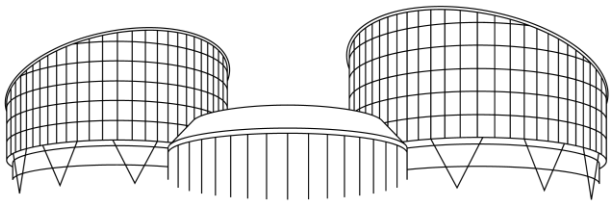

EUROPEAN COURT OF HUMAN RIGHTS
COUR EUROPÉENNE DES DROITS DE L'HOMME

THIRD SECTION

CASE OF MAKHARADZE AND SIKHARULIDZE v. GEORGIA

(Application no. 35254/07)

JUDGMENT

STRASBOURG

22 November 2011

FINAL

22/02/2012

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

In the case of Makharadze and Sikharulidze v. Georgia,

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

Josep Casadevall, *President*,
Alvina Gyulumyan,
Egbert Myjer,
Ján Šikuta,
Luis López Guerra,
Nona Tsotsoria,
Mihai Poalelungi, *judges*,
and Marialena Tsirli, *Deputy Section Registrar*,

Having deliberated in private on 3 November 2011,

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

PROCEDURE

1. The case originated in an application (no. 35254/07) against Georgia lodged with the Court under Article 34 of the Convention for the Protection of Human Rights and Fundamental Freedoms ("the Convention") by two Georgian nationals, Mr Niko Makharadze and Mrs Dali Sikharulidze ("the applicants"), on 16 July 2007 and 3 June 2009 respectively. On 29 January 2009 Mr Niko Makharadze ("the first applicant") died. On 3 June 2009 Mrs Dali Sikharulidze, his wife, informed the Court of her intention to pursue the proceedings in her own name as well as on behalf of her late husband.

2. The applicants were successively represented by Mr Zaza Khatiashvili and Mr Ioseb Khatiashvili, lawyers practising in Tbilisi. The Georgian Government ("the Government") were represented by their Agent, Mr Levan Meskhoradze.

3. The applicants alleged, in particular, that the respondent State had failed to protect the first applicant's life and health in prison and to implement a medical interim measure indicated by the Court.

4. On 11 December 2009 the Court decided to communicate the complaints under Articles 2, 3 and 34 of the Convention to the Government (Rule 54 § 2(b) of the Rules of Court). It was also decided to rule on the admissibility and merits of the application at the same time (Article 29 § 1).

THE FACTS

I. THE CIRCUMSTANCES OF THE CASE

A. Domestic proceedings

5. On 14 March 2006 the first applicant, born in 1967, was arrested on account of his purported connection with the criminal world and possession of drugs, offences prosecuted respectively by Articles 223(1) § 2 and 260 § 2 (a) of the Criminal Code. On 16 March the Tbilisi City Court ordered his detention pending trial. He was subsequently placed in Ksani no. 7 prison.

6. On 17 March 2006 the first applicant appealed against the detention order of 16 March 2006, complaining, *inter alia*, that the pre-trial detention was an unjustifiably severe and unnecessary measure, given the poor conditions in the prison and his critical state of health. In support, he submitted medical documents, dated 11 May 2005 and 16 March 2006, which diagnosed him with pulmonary fibro-cavernous tuberculosis and confirmed that he was a registered patient at a civil tuberculosis hospital, Abastumani Hospital, in Georgia.

7. On 24 March 2006 the Tbilisi Court of Appeal dismissed the first applicant's appeal of 17 March 2006. In reply to the medical complaint, the appellate court stated that "the submitted medical documents show only the diagnosis; no other medical documents about [the first applicant's] current state of health, or the type and stage of his disease have been made available...". The appellate court did, however, inform the prison authorities that the first applicant should be provided with appropriate conditions of detention and medical care in prison.

8. The applicant's state of health drastically deteriorated during the following eleven days of his detention in Ksani no. 7 prison. Notably, he started having acute respiratory difficulties and, with his joints painfully swollen, became unable to move around without assistance. Following the Public Defender's intervention, the applicant was transferred on 25 March 2006 to the Medical Establishment of the Prison Department of the Ministry of Justice ("the old prison hospital").

9. After only two days in the old prison hospital, the first applicant was transferred back to Ksani no. 7 prison on 27 March 2006, where his state of health deteriorated further. Consequently, on 30 March 2006 the authorities returned him to the old prison hospital, where he was initially placed in the intensive care unit.

10. On 24 July 2006 the Tbilisi City Court convicted the first applicant of the offences with which he had been charged. He was sentenced to 7 years in prison.

11. By letters of 22 and 24 August 2006, the Ministry of Justice acknowledged that, following a medical examination conducted by its National Forensic Office ("the NFO") between 1 May and 20 June 2006, the first applicant had been diagnosed with an open form of multidrug-resistant fibro-cavernous (or disseminated) tuberculosis, in the phase of infiltration and decomposition; he was haemorrhaging from the lungs. In addition, the examination results showed that the first applicant had been infected with viral hepatitis C and suffered from a number of serious cardiac and neurosensory disorders. The above-mentioned letters further stated that, since 4 April 2006, the first applicant had been receiving conventional, first-line anti-tuberculosis medication under the DOTS programme (Directly Observed Treatment, Short-course – the treatment strategy for the detection and cure of TB recommended by the World Health Organisation, see paragraph 48 below).

12. On 12 December 2006 the Tbilisi Court of Appeal upheld the first applicant's conviction of 24 July 2006. His cassation appeal was rejected as inadmissible by the Supreme Court on 10 April 2007.

13. Between 26 September and 26 November 2007, medical experts from the NFO conducted an additional examination of the first applicant. Their conclusions ("the medical conclusions of 26 September-26 November 2007") confirmed the previous diagnosis as regards his cardiac problems and tuberculosis. Concerning the latter disease, the experts added that the first applicant should be considered as a gravely ill patient who needed special treatment in a tuberculosis hospital.

14. On 4 July 2008 the first applicant, referring to all the available medical documents about the critical phase of his tuberculosis, including the medical conclusions of 26 September-26 November 2007, requested the suspension of the outstanding part of his prison sentence on the basis of the Order of 27 March 2003 of the Minister of Health ("the Order of 27 March 2003"). He complained, under Articles 2 and 3 of the Convention, that he was not provided with effective anti-tuberculosis drugs in prison, and that, consequently, there was a real risk to his life.

15. On 30 July 2008 the Tbilisi City Court examined the first applicant's request of 4 July 2008 at an oral hearing. Amongst others, the court heard one of the medical experts who had issued the conclusions of 26 September-26 November 2007. The expert confirmed the accuracy of those conclusions, namely that the first applicant required treatment in a specialised hospital with particular drugs of second-line family ("SLDs") to which his tuberculosis had not yet developed a resistance and which were not available in the prison system. The expert suggested that the first applicant's condition would only deteriorate in prison, given the lack of the

necessary drugs there. The expert confirmed that, according to the Order of 27 March 2003 (see paragraph 41 below), the applicant's type of tuberculosis could serve as a basis for release from serving a sentence.

16. The Tbilisi City Court also heard a representative of the prison authorities, who stated that a more comprehensive system of multidrug resistant forms of tuberculosis treatment, DOTS+, would soon be introduced in Georgian prisons, and that the first applicant would be entitled to benefit from it. He was unable to specify the approximate dates of the introduction of that programme. The representative further stated that the first applicant had already been provided with permanent medical supervision in prison, and that the authorities would transfer him to a specialised hospital if his condition deteriorated.

17. During the hearing of 30 July 2008, the first applicant's representative submitted a handwritten letter of his client dated 29 July 2008 informing the Tbilisi City Court of his inability to attend the hearing in person owing to his state of health. His counsel also submitted a medical opinion of Dr T.J., the doctor who was treating the applicant in prison, dated 30 July 2008, which confirmed the first applicant's diagnosis at that time and stated that all the previous attempts to treat him in prison with the medication available through the already introduced DOTS programme had proved unsuccessful. The doctor confirmed that the comprehensive DOTS+ programme was planned to be introduced in the near future.

18. On the same day, 30 July 2008, the Tbilisi City Court delivered a decision dismissing the first applicant's request for the suspension of his sentence as manifestly ill-founded. The court reasoned that no recent medical document about his current state of health had been made available.

19. On 15 August 2008 the first applicant lodged an appeal against the decision of 30 July 2008, denouncing the City Court's failure to endorse the medical opinion of 30 July 2008 as proof of his current medical condition. He reiterated his fears that, without proper medical treatment in prison, the violation of his right under Article 3 of the Convention would persist and, in the worst scenario, could lead to his death, in violation of Article 2.

20. In the course of the appellate proceedings the first applicant made a request for an additional medical examination, so that all possible doubts about his state of health at that time could be dissipated. The Tbilisi Court of Appeal granted that request on 25 September 2008, ordering the prison authorities, and in particular the NFO, to examine the first applicant with the aim of establishing the nature and gravity of his diseases and obtaining recommendations on appropriate treatment for him.

21. In a reply dated 20 October 2008, the NFO implicitly refused to enforce the court order of 25 September 2008, stating that the first applicant's state of health had already been assessed between 26 September and 26 November 2007, and that, prior to assessing the need for an

additional examination, the Tbilisi Court of Appeal should first hear the relevant medical experts.

