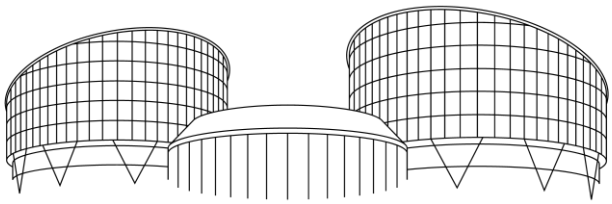

EUROPEAN COURT OF HUMAN RIGHTS
COUR EUROPÉENNE DES DROITS DE L'HOMME

FIRST SECTION

CASE OF KOZHOKAR v. RUSSIA

(Application no. 33099/08)

JUDGMENT

STRASBOURG

16 December 2010

FINAL

20/06/2011

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

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

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

Christos Rozakis, *President,*
Anatoly Kovler,
Elisabeth Steiner,
Dean Spielmann,
Sverre Erik Jebens,
Giorgio Malinverni,
George Nicolaou, *judges,*
and Søren Nielsen, *Section Registrar,*

Having deliberated in private on 25 November 2010,

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

PROCEDURE

1. The case originated in an application (no. 33099/08) 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 Vladimir Semenovich Kozhokar ("the applicant"), on 23 April 2008.

2. The applicant, who had been granted legal aid, was represented by Mr P. Finogenov, a lawyer with the International Protection Centre. 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 he had been detained in inhuman conditions, that he had not received adequate medical care and that he had not had adequate remedies at his disposal for his complaint about the inhuman conditions of his detention.

4. On 24 November 2009 the President of the First Section decided to communicate the above complaints to the Government. It was also decided to rule on the admissibility and merits of the application at the same time (Article 29 § 1). The President made a decision to give the application priority treatment (Rule 41 of the Rules of Court).

THE FACTS

I. THE CIRCUMSTANCES OF THE CASE

5. The applicant was born in 1980 and is currently serving a prison sentence in correctional colony no. 7 in the Tula Region.

A. Criminal proceedings against the applicant

6. In 2002 the applicant was convicted of drug trafficking and sentenced to seven years and three months' imprisonment. In 2005 he was granted an early release.

7. In the summer of 2006 the police received an anonymous complaint stating that the applicant and his friend Mr O. were making and selling drugs in their flats. The police questioned the applicant's neighbours, who confirmed unanimously that the applicant and Mr O. were drug dealers.

8. The police made a series of test purchases of drugs from the applicant and Mr O. In September and early October 2006 two persons code-named "Shadow" and "Yermak" asked the applicant and Mr O. to make drugs for them. They went on several occasions to Mr O.'s flat accompanied by their acquaintance Ms G. The applicant and Mr O. made opium from the ingredients bought by the applicant with Shadow's and Yermak's money. They then consumed the opium together.

9. On 18 October 2006 Yermak called the applicant, complained of withdrawal symptoms and asked him to procure him drugs. The applicant asked Ms G. to take 500 Russian roubles from Yermak and to change it in a nearby pharmacy. He then bought opium ingredients with that money and made opium in his flat. He met Yermak several hours later, handed a part of the opium over to him and left the remainder for himself. Yermak gave the opium received from the applicant to the police.

10. On the same day the applicant was arrested and charged with drug trafficking.

11. During the trial the Proletarskiy District Court of Tula heard numerous witnesses, including Shadow, Ms G., the applicant's neighbours and the police officers who had supervised the test purchases. Yermak's pre-trial depositions were read out as he had died before the start of the trial. The trial court also examined expert opinions and material evidence, such as the opium received by Shadow and Yermak from the applicant and Mr O. and utensils for making opium found in the applicant's and Mr O.'s flats.

12. On 19 September 2007 the Proletarskiy District Court of Tula acquitted the applicant of drug trafficking in respect of the episodes of September and early October, finding that on those occasions he had made drugs for personal consumption with his acquaintances rather than for sale.

It further convicted the applicant of drug trafficking for selling drugs on 18 October 2006. The applicant was sentenced to seven years' imprisonment.

13. On 12 December 2007 the Tula Regional Court upheld the judgment on appeal.

B. Conditions of the applicant's detention in the remand centre

1. The Government's description of the conditions of detention

14. From 20 October 2006 to 27 December 2007 the applicant was held in remand centre no. IZ-71/1 in Tula.

15. According to certificates of 23 October 2009 issued by the remand centre administration and submitted by the Government, from 20 October to 13 November 2006 the applicant was held in cell no. 77, which measured 80.4 sq. m and housed thirty-one to forty inmates. From 13 November 2006 to 31 January 2007 he was held in cell no. 76, which measured 37.4 sq. m and housed thirteen to twenty inmates. From 31 January to 26 September 2007 he was held in cell no. 17, measuring 76.9 sq. m and housing twenty-two to forty inmates. The Government also produced the plan of those cells confirming the cell measurements.

16. The same certificates state that the inmates were allowed to take a shower once a week for forty minutes and had an hour-long daily walk. It was not possible to establish the frequency of family visits or of the applicant's meetings with counsel. The applicant was also frequently taken out of the cell to see a doctor. Inmates suffering from infectious diseases, such as scabies, tuberculosis, HIV, hepatitis or sexually transmittable diseases, were held separately from other inmates. The applicant was never held together with anyone suffering from scabies or tuberculosis.

2. The applicant's description of the conditions of detention

17. According to the applicant, he was held in cells nos. 77, 76, 17 and 117. Cell no. 77 measured 48 sq. m. It was equipped with fifty bunks and housed forty-four to forty-seven inmates. Cell no. 76 measured 24 sq. m, was equipped with twenty bunks and housed thirty to forty-seven inmates. Cell no. 17 measured 48 sq. m. It was equipped with forty-two bunks and housed twenty-seven to fifty-eight inmates. As the number of bunks was often insufficient, inmates had to take turns to sleep. Punishment cell no. 117, where the applicant was held alone from 2 to 17 February 2007, measured 2 sq. m.

18. All cells were insufficiently lit. There was only one 50-watt light bulb in each cell. The windows were small. Some of them were broken and inmates had to cover the holes with cloth. There was no forced ventilation

and it was extremely hot in summer and very cold in winter. The cells were stuffy and smoky.

