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

SECOND SECTION

CASE OF ENHORN v. SWEDEN

(Application no. 56529/00)

JUDGMENT

STRASBOURG

25 January 2005

In the case of Enhorn v. Sweden,

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

Mr J.-P. COSTA, *President*,
Mr A.B. BAKA,
Mr I. CABRAL BARRETO,
Mr R. TÜRMEN,
Mr M. UGREKHELIDZE,
Mrs E. FURA-SANDSTRÖM,
Mrs D. JOČIENĖ, *judges*,
and Mrs S. DOLLÉ, *Section Registrar*,

Having deliberated in private on 10 December 2002 and 4 January 2005,

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

PROCEDURE

1. The case originated in an application (no. 56529/00) against the Kingdom of Sweden lodged with the Court under Article 34 of the Convention for the Protection of Human Rights and Fundamental Freedoms ("the Convention") by a Swedish national, Mr Eie Enhorn ("the applicant"), on 3 April 2000.

2. The applicant, who had been granted legal aid, was represented by Mrs E. Hagstrom, a lawyer practising in Stockholm. The Swedish Government ("the Government") were represented by their Agent, Mrs E. Jagander, of the Ministry of Foreign Affairs.

3. The applicant alleged that he had been deprived of his liberty in breach of Article 5 of the Convention.

4. The application was initially allocated to the Fourth Section of the Court (Rule 52 § 1 of the Rules of Court).

5. By a decision of 10 December 2002, the Chamber declared the application admissible.

6. The Government, but not the applicant, filed observations on the merits (Rule 59 § 1).

7. On 1 November 2004 the Court changed the composition of its Sections (Rule 25 § 1). This case was assigned to the newly composed Second Section (Rule 52 § 1). Within that Section, the Chamber that would consider the case (Article 27 § 1 of the Convention) was constituted as provided in Rule 26 § 1.

THE FACTS

I. THE CIRCUMSTANCES OF THE CASE

8. The applicant was born in 1947 and is homosexual. In 1994 it was discovered that he was infected with the HIV virus and that he had transmitted the virus to a 19-year-old man with whom he had first had sexual contact in 1990.

9. In this context, on 1 September 1994 a county medical officer (*smittskyddsläkaren*) issued the following instructions to the applicant pursuant to the 1988 Infectious Diseases Act (*smittskyddslagen* – "the 1988 Act").

> "[The applicant] is not allowed to have sexual intercourse without first informing his partner about his HIV infection. He is required to use a condom. He is to abstain from consuming such an amount of alcohol that his judgment would thereby be impaired and others put at risk of being infected with HIV. If the applicant is to have a physical examination, an operation, a vaccination or a blood test or is bleeding for any reason, he must tell the relevant medical staff about his infection. He must also tell his dentist [about it]. Moreover, the applicant is prohibited from giving blood and donating organs or sperm. Finally, he is to visit his consulting physician again and to keep appointments fixed by the county medical officer."

It appears to be in dispute whether the instructions were included in the applicant's medical record as prescribed by section 16 of the 1988 Act. It is not in dispute, however, that the applicant was informed of the instructions, which were issued to him on 1 September 1994, both orally and in writing.

10. The applicant kept three appointments with the county medical officer in September 1994 and one in November 1994. He also received two home visits by the county medical officer. He failed to appear as summoned five times during October and November 1994.

11. On 2 February 1995 the county medical officer petitioned the County Administrative Court (*länsrätten*) for a court order that the applicant be kept in compulsory isolation in a hospital for up to three months pursuant to section 38 of the 1988 Act.

The court's record of the applicant's statement reads, *inter alia*, as follows:

> "After learning about his HIV infection he had hardly had any sexual relationships. Henceforward he would only have sexual relations with other HIV infected persons. The applicant did not wish to visit the county medical officer or a psychiatrist, but finding his communication with his consulting physician satisfactory he intended to pay the latter monthly visits."

The county medical officer stated, among other things:

> "[The applicant] may not be sexually active at present, but experience has shown that when the opportunity arises he is likely to have sexual relations, preferably with younger men and without thinking of the consequences. [The applicant] refuses to face his situation, does not want to change his conduct and distorts reality in such a way that he is never to blame for anything. In order for [the applicant's] behaviour to change it is necessary for him to consult a psychiatrist. Having regard to his [resistance thereto], the risk of him spreading the disease is obvious."

12. A statement of 16 February 1995 was submitted to the County Administrative Court by a deputy chief physician and specialist in psychiatry, S.A., who had met the applicant twice in a psychiatric ward at an infection clinic. He found, *inter alia*:

> "Having learnt that he was HIV-positive, the applicant reacted with a high level of anxiety, which he attempted to alleviate with alcohol. He has maintained that he drinks three strong beers at night in order to be able to sleep. He has had periods of extensive [alcohol] abuse as a consequence of learning that he was infected with HIV but also when he lost his job. [The applicant's] lack of social contact and his feeling of being an outsider, in combination with possible alcohol abuse, could increase the risk of destructive sexual relations."

13. In a judgment of 16 February 1995, finding that the applicant had failed to comply with the measures prescribed by the county medical officer, aimed at preventing him from spreading the HIV infection, the County Administrative Court ordered that the applicant should be kept in compulsory isolation for up to three months pursuant to section 38 of the 1988 Act.

The order took effect immediately, but the applicant failed to report to the hospital; the police accordingly took him there on 16 March 1995.

14. It appears that the order and others subsequently issued by the County Administrative Court were upheld on appeal by the Administrative Court of Appeal (*kammarrätten*), so that the applicant's compulsory confinement was repeatedly prolonged by periods of six months at a time.

15. While being isolated the applicant had the opportunity to go outdoors every day together with members of the hospital staff, but not on his own. Also, he was able to accompany staff members on different activities outside the hospital grounds.

The applicant absconded from the hospital several times, first on 25 April 1995. The police, whom he had contacted voluntarily, returned him to the hospital on 11 June 1995. On 27 September 1995 he ran away again and was at large until the police found him on 28 May 1996. The applicant absconded for a third time on 6 November 1996 but returned of his own accord on 16 November 1996. He ran away for the fourth time on 26 February 1997 and was not returned until 26 February 1999.

During the period from 26 February until 2 March 1999 the applicant was detained in his room.

16. On 14 April 1999 the county medical officer petitioned the County Administrative Court anew for an extension of the applicant's compulsory isolation. According to the record of a hearing held in camera on 20 April 1999, the applicant explained, among other things, the following:

> "... before 1994 he had had ten to twelve sexual relations per year. His partners were partly old acquaintances, partly new ones, whom he met in parks and so on. The boy, who was 15 years old when they met, took the initiative both emotionally and sexually. Today [the applicant] realises that he infected the boy, which he finds very regrettable. A relative with psychiatric problems, with whom [the applicant] had had a longer sexual relationship, was likewise the initiator. While he was on the run from [26 February] 1997 until [26 February] 1999, he had had no sexual relations. He had taken precautions against spreading the disease and, having had to visit physicians twice during his period at large, on both occasions he had informed them about his HIV infection. Mostly he had kept to himself. From October 1997 until June 1998 and from August 1998 until February 1999, he had lived at a farm hostel and, during the periods in between, when the hostel was full, he had camped. He had spent his time shopping, cooking, watching TV, spending money on lottery games and drinking beer. He had drunk approximately six strong beers a week and never got drunk. He dreamt of living on his own in a flat, supporting himself on sickness benefit. He had lost all sexual desire and would in future have to decline all sexual relations. If he were to be exempted from compulsory isolation he would follow the instructions issued by the county medical officer."

