant was released from the hospital to correctional colony no. 2 with a recommendation to continue treatment on an HE regimen. The medical records indicate that the applicant had been attended to a number of times throughout his detention in the colony in 2002 and 2003 and had been prescribed tests and medication. However, the same records show that the applicant's treatment in the colony was unregulated and erratic. In particular, there is no evidence that the hospital's

recommendation to continue treatment with isoniazid and ethmbutol was followed through. In fact, it was not until March 2003 that the applicant finally gained access to treatment with anti-bacteriological drugs (see paragraph 17 above). It also does not appear that the applicant was attended by doctors on a regular or systematic basis. The Court is mindful that the first examination of the applicant was performed by the colony doctor on 9 October 2002, more than three months after the applicant's return to the correctional colony. It also does not lose sight of the fact that the colony authorities regularly delayed quarterly X-ray examination and clinical testing of the applicant. Given that the above tests and examinations were essential for effective monitoring of the applicant's condition and timely diagnosis of possible reappearance of symptoms of TB, it is regrettable that they were performed haphazardly. In addition, the Court notes the authorities' inert response to the applicant's health complaints in January 2003 and discovery of certain changes in his left lung during an X-ray examination not long after the complaints had been raised. In the light of these considerations the Court does not deem such medical attention to be adequate and reasonable, given the condition from which the applicant was suffering (see, for similar reasoning, *Hummatov*, cited above, §§ 114-115).

73. Further developments in the applicant's case give even stronger support to the Court's finding of inadequate medical assistance in the colony. In this respect, the Court is particularly mindful of the fact that only days after a special tuberculosis medical panel had, without observing the applicant in person or hearing his complaints, declared him "clinically cured" of tuberculosis (see paragraphs 18 and 19 above), the applicant suffered a spontaneous pneumothorax of the left lung. Furthermore, the authorities' reaction to this situation gives rise to criticism. In particular, almost a month passed between the applicant complaining of a deterioration of his health and an X-ray exam revealing a pneumothorax. Despite the applicant's acute condition requiring immediate medical assistance, the colony administration delayed his transfer to the tuberculosis hospital for four days. The applicant's further transfer to the surgical department of the Oryol Regional Tuberculosis Hospital resulted in another two-day delay before he started receiving treatment. The Court is concerned that the authorities' failure to promptly and effectively address the applicant's situation could have contributed to a rapid deterioration of his health and resulted in his being exposed to additional suffering and distress concomitant to his medical condition.

74. Finally, the Court reiterates that the applicant's release from the Oryol Regional Tuberculosis Hospital was accompanied by an important recommendation to subject him to a two-month chemotherapy regimen with four anti-tuberculosis drugs. Being aware that regular and complete medication intake gives individual TB patients the best chance of cure, the Court finds it disturbing that, having commenced on 14 April 2004, the

treatment was stopped less than a month later, on 6 May 2004. The applicant's medical records furnish no explanation for the interruption of his treatment. Given the seriousness of the possible negative effects of interruption of treatment for the applicant, the Court notes that there is no indication that the authorities have ever considered whether the applicant should return to the prescribed treatment or whether that instance of incomplete medication necessitated additional caution and probably additional treatment for the applicant.

75. To sum up, the evidence put before the Court shows that the authorities failed to promptly diagnose the applicant with tuberculosis and delayed the initiation of effective therapy. It further considers that during the period under examination the applicant did not receive comprehensive, effective and transparent medical assistance in respect of his tuberculosis during detention in correctional colony no. 2. In addition the Court attributes particular weight to the fact that the applicant's state of health suddenly and seriously deteriorated in March 2004, leading to his requiring surgery. The Court believes that, for lack of adequate medical treatment, the applicant was exposed to prolonged mental and physical suffering diminishing his human dignity. The authorities' failure to provide the applicant with the requisite medical care amounted to inhuman and degrading treatment within the meaning of Article 3 of the Convention.

76. Accordingly, there has been a violation of Article 3 of the Convention on account of the authorities' failure to duly diagnose the applicant with tuberculosis and comply with their responsibility to ensure adequate medical assistance to him during his detention in the correctional colony from October 1998 to September 2004.

ii. Medical assistance from September 2004

77. As shown by the applicant's medical history and the parties' submissions, after 1 September 2004 the applicant persistently refused to undergo seasonal prophylactic treatment against tuberculosis and to submit to fluorography examinations and clinical tests within the schedule developed by the attending tuberculosis specialists. In his observations to the Court the applicant explained his decision by his general dissatisfaction with the quality of the medical assistance afforded to him in detention and his wish to be treated by independent medical specialists.

