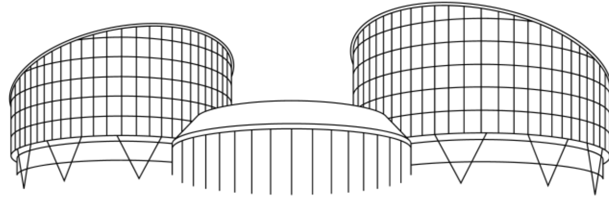

EUROPEAN COURT OF HUMAN RIGHTS
COUR EUROPÉENNE DES DROITS DE L'HOMME

FIRST SECTION

CASE OF PAKHOMOV v. RUSSIA

(Application no. 44917/08)

JUDGMENT

STRASBOURG

30 September 2010

FINAL

30/12/2010

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

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

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

Christos Rozakis, *President,*
Nina Vajić,
Anatoly Kovler,
Elisabeth Steiner,
Khanlar Hajiyev,
Giorgio Malinverni,
George Nicolaou, *judges,*
and Søren Nielsen, *Section Registrar,*

Having deliberated in private on 9 September 2010,

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

PROCEDURE

1. The case originated in an application (no. 44917/08) 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 Anton Valeryevich Pakhomov ("the applicant"), on 21 July 2008.

2. The applicant, who had been granted legal aid, was represented by Mr S. Onishchenko, a lawyer practising in Vladivostok. The Russian Government ("the Government") were represented by Mr G. Matyushkin, Representative of the Russian Federation at the European Court of Human Rights.

3. The applicant alleged, in particular, that his conviction for drug trafficking had been based on statements by an anonymous witness and prosecution witnesses whom he had been unable to confront in open court. In addition, in a letter of 9 June 2009 requesting priority treatment for his application, the applicant complained of serious deterioration of his health in view of the absence of adequate medical assistance.

4. Further to the applicant's request, on 16 June 2009 the Court granted priority to the application (Rule 41 of the Rules of Court).

5. On 23 September 2009 the President of the First Section decided to give notice of the application to the Government. It was also decided to examine the merits of the application at the same time as its admissibility (Article 29 § 1).

THE FACTS

I. THE CIRCUMSTANCES OF THE CASE

6. The applicant was born in 1980 and lives in the town of Artyom, Primorye Region.

A. Criminal proceedings against the applicant

7. On 27 April 2007 a group of police officers entered the applicant's flat, intending to search it. The applicant, who had been offered the opportunity to hand over any illegal substances before the search, handed the police officers 2.5 grams of tobacco and marijuana compound. No other illegal substances or money were found during the subsequent search of the flat carried out by the police. The applicant was arrested and taken to the Artyom town temporary detention centre, where a police investigator, Mr S., informed him that he had been arrested on suspicion of selling drugs to an anonymous person, whom the police called Mr I., during a police-controlled purchase on 27 February 2007. The investigator also notified the applicant of an identification parade scheduled for the following day, in which Mr I. was to participate.

8. On 28 April 2007 the applicant was taken to the Artyom Town Department of the Federal Service for Drug Control where he remained handcuffed to a heating device for several hours. The identification parade did not take place.

9. On the same day the Artyom Town Court authorised the applicant's placement in custody for two months. He was transferred to temporary detention facility no. IZ-25/1 in Vladivostok.

10. In the middle of May 2007 the applicant was notified of another charge brought against him. The prosecution authorities accused him of selling drugs to Mr I. on another occasion, namely 9 March 2007.

11. On 11 June 2007 the police investigator, Mr S., served the applicant and his lawyer with a bill of indictment. The investigation offered the following version of events on which the charges against the applicant were grounded. According to the investigating authorities, on an unspecified date an anonymous person, whose personal data could not be disclosed and who was called "Mr I.", approached a police officer, Mr Za., and informed the latter that he could buy drugs from the applicant. The police officer Za. decided to act on the information received from Mr I. and organised a police-controlled purchase of drugs. He invited two soldiers serving in the local military unit, Mr K. and Mr M., to act as lay witnesses during the purchase. On 27 February 2007 police officer Za., accompanied by another police officer, Mr G., two lay witnesses, Mr K. and Mr M., and Mr I., drove

to the applicant's house. On arrival to the applicant's block of flats, officer Za. gave Mr I. money to purchase drugs from the applicant. Serial numbers of the bills were recorded in advance. Mr I., accompanied by Mr K., left the car and went to the applicant's flat. Mr K. did not enter the flat, waiting for Mr I. on the ground floor. Mr I. spent approximately fifteen minutes in the applicant's flat. After he had returned to the car, Mr I. handed the police officers a package containing 2.08 grams of a substance, later identified by forensic experts as a compound of tobacco and cannabis, and stated that he had bought drugs from the applicant. The investigating authorities also insisted that the same sequence of events, albeit with the participation of other lay witnesses, Mr Se. and Mr B., occurred on 9 March 2007.