17. The owner of the farm hostel gave evidence on the applicant's behalf. The record of his statement reads, *inter alia*, as follows:

> "[The applicant], under a pseudonym, had stayed at his farm hostel from October 1997 until June 1998 and from August 1998 until January 1999. [The owner] had talked briefly with him almost every day during those periods. [The applicant] had not bothered anybody and had not formed any personal relationships. He used to go shopping once a day, usually for beer, and [the witness] would estimate that he had drunk between four and six cans of beer every day ... [The applicant] had gone to Stockholm or Norrköping on a few occasions in order to deal with money matters ... However, in Norrköping he had primarily gone to the liquor store ... [The witness] could hardly imagine that [the applicant] had had any sexual relations while living at the hostel ..."

18. Also on the applicant's behalf, an opinion was submitted by a chief physician, P.H., on 16 April 1999 regarding the applicant's alcohol consumption. Having examined various laboratory tests performed since 31 July 1995 in order to check the applicant's liver, he found no divergent results. The most recent laboratory test, carried out on 18 March 1999, indicated that the applicant had a healthy liver.

It was noted that subsequent to his return the applicant had been in contact with a chief physician and specialist in psychiatry, C.G., who was not connected to the hospital.

19. A statement was submitted to the court by a consulting psychiatric chief physician, P.N., connected to the special care facility at the hospital to which the applicant had been admitted. After the applicant's involuntary return, P.N. had attempted to establish contact with him three times, but in

vain. He claimed that on the latest occasion, in March 1999, the applicant had made a lunge at him. In P.N.'s view, the applicant had not made any positive progress since 10 October 1996, the date of P.N.'s most recent official opinion regarding the applicant's condition, in which he had, *inter alia*, made the following assessment:

> "The applicant suffers from a paranoid personality disorder and from alcohol abuse. He is considered to be completely devoid of any sense of being ill and also lacks awareness. The combination of a sexual leaning towards younger men and a possible alcohol-related neuro-psychological functional impairment with, from time to time, a probably paranoid personality disorder, close to psychosis, and previous dangerous behaviour from the infection-spreading viewpoint, is deemed unfavourable. The chances of eliminating or limiting the continuous risk of the infection being spread by means of a prolonged placement in isolation in accordance with the Act are deemed – all facts considered – to have not yet completely vanished."

20. Also submitted was a statement of 8 April 1999 by B.S., a psychologist at the special care facility at the hospital who had met the applicant once. B.S. found that the applicant was intellectually above average and that he appeared immature and fragile and showed signs of being suspicious and distrustful.

21. The statement of the county medical officer, who gave evidence before the court, is recorded, *inter alia*, as follows:

> "During the last two years when he was on the run, [the applicant] sought medical treatment twice and it has been established that both times he said that he had the HIV virus [as opposed to the period when he absconded between September 1995 and May 1996, during which he failed three times to inform medical staff about his condition]. Moreover, [the applicant] has [finally] accepted that he infected the young man with whom he had a long-lasting relationship from the beginning of the 1990s, thus admitting that it was not the other way around. Also, he has agreed to sign a treatment plan and to consult two physicians of his own choice ... These circumstances suggest the beginning of an improvement in [the applicant's] attitude towards treatment. Nevertheless, it has not been established that [the applicant] has materially changed his attitude regarding the risk that he may spread the disease. He continues to show himself unable to accept the aid and support measures he is entitled to receive; he has refused to consult the psychiatrist P.N. and the psychologist B.S. Moreover, having been in touch with the physicians whom [the applicant] has [recently] contacted voluntarily [P.H. and C.G.], the county medical officer considers that these consultations were partly economically motivated [on account of the fact that the applicant needed medical certificates in order to continue to receive sickness benefit], partly motivated by his wish to be declared mentally healthy, but [not motivated] by any willingness to commence treatment. During [the applicant's] contact with the doctors in question, they did not discuss the risk of spreading the disease at all. A treatment plan was not formally signed [by the applicant]. In conclusion, in the county medical officer's opinion, [if released the applicant] will not voluntarily comply with the instructions given or limit the spreading of the disease."

As regards the laboratory tests concerning the applicant's liver, the county medical officer found these to be of doubtful value, since they had been performed in connection with the compulsory isolation of the applicant at the hospital, but never in connection with a period of intoxication.

22. On 23 April 1999 the County Administrative Court delivered its judgment, finding against the applicant for the following reasons:

> "[The applicant] is HIV-positive and thus carries the HIV infection. He has been subjected to compulsory isolation since February 1995 and has during this period absconded from the hospital on several occasions – on the latest occasion for more than two years. During these two years he did not have any contact with the county medical officer or the consulting physician. Periodically he has used a false name and has been living a very secluded life, obviously owing to the risk of being discovered. A life at liberty makes great demands upon the person carrying the infection. During the time preceding his compulsory isolation, [the applicant] was not able to follow the practical instructions issued. Subsequently, he has consistently declined the help offered by the consulting physician and the psychiatrist at the special care facility at the hospital and has instead responded with aversion and mistrust – and by escaping. [The Court] finds that it has been difficult for [the applicant] to accept the information regarding the HIV infection and that he needs help in dealing with this critical situation. It appears from the evidence that [the applicant] still shows aversion to the treatment offered and that he is considered likely to abscond. [The Court] has not been convinced that [the applicant] is not misusing alcohol and finds that, especially in connection with alcohol consumption, [the applicant] is likely to be unable to control his sexual behaviour. Against this background, [the Court] finds that there is good reason to suppose that, if he remains free, [the applicant] will not comply with the practical instructions issued and that this entails a risk of the infection spreading."

23. On 12 June 1999 the applicant again absconded, leaving his whereabouts unknown. In the meantime, he had appealed against the above judgment to the Administrative Court of Appeal, before which he relied on an opinion of 14 May 1999 by the aforementioned chief physician and specialist in psychiatry, C.G., which stated, *inter alia*, the following:

> "The opinions [by other psychiatrists and one psychologist] resulting from previous examinations were fairly unanimous in their conclusion that [the applicant] was a man with a paranoid personality disorder, who misused alcohol. 'Misuse' in psychiatric terms is defined as a maladaptive use of substances ... This diagnosis is to be distinguished from alcohol dependency, which means a compulsive use of alcohol with abstinence and social complications, and is more difficult to master. The diagnosis 'paranoid personality disorder' is defined as a pervading suspiciousness and lack of trust in other people, whose motives are consistently perceived as malicious. It follows from the definition of 'paranoid personality disorder' itself that this is manifest in the patient's personality from the time he or she becomes an adult. Owing to the fact that the person in question perceives the disorder as part of his or her own self, the motivation for change is usually insufficient. It is not correct to talk in terms of lack of awareness of a disease, since it is not considered that a disease is involved but rather a variation in personality, although the latter may well cause complications in relations with other individuals and society. When such complications occur, an individual with a personality disorder may display different symptoms such as depression, anxiety, etc. In [my] interview with [the applicant], the latter was fairly open and talkative. When he talked about experiences from his time at school, he displayed different emotions. He also showed empathy as far as other people from those years were concerned. He was also partly able to shoulder responsibility for his own mistakes, without blaming others. However, he was very rigid in his interpretation of what had occurred in his adult life and particularly the events of recent years after he had been informed that he had the HIV virus in September 1994. His attitude towards the