22. On 21 October 2008 the first applicant began a hunger strike to protest against the non-enforcement of the court order of 25 September 2008. In particular, and in line with that order, he requested a transfer to a specialised medical setting for diagnostic examinations, and denounced the fact that, despite his very critical condition, he was detained in a closed, "cellar-type" establishment. On the same day, the head of the old prison hospital issued an order putting the medical staff on alert for the duration of the applicant's hunger strike. As disclosed by his medical file, the applicant was advised by doctors on a daily basis throughout the entire duration of his hunger strike (see paragraph 26 below) about the damage his self-harming conduct could cause to his health.

23. On 24 October 2008 representatives from the Public Defender's Office visited the first applicant in the old prison hospital. As disclosed by the minutes of their visit, they found him in a critical condition – with his swollen joints, he remained bedridden, was vomiting purulent blood, and so on. The representatives also noted that only his family had been providing the applicant with such SLDs as cycloserin, p-aminosalicylic acid ("PAS").

24. On 28 October 2008 the Public Defender's Office expressed its concern about the first applicant's aggravated state of health and invited the prison authorities to ensure his appropriate treatment.

25. On 31 October 2008, pursuant to the court order of 25 September 2008, the NFO started the first applicant's medical examination, which ended on 7 November 2008. Its results ("the medical recommendations of 31 October-7 November 2008") fully confirmed the previously diagnosed grave form of tuberculosis, showed that the disease had deteriorated since the previous examination and recommended that the applicant be treated with SLDs in a hospital specialised in tuberculosis treatment.

26. In the meantime, on 4 November 2008, the first applicant terminated his hunger-strike as the court order of 25 September 2008 had been enforced. On the same day his advocate enquired of the head of the old prison hospital whether or not the prison was able to provide the applicant with SLDs (such as cycloserin and PAS). The reply was negative.

27. On 27 November 2008 the first applicant was transferred to the newly opened medical wing of Tbilisi no. 8 prison ("the new prison hospital"). He was visited there on 2 December 2008 by representatives of the Public Defender's Office, who witnessed that, although he was in a newly refurbished room, he was not being provided with the necessary SLDs and diet, or allowed to receive food parcels from his family, and the hospital staff would not change his bed-linen regularly even though he was sweating profusely.

28. On 5 December 2008 the first applicant started another hunger strike in protest against the failure to follow the medical recommendations of

31 October-7 November 2008. In particular, he requested that the prison authorities either provide him with the SLDs or transfer him to a specialised hospital. The new prison hospital was put on alert. As disclosed by the applicant's medical file, he was reminded by the doctors on a daily basis, throughout the entire duration of his strike (see paragraph 31 below), how deleterious his refusal to take meals was for his state of health. The applicant also refused blood transfusions during that period.

29. On 8 December 2008 the Tbilisi Court of Appeal examined the first applicant's appeal against the decision of 30 July 2008 at an oral hearing. The court heard one of the medical experts who had issued the medical recommendations of 31 October-7 November 2008. The expert confirmed the gravity of the applicant's condition and stated that his anti-tuberculosis treatment had been unsuccessful owing to the lack of the necessary drugs in prison. The expert added that the applicant required a special diet and the exposure to fresh air, suggesting that there were some chances of successful treatment of his type of tuberculosis outside of prison. The appellate court also heard a representative of the prison authorities, who submitted an opinion of Dr T.J, the doctor who was treating the applicant in prison, dated 1 December 2008. According to that opinion, the applicant had been provided with a combination of unspecified SLDs since 22 June 2008 against which his tuberculosis maintained sensitivity. The examination of various parties during the hearing further disclosed the fact that it was the applicant's family who had procured those SLDs from Germany.

30. In a decision of 8 December 2008, relying on the medical opinion of 1 December 2008 the Tbilisi Court of Appeal dismissed the first applicant's appeal against the decision of 30 July 2008 as being unfounded.

31. On 9 December 2008 the first applicant terminated his hunger strike.

32. As disclosed by his medical file, from early January 2009 the applicant refused to take PAS and cycloserin, the SLDs procured by his family, in protest against the prison administration's failure to provide him with a diet necessary for his condition. On 20 January 2009 the Public Defender's Office complained about that problem to the prison authorities.

33. On the same day, 20 January 2009, following a drastic deterioration in his condition, the first applicant was placed in the intensive therapy unit of the new prison hospital. Nevertheless, his condition continued to deteriorate and he died at midnight on 29 January 2009.

B. The proceedings before the Court

34. On 24 October 2008 the first applicant requested, under Rule 39 of the Rules of Court, that the Government be indicated to transfer him to a specialised tuberculosis hospital, to arrange for his medical examination and treatment and to suspend his sentence pending treatment.

35. On 10 November 2008 the President of the Chamber partly granted the above-mentioned request, indicating to the Government that the first applicant should be placed in a specialised medical establishment capable of dispensing appropriate anti-tuberculosis treatment. That measure was imposed until further notice. In so far as the case file, as it stood at the material time, did not disclose that the Tbilisi Court of Appeal's decision of 25 September 2008 ordering the applicant's medical examination had already been enforced (see paragraph 25 above), the President indicated to the Government to ensure that it was enforced. The Government were further invited to report on the implementation of the indicated medical measures by 1 December 2008.

36. By a letter of 1 December 2008, the Government submitted to the Court the medical recommendations of 31 October-7 November 2008 in support of the fact that the court decision of 25 September 2008 had duly been enforced.

37. As to the first applicant's transfer to a specialised tuberculosis hospital, the Government stated that such a measure was not necessary for the following reasons. First, the applicant had already been transferred, on 27 November 2008, to the new prison hospital, the medical services of which were comparable if not superior to those of a civil tuberculosis hospital. Secondly, even if the applicant were allowed to be treated at an outside tuberculosis hospital, such treatment would in any event be limited to DOTS, to which programme he had already had access in prison.

38. The Government further stated that the shortage of SLDs was a general pharmaceutical problem on a nationwide scale, which could in no way be imputed to the prison only. They promised that as soon as ofloxacin, PAS and cycloserin, the drugs capable of fighting the first applicant's tuberculosis, appeared in the country's pharmaceutical network, they would immediately be dispensed to him. In the meantime, the authorities allowed the applicant's family to provide him with those drugs in prison.

39. In a letter of 27 January 2009, addressed to the Minister of Justice, the Public Defender expressed his deep concern about the failure to transfer the first applicant to a specialised tuberculosis hospital, contrary to the interim measure indicated by the Court on 10 November 2008; the Minister was urged to ensure the immediate enforcement of that measure.

II. RELEVANT DOMESTIC LAW AND OTHER NATIONAL AND INTERNATIONAL DOCUMENTS

A. The Act of 22 July 1999 on Imprisonment ("the Imprisonment Act") and Order no. 72 issued by the Minister of Healthcare on 27 March 2003, as they read at the material time

40. Pursuant to section 65 §§ 1 (b) and 2 of the Imprisonment Act, a convict could be released from detention on account of his or her grave and/or incurable illness. The list of such grave/incurable illnesses was to be prepared by the Ministry of Healthcare.

41. On 27 March 2003 the Minister of Health issued an Order (Order no. 72) on the basis of section 65 of the Imprisonment Act, which established that destructive forms of pulmonary tuberculosis (fibro-cavernous, milliary or cirrhotic) as well as poly- or multi-drug resistant tuberculosis are grounds for requesting early release.

B. The Code of Criminal Procedure ("the CCP"), as it read at the material time

42. Pursuant to Article 607 § 1 (a) of the CCP, a court could suspend a prison sentence in view of the convict's grave state of health, if his or her illness impeded the proper execution of the sentence, pending the convict's full or partial recovery.

43. Article 608 of the CCP provided for a possibility of early release by a court on account of the convict's grave or incurable illness, which fact was to be established by a qualified medical opinion.

C. Report to the Georgian Government on the visit to Georgia carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 21 March to 2 April 2007 (CPT/Inf (2007) 42)

44. The relevant excerpts from the above-mentioned Report, bearing on the problem of tuberculosis in Georgian prisons, read:

> "**Health-care services**
>
> 76. Despite the goodwill and commitment of health-care staff at the penitentiary establishments visited, the provision of health care to prisoners remained problematic, due to the shortage of staff, facilities and resources. The delegation heard a number of complaints from prisoners at all the establishments visited concerning delays in access to a doctor, the inadequate quality of care ... and difficulties with access to outside specialists and hospital facilities.

77. The delegation noted that the supply and range of medication available at the establishments visited had considerably improved in recent years. Nevertheless, a number of prisoners complained that they depended on their families for the acquisition of most of the necessary medication.

As to the equipment available at the establishments visited, it was generally limited to a stethoscope and an apparatus for measuring blood pressure; there were no facilities for taking X-rays or basic blood tests. This made the screening for transmissible diseases, including the detection of cases of tuberculosis unfeasible...

81. The CPT is concerned that the progress observed during the second periodic visit in the area of combating tuberculosis is jeopardised by the steep increase in the prison population and the ensuing problem of prison overcrowding. Despite the efforts of the ICRC, it was no longer possible to screen all new arrivals at Prison No. 5 in Tbilisi. Further, in the absence of routine medical examination upon arrival and the necessary laboratory equipment, no systematic screening for tuberculosis was performed at Prison No. 4 in Zugdidi, Prison No. 6 in Rustavi, Prison No. 7 in Tbilisi or Penitentiary establishment No. 2 in Rustavi. ...