12. On 16 October 2007 the applicant's lawyer recorded a conversation with a Mr A., who insisted that he could identify Mr I. According to Mr A., in the middle of March 2007 he had met with the person identified as Mr I. The latter had told Mr A. that he had framed the applicant in a drug case. According to Mr I., the police had arrested him when he was carrying drugs and as a result he had been forced to participate in two police-controlled drug purchases. Mr I. allegedly explained that he had kept the money which the police officers had given him for drug purchases and in return he had allegedly given the police officers drugs which he had hidden in advance behind a heating device in the hall near the applicant's flat.

13. On 14 December 2007 the Artyom Town Court found the applicant guilty of two counts of attempted drug trafficking and one count of drug possession, and sentenced him to eight years' imprisonment. The conviction was based on the following evidence:

- statements by Mr I., given during the pre-trial investigation and read out in open court, despite the applicant's objection. In those statements Mr I. gave a detailed description of the events on 27 February and 9 March 2007 pertaining to his participation in the police-controlled purchases of drugs from the applicant. As follows from the Town Court's judgment, Mr I.'s personal data were not disclosed to the applicant. Mr I.'s absence from trial hearings had been considered “exceptional”. Having cited no reasons which could justify Mr I.'s absence from the court hearing, the Town Court held that the absence was prompted by “exceptional circumstances”. On a number of occasions the defence unsuccessfully asked the Town Court to disclose Mr I.'s identity.

- statements made in open court by Ms M. and Ms D., lay witnesses who had assisted the police officers during the search of the applicant's flat on 27 April 2007. Both Ms M. and Ms D. confirmed that the applicant had voluntarily turned over to the police officers a small package of a substance containing marijuana.

- statements made in a trial hearing by Mr Se., who had acted as a lay witness during the police-controlled purchase of drugs from the applicant on 9 March 2007. Mr Se. explained that on a request from a police

officer he had followed Mr I. to the door of the applicant's flat. Mr I. had spent several minutes in the flat. After Mr I. left the flat he had a small package, which he gave to the police officers.

- statements given by another lay witness, Mr B., during the pre-trial investigation and read out in open court with the parties' consent. Mr B.'s statements were similar to those given by Mr Se.

- statements by Mr K., a lay witness who had participated in the police-controlled purchase of drugs from the applicant on 27 February 2007. Those statements were given by Mr K. during an interview with an investigator and read out in a trial hearing. The Town Court, without providing any further details, held that reasons for Mr K.'s absence from the trial were "exceptional". In his statements Mr K. provided a detailed description of events on 27 February 2007 and corroborated the prosecution's version.

- statements by police officer Za., made in open court. The police officer set out an account of events on 27 February, 9 March and 27 April 2007, insisting that on the first two dates Mr I. had purchased drugs from the applicant during the police-controlled operations and that on the later date drugs had been found in the applicant's flat during the search.

- report on a body search of Mr I. on 27 February 2007 showing that Mr I. had had no illegal substances or money on him before he took part in the police-controlled purchase of drugs from the applicant.

- report drawn up by police officer Za. on 27 February 2007 showing that the latter had given Mr I. four 100-rouble bills to purchase drugs from the applicant;

- report of 27 February 2007 indicating that on his return from the applicant's flat Mr I. had handed the police officers a package containing a phytogenous substance.

- an expert report confirming that the substances which Mr I. had handed to the police officers during the police-controlled operations on 27 February and 9 March 2007 contained cannabis.

- an expert report, according to which cannabis handed over by Mr I. to the police on 27 February and 9 March 2007 most probably had the same origin. However, the cannabis which the applicant voluntarily turned over to the police during the search of his flat was from a different batch.

14. On request by the defence the Town Court heard a number of witnesses and rejected their testimony as unreliable. Two defence witnesses testified that they had visited the applicant on 9 March 2007 and had been in his flat at the time when the police had allegedly performed the controlled drug purchase. They insisted that no one had visited the applicant's flat when they had been there and that the applicant had not sold drugs to anyone. Another witness testified that she had been in the applicant's flat with her brother on 27 February 2007 at the time of the alleged drug purchase. She stressed that there had been no other visitors. The Town

Court interviewed Mr So., the head of the military unit where lay witnesses Mr K. and Mr P. had been performing military service. Mr So. stated that, on a written request from the applicant's lawyer, he had had a conversation with Mr K., who had insisted that he had not seen Mr I. entering the applicant's flat. The Town Court also studied a statement written by Mr K. at the end of that conversation. Mr K. confirmed that after Mr I. had approached the door of the applicant's flat he had ordered Mr K. to go down to the ground floor and thus Mr K. had been unable to observe Mr I. entering the flat. The Town Court refused to call Mr A., whom the applicant had asked to be questioned about Mr I.'s identity.