> county medical officer and the staff at the infection ward, whom he believed had kept harassing him unjustly, was almost hateful. [The applicant] felt that he had been subjected to persecution between 1994 and 1995. This could possibly be interpreted as a symptom of delusion. From 1996, he had not experienced feelings of persecution, *inter alia* since he had secured his own liberty. With regard to sexual relations, [the applicant] has stated that he preferred sexual contact with boys around the age of 17. He was not interested in pre-pubescent boys. He had been celibate since 1996 and had no longer any particular sexual desires or fantasies. He was fully aware that he was carrying the HIV virus and was careful to stress that he was not afraid to die. His attitude towards medication against the HIV infection was negative. The reasons for this were that such medication could have side effects and perhaps, above all, because it would entail limitations on his freedom since he would be subjected to various check-ups. [The applicant] spontaneously expressed a wish to have further talks on a voluntary basis. When asked whether such talks could be part of a treatment plan in cooperation with the county medical officer and the staff at the infection ward, he answered 'no', the reason being that he would feel ashamed of himself if he were to give up this fight."

In conclusion, C.G., found that the applicant fulfilled the criteria for a paranoid personality disorder, and that, judging from previous information, the applicant suffered from misuse of alcohol but not from alcohol dependency. According to C.G. the applicant could be described in everyday terms as an odd person, but not as mentally ill. With regard to the risk that the applicant might pass on the HIV infection to other persons, C.G. believed that neither he nor anyone else could do anything but guess. The weightiest indications in this regard, however, ought to be deduced from the applicant's behaviour during the years he had spent at large.

24. In a judgment of 18 June 1999, the Administrative Court of Appeal found against the applicant. Leave to appeal against the judgment was refused by the Supreme Administrative Court (*Regeringsrätten*) on 5 October 1999.

25. Several applications for an extension of the applicant's compulsory isolation were submitted by the county medical officer after June 1999 and granted, until on 12 December 2001 an application was turned down by the County Administrative Court, which referred to the fact that the applicant's whereabouts were unknown and that therefore no information was available regarding his behaviour, state of health and so on.

26. It appears that since 2002 the applicant's whereabouts have been known, but that the competent county medical officer has made the assessment that there are no grounds for the applicant's further involuntary placement in isolation.

II. RELEVANT DOMESTIC LAW AND PRACTICE

27. The 1988 Infectious Diseases Act ("the 1988 Act") divides infectious diseases into diseases dangerous to society and other infectious diseases. One of the diseases described as dangerous to society is the infection by the human immunodeficiency virus (HIV). The relevant provisions of the 1988 Act read as follows:

Section 5

"Each county council [*landsting*] shall be responsible for ensuring that the necessary measures for the prevention of infectious diseases are taken within its area ..."

Section 6

"Every county council shall have a county medical officer ..."

Section 13

"It shall be the duty of any person having reason to suspect that he has been infected with a disease dangerous to society to consult a physician without delay and to allow the physician to carry out examinations and to take any specimens needed in order to establish whether he has been infected with such a disease. It shall also be his duty to comply with the practical instructions issued to him by the physician. The same shall apply when a person, having been infected with a disease dangerous to society, states that he has been in contact with some other person in such a way that the infection may have been transmitted."

Section 14

"Any person infected with a disease dangerous to society must supply the consulting physician with information concerning the person or persons from whom the infection may have come or to whom it may have been passed on, and must supply general particulars concerning the possible source of the infection and where it may have been spread further."

Section 16

"The consulting physician shall issue to a person being examined for a disease dangerous to society any practical instructions needed to prevent the spread of the infection. These instructions may refer to that person's contact with the physician, hygiene, isolation in the home, employment and attendance at educational establishments, as well as his general way of life. The instructions shall be included in the infected person's medical record. The physician must as far as possible see to it that the instructions are complied with."

Section 17

"At the request of the individual concerned or of his own motion, the county medical officer may alter the instructions in the manner he finds most appropriate."

Section 25

"A consulting physician having reason to believe that a patient infected or suspected of being infected with a disease dangerous to society will not comply, or is not complying with the practical instructions issued, must promptly notify the county medical officer. This shall also apply when such a patient discontinues his current treatment without the consent of the consulting physician."

Section 28

"... Before resorting to any coercive measure, the county medical officer must try to obtain voluntary compliance if this can be done without the risk of the infection being spread."

Section 30

"A county medical officer who has been informed by a consulting physician that a patient carrying the HIV infection has not complied, or is suspected of not complying, with the practical instructions issued shall notify the social welfare committee, the police authority and the principal probation officer. In doing so he shall supply particulars concerning the identity of the person to whom the practical instructions apply and the implications of those instructions. No information shall be supplied if the county medical officer believes this unnecessary in order to secure compliance with the practical instructions or otherwise finds it immaterial with regard to the prevention of communicable disease."

Section 38

"The County Administrative Court, on being petitioned by the county medical officer, shall make an order for the compulsory isolation of a person infected with a disease dangerous to society if that person does not voluntarily comply with the measures needed in order to prevent the infection from spreading. An order of this kind shall also be made if there is reasonable cause to suppose that the infected person is not complying with the practical instructions issued and this omission entails a manifest risk of the infection being spread. Compulsory isolation shall take place in a hospital run by a county council."

Section 39

"If a compulsory isolation order by the County Administrative Court cannot be awaited without danger, the county medical officer shall issue an order of the kind referred to in section 38. The order issued shall thus be submitted immediately to the County Administrative Court for approval."

Section 40

"Compulsory isolation may continue for up to three months from the day on which the infected person was admitted to hospital under the isolation order."

Section 41

"Following a petition from the county medical officer, the County Administrative Court may order the continuation of compulsory isolation beyond the maximum period indicated in section 40. An order of this kind may not exceed six months at a time."

Section 42

"When there is no longer cause for compulsory isolation, the county medical officer shall order its termination immediately ..."

Section 43

"A person in compulsory isolation shall be properly cared for. He shall be offered the support and help needed, and shall be encouraged to change his attitude and way of life in order to terminate his involuntary confinement. Subject to the provisions of this Act, a person in compulsory isolation may not be subjected to any other restriction of his liberty. A person in compulsory care shall be offered employment and physical training suitable for his age and state of health. Unless there are exceptional circumstances, he must have an opportunity to be outdoors every day for at least an hour."

Section 44

"A person in compulsory isolation may be prevented from leaving the hospital premises or that part of the hospital to which he is admitted, and may in other respects be subjected to such constraints on his liberty of movement as are necessary to ensure his compulsory isolation. His freedom of movement may also be restricted when considerations of his own safety or that of other persons so demand."