[R]ecommendations

- the Georgian authorities to take steps to ensure that all newly arrived prisoners are seen by a health-care staff member within 24 hours of their arrival. The medical examination on admission should be comprehensive, including appropriate screening for transmissible diseases (paragraph 79);...

- the Georgian authorities to persevere in their efforts to combat tuberculosis in the prison system, through systematic screening and treatment of prisoners in accordance with the DOTS method for tuberculosis control (paragraph 81).”

D. Report to the Georgian Government on the visit to Georgia carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 5 to 15 February 2010 (CPT/Inf (2010) 27)

45. The relevant excerpts from the above-mentioned Report, bearing on the problem of tuberculosis in Georgian prisons, read:

“46. Georgia’s imprisonment rate is very high by international standards and, as noted in the report on the visit in 2007, cannot be convincingly explained away by a high crime rate. If no steps are taken to limit the number of persons sent to prison, all attempts to improve conditions of detention will inevitably founder. ...

Health care

94. The spread of tuberculosis in the prison system remains a major challenge for the Georgian authorities. The progress made over the years, with the important assistance of the International Committee of the Red Cross (ICRC), has been jeopardised by the increase in the inmate population and the ensuing problem of prison overcrowding.

The delegation was concerned to note that, in the absence of routine medical examination upon arrival, no systematic screening for tuberculosis was performed ... TB case finding was based on a passive method (which essentially means waiting for prisoners with symptoms of TB to present themselves to clinical staff for diagnosis)....

99. The Medical establishment for prisoners in Tbilisi (Gldani), located within the perimeter of the Gldani penitentiary complex, represents a great improvement on the Central Prison Hospital visited by the CPT in 2001 and 2004. The delegation gained a globally positive impression of this new facility, inaugurated at the end of 2008 but in fact functioning fully only for a few months. With an official capacity of 258 beds, the establishment was accommodating 231 sick prisoners at the time of the visit. All the patients were men.

There were five wards: surgery, psychiatry, infectious diseases, internal medicine and intensive care/reanimation. Further, there was an admissions unit, an X-ray unit, a dental office, a laboratory, rooms for endoscopy and physiotherapy, and a pharmacy.

100. The diagnostic equipment was modern and functional, and the establishment offered an adequate range of hospital treatments for prisoners. It was also possible to transfer sick prisoners to other hospital facilities for diagnostic treatments which were not available at the Medical establishment (an average of 5 transfers per week)....

[R]ecommendations

- ensure that prisoners in need of diagnostic examination and/or hospital treatment are promptly transferred to appropriate medical facilities...;

- further steps to be taken to ensure the supply of appropriate medication in sufficient quantities to all establishments ...;

- urgent measures to be taken to ensure that all newly arrived prisoners ... are seen by a health-care staff member within 24 hours of their arrival. The medical examination on admission should be comprehensive, including appropriate screening for transmissible diseases and injuries (paragraph 91);

- the Georgian authorities to persevere in their efforts to combat tuberculosis in the prison system, through systematic screening and treatment of prisoners in accordance with the DOTS method for tuberculosis control. In this context, steps to be taken to ensure that prisoners diagnosed as BK-positive are promptly transferred to a hospital facility for treatment and that inmates with whom such prisoners have been in contact are screened for TB (paragraph 95)."

E. *Undue Punishment – Abuses against Prisoners in Georgia*, Report by Human Rights Watch, 13 September 2006 (Volume 18, No. 8 (D))

46. The relevant excerpts from the above-mentioned Report read:

"Tuberculosis nevertheless remains a serious problem in the Georgian prison system. The spread of multi-drug resistant forms of tuberculosis remains a real threat, particularly in prisons, where lack of proper hygiene, lack of adequate medical

facilities, insufficient medical staff, and, in particular, overcrowding, leave detainees more vulnerable to becoming infected with this highly contagious disease. Tuberculosis isolation facilities also become overcrowded and overburdened as the prison population increases; as a result, existing facilities may not be sufficient to isolate all tuberculosis patients from the general prison population. The growth of a tuberculosis epidemic in the prison system also places society at a real risk of an epidemic, as the disease can be readily transmitted from detainees to prison employees and to family members and others once detainees are released. Some experts also believe that there is a serious risk of an increase in coinciding HIV and tuberculosis epidemics in the region....

Recommendations

... Convicted persons who are seriously ill, in the final stages of terminal illness, or have diseases that require consistent and high-level treatment must be adequately monitored in detention. As conditions of detention risk exposing such vulnerable persons to inhuman and degrading situations, imprisonment should be used strictly as a last resort; efforts should be made to release such persons who are currently detained and alternative sanctions should be imposed whenever possible....

Conduct, without fail, systematic screening for tuberculosis of prisoners entering all facilities...

Ensure that the internationally-recommended tuberculosis control strategy, directly observed therapy, short course (DOTS), is undertaken effectively by providing a regular supply of anti-tuberculosis drugs in sufficient quantities to all facilities and by training medical personnel in issuing DOTS.

Provide nutrition and material conditions that are conducive to the improvement of tuberculosis patients' health."

F. *The right to health and problems related to the exercise of this right within the penitentiary system of Georgia* - Special Report by the Public Defender of Georgia, covering 2009 and the first half of 2010

47. The relevant excerpts from the above-mentioned report read:

"Tuberculosis

The high prevalence of tuberculosis in prisons is not something new, and constitutes one of the serious problems [facing] the penitentiary system worldwide. In spite of a series of projects implemented within the Georgian penitentiary system in coordination with the International Committee of the Red Cross, the problem of tuberculosis has ... worsened, far less been resolved. This is shown by the especially high number of persons who deceased with tuberculosis in 2009. In our view, one reason for this worsened situation is ineffective implementation of standard anti-tuberculosis measures within the Georgian reality, with no regard to local specificities and without having assessed and analyzed the risk of a spread in TB.

Medical personnel require in-depth preparation. Individual short-term training is not sufficient to resolve the problem, since the medical personnel are either unaware of or unable to use basic skills and knowledge of TB-infection management, given their very low medical autonomy and independence in taking decisions...

Tuberculosis is currently the most widespread disease within the penitentiary system's establishments in Georgia. In addition, as in previous years, in 2009 tuberculosis remained the number-one cause of death ... in prisons. Monitoring has revealed a high frequency of multi-resistant forms of tuberculosis.

Extra-pulmonary forms of TB are not a rarity either, and their spectrum has significantly expanded so as to include [other] diseases, starting with TB pleurisy and ending with neuro-tuberculosis, which damages almost all internal organs. In our view, such a trend is a direct result of inadequate management of TB infection within the penitentiary system.

Although a great number of penitentiary establishments do carry out screening for TB, and identify and include infected prisoners in relevant programmes, such measures are not effective enough, especially against the background that systemic and specific reasons for the spread of the disease have remained unresolved for years.

Newly-built penitentiary establishments are not planned with a view to due consideration of lighting and aeration systems, which are crucial components in preventing the spread of tuberculosis. The infection is spread by inhaling air containing airborne parcels of mycobacterium tuberculosis, coughed out by a person infected with tuberculosis. Mycobacterium survives a few hours in the air and depends on the actual environment. Infection occurs, as a rule, in a closed space (room) that is not properly aerated. It should also be mentioned that direct sunbeams can quickly kill the mycobacterium tuberculosis, which is not possible in a closed space...

We have discovered through monitoring that a total of 1,579 persons suffering from tuberculosis were identified by screening and further tests conducted in the establishments of the Georgian penitentiary system. Of these, 1,172 persons were involved in the DOTS program. 60 persons were diagnosed with the multi-resistant form of tuberculosis, of whom 59 persons were involved in the DOTS+ programme...

Death rate in the penitentiary system of Georgia

The Office of the Public Defender has been studying the death rate in Georgian penitentiary establishments for the last few years. 371 prisoners died in 2006-2009. 90 prisoners die every year on average... Based on various sources, including the results of the monitoring, the Office of the Public Defender has found that 91 prisoners (1 woman and 90 men) died in Georgia in 2009...

As for the spread of tuberculosis and its effect on the [prisoners'] death rate, it should be noted that tuberculosis was found in 46 of the 91 deceased patients. As in previous years, tuberculosis remains a major cause of death within Georgian penitentiaries. Half of the prisoners (50.54%) who died in 2009 had lung tuberculosis. The increase in the proportion of prisoners infected with tuberculosis in the total number of deceased prisoners has become a recurrent trend.

An increase in the number of extra-pulmonary forms of tuberculosis in recent years should be regarded as being directly caused by inadequate management of the tuberculosis infection. 13.18% of the deceased prisoners were infected with the multi-resistant form of tuberculosis. Also, 19% of the deceased prisoners had pneumonia (39% of those who died from tuberculosis). Among the causes death in patients infected with tuberculosis, hemorrhagic shock and acute anemia were the direct cause of death in a number of cases. These, in their turn, were caused by bleeding from TB-infected lungs. Instances of pulmonary bleeding of varying intensities are described in 9 forensic medical reports.

It should be mentioned that even the Medical Establishment for Tubercular Convicts does not offer TB-surgery services. Hence, such patients are, in fact, destined to die. TB infection is often contracted at the same time as virus hepatitis and human immunodeficiency virus...

The index of prisoners who died from the multi-resistant form of tuberculosis was higher in the second half of 2009 than in the first half. For this reason, we think it is necessary to enquire into details of how the DOTS+ programme is progressing and to include the country's leading specialists and institutions in future planning. Organisational errors are also frequent in the management of tuberculosis."