15. The applicant's lawyer appealed against the conviction, arguing, *inter alia,* that the Town Court had read out statements by Mr I. and Mr K., disregarding the objection by the defence to that effect, and that it had refused to hear Mr A.

16. On 3 March 2008 the Primorye Regional Court upheld the judgment of 14 December 2007, endorsing the reasons given by the Town Court. As regards the applicant's argument concerning the statements by Mr I. and Mr K., the Regional Court held as follows:

> “The [Town] court read out the statements by Mr I. and Mr K. in open court, complying with the requirements of Article 281 of the Russian Code of Criminal Procedure, because the [Town] court found that the reasons for their absence from the hearings were exceptional and [it] issued a reasoned judgment to that effect.”

The Regional Court also concluded that the Town Court had rightfully dismissed the applicant's and his lawyer's requests for the disclosure of Mr I.'s identity.

17. On 15 January 2010 the Presidium of the Primorye Regional Court, by way of a supervisory review, quashed the judgments of 14 December 2007 and 3 March 2008 in the part concerning the applicant's conviction for drug trafficking, and upheld the conviction for possession of drugs found in his flat during the search. It stressed that having based, to a substantial degree, the applicant's conviction for drug trafficking on statements by witnesses whom the applicant had been unable to confront in open court, including the anonymous witness I. and a lay witness K., the domestic courts had violated Article 6 § 3 (d) of the European Convention for the Protection of Human Rights and Fundamental Freedoms. The Presidium concluded that there was no evidence that the applicant was guilty of drug trafficking. Having acquitted the applicant of that charge, the Presidium reduced his sentence to two years' imprisonment and authorised his immediate release, as he had already served the entire sentence. The Presidium also confirmed the applicant's right to rehabilitation.

B. Medical assistance during imprisonment

18. The following account has been drawn up from the medical records submitted by the Government.

19. In 2003 the applicant was diagnosed with pulmonary tuberculosis. He underwent treatment in a tuberculosis hospital in Artyom.

20. On 28 April 2007, on his admission to temporary detention facility no. IZ-25/1, the applicant informed an attending prison doctor that he had tuberculosis and complained of a cough and general fatigue. The doctor noted in the admission record that an examination by a tuberculosis specialist was required.

21. Three days later the applicant underwent an X-ray examination which revealed the presence of a tuberculoma, measuring two centimetres in width and three centimetres in length, in the upper lobe of the left lung and dense foci in the right lung. On the basis of the X-ray examination the tuberculosis specialist recorded the following diagnosis in the applicant's medical history: "large residual changes in the form of a tuberculoma on the left and dense foci on the right after the recent tuberculosis; "D" control is not required; R-control should be carried out twice a year". The next X-ray exam was prescribed for a month later.

22. On 29 June 2007 the applicant received the second chest X-ray examination, which showed no relapse.

23. On 13 July 2007 the applicant requested to see a prison doctor to whom he complained of fatigue, a high temperature in the evenings and excessive sweating. The doctor diagnosed the applicant with acute viral respiratory infection, authorised a number of analyses, including general blood and urine tests, sputum analysis and a survey X-ray exam, and prescribed treatment with floracyd, a cough medicine and multivitamins.

24. A survey X-ray examination performed on 16 July 2007 revealed the reactivation of the tuberculosis and the need for in-patient treatment for the applicant. The doctor's diagnosis was "infiltrative tuberculosis on the right side".

25. On 17 July 2007 the applicant was transferred to the pulmonary tuberculosis ward of the medical department in the detention facility, where he remained until 3 April 2008. On 19, 20 and 23 July 2007 bacteriological sputum tests were performed by way of bacterioscopy, and showed no mycobacterium tuberculosis ("MBT"). Subsequently similar tests were performed once a month, each time producing negative results. On 23 July 2007 a sputum sample taken for culture turned out positive. At the same time results of the applicant's drug susceptibility testing ("DST") were made available to the facility medical personnel, guiding the choice of the applicant's treatment regimen. Between 17 July 2007 and 25 March 2008 the applicant was subjected to an intensive chemotherapy regimen, comprising a number of drugs: isoniazid, pyrazinamide, rifampicin,

ethambutol, streptomycin, phosphoglif and multivitamins. During the initial stage of the treatment the applicant adhered to a strict medication regime, having received ninety doses of anti-bacteriological medicines. An intake of every dose was observed by the facility medical staff. Attending tuberculosis specialists examined the patient once in three or four days in view of identifying whether a correction of the drug regimen was necessary. Monthly clinical blood and urine analyses were also carried out. Every two months the applicant received chest radiography. Liver examinations were conducted regularly.

26. After a sputum culture testing had showed that the applicant was no longer smear positive and similar results had been received by way of sputum smear bacterioscopy at completion of the intensive phase of the treatment, the continuation phase of the therapy commenced, comprising treatment with isoniazid, rifampicin and ethambutol ("HRE regimen").