Section 52

"Appeals against a decision by the county medical officer under the 1988 Act may be lodged with the County Administrative Court if the decision concerns:

1. practical instructions under section 17;
2. temporary detention under section 37;
3. rejection of a request for the termination of compulsory isolation;

..."

28. There is no particular provision in the Act concerning criminal sanctions against a person who transmits a dangerous disease. Certain types of behaviour, however, are considered to be criminal and therefore fall under the Criminal Code.

In March 1999 a parliamentary committee entrusted with the task of reviewing the present legislation concerning infectious diseases submitted

its report (SOU 1999:51). The committee expressed the view that compulsory isolation should take place only in very particular and exceptional circumstances. The committee proposed, having regard, among other things, to Article 5 of the Convention, a fixed time-limit permanently ending any compulsory isolation after a maximum of three months. So far, no government bill has been presented to Parliament.

III. RELEVANT INTERNATIONAL LAW AND PRACTICE

29. Numerous charters and declarations which specifically or generally recognise the human rights of people living with HIV/Aids have been adopted at national and international conferences. A few of these are mentioned below.

In 1998 the Office of the High Commissioner for Human Rights (OHCHR) and the Joint United Nations Programme on HIV/Aids (UNAIDS) issued "International Guidelines on HIV/Aids and Human Rights". These guidelines built on expert advice to integrate the principles and standards of international human rights law into the HIV/Aids response. Under the heading "III. International human rights obligations and HIV/Aids" (subheading "C. The application of specific human rights in the context of the HIV/Aids epidemic"), several examples of the application of specific human rights to HIV/Aids are illustrated. For example, Section 9, "Right to liberty and security of person" reads as follows:

> "110. Article 9 of the International Covenant on Civil and Political Rights provides that 'Everyone has the right to liberty and security of person. No one shall be subjected to arbitrary arrest or detention. No one shall be deprived of his liberty except on such grounds and in accordance with such procedures as are established by law'.
>
> 111. The right to liberty and security of person should, therefore, never be arbitrarily interfered with, based merely on HIV status by using measures such as quarantine, detention in special colonies, or isolation. There is no public health justification for such deprivation of liberty. Indeed, it has been shown that public health interests are served by integrating people living with HIV/Aids within communities and benefiting from their participation in economic and public life.
>
> 112. In exceptional cases involving objective judgments concerning deliberate and dangerous behaviour, restrictions on liberty may be imposed. Such exceptional cases should be handled under ordinary provisions of public heath, or criminal laws, with appropriate due process protection.
>
> 113. Compulsory HIV testing can constitute a deprivation of liberty and a violation of the right to security of person. This coercive measure is often utilised with regard to groups least able to protect themselves because they are within the ambit of government institutions or the criminal law, e.g. soldiers, prisoners, sex workers, injecting drug users and men who have sex with men. There is no public health justification for such compulsory HIV testing. Respect for the right to physical integrity requires that testing be voluntary and that no testing be carried out without informed consent."

In order to reflect new standards in HIV treatment as regards the international law on health rights, Guideline 6 concerning "Access to prevention, treatment, care and support" was revised following the Third International Consultation on HIV/Aids and Human Rights in Geneva on 25 to 26 July 2002.

In its Recommendation on the ethical issues of HIV infection in the health care and social settings, the Committee of Ministers of the Council of Europe recommended the following with regard to health controls (Appendix to Recommendation No. R (89) 14, I. Public heath policy, C. Health controls):

> "Public health authorities are recommended to:
>
> – refrain from introducing restrictions on freedom of movement through ineffective and costly border procedures, for travellers of all kinds, including migrant workers;
>
> – not resort to coercive measures such as quarantine and isolation for people infected with HIV or those who have developed Aids."

When this recommendation was adopted on 24 October 1989, the Representative of Sweden, referring to Article 10.2.*d* of the Rules of Procedure of the meetings of the Ministers' Deputies, recorded her abstention and, in an explanatory statement, said that her government would not consider itself bound by the recommendation.

THE LAW

I. ALLEGED VIOLATION OF ARTICLE 5 OF THE CONVENTION

30. The applicant complained that the compulsory isolation orders and his involuntary placement in hospital during the periods from 16 March 1995 until 25 April 1995, 11 June 1995 until 27 September 1995, 28 May 1996 until 6 November 1996, 16 November 1996 until 26 February 1997, and 26 February 1999 until 12 June 1999 had been in breach of Article 5 § 1 of the Convention, the relevant parts of which read as follows:

> "1. Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law:
>
> ...
>
> (b) the lawful arrest or detention of a person for non-compliance with the lawful order of a court or in order to secure the fulfilment of any obligation prescribed by law;
>
> ...
>
> (e) the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants;
>
> ..."

A. The parties' submissions

1. The applicant

31. The applicant submitted that the order to deprive him of his liberty had been "unlawful".

Firstly, it had had no legal basis in Swedish law. Section 38 of the 1988 Act did not fulfil the requirements of being "precise and foreseeable". In particular, the notions "reasonable cause" and "a manifest risk of the infection being spread" were too vague and the preparatory notes gave no indication as to their meaning. Moreover, the requirements set out in the provision in question had never been fulfilled, since it required not only that he should have failed to comply with the practical instructions issued, but also that this should have entailed a manifest risk of his spreading the HIV virus. In addition, the instructions issued by the county medical officer had not been included in his medical record as prescribed by section 16 of the 1988 Act.

Thus, although admittedly he had failed to appear at some of his appointments with the county medical officer and had absconded, thereby failing to comply with practical instructions issued by the county medical officer, this could not be said to have entailed a manifest risk of his spreading the HIV infection. In this connection, he referred to the fact that, during his last two years on the run, he had had to seek medical treatment twice and on both occasions he had said that he had the HIV virus. Moreover, he referred to his present conduct, including his sexual conduct, as confirmed by the witness who owned the farm hostel where he had stayed during his period at large from February 1997 until February 1999. He noted in addition, taking into consideration the advanced system in Sweden for registering the spreading of disease, that during his periods at large, which altogether amounted to more than four and a half years, there had been no indication that he had infected anybody. Furthermore, he drew attention to the statement submitted by the specialist in psychiatry, C.G.

Secondly, pointing out that undergoing psychiatric interviews or conversations had not been among the practical instructions issued by the county medical officer on 1 September 1994, the applicant maintained that the court orders for his compulsory isolation in order to prevent him from spreading the HIV virus had infringed the principle of proportionality required by Article 5 § 1 (e) of the Convention. Even if he had, in fact, been isolated for "only" one and a half years, he pointed out that the parliamentary committee entrusted with the task of reviewing the legislation concerning infectious diseases had proposed in its report, having regard to Article 5 of the Convention, that any compulsory isolation should permanently end after a maximum of three months.

2. The Government

32. The Government contended that the involuntary placement of the applicant had fulfilled the requirements of both Article 5 § 1 (b) and (e) of the Convention. The detention had been lawful and free from arbitrariness and the 1988 Act satisfied the test of being precise and foreseeable as to effect.