78. The Court observes that each time the authorities encountered the applicant's refusals to cooperate and his resistance to medical supervision and treatment they took steps to ensure that the applicant's decision was well informed and that he had complete understanding of the consequences of his actions. It appears that the authorities took care to evaluate the refusals and considered individually each refusal of treatment on the applicant's part to determine a proper response and, if possible, to adjust to the applicant's demands. They offered him psychological support and

attention, having provided clear and complete explanations of medical procedures, the sought outcome of the treatment and negative side effects of irregular medication (see, by contrast, *Gorodnitchev*, cited above, § 91; *Testa v. Croatia*, no. 20877/04, § 52, 12 July 2007; and *Tarariyeva v. Russia*, no. 4353/03, § 80, ECHR 2006-XV (extracts)). The discussions, as well as any limits or conditions that the applicant set on a refusal, were clearly documented in his medical records. Despite the applicant's consistent and occasionally aggressive refusals to comply with medical recommendations, the authorities did not interpret such behaviour as firm and complete refusal of other medical interventions, and did not abandon their attempts to comply with the schedule of medical procedures and treatment, even inviting representatives of the supervising State body and human rights organisations in an attempt to persuade the applicant not to refuse medical care (see paragraphs 22 and 26 above). The authorities' openness to dialogue with the applicant is also confirmed by their offers to the applicant of alternative medical facilities for the purpose of medical examinations. However, even when the examinations were performed in full compliance with the applicant's demands and at a hospital of his choice, he still refused to follow the doctors' instructions in their entirety.

79. The Court is of the opinion that, in the absence of any evidence that the applicant's refusals were the result of coercion or manipulation by outsiders or of his insufficient knowledge of the risks faced, as well as in the absence of any indication that the progress of his illness was such as to endanger himself or others, the authorities had no choice ultimately but to accept the applicant's decision to decline medical services. Patients, such as the applicant, have the responsibility to communicate and cooperate with health authorities, to follow treatment and to contribute to community health. The Court does not lose sight of the fact that the applicant's refusals to undergo treatment or medical examinations were occasionally linked to his requests for those procedures to be performed in a particular medical establishment. In this respect, the Court would like to reiterate its constant jurisprudence according to which a State has a sufficient margin of discretion in defining the manner in which it fulfils its obligation to provide detainees with the requisite medical assistance, *inter alia*, by choosing an appropriate medical facility, taking into account "the practical demands of imprisonment" as long as the standard of chosen care is "compatible with the human dignity" of a detainee (see *Aleksanyan*, cited above, § 140). There is no indication in the file that the authorities' choice of medical facility for the applicant was incompatible with the required standard of care.

80. Having regard to the above findings, the Court is unable to conclude that the applicant was deprived of medical assistance in respect of his tuberculosis in the period after September 2004. In reaching this conclusion the Court also does not lose sight of the fact that the occasional medical

examinations to which the applicant did consent did not reveal any deterioration of his health during the period under examination. Furthermore, the applicant, who is no longer detained, did not provide any evidence in support of his claim that his condition had worsened. Accordingly, there has been no violation of Article 3 of the Convention on account of the alleged failure to provide him with requisite medical care after September 2004.

II. OTHER ALLEGED VIOLATIONS OF THE CONVENTION

81. Lastly, the Court has examined the other complaints submitted by the applicant. However, having regard to all the material in its possession, and in so far as these complaints fall within the Court's competence, it 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 must be rejected as being manifestly ill-founded, pursuant to Article 35 §§ 3 and 4 of the Convention.

III. APPLICATION OF ARTICLE 41 OF THE CONVENTION

82. 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

83. The applicant claimed 70,000 euros (EUR) in respect of non-pecuniary damage.

84. The Government averred that the applicant had failed to submit any proof that the damage had in fact been incurred. They further noted that the requested sum was in any case excessive.

85. The Court reiterates, firstly, that the applicant cannot be required to furnish any proof of the non-pecuniary damage he sustained (see *Gridin v. Russia*, no. 4171/04, § 20, 1 June 2006). It further notes that it has found a serious violation of the Convention in the present case. In these circumstances the Court considers that the applicant's suffering and frustration caused by the inhuman conditions of his detention and the fact that he did not receive adequate medical assistance in detention, cannot be compensated for by a mere finding of a violation. However, the sum claimed by the applicant appears to be excessive. Making its assessment on

an equitable basis, it awards the applicant EUR 18,000 in respect of non-pecuniary damage, plus any tax that may be chargeable on that amount.

B. Costs and expenses

86. The applicant did not claim costs and expenses. Accordingly, there is no call to make an award under this head.

C. Default interest

87. The Court considers it appropriate that the default interest 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 the applicant's belated diagnosis with tuberculosis and allegedly inadequate medical care during his imprisonment in the correctional colony admissible and the remainder of the application inadmissible;

2. *Holds* that there has been a violation of Article 3 of the Convention on account of the authorities' failure to duly diagnose the applicant with tuberculosis and comply with their responsibility to ensure adequate medical assistance for him during his detention in the correctional colony before 1 September 2004;

3. *Holds* that there has been no violation of Article 3 of the Convention on account of the quality of the medical care afforded to the applicant in detention after 1 September 2004;

4. *Holds*
   (a) that the respondent State is to pay the applicant, within three months from the date on which the judgment becomes final in accordance with Article 44 § 2 of the Convention, EUR 18,000 (eighteen thousand euros) in respect of non-pecuniary damage, to be converted into Russian roubles at the rate applicable at the date of the 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;

5. *Dismisses* the remainder of the applicant's claim for just satisfaction.

Done in English, and notified in writing on 5 April 2011, pursuant to Rule 77 §§ 2 and 3 of the Rules of Court.

Søren Nielsen	Nina Vajić
Registrar	President