G. Guidelines for the Management of Drug-Resistant Tuberculosis adopted by the World Health Organisation (WHO/TB/96.210)

48. In 1992 the World Health Organisation ("the WHO") developed a global strategy for treatment of ordinary tuberculosis, which was called DOTS (Directly Observed Treatment, Short-course). In 1997 the WHO extended the initial DOTS programme to include the treatment of multi-drug resistant forms of tuberculosis. To facilitate the implementation of this new, extended programme, which was subsequently called DOTS+, the WHO published in the same year Guidelines for the Management of Drug-Resistant Tuberculosis. The relevant excerpts from these Guidelines read as follows:

"**FOREWORD**

1. About one third of the world's population is infected by M. tuberculosis. Worldwide in 1995 there were about nine million new cases of tuberculosis with three million deaths. M. tuberculosis kills more people than any other single infectious agent. Deaths from tuberculosis comprise 25% of all avoidable deaths in developing countries. 95% of tuberculosis cases and 98% of tuberculosis deaths are in developing countries; 75% of these cases are in the economically productive age group (15 - 50 years).

2. As a consequence, the world is facing a much more serious situation as we approach the twenty-first century than in the mid-1950s. Due to demographic factors, socio-economic trends, neglected tuberculosis control in many countries, and in addition, the HIV epidemic, there are many more smear-positive pulmonary tuberculosis cases, often undiagnosed and/or untreated. When tuberculosis cases are

treated, poor drug prescription and poor case management are creating more tuberculosis patients excreting resistant tubercle bacilli.

3. In 1991, the World Health Assembly adopted Resolution WHO 44.8, recognizing "effective case management as the central intervention for tuberculosis control", and recommending the strengthening of national tuberculosis programmes by introducing short course chemotherapy and improving the treatment management system.

Since 1992, the WHO Global Tuberculosis Programme has developed a new strategy, to meet the needs of global tuberculosis control. "DOTS" is the brand name of the WHO recommended tuberculosis control strategy. ...

6. The issue of the treatment of those pulmonary tuberculosis patients who remain sputum smear-positive following fully supervised WHO retreatment regimen should be considered. Although these cases represent a small minority of tuberculosis patients, they constitute an ongoing problem for programme managers.

Due to the lack of financial resources, many countries cannot provide the range of the expensive second-line drugs which might give some hope of cure to these patients. However, more economically prosperous countries might wish to do so, especially if they have inherited a significant number of patients with multi drug resistant (MDR) tuberculosis from a period when treatment was unorganized and chaotic. Many countries also lack information about the correct use of second-line drugs.

The WHO Tuberculosis Control Workshop held in Geneva, October 1995, discussed this issue and recommended that a country prepared to go to this expense should only provide these second-line drugs for a **specialised unit** (or units in large countries), in close connection with a **laboratory** able to carry out cultures and reliable susceptibility tests of M. tuberculosis to the drugs.

The WHO Global Tuberculosis Programme has prepared these "Guidelines for the Management of Drug-Resistant Tuberculosis", to meet the need for clear advice on this issue. ...

1.2 HOW IS MDR TUBERCULOSIS PRODUCED?

As with other forms of drug resistance, the phenomenon of MDR tuberculosis is entirely man-made.

Drug resistant bacilli are the consequence of human error in any of the following:

- prescription of chemotherapy;
- management of drug supply;
- case management;
- process of drug delivery to the patient.

The most common medical errors leading to the selection of resistant bacilli are the following:

(a) the prescription of inadequate chemotherapy to the multibacillary pulmonary tuberculosis cases (e.g. only 2 or 3 drugs during the initial phase of treatment in a new smear-positive patient with bacilli initially resistant to isoniazid);

(b) the addition of one extra drug in the case of failure, and repeating the addition of a further drug when the patient relapses after what amounts to monotherapy.

The most common errors observed in the management of drug supply are the following:

(a) the difficulty experienced by poor patients in obtaining all the drugs that they need (due to lack of financial resources or social insurance);

(b) frequent or prolonged shortages of antituberculosis drugs (due to poor management and/or financial constraints in developing countries);

(c) use of drugs (or drug combinations) of unproven bioavailability.

The following also have the effect of multiplying the risk of successive monotherapies and selection of resistant bacilli:

(a) the patient's lack of knowledge (due to a lack of information or due to inadequate explanation before starting treatment);

(b) poor case-management (when the treatment is not directly observed, especially during the initial phase). ...

2.1 SPECIALISED UNIT

Treatment of patients with MDR tuberculosis (especially those with resistance to rifampicin and isoniazid) may have to involve "second line" reserve drugs. These are drugs other than the "standard" essential antituberculosis drugs, i.e. rifampicin (R), isoniazid (H), streptomycin (S), ethambutol (E), pyrazinamide (Z), thioacetazone (T). These reserve drugs are much more expensive, less effective and have many more side effects than standard drugs. They should only be made available to a specialised unit and not in the free market. It is the responsibility of national health authorities to establish strong pharmaceutical regulations to limit the use of second-line reserve drugs in order to prevent the emergence of incurable tuberculosis.

2.2 DESIGNING AN APPROPRIATE REGIMEN

Designing an appropriate regimen for the individual patient needs experience and skill. It includes allocating the time and patience to define precisely the following:

(a) which regimen(s) the patient had previously received;

(b) whether the patient took all the drugs in each regimen prescribed and for how long;

(c) to find out what happened bacteriologically, in terms of sputum positivity (at least by direct smear, if possible also by culture and susceptibility tests) during and after the administration of each regimen. Clinical and radiological progress or

deterioration is much less reliable but may be used as a check on the bacteriological results.

2.3 RELIABLE SUSCEPTIBILITY TESTING

The specialised unit must have the services of a laboratory able to carry out culture and reliable tests for drug resistance (to the essential drugs and also to second-line drugs).

The quality of the susceptibility tests carried out in this laboratory should be regularly checked by another reference laboratory at national or supranational level.

2.4 RELIABLE DRUG SUPPLIES

The unit must also be guaranteed reliable supplies of the expensive "second line" reserve drugs, so as to ensure that any treatment undertaken for an individual patient can be successfully completed.

THE LAW

I. ALLEGED VIOLATION OF ARTICLES 2 AND 3 OF THE CONVENTION

49. The applicants complained that the respondent State had failed to protect the first applicant's health, physical well-being and life, contrary to Articles 2 and 3 of the Convention. These provisions read:

Article 2

"1. Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.

2. Deprivation of life shall not be regarded as inflicted in contravention of this article when it results from the use of force which is no more than absolutely necessary:

(a) in defence of any person from unlawful violence;

(b) in order to effect a lawful arrest or to prevent the escape of a person lawfully detained;

(c) in action lawfully taken for the purpose of quelling a riot or insurrection."

Article 3

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

A. Admissibility

50. The Government submitted that the complaints under Articles 2 and 3 of the Convention were premature, as the second applicant had not sought monetary compensation for the alleged lack of adequate medical treatment for her husband and his resultant death in prison. Referring to a number of court decisions in unrelated but relevant civil cases, where similar claims for compensation were allowed by domestic courts, the Government argued that the second applicant should have sued the relevant State authority and requested non-pecuniary damage under Article 413 of the Civil Code. Since she had failed to do so, the application should be rejected under Article 35 §§ 1 and 4 of the Convention for non-exhaustion of domestic remedies.

51. The second applicant did not comment on this objection.

52. The Court notes first that the second applicant may claim to be a victim within the meaning of Article 34 of the Convention of the violations alleged by and on behalf of her late husband under Articles 2 and 3 of the Convention (see, *inter alia*, *Renolde v. France*, no. 5608/05, § 69, 16 October 2008; and *Çelikbilek v. Turkey* (dec.), no. 27693/95, 22 June 1999).

53. As regards the Government's objection of non-exhaustion, the Court considers that a decisive question in assessing the effectiveness of a domestic remedy for a complaint under Articles 2 and 3 of the Convention with regard to a lack of sufficient care for a suffering applicant in prison is whether that remedy can bring direct and timely relief. Such a remedy can, in principle, be both preventive and compensatory in nature. Where the applicant has already resorted to either of the available and relevant remedies, considering it to be the most appropriate course of action in his or her particular situation, the applicant should not then be reproached for not having pursued an alternative remedial course of action (see *Melnik v. Ukraine*, no. 72286/01, § 68 and 70, 28 March 2006).

54. Apart from the fact that the inadequate monitoring and treatment of prisoners suffering from serious contagious diseases, such as tuberculosis, represented, at the material time, a structural problem in the Georgian penitentiary system (see *Poghosyan v. Georgia*, no. 9870/07, § 69, 24 February 2009; and *Ghavtadze v. Georgia*, no. 23204/07, § 104, 3 March 2009), the particular circumstances of the present case clearly show that the prison administration was well aware of the first applicant's medical condition and of his persistent complaints about the lack of adequate

treatment (see *Melnik*, cited above, § 70; *Sławomir Musiał v. Poland*, no. 28300/06, § 74, ECHR 2009-... (extracts); and *Hummatov v. Azerbaijan*, nos. 9852/03 and 13413/04, § 92, 29 November 2007). Furthermore, by initiating the proceedings for suspension of his prison sentence on health grounds, the applicant also brought his medical grievances before the penitentiary judges, clearly voicing his fears for his life (see *Dybeku v. Albania*, no. 41153/06, § 28, 18 December 2007).