With specific regard to Article 5 § 1 (b), the Government observed that, pursuant to section 13 of the 1988 Act, it was incumbent on a person infected with a serious disease to comply with the instructions issued by a physician. Such instructions had been issued to the applicant by the county medical officer on 1 September 1994. The latter had, however, failed to satisfy a number of specific and concrete obligations that followed from those instructions. Moreover, it could be deduced from the 1988 Act that involuntary placement in a hospital was viewed as the last resort when voluntary measures had failed or were considered inadequate in order to protect other members of society. Thus, the applicant's detention had not been intended to punish him for not complying with the instructions but had been resorted to in the hope that his attitude and behaviour would change.

With specific regard to Article 5 § 1 (e), the Government noted the Court's lack of case-law as to the detention of persons for the prevention of the spreading of infectious diseases. They noted the "*Winterwerp* conditions" relating to the detention of people of unsound mind and found that these conditions could also reasonably be applied in the present case.

As to the question whether the measures taken were proportionate to the aim pursued, the Government stated that the objective of the measure in dispute had not been to provide medical treatment for the disease. They added that no treatment of an HIV-infected person would be carried out by means of coercive measures. Instead, the aim of confinement was to support, assist and encourage the carrier of the dangerous infection to change his or her attitude and lifestyle in such a way that his or her compulsory isolation could be ended as soon as possible.

The Government considered that a number of voluntary measures had been attempted in vain during the period between September 1994 and February 1995 to ensure that the applicant's behaviour would not contribute to the spread of the HIV infection. Also, they noted the particular circumstances of the case, notably: the applicant's personality and behaviour, as described by various physicians and psychiatrists; his preference for teenage boys; the fact that he had transmitted the HIV virus to a young man; and the fact that he had absconded several times and refused to cooperate with the staff at the hospital. Thus, the Government found that the involuntary placement of the applicant in hospital had been proportionate to the purpose of the measure, namely to prevent him from spreading the infectious disease.

As to the duration of the detention, the Government pointed out that even though the compulsory isolation order had been in force for several years

the applicant's actual deprivation of liberty within the meaning of Article 5 of the Convention had lasted for approximately one and a half years. Furthermore, they alleged that had the applicant not absconded so many times it might have been possible for the staff to assist and support him in such a way that a change in his attitude would have taken place earlier, thus shortening the length of his compulsory isolation.

B. The Court's assessment

1. Whether the applicant was "deprived of his liberty"

33. It was common ground between the parties that the compulsory isolation orders and the applicant's involuntary placement in the hospital amounted to a "deprivation of liberty" within the meaning of Article 5 § 1 of the Convention. The Court reaches the same conclusion.

2. Whether the deprivation of liberty was justified under any of sub-paragraphs (a) to (f) of Article 5 § 1

34. Article 5 § 1 of the Convention contains an exhaustive list of permissible grounds of deprivation of liberty. However, the applicability of one ground does not necessarily preclude that of another; a detention may, depending on the circumstances, be justified under more than one sub-paragraph (see, for example, *Eriksen v. Norway*, judgment of 27 May 1997, *Reports of Judgments and Decisions* 1997-III, p. 861, § 76, and *Brand v. the Netherlands*, no. 49902/99, § 58, 11 May 2004).

35. Both parties found that the applicant's detention could be examined under Article 5 § 1 (e) in that its purpose was to prevent the applicant from spreading the HIV disease. The Court notes that the applicant's compulsory confinement was imposed pursuant to section 38 of the 1988 Act (see paragraph 27 above). Accordingly, the Court endorses the view that Article 5 § 1 (e) is applicable. As a result, it considers that there is no need to deal with the Government's submission that sub-paragraph (b) is also applicable, or with the applicability of any of the remaining sub-paragraphs of Article 5 § 1 of the Convention.

3. Whether the detention in issue was "lawful" and free from arbitrariness

36. The expressions "lawful" and "in accordance with a procedure prescribed by law" in Article 5 § 1 essentially refer back to national law and state the obligation to conform to the substantive and procedural rules thereof. Where deprivation of liberty is concerned, it is particularly important that the general principle of legal certainty be satisfied. It is therefore essential that the conditions for deprivation of liberty under domestic law be clearly defined and that the law itself be foreseeable in its application, so that it meets the standard of "lawfulness" set by the Convention, a standard which requires that all law be sufficiently accessible and precise to allow the person – if necessary with appropriate advice – to foresee, to a degree that is reasonable in the circumstances, the consequences a given action may entail (see, for example, *Varbanov v. Bulgaria*, no. 31365/96, § 51, ECHR 2000-X; *Amann v. Switzerland* [GC], no. 27798/95, § 50, ECHR 2000-II; *Steel and Others v. the United Kingdom*, judgment of 23 September 1998, *Reports* 1998-VII, p. 2735, § 54; *Amuur v. France*, judgment of 25 June 1996, *Reports* 1996-III, pp. 850-51, § 50; and *Hilda Hafsteinsdóttir v. Iceland*, no. 40905/98, § 51, 8 June 2004).

Moreover, an essential element of the "lawfulness" of a detention within the meaning of Article 5 § 1 (e) is the absence of arbitrariness (see, amongst other authorities, *Chahal v. the United Kingdom*, judgment of 15 November 1996, *Reports* 1996-V, p. 1864, § 118, and *Witold Litwa v. Poland*, no. 26629/95, § 78, ECHR 2000-III). The detention of an individual is such a serious measure that it is only justified where other, less severe measures have been considered and found to be insufficient to safeguard the individual or the public interest which might require that the person concerned be detained. That means that it does not suffice that the deprivation of liberty is in conformity with national law, it must also be necessary in the circumstances (see, for example, *Witold Litwa*, cited above, § 78) and in accordance with the principle of proportionality (see, for example, *Vasileva v. Denmark*, no. 52792/99, § 41, 25 September 2003).

37. With regard to the relevant domestic legislation, the applicant maintained that the notions "reasonable cause" and "manifest risk of the infection being spread" under section 38 of the 1988 Act were too vague; that the preparatory work on the Act did not give any indications in this regard; and that the requirements of clearness and foreseeability had therefore not been fulfilled.

38. It is in the first place for the national authorities, notably the courts, to interpret and apply domestic law (see, among other authorities, *Bouamar v. Belgium*, judgment of 29 February 1988, Series A no. 129, p. 21, § 49). In the instant case, pursuant to section 16 of the 1988 Act, the consulting physician was entrusted with a wide discretion when issuing the practical

instructions needed to prevent the spread of infection. Those instructions could refer to the "person's contacts with the physician, hygiene, isolation in the home, employment and attendance at educational establishments, as well as his general way of life ...". Under section 17 of the Act, the county medical officer could alter those instructions in the manner he found most appropriate.

On 1 September 1994 the county medical officer issued the following instructions to the applicant: he was not allowed to have sexual intercourse without first informing his partner about his HIV infection; he was required to use a condom; he was to abstain from consuming such an amount of alcohol that his judgment would thereby be impaired and others put at risk of being infected with HIV; if the applicant was to have a physical examination, an operation, a vaccination or a blood test or was bleeding for any reason, he was obliged to tell the relevant medical staff about his HIV infection; he was also to inform his dentist about it; he was prohibited from giving blood and donating organs or sperm; and finally, he was to visit his consulting physician again and keep appointments fixed by the county medical officer.