27. The applicant's medical history contained a number of entries made by attending tuberculosis specialists, recording the applicant's negative attitude towards the treatment and his refusal to take anti-bacteriological medicines on at least five occasions. The attending doctors had conversations with the applicant, persuading him to continue the treatment and warning about a possible relapse of the illness or development of severe multi-drug-resistant tuberculosis. In addition, during examinations doctors occasionally reminded him of the negative effects of treatment interruption.

28. Following the applicant's final conviction on 3 March 2008, on 3 April 2008 the applicant was discharged from the medical department of the detention facility with a final diagnosis of infiltrative tuberculosis of the right lung in the resolution and consolidation phase and recommendations to continue treatment on an HRE regimen with a daily special dietary food ration. He was sent for subsequent treatment to Specialised Medical Establishment no. 47 ("the tuberculosis hospital") for prisoners suffering from tuberculosis, located in the Primorye Region.

29. On 7 April 2008, on admission to the tuberculosis hospital, the applicant was examined by a tuberculosis specialist. A clinical blood analysis and sputum smear bacterioscopy were performed. It was decided to continue the extension phase of the medicine regimen as prescribed by medical specialists of the detention facility. A chest X-ray examination and sputum culture testing were scheduled to be performed at the end of the extension phase. The applicant was also assigned a special diet.

30. Once a month the applicant received a full medical examination. Each time the attending tuberculosis specialists recorded the total number of doses of anti-bacteriological medicines taken by the applicant. Clinical blood and urine tests were performed every three months. A sputum smear was regularly taken for bacterioscopy testing, revealing no presence of MBT. The applicant's medical record also showed that medical personnel

discussed with the applicant the necessity of the treatment and adherence to a strict medical regimen.

31. On 25 February 2009 the applicant was examined by a medical panel comprising a number of medical specialists. Having studied his medical records, including results of three most recent X-ray examinations, blood and urine analysis and sputum smear tests, the panel issued the following diagnosis: "clinical recovery from infiltrative pulmonary tuberculosis accompanied by the presence of extensive post-tuberculosis changes in the form of foci and fibrous foci... in both lungs". A schedule showing future medical procedures and their frequency was developed. The applicant was also prescribed seasonal retreatment courses with isoniazid, ethambutol and vitamins, to prevent relapse of the illness.

32. On 7 April 2009 the applicant was transferred to correctional colony no. 20. On arrival he was examined by a colony physician, who diagnosed the applicant with acute maxillary sinusitis for which he received treatment between 7 and 20 April 2009. As follows from the applicant's medical history, the correctional colony medical staff complied fully with the recommendations issued by the specialists of the tuberculosis hospital in respect of medical tests and anti-relapse treatment for the applicant.

II. RELEVANT DOMESTIC LAW

A. 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 principles of legality, compliance with the rights of an 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 is provided to citizens when they voluntarily apply [for such aid] or when they consent [to such aid], safe 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 receive such an aid in medical anti-tuberculosis facilities, licensed to provide [that aid].

2. Individuals who are or have been in contact with an individual suffering from tuberculosis should undergo an examination for detection of tuberculosis in compliance with requirements of law of the Russian Federation...”

Section 9. Regular medical examinations

1. Regular medical examinations of persons suffering from tuberculosis is performed in compliance with the procedure laid down by a respective federal executive body...

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

3. A medical commission appointed by the head of a medical anti-tuberculosis facility... takes a decision authorising regular medical examinations or terminating them and records such a decision in medical documents...; an individual in respect of whom such a decision has been issued, is 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 detection of tuberculosis or avoid treating it, should be admitted, by a 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, 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 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 must;

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 suffering from tuberculosis [visit them].”

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

“4. Individuals... suffering from tuberculosis should 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*

33. Russian law gives detailed guidelines for provision of medical assistance to detained individuals. These guidelines, found in the joint Decree of the Ministry of Health and Social Development and the Ministry of Justice no. 640/190 on Organisation of Medical Assistance to Individuals Serving Sentences or Detained (“the Regulation”), enacted on 17 October 2005, are applicable without exception to all detainees. 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 should 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 and those in need of urgent medical assistance. Particular attention should 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 X-ray. 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.

34. Subsequent medical examinations of detainees are performed at least twice a year or on detainees' complaints. 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 comprehensively informed about the results of the medical examinations.

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

36. 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.

37. 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, 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. The prophylactic and anti-relapse treatment of tuberculosis patients should be performed 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 impacts of the refusal should follow. Detainees suffering from tuberculosis should also be transferred to a special dietary ration.

3. Anti-Tuberculosis Decree

38. 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 “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 of tuberculosis which conform to 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; laid down rules on vaccination; determined courses and regimens of therapy for particular categories of patients, and so on.