55. In other words, at the most pertinent time, when the first applicant was still alive and could personally care for his well-being, he did everything reasonable to alert the relevant authorities with respect to his multi-drug resistant tuberculosis, seeking a preventive remedial action for the grievances alleged in the present application. In such circumstances, it would be wholly inappropriate, from the point of Article 35 § 1 of the Convention, to reproach the second applicant for not having requested, *ex post factum*, monetary compensation for the State's failure to protect her husband's health and life. Consequently, the Court dismisses the Government's objection of non-exhaustion.

56. Having regard to the above considerations, the Court considers that the applicants' complaints under Articles 2 and 3 of the Convention are not manifestly ill-founded within the meaning of Article 35 § 3 of the Convention. It further finds that they are not inadmissible on any other grounds. They must therefore be declared admissible.

B. Merits

1. The Government's submissions

57. The Government submitted that the first applicant's death should not be imputed to the State, since the relevant domestic authorities had provided him with all necessary medical assistance as available at that time in the country. They claimed that there had been no lack of due diligence on the part of the prison medical staff in dealing with the applicant's tuberculosis and that, consequently, his death could not be said to have been the result of medical negligence.

58. Referring to the relevant excerpts from the first applicant's medical file, which disclosed that he had been a registered patient of various civil tuberculosis hospitals in Georgia and Ukraine, the Government emphasised that the first applicant had not contracted tuberculosis in prison but, on the contrary, had been suffering from that disease for more than sixteen years prior to the initiation of the criminal proceedings against him in the present case on 16 March 2006 (see paragraph 5 above); at the time of his placement in detention, the disease had already reached the dangerous stage of infiltration and decomposition.

59. The Government noted that, subsequent to his arrest and detention, the applicant had stayed in an ordinary prison, Ksani prison no. 7, for a total of only eleven days in March 2006, whilst the rest of his life had been spent in prison medical establishments (see paragraphs 5, 8 and 9 and 33 above). Relying on his medical file, the Government stated that, following his placement in the old prison hospital on 30 March 2006 the first applicant had been subjected to various laboratory tests and other medical examinations (sputum, blood and urine tests, electrocardiography, X-ray of the thorax and so on) and was examined on a regular basis by various medical specialists (phtisiologist, pulmonologist, cardiologist, neurologist, otorhinolaryngologist and so on), including those invited by the prison authorities from a civil tuberculosis hospital – the National Centre for Tuberculosis and Lung Diseases. On the basis of the results of those examinations, the first applicant was then included in the DOTS programme (see paragraph 11 above) and started receiving such conventional, first-line anti-tuberculosis agents as isoniazid, ethambutol, rifampicin, pyrazinamide and streptomycin. In addition, the applicant was provided with various hepatoprotector and antioxidant drugs, vitamins, blood transfusions and so on. The prison medical staff also ensured that the applicant received a special diet.

60. The Government further submitted that, in order to establish whether treatment by the first-line anti-tuberculosis drugs was yielding any positive results, the relevant mycobacterial sensitivity tests were conducted in the laboratory of the old prison hospital on 26 June and 9 November 2006 and 22 June and 28 August 2007. Unfortunately, the results of all those tests showed that the first applicant's mycobacterium proved to be steadily resistant to all the above-mentioned first-line agents.

61. From the first applicant's medical file, the Government also submitted the results of two additional, specific (susceptibility) laboratory tests. The first test was conducted in a bacteriological laboratory located in Heidelberg, Germany, on 24 September 2007. The second was conducted in Georgia, in a laboratory of the National Centre for Tuberculosis and Lung Diseases, a civil establishment, on 26 January 2009. The results of both tests showed that the applicant's mycobacterium retained sensitivity to and thus could be cured by two types of SLDs – cycloserin and p-aminosalicylic acid ("PAS").

62. Excerpts from the applicant's medical file, accounting for his treatment in the old prison hospital, further disclosed that, shortly after the first SLD sensitivity test of 24 September 2007, a doctor prescribed him a daily dosage of cycloserin and PAS on 8 October 2007. However, the doctor then noted in his log that those SLDs were not available in the country and thus could not be administered to the patient.

63. Indeed, the Government confirmed, with reference to the relevant excerpts from the applicant's medical file, that he had started receiving

cycloserin and PAS only on 22 June 2008. The Government further submitted that those drugs had been procured for the first applicant by his family and that the prison authorities had never objected. It was the first applicant himself who had gone on repeated hunger strikes and refused the administration of those SLDs on three occasions – from 22 October to 4 November 2008, from 5 November to 9 December 2008 and from 14 January 2009 until his death. The Government argued that it was that self-harming behaviour which had itself caused the fatal outcome, which could by no means be imputed to the management of the old prison hospital. The Government referred in this respect to the case of *Đermanović v. Serbia* (no. 48497/06, § 59, 23 February 2010), in which the Court refused to hold the State liable for a deterioration in the applicant's health condition which had been caused by the latter's own self-harming behaviour.

64. The Government also submitted that the domestic courts, when examining the applicant's request for the suspension of his prison sentence, had taken every possible measure in order to assess his condition and the associated risks to his life. Thus, the domestic courts heard the applicant and the prison administration as well as various medical experts and the doctors treating the applicant in the old prison hospital. Of particular importance for the Tbilisi Court of Appeal was, according to the Government, the fact that the applicant had started taking SLDs on 22 June 2008. Furthermore, in matters of suspension of sentence/early release, the domestic courts enjoyed, by virtue of Article 607 and 608 of the CCP, a large margin of appreciation and made their decisions on a case-by-case basis. Thus, in the applicant's particular case, the domestic courts took into account, according to the Government, such factors as the applicant's dangerousness for society (in view of the established fact of his association with the criminal underworld) and the record of his previous breaches of prison rules. With respect to the latter argument, the Government provided the Court with a copy of three administrative orders issued by the Head of the old prison hospital on 3 and 11 October 2006 and 23 January 2007, reprimanding the applicant for certain breaches of a minor nature.

65. The Government further argued that, even had the domestic courts granted the applicant's request for the suspension of his sentence, that would hardly have led to an improvement in his state of health, since, at that time, the DOTS+ programme of treatment for multi-resistant tuberculosis had not yet been introduced in the civil sector either. In support of that argument, the Government submitted an explanatory memo addressed by the Deputy Head of the Penitentiary Department to the Government Agent on 16 April 2010. According to that memo, the DOTS+ programme of treatment for multi-drug resistant forms of pulmonary tuberculosis was introduced to the healthcare system of Georgia on 17 March 2008. Thus, on that date Abastumani Hospital, specialised in the treatment of tuberculosis, became the first civil medical establishment to implement the programme.

Subsequently, in August 2008, the programme was introduced to another civil medical establishment, the National Centre for Tuberculosis and Lung Diseases. It was only in February and April 2009, the memo continued, that the DOTS+ programme officially started to operate in the penitentiary sector, namely in Ksani Prison, housing prisoners with tuberculosis, and in the new prison hospital.

66. A major reason for the delay in introducing the DOTS+ programme to Georgian prisons was, as explained in the above-mentioned memo, a lack of sufficient medical infrastructure in the penitentiary sector in comparison to the civil healthcare system. In particular, the memo continued, the proper management of multi-drug resistant tuberculosis was significantly dependant on the existence of specially trained medical staff. Thus, SLDs are known to be highly toxic and to have serious side-effects, the management of which is always a challenge even for experienced clinicians. The Deputy Head then explained to the Government Agent that the first doctor and nurse of the prison hospital received special training in the management of the multi-drug resistant tuberculosis in February and April 2009 respectively; two other doctors from the prison hospital underwent that training in June 2009.

67. At the end of the memo, the Deputy Head confirmed to the Government Agent that the applicant had been able to benefit from the necessary SLDs since June 2008; those drugs had been procured for him by his family. Assessing this fact against the above-mentioned chronology for the introduction of the DOTS+ programme in the penitentiary sector, the Deputy Head added that the prison authorities had lacked the possibility to provide the applicant with those drugs, as, at that time, such SLDs were available only in the two above-mentioned civil tuberculosis hospitals, the National Centre for Tuberculosis and Drug Diseases and Abastumani Hospital.

68. Lastly, as further proof of the claim that the first applicant's death was not the result of medical negligence, the Government also submitted an explanatory memo issued on 16 April 2010 by the doctor who had been treating the applicant in prison, Dr T.J. (see paragraph 29 above). The doctor, after accounting in detail for all the medical tests, consultations by the relevant medical specialists and the dosages of various drugs administered to the applicant in the prison hospitals, stated that the main cause of the applicant's death had been the three instances of his going on hunger strike and the refusal to take the SLDs, and not medical negligence. The doctor then added:

> "In prison, [the applicant] received adequate medical treatment with the SLDs, which maintained their sensitivity with respect to his tuberculosis, for four months only. Therefore, given that short period of effective treatment for his multi-resistant form of tuberculosis, it was not possible to foresee, in the course of the treatment, a positive outcome. At the end of those four months, the applicant ceased taking the

medication of his own will and went on multiple hunger strikes, which caused a drastic deterioration in his general condition...”

2. The applicant’s submissions

69. In reply, the second applicant simply maintained, without giving any new argument or submitting additional evidence, that her husband had died as a result of the lack of due care in prison. She added that her husband’s decision to go on hunger strike had been determined by the State’s failure to provide him with the requisite anti-tuberculosis treatment. In particular, he should have been transferred to a civil tuberculosis hospital in due time.