Throughout the domestic proceedings the applicant's conduct, including his sexual conduct, and his compliance with the instructions set out by the county medical officer were thoroughly examined. Moreover – despite the fact that being admitted to psychiatric treatment or treatment for alcohol abuse was not amongst the instructions issued by the county medical officer on 1 September 1994 – subjects relating to those topics were extensively inquired into in respect of the applicant. These examinations led the County Administrative Court to conclude, in its judgment of 16 February 1995, and its subsequent orders to prolong the compulsory confinement of the applicant, that the requirements of section 38 of the 1988 Act were fulfilled. The same conclusion was reached in its judgment of 23 April 1999, upheld on appeal by the Administrative Court of Appeal on 18 June 1999. Accordingly, the national courts considered that the applicant had not voluntarily complied with the measures needed to prevent the virus from spreading; that there was reasonable cause to suspect that the applicant, if released, would fail to comply with the practical instructions issued by the county medical officer; and that such non-compliance would entail a risk of the infection spreading.

39. In these circumstances the Court is satisfied that the applicant's detention had a basis in Swedish law.

40. The Court must therefore proceed to examine whether the deprivation of the applicant's liberty amounted to "the lawful detention of a person in order to prevent the spreading of infectious diseases" within the meaning of Article 5 § 1 (e) of the Convention.

41. The Court has only to a very limited extent decided cases where a person has been detained "for the prevention of the spreading of infectious

diseases". It is therefore called upon to establish which criteria are relevant when assessing whether such a detention is in compliance with the principle of proportionality and the requirement that any detention must be free from arbitrariness.

42. By way of comparison, for the purposes of Article 5 § 1 (e), an individual cannot be deprived of his liberty as being of "unsound mind" unless the following three minimum conditions are satisfied: firstly, he must reliably be shown to be of unsound mind; secondly, the mental disorder must be of a kind or degree warranting compulsory confinement; and thirdly, the validity of continued confinement depends upon the persistence of such a disorder (see *Winterwerp v. the Netherlands*, judgment of 24 October 1979, Series A no. 33, pp. 17-18, § 39; *Johnson v. the United Kingdom*, judgment of 24 October 1997, *Reports* 1997-VII, p. 2409, § 60; and, more recently, *Varbanov*, cited above, § 45). Furthermore, there must be some relationship between the ground of permitted deprivation of liberty relied on and the place and conditions of detention. In principle, the "detention" of a person as a mental health patient will only be "lawful" for the purposes of sub-paragraph (e) of paragraph 1 if effected in a hospital, clinic or other appropriate institution (see *Ashingdane v. the United Kingdom*, judgment of 28 May 1985, Series A no. 93, p. 21, § 44).

Also by way of comparison, for the purposes of Article 5 § 1 (e), an individual cannot be deprived of his liberty for being an "alcoholic" (within the autonomous meaning of the Convention as set out in *Witold Litwa v. Poland*, cited above, §§ 57-63) unless other, less severe measures have been considered and found to be insufficient to safeguard the individual or public interest which might require that the person concerned be detained. That means that it does not suffice that the deprivation of liberty is executed in conformity with national law; it must also be necessary in the circumstances (see, for example, *Witold Litwa*, cited above, § 78, and *Hilda Hafsteinsdóttir*, cited above, § 51).

43. Moreover, Article 5 § 1 (e) of the Convention refers to several categories of individuals, namely persons spreading infectious diseases, persons of unsound mind, alcoholics, drug addicts and vagrants. There is a link between all those persons in that they may be deprived of their liberty either in order to be given medical treatment or because of considerations dictated by social policy, or on both medical and social grounds. It is therefore legitimate to conclude from this context that a predominant reason why the Convention allows the persons mentioned in paragraph 1 (e) of Article 5 to be deprived of their liberty is not only that they are a danger to public safety but also that their own interests may necessitate their detention (see *Guzzardi v. Italy*, judgment of 6 November 1980, Series A no. 39, pp. 36-37, § 98 *in fine*, and *Witold Litwa*, cited above, § 60,).

44. Taking the above principles into account, the Court finds that the essential criteria when assessing the "lawfulness" of the detention of a

person "for the prevention of the spreading of infectious diseases" are whether the spreading of the infectious disease is dangerous to public health or safety, and whether detention of the person infected is the last resort in order to prevent the spreading of the disease, because less severe measures have been considered and found to be insufficient to safeguard the public interest. When these criteria are no longer fulfilled, the basis for the deprivation of liberty ceases to exist.

45. Turning to the instant case, it is undisputed that the first criterion was fulfilled, in that the HIV virus was and is dangerous to public health and safety.

46. It thus remains to be examined whether the applicant's detention could be said to be the last resort in order to prevent the spreading of the virus, because less severe measures had been considered and found to be insufficient to safeguard the public interest.

47. In a judgment of 16 February 1995, the County Administrative Court ordered that the applicant be kept in compulsory isolation for up to three months under section 38 of the 1988 Act. Thereafter, orders to prolong his deprivation of liberty were continuously issued every six months until 12 December 2001, when the County Administrative Court turned down the county medical officer's application for an extension of the detention order. Accordingly, the order to deprive the applicant of his liberty was in force for almost seven years.

Admittedly, since the applicant absconded several times, his actual deprivation of liberty lasted from 16 March 1995 until 25 April 1995, 11 June 1995 until 27 September 1995, 28 May 1996 until 6 November 1996, 16 November 1996 until 26 February 1997, and 26 February 1999 until 12 June 1999 – almost one and a half years altogether.

48. The Government submitted that a number of voluntary measures had been attempted in vain during the period between September 1994 and February 1995 to ensure that the applicant's behaviour would not contribute to the spread of the HIV infection. Also, they noted the particular circumstances of the case, notably as to the applicant's personality and behaviour, as described by various physicians and psychiatrists; his preference for teenage boys; the fact that he had transmitted the HIV virus to a young man; and the fact that he had absconded several times and refused to cooperate with the staff at the hospital. Thus, the Government found that the involuntary placement of the applicant in hospital had been proportionate to the purpose of the measure, namely to prevent him from spreading the infectious disease.

49. The Court notes that the Government have not provided any examples of less severe measures which might have been considered for the applicant in the period from 16 February 1995 until 12 December 2001, but were apparently found to be insufficient to safeguard the public interest.

50. It is undisputed that the applicant failed to comply with the instruction issued by the county medical officer on 1 September 1994, which stated that he should visit his consulting physician again and keep to appointments set up by the county medical officer. Although he kept to three appointments with the county medical officer in September 1994 and one in November 1994, and received two home visits by the latter, on five occasions during October and November 1994 the applicant failed to appear as summoned.

51. Another of the practical instructions issued by the county medical officer on 1 September 1994 was that, if the applicant was to have a physical examination, an operation, a vaccination or a blood test or was bleeding for any reason, he was obliged to tell the relevant medical staff about his infection. Also, he was to inform his dentist about his HIV infection. In April 1999, before the County Administrative Court, the county medical officer stated that during the last two years, while on the run, the applicant had sought medical treatment twice and that it had been established that both times he had said that he had the HIV virus, as opposed to the period when he had absconded between September 1995 and May 1996, during which the applicant had failed on three occasions to inform medical staff about his virus.