19. Each cell was equipped with a lavatory bowl which had no flush system. This was not separated from the living area and the person using the toilet was in view of the other inmates. The dining table was very close to the toilet.

20. The cells swarmed with rats, bugs, lice, spiders and cockroaches. The walls were covered with mould. Articles of hygiene were sparse. The bedding was dirty and ragged. All complaints to the detention facility administration about poor sanitary conditions went unanswered.

21. The applicant shared his cell with persons suffering from tuberculosis and scabies. He allegedly contracted scabies while in IZ-71/1.

22. Inmates were allowed to take a shower once a week. The entire cell population was taken to the shower hall for a total of twenty or thirty minutes. There were only four shower stands and the inmates had insufficient time to shower.

23. The food was insipid. There was neither fruit nor meat. Vegetables were rarely served. Fish was served in small quantities of no more than 40 grams per person per day. Although the applicant was prescribed a special diet by a doctor, no special food was provided.

24. The applicant submitted written statements by his co-detainees confirming his description of the conditions of detention.

25. The applicant attempted to lodge complaints about the appalling conditions with the prosecutor of the Tula region and the head of the penitentiary department of the Tula region. The remand centre administration did not dispatch his complaints. The warders threatened that he would suffer if he attempted to complain again. He was then put in a punishment cell for ten days.

26. It appears from the decision of 2 February 2007 issued by the acting head of remand centre no. IZ-71/1 that the applicant was put in a punishment cell for wrenching the tap off a drinking water tank and using it to make a hole in the wall through which he communicated with the inmates in the neighbouring cell.

27. The applicant also alleged that during the trial he had been regularly transported to the courthouse in inhuman conditions.

C. Medical assistance

28. According to a certificate of 23 October 2009 issued by the remand centre administration and submitted by the Government, remand centre no. IZ-71/1 in Tula, where the applicant was held from 20 October 2006 to 27 December 2007, had a medical unit. The medical staff consisted of a general physician, a specialist in skin and venereal diseases, a surgeon, an otolaryngologist, a dentist, a radiologist, a tuberculosis specialist, physician

assistants and nurses. The unit had all the necessary equipment and medication.

29. On 23 October 2006 the applicant was examined by a physician. He informed the doctor that he had been HIV-positive since 1999 and that he was also infected with hepatitis B and C viruses. On the same day he was examined by a psychiatrist who diagnosed him with drug withdrawal syndrome. An HIV antibody blood test confirmed that the applicant was indeed HIV-positive. A chest photofluorography was also performed.

30. On 13 November 2006 the applicant was examined by a drug addiction specialist from an HIV medical unit. He noted that the disease had attained clinical stage 3, but that the applicant's state of health was satisfactory. He prescribed a special diet. He further recommended that the applicant be held in a special cell for HIV-positive inmates and that general blood and urine tests and chest photofluorography be performed every six months.

31. On 23 January 2007 the applicant was examined by a psychiatrist. He complained of headache and liver pain. The doctor prescribed a pain reliever and liver pills.

32. On 7 March 2007 the applicant was examined by a nurse. He complained of liver pain. The nurse prescribed hepatoprotective herbal pills and antispasmodic pills.

33. On 23 March 2007 the applicant was examined by a surgeon. On 27 March 2007 a chest photofluorography was performed.

34. On 9 April 2007 general blood and urine tests were performed.

35. On 20 April 2007 a hepatitis C antibody blood test confirmed that the applicant was suffering from chronic hepatitis C.

36. On 22 April 2007 the applicant was examined by a psychiatrist.

37. On 25 April 2007 CD4, CD8 and viral load tests were made. The applicant's CD4 count was 0.462 x 10^9/l (equivalent to 462 cells/mm^3), while his HIV RNA (viral load) was 9,215 copies/ml.

38. On 8 June 2007 a nurse explained to the applicant the results of the CD4 and viral load tests.

39. On 22 August 2007 the applicant was examined by a general physician. He complained of pain in his left shoulder joint. He was diagnosed with arthrosis and prescribed anti-inflammatory treatment.

40. On 26 September 2007 a chest photofluorography was performed.

41. On 24 October 2007 CD4 and viral load tests were made for the second time. The applicant's CD4 count was 0.231 x 10^9/l (equivalent to 231 cells/mm^3), while his HIV RNA (viral load) was 5,282 copies/ml.

42. On 25 October 2007 the applicant was diagnosed with dermatitis and prescribed treatment for dermatitis and hepatoprotective pills.

43. On 30 October 2007 the applicant complained about insomnia and was prescribed sleeping pills.

44. At the end of 2007 a treatment schedule for 2008 was prepared. It was recommended that the applicant should be examined twice a year by a general physician, a tuberculosis specialist and an infectious disease specialist. Chest photofluorography and abdominal ultrasound scans were to be performed twice a year and the applicant was to receive a special diet.

45. On 27 December 2007 the applicant was examined by a general physician before being transferred to the correctional colony. The examining doctor confirmed the previous diagnosis. On the same day the applicant was transferred to correctional colony no. 7 in the Tula region.

46. On 17 January 2008 general blood and urine tests were performed.

47. On 20 February 2008 the applicant was examined by the colony's physician assistant. He noted that the applicant's health was satisfactory, his skin was healthy and the lymph nodes were not enlarged.

48. On 22 February 2008 the applicant was admitted to the prison hospital of the Tula region (no. IK-2, hereafter "Tula prison hospital"). He was examined by a neuropathologist and an ophthalmologist and underwent an abdominal ultrasound scan and a general blood test. The doctors prescribed anti-inflammatory treatment for arthrosis, hepatoprotective pills and vitamins.

49. On 27 February 2008 CD4 and viral load tests were performed. The applicant's CD4 count was 0.447 x 10^9/l (equivalent to 447 cells/mm^3), while his HIV RNA (viral load) was 3,377 copies/ml.

50. The applicant was discharged from hospital on 28 February 2008.

51. On 6 March 2008 the applicant was examined by the colony's physician assistant. He complained of an aching shoulder joint and liver pains. The physician's assistant noted that the applicant's health was satisfactory.

52. On the same day the applicant was examined by a psychiatrist who diagnosed him with heroin addiction in forced remission.

53. On 16 June 2008 the applicant complained of dizziness. He was examined by a nurse who diagnosed him with low blood pressure and prescribed vitamins.