3. The Court’s assessment

70. Having regard to the circumstances of the present case, in particular to the first applicant’s death caused by tuberculosis, the Court will first examine the complaint about the lack of medical care in prison under Article 2 of the Convention (see *Gagiu v. Romania*, no. 63258/00, § 54, 24 February 2009; and *Geppa v. Russia*, no. 8532/06, § 74, 3 February 2011). It will then consider whether an additional examination under Article 3 of the Convention is required.

(a) General principles under Article 2 of the Convention

71. In the light of the importance of the protection afforded by Article 2 of the Convention, the Court must subject deprivations of life to the most careful scrutiny, taking into consideration not only the actions of State agents but also all the surrounding circumstances. Persons in custody are in a vulnerable position and the authorities are under a duty to protect them. In particular, the national authorities have an obligation to protect the health and well-being of persons who have been deprived of their liberty (see *Naumenko v. Ukraine*, no. 42023/98, § 112, 10 February 2004; and *Dzieciak v. Poland*, no. 77766/01, § 91, 9 December 2008). The obligation to protect the life of individuals in custody also implies an obligation for the authorities to provide them with the medical care necessary to safeguard their life (see *Taïs v. France*, no. 39922/03, § 98, 1 June 2006; and *Huylu v. Turkey*, no. 52955/99, § 58, 16 November 2006).

72. Furthermore, the authorities must account for the treatment of persons deprived of their liberty. A sharp deterioration in a person’s state of health in detention facilities inevitably raises serious doubts as to the adequacy of medical treatment there (see *Farbtuhs v. Latvia*, no. 4672/02, § 57, 2 December 2004; and *Khudobin v. Russia*, no. 59696/00, § 84, ECHR 2006-XII (extracts)). Thus, where a detainee dies as a result of a health problem, the State must offer a reasonable explanation as to the cause of death and the treatment administered to the person concerned prior to his

or her death (see *Kats and Others v. Ukraine*, no. 29971/04, § 104, 18 December 2008).

73. In addition, the positive obligations under Article 2 of the Convention require States to make regulations compelling hospitals, whether civil or prison, to adopt appropriate measures for the protection of patients' lives (see *Tarariyeva v. Russia*, no. 4353/03, § 74, 85 and 87, ECHR 2006-XV (extracts)). They also require an effective independent judicial system to be set up so that the cause of death of patients in the care of the medical profession can be determined and those responsible made accountable (see *Vo v. France* [GC], no. 53924/00, § 89, ECHR 2004-VIII; and *Calvelli and Ciglio v. Italy* [GC], no. 32967/96, § 49, ECHR 2002-I). Where a hospital is a public institution, the acts and omissions of its medical staff are capable of engaging the responsibility of the respondent State under the Convention (see *Glass v. the United Kingdom*, no. 61827/00, § 71, ECHR 2004-II).

(b) Application of these principles to the present case

74. The Court notes that the first applicant died in prison from pulmonary tuberculosis. In order to establish whether or not the respondent State complied with its obligation of protection of life under Article 2 of the Convention, the Court must examine whether the relevant domestic authorities did everything reasonably possible, in good faith and in a timely manner, to try to avert the fatal outcome (see *Renolde*, cited above, § 85). Another, no less important question is whether the respondent State sufficiently accounted for the cause of the applicant's death in prison (see *Tsintsabadze v. Georgia*, no. 35403/06, § 95, 15 February 2011).

i. As to whether the State took all reasonable measures to treat the applicant effectively in prison

75. The Court's first observation is that the contamination of the first applicant by tuberculosis cannot, as such, be linked to the fact of his stay in Georgian prisons in the present case, and thus be arguably imputed to the State (cf., *I.T. v. Romania* (dec.), no. 40155/02, 24 November 2005, and, compare, *a contrario*, with *Melnik*, cited above, § 105; and *Hummatov*, also cited above, § 108). Indeed, the applicant was already suffering from the disease for more than sixteen years at the time of initiation of the criminal proceedings and his consequent placement in detention. Nor do the available medical documents suggest that the mutation of the ordinary tuberculosis bacillus to the multi-drug resistant form, which transformation is often the result of medical mismanagement (see the Guidelines for the Management of Drug-Resistant Tuberculosis ("the Guidelines") at paragraph 48 above), occurred in prison.

76. The Court also notes that, shortly after the prison authorities had noted the deterioration in the applicant's state of health, they transferred him

to the old prison hospital. Nor can it be overlooked that, as was also emphasised by the Government, out of the entire period of his detention, the ill applicant had stayed in an ordinary prison for only eleven days, spending the rest of his life in prison medical establishments. Having duly examined the applicant's medical file, the Court further notes that, during his stay in those establishments, the applicant was regularly examined by various doctors, subjected to various screening and laboratory tests, provided with conventional anti-tuberculosis agents under the DOTS treatment programme, an appropriate diet for his condition, antioxidant drugs, vitamins, blood transfusions and so on (see paragraph 59 above).

77. Consequently, it cannot be said that the respondent State left the ill applicant unattended. However, the question remains whether the State's response to the applicant's disease also proved to be an effective one, in other words whether the treatment administered to the applicant by the prison authorities was adequate to his particular condition (see *Holomiov v. Moldova*, no. 30649/05, § 115, 7 November 2006). Indeed, the core issue of the present application is not the absence of medical care in general, but rather the alleged lack of adequate treatment for a very particular type of disease which caused the applicant's death, namely multi-drug resistant tuberculosis. The Court is mindful of the fact that the adequacy of medical assistance is always the most difficult element to determine. In this task, the Court must reserve, in general, sufficient flexibility, defining the required standard of health care, which must accommodate legitimate demands of imprisonment but remain compatible with the human dignity and the due discharge of its positive obligations by the State, on a case-by-case basis (see *Aleksanyan v. Russia*, no. 46468/06, § 140, 22 December 2008).

78. Having due regard to the Guidelines (see paragraph 48 above), the Court notes that effective treatment of multi-drug resistant tuberculosis, which is a specialised and complex medical enterprise, depends on the existence of at least three basic elements, namely:

i. unlimited access to well-equipped bacteriological laboratories which, based on the relevant specific tests (smear, culture and susceptibility), can provide early and accurate diagnosis so that treatment with the relevant second-line anti-tuberculosis drugs can start as soon as possible;

ii. the availability of all six classes of second-line drugs in stock, so as to ensure that any treatment undertaken for an individual patient can be completed; and

iii. the clinicians who are in charge of administering the relevant SLDs must possess special proficiency in treating multi-drug resistant tuberculosis, so as to be able to monitor the complex and multifaceted process of treatment.

79. As regards the first element necessary for effective treatment of multi-drug resistant tuberculosis, the Court observes that at least by 26 June 2006 the relevant authorities already knew that the applicant's Koch's

bacillus proved to be resistant with respect to the conventional first-line anti-tuberculosis drugs, and was thus not curable by them (see paragraph 60 above). Consequently, the authorities should have immediately arranged for the necessary susceptibility laboratory tests in order to verify the sensitivity of his mycobacterium with respect to SLDs. However, according to the applicant's medical file, the first such test took place more than a year later, on 24 September 2007 (see paragraph 61 above). The Government have not provided any justification for that long delay in the conduct of the test, which was of vital importance for the accurate diagnosis and the consequent design of an individually appropriate medication regimen for the applicant.

80. The significance of that susceptibility test for the commencement of effective treatment becomes even more conspicuous when assessed against the fact that its results turned to be encouraging, as they established the sensitivity of the applicant's mycobacterium with respect to two SLDs – cycloserin and PAS. The doctor treating the applicant in prison even formally prescribed him, on 8 October 2007, a daily dose of those drugs. However, the prescribed treatment did not start immediately, apparently due to a shortage of those drugs in the country. It was only seven months later, in June 2008, that the applicant started finally receiving the SLDs (see paragraphs 29 and 63 above). The Court reiterates in this connection that when necessary medicines are unavailable the overall quality of medical assistance is called into question, all the more so, if, as in the present case, such a pharmaceutical shortage has directly deleterious effects on the applicant's state of health (see *Pitalev v. Russia*, no. 34393/03, § 57, 30 July 2009; and *Mirilashvili v. Russia* (dec.), no. 6293/04, 10 July 2007).

81. As regards the question of whether the medical staff supervising the applicant's treatment in the prison hospitals possessed the requisite expertise in the management of multi-drug resistant tuberculosis, which is another element constitutive of effective treatment, the answer is negative. Thus, the Government acknowledged themselves that the DOTS+ programme, which provided for preliminary special training of doctors and nurses, had been introduced in the new prison hospital as late as April 2009 (see paragraph 65 above), that is, three months after the applicant's death. In other words, the clinicians in charge of the applicant's case could not have possessed all the necessary skills at the time of his treatment. However, it is a well-known fact, acknowledged in the present case by the prison authorities themselves, that complex medical treatment of multi-drug resistant tuberculosis requires constant supervision by adequately trained clinicians, and taking second-line drugs without such supervision may cause more harm than good (see paragraph 66 above). Thus, the Court observes that such drugs are extremely toxic and can cause a range of serious side-effects, including hepatitis, depression, hallucinations and other types of personality disorders, and it is consequently imperative that the clinicians monitoring the treatment be already experienced in that respect, aware of all

the risk factors and undertake measures aimed at the reduction of those risks (see the Guidelines, paragraph 48 above).