52. Yet another of the practical instructions issued by the county medical officer on 1 September 1994 required the applicant to abstain from consuming such an amount of alcohol that his judgment would thereby be impaired and others put at risk of being infected with HIV. However, there were no instructions to abstain from alcohol altogether or to undergo treatment against alcoholism. Nor did the domestic courts justify the deprivation of the applicant's liberty with reference to his being an "alcoholic" within the meaning of Article 5 § 1 (e) and the requirements deriving from that provision.

53. Moreover, although the county medical officer stated before the County Administrative Court in February 1995 that, in his opinion, it was necessary for the applicant to consult a psychiatrist in order to alter his behaviour, undergoing psychiatric treatment was not among the practical instructions issued by the county medical officer on 1 September 1994. Nor did the domestic courts during the proceedings justify the deprivation of the applicant's liberty with reference to his being of "unsound mind" within the meaning of Article 5 § 1 (e) and the requirements deriving from that provision.

54. The instructions issued on 1 September 1994 prohibited the applicant from having sexual intercourse without first having informed his partner about his HIV infection. Also, he was to use a condom. The Court notes in this connection that, despite his being at large for most of the period from 16 February 1995 until 12 December 2001, there is no evidence or indication that during that period the applicant transmitted the HIV virus to

anybody, or that he had sexual intercourse without first informing his partner about his HIV infection, or that he did not use a condom, or that he had any sexual relations at all for that matter. It is true that the applicant infected the 19-year-old man with whom he had first had sexual contact in 1990. This was discovered in 1994, when the applicant himself became aware of his infection. However, there is no indication that the applicant transmitted the HIV virus to the young man as a result of intent or gross neglect, which in many of the Contracting States, including Sweden, would have been considered a criminal offence.

55. In these circumstances, the Court finds that the compulsory isolation of the applicant was not a last resort in order to prevent him from spreading the HIV virus because less severe measures had not been considered and found to be insufficient to safeguard the public interest. Moreover, the Court considers that by extending over a period of almost seven years the order for the applicant's compulsory isolation, with the result that he was placed involuntarily in a hospital for almost one and a half years in total, the authorities failed to strike a fair balance between the need to ensure that the HIV virus did not spread and the applicant's right to liberty.

56. There has accordingly been a violation of Article 5 § 1 of the Convention.

II. APPLICATION OF ARTICLE 41 OF THE CONVENTION

57. 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

58. The applicant claimed compensation for non-pecuniary damage in the amount of 400,000 Swedish kronor (SEK), equivalent to 44,305 euros (EUR)[1], on account of the alleged violation of Article 5 of the Convention. In support of his claim, he submitted that not only had he been deprived of his liberty for a total of one and a half years, he had also been forced to live in hiding for several years.

59. In the Government's view, compensation for non-pecuniary damage should not exceed SEK 100,000, equivalent to EUR 11,076.

60. The Court considers that, in the circumstances of this particular case and making its assessment on an equitable basis, the applicant should be awarded the sum of EUR 12,000 (see, for example, *Witold Litwa*, cited

1. On 10 February 2003, the date on which the claims were submitted.

above, § 85; *Magalhães Pereira v. Portugal*, no. 44872/98, § 66, ECHR 2002-I; and *Morsink v. the Netherlands*, no. 48865/99, § 74, 11 May 2004).

B. Costs and expenses

61. The applicant claimed reimbursement of SEK 18,809, equivalent to EUR 2,083, for his costs and expenses before the Court.

62. The Government found this claim reasonable.

63. The Court is satisfied that there was a causal link between the sum claimed in respect of the applicant's costs and expenses before the Court and the violation it has found of the Convention. Accordingly, it awards the sum of EUR 2,083 under this head.

C. Default interest

64. 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. *Holds* that there has been a violation of Article 5 § 1 of the Convention;

2. *Holds*

(a) that the respondent State is to pay the applicant, within three months from the date on which the judgment becomes final according to Article 44 § 2 of the Convention, the following amounts:

(i) EUR 12,000 (twelve thousand euros) in respect of non-pecuniary damage;

(ii) EUR 2,083 (two thousand and eighty-three euros) in respect of costs and expenses;

(iii) any tax that may be payable on these sums;

(b) that from the expiry of the above-mentioned three months until settlement simple interest shall be payable on the above amounts at a rate equal to the marginal lending rate of the European Central Bank during the default period plus three percentage points.

Done in English, and notified in writing on 25 January 2005, pursuant to Rule 77 §§ 2 and 3 of the Rules of Court.

S. DOLLÉ
Registrar

J.-P. COSTA
President

In accordance with Article 45 § 2 of the Convention and Rule 74 § 2 of the Rules of Court, the concurring opinions of Mr Costa and Mr Cabral Barreto are annexed to this judgment.

J.-P.C.
S.D.

CONCURRING OPINION OF JUDGE COSTA

(Translation)

1. Like all my colleagues, I considered that the applicant's involuntary placement in hospital infringed his right to liberty as enshrined in Article 5 of the Convention.

2. I did, however, have some hesitation regarding not so much the operative provisions of the judgment as the reasoning which must be provided as a basis for them.

3. There seems little doubt that in the present case Mr Enhorn's confinement breached Article 5, but why was this so? The answer, in my view, is not so obvious.

4. Admittedly, liberty is in general the rule and deprivation of liberty the exception. For that reason, the Court has always taken the view that the exceptions listed in Article 5 § 1 (a) to (f) are exhaustive and not purely illustrative and that the conditions in which they are to be deemed lawful must be strictly construed.

5. Article 5 § 1 (e), which provides for the possibility of depriving a person of his liberty "in accordance with a procedure prescribed by law" ("*selon les voies légales*" in French) where the purpose is "the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants", has not given rise to a very extensive body of case-law, apart from certain well-known judgments such as *Winterwerp v. the Netherlands*, (judgment of 24 October 1979, Series A no. 33) which relates to persons of unsound mind. There are virtually no precedents concerning "the prevention of the spreading of infectious diseases", and this contributes both to the interest and to the difficulty of the present case.

6. The applicant, who has the human immunodeficiency virus, is incontestably capable of "spreading" this sexually transmitted disease, and it has not been disputed that Article 5 § 1 (e) is applicable in his case. Aids was unknown when the Convention came into force, but the Convention is a living instrument which must be interpreted in the light of present-day conditions of living (and – alas! – dying).

7. The file and the judgment (see paragraph 8 of the judgment) reveal that the applicant did in fact spread the virus – in any event, once – in 1994 as a result of having sexual intercourse with another man. It should be noted, however, that it was at that time that he became aware that he was carrying the virus and that he had therefore spread it (without intending to).

8. The discovery of this fact caused the medical and judicial authorities to take measures in respect of the applicant, consisting firstly of prophylactic recommendations and subsequently, a few months later, of compulsory isolation in a hospital.

9. These measures had a legal basis in domestic law, namely the 1988 Infectious Diseases Act, in particular section 38, which is still in force although a parliamentary committee has recommended that recourse to compulsory isolation should be had only in exceptional cases (see paragraph 28 of the judgment). It seems clear to me that the measures in question were taken "in accordance with a procedure prescribed by law" within the meaning of Article 5 of the Convention.