39. 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 set 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).

B. Witness testimony in criminal cases

Code of Criminal Procedure of the Russian Federation of 18 December 2001, in force since 1 July 2002 ("new CCrP")

40. Article 281 of the new CCrP, in so far as relevant, reads as follows:

> "1. Testimony previously given by a victim or witness during the preliminary investigation or at the trial may be read out... if the victim or witness fails to attend, subject to the parties' consent, save in cases listed in the second part of the present Article.
>
> 2. If a victim or witness fails to appear in court, the court may, at a party's request or on its own initiative, read out statements previously given by them in the following cases:
>
> 1) victim's or witness's death;
>
> 2) grave illness precluding attendance at a court hearing;
>
> 3) refusal by a victim or witness who is a national of a foreign State to attend a hearing when summoned by the court;
>
> 4) natural disaster or any other emergency case precluding attendance at a court hearing."

C. Right to rehabilitation following acquittal

41. The relevant provisions of the new CCrP read as follows:

Article 134. Acknowledgment of the right to rehabilitation

> "1. A court in its judgment.... acknowledges the right to rehabilitation for an individual who has been acquitted... At the same time the rehabilitated [person] should have explained to them the procedure for compensation for damage pertaining to criminal prosecution...."

Article 135. Compensation for pecuniary damage.

“1. Compensation for pecuniary damage to a rehabilitated [person] includes:

1) salary, pension, allowances and other sources of income which he lost as a result of the criminal prosecution;

2) his property confiscated or seized by the State on the basis of the judgment by which he had been convicted...;

3) fines and legal costs and expenses which he paid in compliance with the court's judgment;

4) sums paid by him for provision of legal services...;

5) other expenses.

2. At any moment during the limitation period established by the Russian Civil Code and after the rehabilitated [person] received a copy of the judgment [by which he had been acquitted]... he has the right to apply to [the court which had issued the judgment] with a demand to compensate him damage...

...

4. No later than a month after the demand for compensation was received, the court... must determine its amount and issue a decision authorising the payment in compensation for that damage. That payment should take into account the inflation rate. ...”

Article 136. Compensation for non-pecuniary damage.

“1. A prosecutor should give an official apology in the name of the State to the rehabilitated [person] for damage caused to him.

2. An action for compensation for non-pecuniary damage should be brought within civil judicial proceedings....”

Article 138. Restoration of other rights of a rehabilitated [person].

“1. Restoration of labour, pension, housing and other rights of a rehabilitated [person] should be performed in compliance with [the CCrP] established for execution of court judgments....”

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")

42. 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”)

43. 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*

44. A further elaboration of European expectations towards 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 of 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 undertaken 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*

45. 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*

46. 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 held 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. Reports on the Russian Federation

1. The CPT Report on Russia

47. 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

48. 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 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 (phluorography). Specificity, sensitivity, and cost-effectiveness considerations were not features of this approach. Bacille Calmette-Guerin (BCG) immunization was a key feature of the TB...

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 into 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

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

"Previously treated patients may have acquired drug resistance. They are more likely than new patients to harbour and excrete bacilli resistant to at least isoniazid. The re-treatment regimen consists of initially 5 drugs, with 3 drugs in the continuation phase. The patient receives at least 2 drugs in the initial phase which are still effective. This reduces the risk of selecting further resistant bacilli....

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.”

50. In the fourth edition of the *Guidelines,* published in 2009, the WHO recommended as follows:

> “DST [a drug susceptibility testing] before or at the start of therapy is strongly recommended for all previously treated persons.” (p. 11)

THE LAW

I. PRELIMINARY CONSIDERATIONS

51. The Court observes at the outset that in his application to the Court the applicant complained that the criminal proceedings leading to his conviction for drug trafficking were unfair. In a subsequent letter received by the Court on 9 June 2009 he successfully requested the Court to treat his application as a priority, alleging that Russian prison authorities, although fully aware that he was suffering from tuberculosis, did not provide him with adequate medical treatment. In his observations, lodged with the Court in April 2010, the applicant, while maintaining his health-related complaint, adduced an alternative complaint. In particular, he complained that on his admission to facility no. IZ-25/1 he had been a healthy person as tuberculosis had been “completely cured” and that the Russian authorities had failed to safeguard his health as a relapse of the illness had been caused by appalling conditions of his detention in that facility.

52. In this connection the Court reiterates that it has jurisdiction to review, in the light of the entirety of the Convention's requirements, the circumstances complained of by an applicant. In the performance of its task, the Court is free to attribute to the facts of the case, as established on the evidence before it, a characterisation in law different from that given by the applicant or, if need be, to view the facts in a different manner. Furthermore, it has to take into account not only the original application but also the additional documents intended to complete the latter by eliminating initial omissions or obscurities (see *Ringeisen v. Austria*, 16 July 1971, § 98, Series A no. 13, as compared with § 79 and §§ 96-97 of that judgment).