54. On 15 September 2008 the applicant was again examined by the colony's physician assistant. The applicant again complained of liver pain and an aching shoulder joint. The physician assistant noted that the applicant's gall bladder was deformed but his health was otherwise satisfactory.

55. On 31 October 2008 the applicant again complained of an aching shoulder joint. He was prescribed pain relievers.

56. On 7 November 2008 the applicant was admitted to the surgery unit of Tula prison hospital. His shoulder joint was X-rayed and general blood and urine tests were made. He was diagnosed with arthrosis and prescribed pain relievers and physiotherapy.

57. On 14 November 2008 the applicant was discharged from hospital.

58. At the end of 2008 a treatment schedule for 2009 was prepared. It was noted that the applicant's HIV condition had attained clinical stage 3. It was recommended that the applicant be examined twice a year by a general physician, a tuberculosis specialist and an infectious disease specialist. He was also to undergo laboratory examinations twice a year, and chest photofluorography and abdominal ultrasound scans were to be performed twice a year. The applicant was also to receive a special diet.

59. On 12 February 2009 the applicant was granted disability status.

60. On 19 February 2009 the applicant was examined by the colony's physician assistant, who found that his health was satisfactory.

61. On 24 September 2009 the applicant was again examined by a physician assistant, who prescribed treatment for a respiratory infection and gum inflammation.

62. On 22 October 2009 the applicant was examined by a physician. He complained of fever, abdomen pains, cough, headache and heartburn. He was prescribed antibacterial pills.

63. On 23 October 2009 general blood and urine tests were made.

64. On 10 November 2009 the applicant was taken to Tula prison hospital for examination. He was examined by an ophthalmologist, a surgeon, a neuropathologist, a dentist, a psychiatrist and a general physician. He underwent general blood and urine tests, an ultrasound scan of the abdominal area and an electrocardiogram. He received vitamins and neuroleptic drugs.

65. On 11 November 2009 CD4 and viral load tests were performed. The applicant's CD4 count was 0.562 x 10^9/l (equivalent to 562 cells/mm^3), while his HIV RNA (viral load) was 7,845 copies/ml.

66. On 20 November 2009 the applicant was discharged from hospital.

67. At the end of 2009 a treatment schedule for 2010 was prepared. It was recommended that the applicant be examined twice a year by a physician, a tuberculosis specialist and an infectious disease specialist. Chest photofluorography, abdominal ultrasound scans and gastro-duodenoscopy were to be performed twice a year and the applicant was to receive a special diet.

68. On 28 January 2010 the applicant was again taken to Tula prison hospital for examination. He was examined by an ophthalmologist, a surgeon, a neuropathologist, a dentist, a psychiatrist, a dermatologist and an otolaryngologist and underwent an ultrasound scan of the abdominal area and a chest photofluorography. General blood and urine tests were also made. He received vitamins and physiotherapy. He was discharged on 10 February 2010. The hospital doctors recommended treatment for arthritis and gall bladder deformation and regular supervision by a general physician and a psychiatrist.

69. On 25 February 2010 the applicant was examined by a physician assistant, who found that his condition was satisfactory.

70. On 10 March 2010 a hepatitis B antibody blood test was performed which established that the applicant did not have hepatitis B.

II. RELEVANT DOMESTIC LAW

71. Section 22 of the Detention of Suspects Act (Federal Law no. 103-FZ of 15 July 1995) provides that detainees should be given free food sufficient to maintain them in good health according to standards established by the Government of the Russian Federation. Section 23 provides that detainees should be kept in conditions which satisfy sanitary and hygienic requirements. They should be provided with an individual sleeping place and given bedding, tableware and toiletries. Each inmate should have no less than four square metres of personal space in his or her cell.

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

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

74. 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.

75. Section X of the Regulation regulates medical examinations, monitoring and treatment of detainees suffering from HIV. In particular, it provides that medical examinations, monitoring and treatment of detainees infected with HIV should be performed in accordance with the general standards of medical assistance to HIV-positive patients. All HIV-positive detainees should be registered and their condition should be monitored regularly to secure timely diagnosis and treatment of diseases that may accelerate the progression of the HIV infection, timely identification of symptoms of such progression and timely prescription of specific therapy. During the initial examination of an HIV-infected detainee a doctor must confirm his HIV status, identify the clinical stage of the disease, detect possible opportunistic infections and set up an adequate course of treatment. The frequency of subsequent medical examinations depends on the clinical stage of the disease and the detainee's CD4 count. A detainee in clinical stage 3 of the disease and with a CD4 count exceeding 500 cells/mm³ must be examined by a doctor every twenty-four weeks, while a detainee in clinical stage 3 of the disease with a CD4 count lower than 500 cells/mm³ must be examined by a doctor every twelve weeks.

76. Order no. 474, on Standard medical assistance to persons infected with HIV, issued by the Ministry of Health and Social Development on 9 July 2007, provides that a person infected with HIV must be subjected to the following tests and examinations in particular, irrespective of the clinical stage of the disease:

- abdominal ultrasound scan twice a year;
- electrocardiography twice a year;
- chest photofluorography once or twice a year;
- a general blood test three or four times a year;
- a general urine test once a year;
- psychology consultation six times a year;
- HIV RNA (viral load) test twice a year;
- CD4 test four times a year.

III. RELEVANT INTERNATIONAL MATERIALS

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

"**4.2. Immunological assessment of HIV-infected adults and adolescents**

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

Table 3. CD4 criteria for the initiation of ART in adults and adolescents

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

...

The benchmark threshold marking a substantially increased risk of clinical disease progression is a CD4 cell count of 200 cells/mm^3. Although it is never too late to initiate ART, patients should preferably begin the therapy before the CD4 cell count drops to or below 200 cells/ mm^3. The optimum time to initiate ART with a CD4 cell count of 200−350 cells/mm^3 is unknown. Patients with CD4 cell counts in this range require regular clinical and immunological evaluation.