10. For a detention to be "lawful", however, it must also, like any measure depriving a person of his liberty, be compatible with the purpose of Article 5, namely to protect the individual from arbitrariness (see, for example, *K.-F. v. Germany*, judgment of 27 November 1997, *Reports of Judgments and Decisions* 1997-VII, p. 2674, § 63).

11. That is where the assessment becomes delicate. On the one hand, allowing a person to infect healthy individuals, thereby exposing them to a serious and usually fatal illness, poses a grave danger to public health and, above all, to the right of individuals to health. A few days ago in France a person was sentenced to six years' imprisonment for deliberately transmitting Aids to uninfected partners. On the other hand, it should again be emphasised that liberty (which gives rise to responsibility) is and should be the rule. Systematic confinement of persons capable of spreading infectious diseases would turn them into outcasts; this would be an unacceptable step backwards in terms of human rights, which are founded on the principle of freedom and responsibility of the human being. It is acceptable only for limited periods ("quarantine"), where the disease is curable, as in the case of tuberculosis (I do not think that placement in a sanatorium is in principle contrary to Article 5), and where the disease is spread unintentionally, which is not normally the case with sexually transmitted diseases: what could be more intentional than the conduct of a person who has sexual intercourse without any precautions when he knows that he is infected (this was not the case for the applicant in 1994 – see paragraph 7 of this opinion)?

12. Paragraph 54 of the judgment attempts to provide a key to the problem. Repeated orders for the applicant's isolation were made over a total period of seven years. Such orders are the most radical measures available; other, less severe ones could have been taken. In sum, therefore, they were not balanced or proportionate, hence the finding of a violation.

13. I both agree and disagree with this reasoning. On a general level, it is consistent with the case-law, at least with regard to the existence of "less severe" measures (see, for example, *Witold Litwa v. Poland*, no. 26629/95, §§ 26 and 79, ECHR 2000-III) – although the judgment does not identify them. It could and should have done so, I feel, by reiterating the instructions issued to the applicant (see paragraph 9 of the judgment) before recourse was had to compulsory isolation.

14. However, I consider above all that the judgment should have drawn attention to two – contradictory – weaknesses in the approach taken by the Swedish authorities in this case. Firstly, for more than three-quarters of the lengthy period in which he was placed in isolation the applicant was at large, having absconded several times, apparently without any great effort being made to find him. If he was so dangerous that his confinement had to be prolonged, why was he *de facto* left at liberty with the risk of transmitting Aids? Secondly, it appears from the evidence that Mr Enhorn did not actually infect anyone, or indeed have any sexual relations, after 1994 (see the reference in paragraph 23 to the report drawn up in 1999 by a qualified psychiatrist). *A fortiori*, if there was no established risk that the applicant might pass on Aids, why was the order for his continued isolation extended for a further two and a half years?

15. All in all, this case illustrates both the difficulty of striking a balance between liberty (which should ultimately prevail) and the "protection of society", and perhaps a degree of hesitation in the Article 5 case-law between the criteria of *protection from arbitrariness*, *necessity*, and *proportionality*. I can accept in conceptual terms that a disproportionate deprivation of liberty is not necessary and that, if it is not necessary, it borders on arbitrary. However, some clarification would be desirable, particularly with a view to ensuring legal certainty. This would be especially helpful as developments in epidemiology might unfortunately lead to a greater number of applications similar to that of Mr Enhorn.

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CONCURRING OPINION OF JUDGE CABRAL BARRETO

(Translation)

I agree with the finding that there has been a violation of Article 5 § 1 of the Convention in the present case. However, in view of the significance of the interests at stake, I should like to add the following observations to explain why I came to that conclusion.

The facts of the case relate to a deprivation of liberty in the context of the measures which States are called upon to take in order to protect society from the potential acts of individuals who have contracted an infectious disease such as the Aids virus. The obvious aim of such measures is to prevent the spread of a disease whose consequences are exceptionally serious. The problem is that where such measures entail deprivation of liberty within the meaning of Article 5 § 1 of the Convention, they must be consistent with the Court's settled case-law, which is rightly stringent. I would point out in this connection that "when the matter is one which concerns *ordre public* within the Council of Europe, a scrupulous supervision by the organs of the Convention of all measures capable of violating the rights and freedoms which it guarantees is necessary in every case" (see *De Wilde, Ooms and Versyp v. Belgium*, judgment of 18 June 1971, Series A no. 12, p. 36, § 65). The aim of Article 5, which relates to individual liberty, is "to ensure that no one should be dispossessed of this liberty in an arbitrary fashion" (see *Guzzardi v. Italy*, judgment of 6 November 1980, Series A no. 39, p. 33, § 92). Furthermore, the list of exceptions to the right to liberty secured in Article 5 § 1 is an exhaustive one, meaning that "only a narrow interpretation of those exceptions is consistent with the aim and purpose of that provision" (see *Quinn v. France*, judgment of 22 March 1995, Series A no. 311, pp. 17-18, § 42).

The extensive case-law concerning the detention of persons of unsound mind (one of the scenarios referred to in paragraph 1 (e) of the provision in question) shows that the Court has always been particularly careful to examine whether a deprivation of liberty on this account was necessary when reviewing its "lawfulness" under the Convention. Such lawfulness "presupposes conformity with the domestic law in the first place and also, as confirmed by Article 18, conformity with the purpose of the restrictions permitted by Article 5 § 1 (e); it is required in respect of both the ordering and the execution of the measures involving deprivation of liberty". The validity of continued confinement depends upon the persistence of the disorder in question (see *Winterwerp v. the Netherlands*, judgment of 24 October 1979, Series A no. 33, pp. 17-18, § 39).

Confirmation of this manner of interpreting the safeguards in Article 5 may be found in a judgment concerning the detention of an applicant who, having caused a disturbance in a public place while in a state of

intoxication, was held in a sobering-up centre. In that particular case the Court held that "[t]he detention of an individual is such a serious measure that it is only justified where other, less severe measures have been considered and found to be insufficient to safeguard the individual or public interest which might require that the person concerned be detained" and that "it does not suffice that the deprivation of liberty is executed in conformity with national law but it must also be necessary in the circumstances" (see *Witold Litwa v. Poland*, no. 26629/95, § 78, ECHR 2000-III). The Court found that that had not been the case, seeing that the authorities had not shown that other measures less severe than deprivation of liberty had been considered and found to be insufficient to safeguard the individual or public interest requiring the detention.

In conclusion, I agree with the reasoning set out in the first part of paragraph 54 of the present judgment to the effect that the measures taken in respect of the applicant were not "relevant and sufficient".

However, I would like to distance myself from the reasoning – appearing, incidentally, as a supplementary consideration – concerning the review of the proportionality of the measure in terms of the fair balance to be struck between individual rights and the needs of the community. In my opinion, it follows both from the letter of the Court's settled case-law on deprivation of liberty and, above all, from the spirit that has imbued it and continues to do so, that if a review of a measure depriving a person of his liberty were to allow the State a certain margin of appreciation in such matters, this would not in any way accord with a line of case-law which, ever since *Lawless*, has taken care to stress the importance of the Article 5 safeguards even in a context in which recourse to Article 17 of the Convention might be necessary (see *Lawless v. Ireland* (merits), judgment of 1 July 1961, Series A no. 3, pp. 45-46, § 7).