53. Turning to the present case, the Court observes that the new complaint pertaining to the conditions of the applicant's detention from 28 April 2007, when he was placed in detention facility no. IZ-25/1, to 17 July 2007, when he was transferred to the pulmonary tuberculosis ward

of the medical department, was submitted after notice of the initial application had been given to the Government on 23 September 2009. In the Court's view, the new complaint raised under Article 3 of the Convention is not an elaboration of his original complaints lodged with the Court almost two years earlier, on which the parties have already commented. The Court therefore decides not to examine the new complaint within the framework of the present proceedings (see *Nuray Şen v. Turkey (no. 2)* judgment of 30 March 2004, no. 25354/94, § 200; *Melnik v. Ukraine*, no. 72286/01, §§ 61-63, 28 March 2006; *Kravchenko v. Russia*, no. 34615/02, §§ 26-28, 2 April 2009; and *Isayev v. Russia*, no. 20756/04, §§ 81-83, 22 October 2009).

II. ALLEGED VIOLATION OF ARTICLE 3 OF THE CONVENTION

54. The applicant complained under Article 3 of the Convention that the detention authorities had failed to take steps to safeguard his health and well-being, having failed to provide him with adequate medical assistance in respect of his tuberculosis. Article 3 reads as follows:

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

A. Submissions by the parties

55. The Government submitted that the Russian authorities had taken all appropriate measures to safeguard the applicant's health. On admission to detention facility no. IZ-25/1 the applicant was examined by a prison doctor. Having studied the applicant's medical history and having learnt that he had had tuberculosis since 2003, the doctor placed the applicant under proactive medical supervision which included regular medical check-ups, X-ray examinations, clinical analysis and so on. When a relapse of the illness was recorded, the applicant was immediately moved to the pulmonary tuberculosis ward of the facility medical department. The treatment administered to the applicant by the prison doctors corresponded to that laid down by the Anti-Tuberculosis Decree (see paragraphs 38 and 39 above) which in its turn conformed to recommendations given by the World Health Organisation for treatment of tuberculosis (see paragraph 49 above). Positive elements in the progress of the applicant's illness were recorded by the medical personnel during the treatment. The treatment resulted in clinical recovery from tuberculosis. At the same time, despite the positive effect of the treatment, the doctors continued their supervision, assigning the applicant to regular medical examinations and procedures, and providing him with seasonal further courses of anti-tuberculosis treatment,

to avoid a relapse. In addition, the applicant was provided with a specialised enriched food regimen.

56. The applicant stressed that he had acquired his illness in 2003. He underwent necessary treatment and the illness was rendered inactive. It was not until his arrest that his health seriously deteriorated in view of the complete absence of medical attention. As a result, he relapsed and he was forced to undergo painful and stressful treatment, including agonising chemotherapy, for almost two years. Moreover, the medical personnel of the detention facilities ignored his complaints and requests. The proper treatment was only administered after intervention by the applicant's lawyer.

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 43 above). However, the Court does not always adhere to this standard, at least when it comes to medical assistance for convicted prisoners (as opposed to those in pre-trial detention). While acknowledging that 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*, cited above, §§ 104-106; 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), 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[ian] 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. The Court reiterates that it was not in dispute between the parties that the applicant had contracted tuberculosis in 2003, long before his arrest and placement in detention facility no. IZ-25/1 in April 2007. According to the applicant, when he learned about the infection he underwent treatment in a tuberculosis hospital in his home town. Although the Government did not comment on the outcome of the treatment, they did not dispute the applicant's assertion that the treatment had been a success, resulting in his recovery from active tuberculosis. In any event, medical records produced by the Government confirm that no signs of reactivation of the illness were recorded on the applicant's admission to facility IZ-25/1. In this respect, the Court would like to stress already at this juncture that the medical assessment of the applicant conducted during his first days in the detention facility appear to comply fully with international standards of tuberculosis control policy in prisons, a recognised setting for transmission of tuberculosis (see paragraphs 43- 45 above). In particular, the Court notes that the applicant was seen without delay by an attending prison doctor, who studied his medical history, recorded complaints, organised a meeting with a tuberculosis specialist and scheduled an X-ray examination. The doctor's recommendations were promptly put into practice. Subsequent X-ray exams were also performed without undue delay.

65. However, despite the steps taken by the facility administration which the Court interprets as their evident commitment to control tuberculosis, the applicant suffered a relapse of the illness less than three months after his arrival in the facility. While the cause of the reactivation of the illness is not the subject matter of the Court's examination (see paragraphs 51-53 above), it considers it necessary to reiterate 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 prevention and 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.). This principle should certainly be extrapolated to the case of the

applicant, who suffered a relapse of tuberculosis after his admission to the detention facility. Absent or inadequate treatment for tuberculosis, particularly when the disease has been contracted or reactivated in detention, is most certainly a subject of the Court's concern. The Court is therefore bound to assess the quality of medical services rendered to the applicant in the present case.