The treatment of patients with WHO clinical stage 4 disease should not depend on a CD4 cell count determination: all such patients should initiate ART. For WHO clinical stage 3 conditions, a threshold of 350 cells/ mm^3 has been identified as a level below which functional immune deficiency is present and ART should be considered... For patients with clinical stage 1 or 2 disease, a CD4 count below 200 cells/mm^3 is a clear indication for treatment. Although there are no randomized trial data on the CD4 cell count level at which to start therapy in asymptomatic persons, data from a number of cohorts have been consistent in demonstrating that disease progression is greater in persons who start antiretroviral therapy with CD4 counts below 200 cells/mm^3 than in those starting therapy above this level. In general these studies have not been able to detect a difference in outcome between persons who start therapy at CD4 counts of 200−350 cells/mm^3 and those who do so at CD4 counts above 350 cells/mm^3. However, if the CD4 count is above 350 cells/mm^3, ART should be delayed...

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

WHO clinical staging	CD4 testing not available	CD4 testing available
1	Do not treat	Treat if CD4 count is below 200 cells/mm^3
2	Do not treat	

3	Treat	Consider treatment if CD4 count is below 350 cells/mm^3 and initiate ART before CD4 count drops below 200 cells/mm^3
4	Treat	Treat irrespective of CD4 count

...

4.3. Virological assessment of HIV-infected adults and adolescents

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

13. Considerations in hepatitis B or hepatitis C coinfection

...

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

Irrespective of whether a patient has HIV infection, the optimal treatment for hepatitis C virus infection is pegylated interferon alpha and ribavirin (RBV)... The initiation of ART in HIV/HCV-coinfected patients should follow the same principles and recommendations as for the initiation of ART in HIV-monoinfected patients. However, the patients should be followed up more closely because of the major risk of drug-related hepatotoxicity and for specific drug interactions of some ARVs with anti-HCV drugs... In patients with high CD4 cell counts it is preferable to treat HCV infection before HIV. While concurrent treatment of both infections is feasible, it may be complicated by pill burden ..., drug toxicities and drug interactions. In patients who need ART it may be preferable to initiate ART and delay HCV therapy in order to obtain better anti-HCV response rates after immune recovery...

15. Clinical and laboratory monitoring

...

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

> Secondly, once patients have been initiated on ART, regular monitoring is necessary to assess efficacy, manage side-effects and identify treatment failure...
>
> Because resources are limited, laboratory testing should generally be directed by signs and symptoms and should be done only when the results can be used to guide management decisions. Exceptions are the recommendations to obtain a CD4 cell count every six months...
>
> **15.2. Monitoring of patients who are not yet eligible for ART**
>
> Patients who are not yet eligible for ART should be monitored for clinical progression and by CD4 count measurement every six months. Clinical evaluation should include the same parameters as are used in baseline evaluations, including weight gain or loss and development of clinical signs and symptoms of progressive HIV disease. These clinical parameters and the CD4 cell count should be used to update the WHO disease stage at each visit and to determine whether patients have become eligible for [opportunistic infections] prophylaxis or ART. Clinical evaluation and CD4 counts can be obtained more frequently as the clinical or immunological threshold for initiating ART approaches (Table 4)..."

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

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

THE LAW

I. ALLEGED VIOLATION OF ARTICLES 3 AND 13 OF THE CONVENTION IN RELATION TO THE CONDITIONS OF THE APPLICANT'S DETENTION

80. The applicant complained that the conditions of his detention in remand centre no. IZ-71/1 in Tula had been in breach of Article 3 of the Convention. Relying on Article 13 of the Convention, he claimed that no

domestic remedy had been available to him in order to obtain an improvement in the conditions of detention. The relevant Articles provide:

Article 3

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

Article 13

"Everyone whose rights and freedoms as set forth in [the] Convention are violated shall have an effective remedy before a national authority notwithstanding that the violation has been committed by persons acting in an official capacity."

A. Submissions by the parties

1. The Government

81. The Government submitted, firstly, that the applicant had had effective domestic remedies at his disposal and that he had failed to exhaust them. In particular, he could have complained about the conditions of his detention to a prosecutor. They referred to improvements in the conditions of detention which had been made in response to complaints lodged with the prosecutor's office by Mr N., Mr D., Mr Sh. and Mr Z. (a medical unit had been created, medicines purchased and maintenance work carried out). A prosecutor also had competence to open criminal proceedings against those responsible and his refusal to open such proceedings could be challenged before a court. In the alternative, it was open to the applicant to bring a court action in tort. To prove the effectiveness of that remedy, they cited the case of *Shilbergs v. Russia* (no. 20075/03, 17 December 2009), where the domestic courts had awarded adequate compensation to a detainee held in inhuman conditions. They also submitted copies of two judgments awarding Mr D. and Mr R. compensation for non-pecuniary damage. Mr D. had been awarded 25,000 Russian roubles (RUB) for detention in overcrowded cells, while Mr R. had been granted RUB 300,000 for incompetent medical assistance resulting in blindness. They also referred to two more domestic judgments by which Mr S. and Mr M. had been awarded monetary compensation for inadequate conditions of detention.

82. The Government conceded that the applicant's cells had been overcrowded. They argued, however, that inmates spent substantial periods of time outside the cells. In particular, they participated in the investigative measures, had meetings with the investigator and counsel, had family visits, were taken daily to the exercise yard and regularly to the shower room.

They also had an opportunity to pray in specially-designed premises or work in production workshops. They could also obtain psychological consultation. The conditions of the applicant's detention had therefore been satisfactory and in compliance with the requirements of Article 3.

2. The applicant

83. The applicant argued that he did not have effective remedies for his complaint about the appalling conditions of detention. He referred to the case of *Benediktov v. Russia* (no. 106/02, 10 May 2007), where the Court had found a violation of Article 13 on account of the absence in Russia of an effective remedy in respect of inhuman and degrading conditions of detention. He also cited the cases of *Kalashnikov v. Russia* ((dec.), no. 47095/99, 18 September 2001), *Moiseyev v. Russia* ((dec.), no. 62936/00, 9 December 2004) and *Mamedova v. Russia* (no. 7064/05, § 57, 1 June 2006), where the Court had noted that the problems arising from the conditions of the applicants' detention had apparently been of a structural nature, for which no effective domestic remedy had been shown to exist. In the applicant's opinion, the Government had not put forward any argument capable of calling the above findings into question. The rare examples cited by the Government of redress being obtained by a detainee through an application to the domestic authorities were exceptions to the general rule.