82. In reply to the Government's argument about the first applicant's hunger strikes (see paragraphs 63 and 68 above), the Court confirms that if a deterioration in a detainee's health condition is caused by his going on hunger strike and/or refusing to accept treatment, this deterioration cannot then automatically be held imputable to the authorities (see *Đermanović*, cited above, § 59). However, the Court, sharing the principles expressed by the World Medical Association ("the WMA") (see the Declaration of Malta on Hunger Strikes, adopted by the 43rd Wold Medical Assembly in November 1991, subsequently revised by the 57th WMA General Assembly in October 2006), also considers that the prison authorities may not be totally absolved of their positive obligations in such difficult situations (see *Renolde*, cited above, §§ 81-83, 98, 104 and 105), passively contemplating the fasting detainee's demise.

83. In particular, since a detainee's decision regarding a hunger strike can be momentous, the prison clinicians must ensure full patient understanding of the medical consequences, verifying, *inter alia*, that that decision to fast is truly voluntary and does not result from a mental impairment of the detainee or any other outside pressure. No less important is continuing communication between the clinicians and the patient during the strike, when the former verify on a daily basis the validity of the detainee's wish to abstain from taking food. It is also crucial, in the Court's opinion, to ascertain the true intention of and real reasons for the detainee's protest, and if those reasons are not purely whimsical but, on the contrary, denounce serious medical mismanagement, the competent authorities must show due diligence by immediately starting negotiations with the striker with the aim of finding a suitable arrangement, subject, of course, to the restrictions that the legitimate demands of imprisonment may impose (see, *mutatis mutandis*, *Holomiov*, cited above, § 119).

84. Having regard to the circumstances of the present case and to the applicant's medical file, the Court is satisfied that the clinicians in the prison hospital warned the first applicant that his strike could entail a deterioration in his health at its outset, and then continued to remind him of the danger on a daily basis. However, the Court cannot discern from the medical file whether relevant medical specialists ever attempted to enquire if the applicant's conduct might have been conditioned by, for instance, SLD-caused mental relapses, thus necessitating the relevant psychological or psychiatric feedback. The Court further notes that the main reason of the applicant's first hunger strike in October 2008 was the authorities' unjustified refusal to conduct his additional medical examination, to which measure he had been fully entitled by the Tbilisi Court of Appeal's final and enforceable decision of 25 September 2008. Then, as regards his second hunger strike in November 2008, the main reason for it was the authorities'

failure to implement the medical recommendations of 31 October-7 November 2008 by transferring him to a specialised tuberculosis hospital. In the light of the foregoing, the Court considers that the applicant's reasons for his protest, whereby he requested something which the medical experts had prescribed him, could not be said to have been whimsical. On the contrary, it is yet another sign of the inadequacy of medical care when the prison authorities refuse to implement a qualified medical recommendation (see, for instance, *Sławomir Musiał*, cited above, § 92; *Sarban v. Moldova*, no. 3456/05, § 84, 4 October 2005; *Holomiov*, cited above, § 117; and *Hummatov*, cited above, § 116). It should be noted in this regard that, at the material time, two civil hospitals – the National Centre for Lung Diseases and Abastumani Hospital – represented specialised medical units running the DOTS+ programme and were thus fit for treatment of multi-drug resistant tuberculosis (see paragraph 66 above). That being so, the Court considers the domestic authorities' failure to have recourse to those specialised medical facilities was reproachable (see *Akhmetov v. Russia*, no. 37463/04, § 81, 1 April 2010).

85. Lastly, reiterating that in an exceptional situation a conditional release of a seriously ill prisoner may be required under the Convention (see, amongst many others, *Aleksanyan*, cited above; and *Papon v. France (no. 1)* (dec.), no. 64666/01, ECHR 2001-VI), the Court cannot avoid the question of addressing the domestic courts' position in the proceedings concerning the suspension of the applicant's sentence. Thus, the Court observes that the applicant's type of tuberculosis constituted a ground for his conditional release pending treatment (see paragraphs 15, 40 and 41 above). Obviously, it was not an absolute ground for release, and the penitentiary judges maintained their discretionary power in the examination of the issue.

86. However, the Court notes that the domestic decisions did not properly address any of the relevant elements of the compatibility of an ill prisoner's continued detention with his or her state of health. Thus, the Court notes that both the Tbilisi City Court and the Tbilisi Court of Appeal turned a blind eye to the exceptional gravity of the applicant's condition which, according to the qualified medical experts, was deteriorating in prison conditions, and to the consequent fact that the medical assistance dispensed in prison appeared to be incapable of fighting his tuberculosis (compare with, for instance, *Mouisel v. France*, no. 67263/01, § 40-42, ECHR 2002-IX). Nor did the domestic courts address the advisability of the continued detention in the light of any other legitimate considerations. Thus, whilst the Government claimed in their observations that the applicant could not have been released due to his allegedly high dangerousness for society and breach of certain prison rules, the Court notes that those particular reasons were never mentioned in the decisions of the domestic courts. Consequently, the Court cannot accept the respondent Government's

justifications, which were invoked for the first time in the proceedings before it (see, *a contrario*, *Sakkopoulos v. Greece*, no. 61828/00, § 44, 15 January 2004; and *Sarban*, cited above, § 82).

ii. As to whether the State has sufficiently accounted for the first applicant's death in prison

87. The Court is concerned that, as can be inferred from the Government's submissions, no adequate enquiry was conducted into the cause of death of the first applicant. However it is one of the cornerstone principles under Article 2 of the Convention with respect to such similar medical cases that, when a detainee dies from an illness, the authorities must of their own motion and with due expedition open an official probe in order to establish whether medical negligence might have been at stake (see, amongst many other authorities, *Tarariyeva*, cited above, §§ 74-75 and 103; *Gagiu*, cited above, § 68; and *Kats and Others*, cited above, §§ 116 and 120). This obligation does not mean that recourse to the criminal law is always required; under certain circumstances, an investigation conducted in the course of disciplinary proceedings would suffice (see *Mastromatteo v. Italy* [GC], no. 37703/97, § 90, ECHR 2002-VIII). However, in the present case, despite the fact that the applicant died in the prison hospital, which is a public institution directly engaging the State's responsibility, the issue of the individual responsibility of the clinicians in charge of the applicant's treatment was never, according to the case file, subjected to an independent, impartial and comprehensive enquiry.

88. Instead of submitting the results of such a meaningful probe, the Government limited themselves to providing the Court with the explanatory memos from the Head of the Penitentiary Department, which authority was directly in charge of the prison hospital, and of the doctor who had been treating the applicant in that hospital. However, since those very persons were, by virtue of their functions, directly responsible for the quality of the treatment provided to the applicant in prison, their memos, in which the cause of death was attributed to the applicant's own conduct, clearly cannot be accepted by the Court as a reliable and sufficient account of the applicant's death.

89. In other words, the respondent State, in addition to all the above-mentioned deficiencies in the treatment of the applicant, has also failed to account sufficiently for his death. This is a serious omission as, apart from the concern for the respect of the rights inherent in Article 2 of the Convention in each individual case, important public interests are at stake. Notably, the knowledge of the facts and of possible errors committed in the course of medical care are essential to enable the institutions concerned and medical staff to remedy the potential deficiencies and prevent similar errors (see *Byrzykowski v. Poland*, no. 11562/05, § 117, 27 June 2006).

iii. Conclusion

90. Having regard to the particular circumstances of the present case, the Court considers that the respondent State cannot be said to have undertaken in a timely manner adequate measures in order to prevent the lethal outcome in the case of the first applicant, who was suffering from the multi-drug resistant form of tuberculosis in prison. Thus, the State failed to ensure timely access to the relevant susceptibility laboratory tests, which were indispensable for early and accurate diagnosis and planning of a drug regimen necessary for effective treatment of the applicant's type of mycobacterium. Nor did the State take measures to provide the applicant with the SLDs which appeared to be capable of fighting his disease, shifting that vital aspect of effective treatment onto the applicant. Of further concern is that, even after the applicant's family had finally obtained the necessary anti-tuberculosis drugs, the State did not ensure that the administration of those drugs occurred under the strict monitoring of specially trained clinicians. The Court notes with concern that all those omissions were due to the fact that, despite the threatening magnitude of the problem of the transmission of multi-drug resistant forms of tuberculosis and the associated high rate of mortality in Georgian prisons, which has prevailed in the country for many years, the relevant State authorities did not begin implementation of the standard general health-care measures – outlined by the WHO as far back as 1997 – until March 2008 (see paragraphs 46-48 and 65 above). This mismanagement by the State in the medical sphere, which directly resulted in or contributed to the death of the first applicant, cannot be justified, under Article 2 of the Convention, by a lack of resources (see, *mutatis mutandis*, *Dybeku*, cited above, § 50).

91. The Court further considers that at least some of the above-mentioned omissions could have been solved in a more timely manner by allowing the first applicant's placement in one of the two civil hospitals specialised in treatment of tuberculosis, where the DOTS+ programme had been introduced earlier than in the penitentiary, or by ordering the first applicant's conditional release pending full or partial recovery. None of those possibilities were employed by the respondent State. However, the Court reiterates that whenever authorities decide to place and maintain a seriously ill person in detention, they must demonstrate special care in guaranteeing such conditions of detention as correspond to his special needs resulting from his illness (see *Farbtuhs*, cited above, § 56; *Isayev v. Ukraine*, no. 28827/02, § 20756/04, 28 May 2009). Another serious omission was the State's failure to account sufficiently, by conducting an independent and comprehensive probe, for the cause of the first applicant's death.