66. Having studied the applicant's medical records produced by the Government, the authenticity and reliability of which the applicant did not dispute, the Court has already established that after admission to the detention facility the applicant was under constant medical supervision. After the early symptoms of the reactivation of the disease, such as fatigue, excessive sweating and high temperature, began to manifest themselves and subsequent medical examinations, including a survey X-ray exam, revealed a relapse of the illness, the applicant was promptly transferred for in-patient treatment to the pulmonary tuberculosis ward of the medical department in the detention facility. In this respect the Court does not lose sight of the timely and active screening actions of the facility medical personnel in identifying the reactivation of the applicant's infection, a cornerstone measure in the modern strategy of tuberculosis control and treatment.

67. The Court further observes that the quality of the treatment provided to the applicant following the detection of the tuberculosis relapse appears to be adequate. In particular, the evidence put before the Court shows that the Russian authorities employed all existing tools (sputum smear bacterioscopy, culture testing and chest X-ray exams) for correct diagnosis of the applicant, having considered the extent of the disease and determined the tuberculosis severity to prescribe appropriate therapy. In particular, it did not escape the Court's attention that a drug susceptibility test had been performed at the initial stage of the diagnostic process, in line with the WHO's most recent recommendations (see paragraph 50 above). The test not only allowed efficiently finalising diagnostic procedures and allocating the applicant's case to standardised treatment category, but also guided the choice of appropriate regimen adjustments given the results of the test. At the same time the Court is satisfied that the DST did not delay the start of the applicant's treatment.

68. 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 WHO for re-treatment cases, 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 within 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 detention authorities also effectively

implemented the doctors' recommendations of a special dietary ration necessary for the applicant to improve his health (see, by contrast, *Gorodnitchev v. Russia*, no. 52058/99, § 91, 24 May 2007).

69. Furthermore, the Court attributes particular weight to the fact that the facility administration not only ensured that the applicant was attended by doctors, his complaints were heard and he was prescribed a trial of anti-tuberculosis medication, but 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 re-treatment regimen as required by the DOTS strategy (see paragraph 49 above). In addition, in a situation when the authorities met with the applicant's occasional refusal to cooperate and his resistance to the treatment 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 interruption of treatment or 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 authorities' actions permitted the applicant's adherence to the treatment and compliance with the prescribed regimen to be assured, a key factor in tuberculosis treatment success.

70. After conviction, which made the applicant's continued detention in facility IZ-25/1 impossible, he was transferred to the tuberculosis hospital. The medical records pronouncing the applicant's diagnosis on his discharge as “infiltrative tuberculosis of the right lung in the resolution and consolidation phase”, as well as negative results of sputum smear examinations, showed positive dynamics of the applicant's treatment, meaning that he was recovering. The applicant's transfer to the tuberculosis hospital was accompanied by recommendations from doctors of the detention facility no. IZ-25/1 to continue HRE treatment regimen. The Court is particularly mindful of the fact that without bluntly accepting the recommendations of the facility medical personnel, the tuberculosis hospital specialists gave an independent assessment of the applicant's case on the basis of the clinical examinations, radiography and bacteriological tests performed in the hospital. Recommendations of the detention facility doctors having been considered valid, the applicant continued the prescribed treatment regimen. Nothing in the case file can lead the Court to the conclusion that the applicant did not receive comprehensive medical assistance during that stage of his tuberculosis treatment. The list of tests submitted by the Government included regular X-ray exams, sputum smear tests, further clinical analysis and examinations by tuberculosis specialists. The applicant did not deny that medical supervision had been provided and tests had been carried out in the tuberculosis hospital, or that the prescribed

medication had been provided, as indicated in the medical records submitted by the Government. In fact, he did not indicate any defect in his medical care in the tuberculosis hospital.

71. Finally, after the completion of the treatment resulting in the applicant's "clinical recovery from infiltrative pulmonary tuberculosis" he remained under medical supervision aimed at prevention of a relapse of the illness. A detailed list of future medical procedures to follow up on the applicant's condition and effectiveness of the treatment was drawn up and seasonal retreatment courses were prescribed. As it appears from the parties' submissions, the administration of the colony where the applicant had been sent from the tuberculosis hospital followed through with the anti-relapse recommendations.

72. To sum up, the Court considers that the Government provided sufficient evidence to enable it to conclude that the applicant received comprehensive, effective and transparent medical assistance in respect of his tuberculosis. Accordingly, there has been no violation of Article 3 of the Convention on account of the alleged failure to provide the applicant with requisite medical care during his imprisonment.