84. The applicant submitted that he had complained about the inhuman conditions of detention to the supervising prosecutor during his regular inspection tours of the remand centre. The prosecutor had therefore been aware of the appalling conditions in the remand centre. However, no attempts to redress the situation had been made and all complaints had remained unanswered. An action in tort was also ineffective. In the absence of statutory criteria for the evaluation of non-pecuniary damage sustained through detention in inhuman conditions or of established case-law of the domestic courts in that sphere, the outcome of such action would be unpredictable. The applicant also stated that on several occasions he had attempted to send complaints about the inhuman conditions of detention to the prosecutor of the Tula region, the ombudsman and the head of the penitentiary department of the Tula region. Those complaints had however been intercepted by the remand centre management, the applicant had been threatened with reprisals and had been placed in a punishment cell (see paragraphs 25 and 26 above).

85. Further, the applicant challenged the Government's description of conditions in remand centre no. IZ-71/1 as factually untrue. In actual fact the cells had been smaller and the number of inmates per cell had been greater than suggested by the Government. Inmates had in fact had between 0.5 and 1.7 sq. m of personal space. However, even assuming that the Government's account of the cell measurements and the number of inmates

in the cells had been correct, the overcrowding was still so severe that the applicant had only had between 1.9 and 3.5 sq. m of personal space. Given that he had been held in these appallingly overcrowded conditions for more than a year and two months, that factor amounted in itself to inhuman treatment. The cells had moreover been dark, cold, stuffy, smoky and infested with parasites. Toilet facilities had been filthy and foul smelling and offered no privacy. The applicant had not always had a bed for himself. The bedding had been dirty and ragged and had to be shared by several inmates. The food had been of extremely poor quality.

86. The applicant also submitted that he had been confined to his cell day and night, save for the days when he had been transported to the courthouse for a hearing. However, the conditions of transport had been even more appalling than the living conditions in the cells.

87. Finally, the applicant argued that his situation was exacerbated still further by the fact that he suffered from HIV. As a result of overcrowding and poor sanitary conditions he had run a high risk of contracting various infectious diseases, such as tuberculosis and scabies. His health had deteriorated and he had started to suffer from various ailments, such as colds, headaches, abdominal pains, depressions and deteriorating eyesight.

B. The Court's assessment

1. Admissibility

88. The Government raised the objection of non-exhaustion of domestic remedies by the applicant. The Court considers that the issue of exhaustion of domestic remedies is closely linked to the merits of the applicant's complaint that he did not have at his disposal an effective remedy for complaining about the inhuman and degrading conditions of his detention. Thus, the Court finds it necessary to join the Government's objection to the merits of the applicant's complaint under Article 13 of the Convention.

89. The Court further notes that the applicant's complaints under Articles 3 and 13 of the Convention are not manifestly ill-founded within the meaning of Article 35 § 3 of the Convention and that they are not inadmissible on any other grounds. They must therefore be declared admissible.

2. Merits

(a) Article 13 of the Convention

90. The Court reiterates that Article 13 of the Convention guarantees the availability at national level of a remedy to enforce the substance of Convention rights and freedoms in whatever form they might happen to be

secured in the domestic legal order. The effect of Article 13 is thus to require the provision of a domestic remedy to deal with the substance of an "arguable complaint" under the Convention and to grant appropriate relief. The scope of the obligation under Article 13 varies depending on the nature of the applicant's complaint under the Convention. Nevertheless, the remedy required by Article 13 must be effective in practice as well as in law. The "effectiveness" of a "remedy" within the meaning of Article 13 does not depend on the certainty of a favourable outcome for the applicant. Nor does the "authority" referred to in that provision necessarily have to be a judicial authority; but if it is not, its powers and the guarantees which it affords are relevant in determining whether the remedy before it is effective (see, among many other authorities, *Kudła v. Poland* [GC], no. 30210/96, § 157, ECHR 2000-XI). Further, having regard to the "close affinity" between Article 13 and Article 35 § 1 of the Convention (see *Mifsud v. France* (dec.) [GC], no. 57220/00, ECHR 2002-VIII, and *Kudła,* cited above, § 152), the notion of "effective" remedy has the same meaning in both provisions (see, *mutatis mutandis*, *Davenport v. Portugal* (dec.), no. 57862/00, 20 January 2000).

91. The Court notes that it has already found a violation of Article 13 on account of the absence of an effective remedy in respect of inhuman and degrading conditions of detention in Russia (see *Benediktov v. Russia*, no. 106/02, § 29, 10 May 2007), where it concluded:

> "[T]he Government did not demonstrate what redress could have been afforded to the applicant by a prosecutor, a court or other State agencies, taking into account that the problems arising from the conditions of the applicant's detention were apparently of a structural nature and did not only concern the applicant's personal situation (compare *Moiseyev v. Russia* (dec.), no. 62936/00, 9 December 2004; *Kalashnikov v. Russia* (dec.), no. 47095/99, 18 September 2001; and, most recently, *Mamedova v. Russia*, no. 7064/05, § 57, 1 June 2006). The Government have failed to submit evidence as to the existence of any domestic remedy by which the applicant could have complained about the general conditions of his detention, in particular with regard to the structural problem of overcrowding in Russian detention facilities, or that the remedies available to him were effective, that is to say that they could have prevented violations from occurring or continuing, or that they could have afforded the applicant appropriate redress (see, to the same effect, *Melnik v. Ukraine*, no. 72286/01, §§ 70-71, 28 March 2006; *Dvoynykh v. Ukraine*, no. 72277/01, § 72, 12 October 2006; and *Ostrovar v. Moldova*, no. 35207/03, § 112, 13 September 2005)."

92. The Court has also rejected identical objections about the applicant's failure to exhaust domestic remedies raised by the Russian Government in a number of cases regarding the conditions of detention, having found that neither a complaint to the prosecutor (see, for example, *Aleksandr Makarov v. Russia*, no. 15217/07, §§ 84-86, 12 March 2009, and *Ananyin v. Russia*, no. 13659/06, § 62, 30 July 2009) nor a tort action (see, for example, *Aleksandr Makarov*, cited above, §§ 87-89, and *Artyomov v. Russia*,

no. 14146/02, § 112, 27 May 2010) could be regarded as an effective remedy for the purpose of Article 35 § 1 of the Convention.