III. ALLEGED VIOLATION OF ARTICLE 6 OF THE CONVENTION

73. The applicant complained that while finding him guilty of drug trafficking the domestic courts had relied heavily on statements by the anonymous witness, Mr I., and a prosecution witness, Mr K., whom he had been unable to confront in open court. He relied on Article 6 of the Convention, which, in so far as relevant, reads as follows:

> "1. In the determination of ... any criminal charge against him, everyone is entitled to a fair ... hearing ... by [a] ... tribunal ...
>
> ...
>
> 3. Everyone charged with a criminal offence has the following minimum rights:
>
> ...
>
> (d) to examine or have examined witnesses against him and to obtain the attendance and examination of witnesses on his behalf under the same conditions as witnesses against him;"

A. Submissions by the parties

74. The Government argued that the domestic authorities had taken steps to remedy the alleged violation. In particular, on 15 January 2010 the Presidium of the Primorye Regional Court quashed the applicant's conviction for drug trafficking and pronounced him innocent on that charge

in view of the lack of evidence of criminal conduct. As a consequence, the applicant's sentence was decreased to two years and he was released, having served the entire sentence. Moreover, the applicant acquired the right to rehabilitation, enabling him, *inter alia,* to seek compensation for unlawful conviction and detention.

75. The applicant maintained his complaint.

B. The Court's assessment

Admissibility

76. The Court reiterates that under Article 34 of the Convention it is entitled to receive applications from persons, non-governmental organisations or groups of individuals "claiming to be the victim of a violation" by a High Contracting Party of the rights contained in the Convention and its Protocols. In situations where an alleged violation has already occurred, subsequent events can give rise to a loss of the status of "victim", provided that the national authorities have acknowledged, either expressly or in substance, and then afforded redress for, the breach of the Convention (see, among other authorities, *Amuur v. France*, 25 June 1996, § 36, *Reports of Judgments and Decisions* 1996-III).

77. Turning to the facts of the present case, the Court observes that on 15 January 2010 the Presidium of the Primorye Regional Court expressly acknowledged that the Artyom Town Court, which had heard the applicant's criminal case and had issued the judgment of 14 December 2007, and the Primorye Regional Court, which had examined the case on appeal and upheld the conviction of drug trafficking in the judgment of 3 March 2008, had committed a violation of Article 6 § 3 (d) of the Convention, having grounded their findings to a substantial degree on statements by witnesses, including Mr I. and Mr K., who had never been heard in open court. The Presidium quashed the conviction for drug trafficking, having found that there was no evidence of the applicant's guilt. The effect of the proceedings which formed the basis for the applicant's complaints has thus also been quashed (see *Ryabov v. Russia*, no. 3896/04, § 50, 31 January 2008).

78. The Court further notes that following the judgment of 15 January 2010, when the applicant's sentence was reduced to two years in view of his remaining conviction for drug possession, the applicant was released without delay. In addition, by virtue of the Presidium's judgment he acquired the right to rehabilitation which, and it was not disputed by the applicant, enabled him to seek compensation for damages resulting from his conviction for drug trafficking and detention and to claim restoration of other rights, if they had been infringed as a result of the detention and conviction (see paragraph 41 above). While the Court notes that there is no

evidence in the file that the applicant has made use of his right to rehabilitation, that legal avenue still remains open for him.

79. Having regard to the content of the judgment of 15 January 2010, the subsequent acquittal and the rehabilitation avenue which the applicant is able to effectively employ, the Court finds that the national authorities have acknowledged, and then afforded redress for, the alleged breach of the Convention.

80. It follows that the applicant can no longer claim to be a victim of the alleged violation of Article 6 § 1 of the Convention within the meaning of Article 34 of the Convention (see *Hans-Joachim Enders v. Germany*, no. 25040/94, Commission decision of 12 April 1996; *Fedosov v. Russia* (dec.), no. 42237/02, 5 January 2007; and *Brinzevich v. Russia* (dec.), no. 6822/04, 11 December 2007; and, *mutatis mutandis, Hajiyev v. Azerbaijan,* no. 5548/03, 16 June 2005, and *Wong v. Luxemburg* (dec.), no. 38871/02, 30 August 2005) and that this complaint is to be rejected, pursuant to Articles 34 and 35 §§ 3 and 4.

IV. OTHER ALLEGED VIOLATIONS OF THE CONVENTION

81. 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.

FOR THESE REASONS, THE COURT UNANIMOUSLY

1. *Declares* the complaint concerning inadequate medical care during the applicant's imprisonment admissible and the remainder of the application inadmissible;

2. *Holds* that there has been no violation of Article 3 of the Convention.

Done in English, and notified in writing on 30 September 2010, pursuant to Rule 77 §§ 2 and 3 of the Rules of Court.

Søren Nielsen	Christos Rozakis
Registrar	President