93. In the case in hand, the Government submitted no evidence to enable the Court to depart from these findings with regard to the existence of an effective domestic remedy for the structural problem of overcrowding in Russian detention facilities. Although they referred to several prosecutor's decisions and two court judgments concerning Mr S. and Mr M. which had allegedly provided redress for inadequate conditions of detention, they did not produce copies of those decisions and judgments. In the absence of documents supporting the Government's assertion, the Court is unable to identify the relevance of the impugned decisions and judgments to the issue of the effectiveness of a complaint to the prosecutor or a court action for damages as a remedy in the circumstances of the present case. As regards two court judgments copies of which were submitted by the Government, one of them, in respect of Mr R., did not concern detention in overcrowded cells but rather incompetent medical assistance resulting in blindness. The other judgment, by which an award was made in favour of Mr D., does not suffice, in the Court's view, to show the existence of settled domestic practice that would prove the effectiveness of the remedy (see, for a similar approach, *Horvat v. Croatia*, no. 51585/99, § 44, ECHR 2001-VIII). Lastly, the Court takes note of the Government's reliance on the case of *Shilbergs v. Russia* which, in their view, provided an example of adequate compensation awarded by domestic courts to a detainee held in inhuman conditions. The Court, however, observes that it found that, taking into account that the amount of the award was substantially reduced by the domestic courts on account of the State's financial difficulties, the redress afforded to the applicant was insufficient and manifestly unreasonable in the light of its case-law (see *Shilbergs*, cited above, §§ 82-91). It follows that the Government did not point to any effective domestic remedy by which the applicant could have obtained appropriate redress for the allegedly inhuman and degrading conditions of his detention.

94. Accordingly, the Court rejects the Government's argument as to non-exhaustion of domestic remedies and concludes that there has been a violation of Article 13 of the Convention on account of the lack of an effective and accessible remedy under domestic law for the applicant to complain about the conditions of his detention in remand centre no. IZ-71/1.

(b) Article 3 of the Convention

95. The Court notes at the outset that the parties disputed certain aspects of the conditions of the applicant's detention in remand centre no. IZ-71/1 in Tula. In particular, they disagreed about the cell measurements and the number of inmates in the cells. The Court observes that the Government confined their supporting evidence to numerous certificates from the remand centre management issued on 23 October 2009, that is, long after

the applicant had left the remand centre. They have not submitted any source materials on the basis of which the assertions contained in those certificates could be verified. The Court would reiterate that on several previous occasions it has declined to accept the validity of similar certificates on the ground that they could not be viewed as sufficiently reliable given the lapse of time involved and the absence of any supporting documentary evidence (see *Kokoshkina v. Russia*, no. 2052/08, § 60, 28 May 2009; *Sudarkov v. Russia*, no. 3130/03, § 43, 10 July 2008; and *Belashev v. Russia*, no. 28617/03, § 52, 13 November 2007). The certificates are therefore of little evidentiary value for the Court. By contrast, the applicant, who described the conditions of his detention in great detail, submitted written affidavits by his former cell-mates confirming his account. The Court is therefore inclined to give more credit to the applicant's description of the conditions of detention. However, there is no need for the Court to decide the disagreement between the parties and establish the truthfulness of each and every allegation, because it finds a violation of Article 3 on the basis of the facts that have been presented by the respondent Government, for the following reasons.

96. The Court takes note of the Government's concession that the cells in which the applicant was held were overcrowded. According to the information submitted by the Government, for most of his detention in the remand centre, which lasted more than a year and two months, the applicant had between 2 and 3 sq. m of personal space. Although in cell no. 17 his personal space was on some occasions as much as 3.5 sq. m, in cells nos. 76 and 17 it was at times reduced to less than 2 sq. m. The Court reiterates in this connection that in previous cases where the applicants disposed of less than 3 sq. m of personal space, it found that the overcrowding was so severe as to justify, in its own right, a finding of a violation of Article 3 of the Convention. Accordingly, it was not necessary to assess other aspects of the physical conditions of detention (see, for example, *Lind v. Russia*, no. 25664/05, § 59, 6 December 2007; *Kantyrev v. Russia*, no. 37213/02, §§ 50-51, 21 June 2007; *Andrey Frolov v. Russia*, no. 205/02, §§ 47-49, 29 March 2007; *Mayzit v. Russia*, no. 63378/00, § 40, 20 January 2005; and *Labzov v. Russia*, no. 62208/00, § 44, 16 June 2005).

97. Having regard to its case-law on the subject and the material submitted by the parties, the Court notes that the Government have not put forward any fact or argument capable of persuading it to reach a different conclusion in the present case. Even assuming that the applicant occasionally had an opportunity to leave his cell for meetings with the investigator, counsel or relatives and for showers or outdoor exercise, as the Government alleged without any documentary substantiation showing the frequency of such occasions, the fact remains that for the greatest part of the day the applicant was confined to his cell. That the applicant was obliged to live, sleep and use the toilet in the same cell with so many other inmates

was itself sufficient to cause distress or hardship of an intensity exceeding the unavoidable level of suffering inherent in detention, and arouse in him feelings of fear, anguish and inferiority capable of humiliating and debasing him.

98. The Court concludes that by keeping the applicant in overcrowded cells, the domestic authorities subjected him to inhuman and degrading treatment. There has therefore been a violation of Article 3 of the Convention on account of the conditions of the applicant's detention in remand centre no. IZ-71/1 in Tula.

II. ALLEGED VIOLATION OF ARTICLE 3 OF THE CONVENTION ON ACCOUNT OF INSUFFICIENT MEDICAL ASSISTANCE

99. The applicant complained under Article 3 of the Convention of the allegedly inadequate medical assistance afforded to him in remand centre no. IZ-71/1 in Tula and in correctional colony no. 7 in the Tula Region.

A. Submissions by the parties

100. The Government submitted, firstly, that the applicant had failed to exhaust domestic remedies. They further argued that he had received medical assistance appropriate to his condition. Antiviral therapy for hepatitis C and antiretroviral treatment for HIV were not required in his case.

101. The applicant submitted that he suffered from HIV and hepatitis C, very serious and life-threatening diseases. The medical assistance afforded to him in the remand centre and in the correctional colony had been inadequate. He had not been examined by an infectious disease specialist, a hepatologist or an HIV specialist. His CD4 count had not been monitored four times a year as required by domestic law. He had not received antiretroviral therapy. As a result of the insufficient medical assistance his diseases had progressed and his life expectancy had been substantially reduced. He argued that he had complained to the head of the medical unit about the inadequate treatment, but his complaints had gone unanswered.

B. The Court's assessment

1. Admissibility

102. As to the Government's objection of non-exhaustion, the Court reiterates that in the area of the exhaustion of domestic remedies, there is a distribution of the burden of proof. It is incumbent on the Government claiming non-exhaustion to satisfy the Court that the remedy was an

effective one available in theory and in practice at the relevant time, that is to say, that it was accessible, was one which was capable of providing redress in respect of the applicant's complaints and offered reasonable prospects of success. However, once this burden of proof has been satisfied it falls to the applicant to establish that the remedy advanced by the Government had in fact been used or was for some reason inadequate and ineffective in the particular circumstances of the case or that there existed special circumstances absolving him or her from the requirement (see, among other authorities, *Akdivar and Others v. Turkey*, 16 September 1996, § 68, *Reports of Judgments and Decisions* 1996-IV).

103. The Court notes that in the present case the Government did not explain what possible avenues of exhaustion could have been employed by the applicant. Given that the Government did not point to any effective domestic remedy capable of providing preventive or compensatory redress in respect of the applicant's complaints of inadequate treatment of HIV and hepatitis C, the Court dismisses the Government's objection as to the applicant's failure to exhaust domestic remedies.

104. The Court further 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

105. The Court reiterates that although Article 3 of the Convention cannot be construed as laying down a general obligation to release detainees on health grounds, it nonetheless imposes an obligation on the State to protect the physical well-being of persons deprived of their liberty by, among other things, providing them with the requisite medical assistance (see *Khudobin v. Russia*, no. 59696/00, § 93, ECHR 2006-XII (extracts); *Mouisel v. France*, no. 67263/01, § 40, ECHR 2002-IX; and *Kudła,* cited above, § 94). The Court has held on many occasions that the lack of appropriate medical care may amount to treatment contrary to Article 3 (see, for example, *Wenerski v. Poland*, no. 44369/02, §§ 56 to 65, 20 January 2009; *Popov v. Russia*, no. 26853/04, §§ 210 to 213 and 231 to 237, 13 July 2006; and *Nevmerzhitsky v. Ukraine*, no. 54825/00, §§ 100-106, ECHR 2005-II (extracts)).

106. The "adequacy" of medical assistance remains the most difficult element to determine. 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 v. Ukraine*, no. 72286/01, §§ 104-106, 28 March 2006; and, *mutatis mutandis, Holomiov v. Moldova*, no. 30649/05, § 121, 7 November 2006), and that where necessitated by the nature of a medical condition, supervision is regular and systematic and involves a comprehensive

therapeutic strategy aimed at curing the detainee's health problems or preventing their aggravation (see *Hummatov*, cited above, §§ 109 and 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 *Mirilashvili 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).

107. On the whole, the Court retains 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).

108. Turning to the present case, the Court notes that it is undisputed between the parties that the applicant has been HIV-positive since 1999, that at the moment of his arrest in October 2006 his disease was at an advanced stage (clinical stage 3 characterised by emergence of opportunistic infections) and that he was also co-infected with hepatitis C virus. The main dispute between the parties concerns whether antiretroviral therapy for HIV and antiviral therapy for hepatitis C should have been administered to the applicant while in detention. However, it is not the Court's task to rule on matters lying exclusively within medical specialists' field of expertise and establish whether the applicant in fact required such treatment. Instead, in order to determine whether Article 3 of the Convention has been complied with, the Court will focus on determining whether the domestic authorities provided the applicant with sufficient medical supervision capable of effectively assessing his condition and setting up an adequate course of treatment for his diseases. It considers that, given the nature and seriousness of the applicant's ailments, his condition required regular and specialised medical supervision for monitoring of the progression rate of his hepatitis C and HIV diseases, timely prescription of the requisite HIV and hepatitis C therapies and timely diagnosis and treatment of possible opportunistic infections (see, *mutatis mutandis*, *Kats and Others v. Ukraine*, no. 29971/04, § 105, 18 December 2008, and *Popov*, cited above, § 211).

109. In order to determine the scope of such supervision, the Court has regard to Regulation no. 640/190 issued by the Ministry of Health and the Ministry of Justice and Order no. 474 issued by the Ministry of Health establishing the minimum extent of medical assistance required for HIV-positive persons (see paragraphs 75 and 76 above). In accordance with the Regulation, an HIV-positive detainee in clinical stage 3 of the disease must be examined by a doctor every twenty-four or twelve weeks,

depending on his CD4 count. The Order provides that a person suffering from HIV must be regularly subjected to blood and urine tests, including a CD4 count test four times a year, as well as to other examinations, such as an abdominal ultrasound scan, electrocardiography and chest photofluorography. The importance of CD4 testing at least every six months to determine whether the affected person has become eligible for antiretroviral therapy has also been stressed by the World Health Organisation (see paragraph 77 above). Most important of all, recommendations for regular laboratory tests and regular consultations by specialist doctors were made during the applicant's examination by a doctor from an HIV-infection medical unit and in the treatment schedules prepared at the end of each year (see paragraphs 30, 44, 58 and 67 above). Having regard to the above, the Court concludes that the minimum scope of medical supervision required for the applicant's condition included examinations by a general physician, an infectious disease specialist and a tuberculosis specialist twice a year and laboratory examinations consisting of blood and urine tests, chest photofluorography and an abdominal ultrasound scan at least twice a year. The Court will now examine whether this scope of medical supervision was available to the applicant.

110. In this connection, the Court cannot but note the apparent lack of systematic and strategic supervision. While the applicant was repeatedly subjected to blood and urine tests and other laboratory examinations, his medical records reveal that these measures were insufficiently prompt, coherent and regular. Indeed, on many occasions the examination schedule was not adhered to and the tests were performed with notable delays. Thus, no general blood or urine tests were performed between April 2007 and January 2008 and between November 2008 and October 2009. CD4 count tests were even more irregular. The applicant was not subjected to CD4 count tests from February 2008 to November 2009, that is for about a year and nine months. The Court also notes with concern the irregularity of other laboratory examinations, such as chest photofluorography and abdominal ultrasound scans. During the four years the applicant has spent in detention the ultrasound scan was performed only three times, in February 2008, November 2009 and January 2010. As to the chest photofluorography, it was initially performed every six months in accordance with the examination schedule, but that laudable practice was subsequently abandoned and no chest photofluorography was made for two years and four months, from March 2007 to January 2010. Given that the above tests and examinations were essential for effective monitoring of the applicant's condition, timely diagnosis of possible opportunistic infections and identification of the point at which he became eligible for antiretroviral therapy for HIV, it is regrettable that they were performed haphazardly.

111. Further, it follows from the applicant's medical records that during the entire period of his detention he was examined by a general physician

only four times – twice in 2007 and twice in 2009. Except for several consultations by a dentist, ophthalmologist, otolaryngologist, dermatologist, neuropathologist, surgeon and psychiatrist, none of whom had expertise in the treatment of HIV disease and hepatitis C, the applicant's condition was monitored by a physician assistant who apparently took all decisions concerning the applicant's diagnosis and treatment. The applicant was never examined by an infectious disease specialist or a tuberculosis specialist, although biannual consultations by these specialist doctors were repeatedly recommended to him. Having regard to the vulnerability of HIV-positive persons to other serious diseases, the Court finds the lack of expert medical attention to the applicant's condition unacceptable (see, for similar reasoning, *Kats and Others*, cited above, § 107*)*.

112. The fact that the applicant was never examined by an infectious disease specialist is especially striking in view of his repeated complaints of liver pains. Taking into account that the course of hepatitis C-associated liver disease is known to be accelerated among persons with HIV coinfection (see paragraph 77 above), a consultation by an infectious disease specialist or other doctor with expertise in the treatment of hepatitis C seemed to be particularly warranted. It was for such a doctor to examine the applicant physically and to assess whether any additional laboratory examinations were necessary for the correct diagnosis of his condition and whether antiviral treatment was required in his situation. The Court is therefore not convinced by the Government's argument that the applicant did not require antiviral treatment for hepatitis C, because the materials in its possession do not allow it to establish with clarity which doctor made such a decision and on what date (see, for a similar reasoning, *Mechenkov v. Russia*, no. 35421/05, § 108, 7 February 2008).

113. Lastly, the Court observes that the applicant was prescribed a special diet (see paragraphs 30, 44, 58 and 67 above). However, it accepts the applicant's argument, not contested by the Government, that the detention authorities did not implement the doctors' recommendations of a special diet necessary to maintain his health (see *Gorodnitchev v. Russia*, no. 52058/99, § 91, 24 May 2007).

114. To sum it up, the evidence put before the Court shows that the medical supervision of the applicant has been unregulated and erratic. There is no evidence that he has been subjected to systematic examinations or that his condition has been regularly checked by sufficiently qualified medical personnel capable of effectively assessing his condition and setting up an adequate course of treatment for his diseases. In the light of the findings concerning the lack of a comprehensive approach to the applicant's medical supervision and given the serious diseases from which he is suffering, the medical attention provided to him cannot be considered adequate.

115. It follows from the above that the Government did not provide sufficient evidence to enable the Court to conclude that the applicant has

received comprehensive, effective and regular medical assistance in respect of his hepatitis C and HIV diseases during his detention in remand centre no. IZ-71/1 in Tula and in correctional colony no. 7 in the Tula Region. It does not appear from the evidence available that the applicant's condition has seriously deteriorated or that he was exposed to prolonged severe pain due to lack of adequate medical assistance. In such circumstances, the Court finds that the suffering he may have endured did not amount to inhuman treatment. However, the Court considers that the lack of adequate medical treatment posed very serious risks to the applicant's health and must have caused him considerable mental suffering diminishing his human dignity, which amounted to degrading treatment within the meaning of Article 3 of the Convention (see, for similar reasoning, *Hummatov*, cited above, § 121).

116. Accordingly, there has been a violation of Article 3 of the Convention on account of the authorities' failure to comply with their responsibility to ensure adequate medical assistance to the applicant during his detention in the remand centre and in the correctional colony.

III. OTHER ALLEGED VIOLATIONS OF THE CONVENTION

117. Lastly, the Court has examined the other complaints submitted by the applicant. However, having regard to all the material in its possession, and in so far as these complaints fall within the Court's jurisdiction, 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.

IV. APPLICATION OF ARTICLE 41 OF THE CONVENTION

118. 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

119. The applicant claimed 3,000,000 Russian roubles (RUB) in respect of non-pecuniary damage.

120. The Government submitted that the claim was excessive.

121. The Court accepts that the applicant suffered distress and frustration which cannot be compensated for solely by the finding of a

violation. Making its assessment on an equitable basis, the Court awards the applicant EUR 27,000 in respect of non-pecuniary damage.

B. Costs and expenses

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

C. Default interest

123. 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. *Decides* to join to the merits the Government's objection as to the exhaustion of domestic remedies in respect of the applicant's complaint about the allegedly inhuman and degrading conditions of detention and rejects it;

2. *Declares* the complaints concerning the allegedly inhuman conditions of the applicant's detention in remand centre no. IZ-71/1 in Tula, the allegedly inadequate medical assistance afforded to him and the absence of an effective remedy for his complaints about the conditions of detention admissible and the remainder of the application inadmissible;

3. *Holds* that there has been a violation of Article 13 of the Convention on account of the absence of an effective remedy for the complaints about conditions of detention in remand centre no. IZ-71/1;

4. *Holds* that there has been a violation of Article 3 of the Convention on account of the inhuman conditions of the applicant's detention in remand centre no. IZ-71/1 from 20 October 2006 to 27 December 2007;

5. *Holds* that there has been a violation of Article 3 of the Convention on account of the inadequate medical assistance afforded to the applicant;

6. *Holds*
   (a) that the respondent State is to pay the applicant, within three months from the date on which the judgment becomes final in accordance with Article 44 § 2 of the Convention, EUR 27,000 (twenty-seven thousand

euros), plus any tax that may be chargeable, in respect of non-pecuniary damage, to be converted into Russian roubles at the rate applicable at the date of settlement;

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

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

Done in English, and notified in writing on 16 December 2010, pursuant to Rule 77 §§ 2 and 3 of the Rules of Court.

Søren Nielsen Registrar	Christos Rozakis President