92. All in all, even if some of the above-mentioned deficiencies would not alone have been sufficient for a finding of inadequate discharge by the State of its positive obligation to protect the first applicant's health and life

in prison, the Court considers that their coexistence and cumulative effect is more than enough in this regard.

93. It follows that there has been a violation of Article 2 of the Convention on account of the respondent State's failure to protect the first applicant's life in prison.

(c) As regards the complaint under Article 3 of the Convention

94. Having regard to the findings relating to Article 2 of the Convention (see paragraphs 90-93 above), the Court considers that it is not necessary to examine whether, in this case, there has been a violation of Article 3 on account of the respondent State's failure to provide the first applicant with adequate medical care in prison (see, among other authorities, *Geppa*, cited above, § 99).

II. COMPLIANCE WITH ARTICLE 34 OF THE CONVENTION

95. In his correspondence with the Court concerning the implementation of the medical interim measure indicated by the Court under Rule 39 of the Rules of Court on 10 November 2008, the first applicant alleged that the respondent State failed to execute that measure. After his death, the second applicant maintained this grievance, complaining that the Government's refusal to transfer her husband to a specialised hospital had contributed to his death.

Article 34 of the Convention provides:

> "The Court may receive applications from any person, non-governmental organisation or group of individuals claiming to be the victim of a violation by one of the High Contracting Parties of the rights set forth in the Convention or the Protocols thereto. The High Contracting Parties undertake not to hinder in any way the effective exercise of this right."

A. The parties' arguments

96. The Government did not dispute that the medical interim measure indicated by the Court on 10 November 2008 had not been executed. However, they stated that the non-implementation of that measure was the only possibility to save the first applicant's life. In support of that statement, the Government referred to the arguments which they had submitted to the Court on 1 December 2008 (see paragraphs 36-38 above). They added that, since the DOTS+ treatment programme had been introduced in the National Centre for Tuberculosis and Lung Diseases in August 2008, the applicant's transfer there would not necessarily have resulted in his immediate involvement in that programme, as many other civil patients had already been on the waiting list. The Government also reiterated that, at the time of

the indication of the interim measure, the first applicant had already benefited from the intake of the relevant SLDs in the prison hospital.

97. The second applicant maintained that the Government's failure to transfer her husband to a specialised hospital had contributed to the fatal outcome.

B. The Court's assessment

1. General principles

98. The Court reiterates that Article 34 can be breached if the authorities of a Contracting State failed to take all steps which could reasonably have been taken in order to comply with the interim measure indicated by the Court under Rule 39 of the Rules of Court (see *Mamatkulov and Askarov v. Turkey* ([GC], nos. 46827/99 and 46951/99, § 92 et seq., ECHR 2005-...) Where there is plausibly asserted to be a risk of irreparable damage to the enjoyment by the applicant of one of the core rights under the Convention, the object of an interim measure is to preserve and protect the rights and interests of the parties in a dispute before the Court, pending the final decision. It follows from the very nature of interim measures that a decision on whether they should be indicated in a given case will often have to be made within a very short lapse of time, with a view to preventing imminent potential harm from being done. Consequently, the full facts of the case will often remain undetermined until the Court's judgment on the merits of the complaint to which the measure is related. It is precisely for the purpose of preserving the Court's ability to render such a judgment after an effective examination of the complaint that such measures are indicated. Until that time, it may be unavoidable for the Court to indicate interim measures on the basis of facts which, despite making a *prima facie* case in favour of such measures, are subsequently added to or challenged to the point of calling into question the measures' justification (see *Paladi v. Moldova* [GC], no. 39806/05, § 89, ECHR 2009-...).

99. Consequently, it is not open to a Contracting State to substitute its own judgment for that of the Court in verifying whether or not there existed a real risk of immediate and irreparable damage to an applicant at the time when the interim measure was indicated. Neither is it for the domestic authorities to decide on the time-limits for complying with an interim measure or on the extent to which it should be complied with. It is for the Court to verify compliance with the interim measure, while a State which considers that it is in possession of materials capable of convincing the Court to annul the interim measure should inform the Court accordingly. In examining a complaint under Article 34 concerning the alleged failure of a Contracting State to comply with an interim measure, the Court will therefore not re-examine whether its decision to apply interim measures was

correct. It is for the respondent Government to demonstrate to the Court that the interim measure was complied with or, in an exceptional case, that there was an objective impediment which prevented compliance and that the Government took all reasonable steps to remove the impediment and to keep the Court informed about the situation (see *Olaechea Cahuas v. Spain*, no. 24668/03, § 70, ECHR 2006-X (extracts); and *Paladi*, cited above, §§ 90 and 91).

2. Application of these principles to the present case

100. The Court considers that the point of departure for verifying whether the respondent State has complied with the measure is the formulation of the interim measure itself (see *Paladi*, cited above, § 91). Notably, it notes that on 10 November 2008 the Government was indicated under Rule 39 of the Rules of Court, to place the first applicant, who was staying in the new prison hospital at that time, in a specialised medical establishment capable of dispensing appropriate anti-tuberculosis treatment.

101. As disclosed by the formulation of that measure, the Court did not order that the applicant should necessarily have been transferred to a civil hospital. Rather, the major qualifying element of the measure was for a medical establishment in question, whether in the civil or penitentiary sector, to be *specialised* in treatment of tuberculosis. Consequently, a legitimate question arises as to whether the new prison hospital could have represented, at the material time, such a specialised medical unit (see *Aleksanyan*, cited above, § 230). However, the response is negative, since, as was already established above, that hospital did not possess either the necessary laboratory equipment or the second-line anti-tuberculosis drugs, and, most importantly, its medical staff did not possess, at the material time, the necessary skills for the management of complex treatment of multi-drug resistant forms of tuberculosis. All those serious deficiencies of the prison hospital were or should have been known to the respondent Government, as the qualified medical experts had denounced on several occasions the adequacy of the treatment dispensed to the applicant in the penitentiary sector, noting his rapid decline and equally recommending his transfer to a hospital *specialised* in tuberculosis treatment (see paragraphs 13, 15, 25 and 29 above).

102. Another question is whether there could have been an objective impediment preventing the applicant's transfer to an establishment specialised in tuberculosis treatment, and if so, whether the Government took all reasonable steps to remove that impediment in due time (see *Grori v. Albania*, no. 25336/04, § 188, 7 July 2009). In the particular circumstances, the Court considers the only possible objective impediment to the fulfilment of the measure in question could have been the absence of such a specialised establishment in Georgia at the material time. However, referring again to its relevant findings above, the Court notes that, at the

time of the indication of the interim measure of 10 November 2008, two tuberculosis hospitals in the civil sector – the National Centre for Tuberculosis and Lung Diseases and Abastumani Hospital – were already running the DOTS+ programme, which necessarily implied that those hospitals possessed by that time both the required medical equipment and specially trained clinicians. Thus, it was objectively possible to place the applicant in either of these two civil tuberculosis hospitals. Indeed, it should be only natural for the State authorities, and might be even directly required under the Convention, to resort to a specialised medical facility in the civil sector, when a detainee's health condition is critical and no comparable medical assistance is available in the penitentiary sector (see, for instance, *Aleksanyan*, cited above, §§ 155-157, and *Akhmetov*, cited above, § 81).

103. As to the Government's claim that the first applicant would not have received the urgent treatment in the National Centre for Tuberculosis and Lung Diseases because of the long waiting list of other patients (see paragraph 96 above), the Court would remind the Government that if such an impediment had emerged, given the exceptional gravity of the applicant's condition, it would then have been incumbent upon the relevant State authorities, under Article 34 of the Convention, to undertake all the necessary measures to remove that impediment immediately. In particular, the waiting list of patients with tuberculosis in need of the relevant treatment should normally be managed in order of clinical priority. In the first applicant's situation, as was clearly suggested by medical experts at domestic level, the preservation of his health and life was contingent on his placement in a specialised tuberculosis hospital (see paragraph 101 above for further cross-references).

104. In the light of the above considerations, the Court concludes that the Government have not shown that there was any objective impediment to compliance with the interim measure indicated to the respondent State in the present case.

105. Accordingly, there has been a violation of Article 34 of the Convention.

III. OTHER ALLEGED VIOLATIONS OF THE CONVENTION

106. Lastly, the first applicant complained, under Articles 5 § 1 (c), 6 § 1 and 14 of the Convention about the unlawfulness of his pre-trial detention and challenged the outcome of the criminal proceedings against him and of the proceedings aimed at the suspension of his prison sentence.

107. However, in the light of all the material in its possession, and in so far as the matters complained of are within its competence, the Court finds that they do not disclose any appearance of a violation of the rights and freedoms set out in the Convention or its Protocols. It follows that this part

of the application is manifestly ill-founded and must be rejected in accordance with Article 35 §§ 3 (a) and 4 of the Convention.

IV. APPLICATION OF ARTICLE 41 OF THE CONVENTION

108. 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

109. The second applicant claimed 1,000,000 euros (EUR) in respect of non-pecuniary damage.

110. The Government argued that the amount claimed was excessive.

111. Having regard to its conclusions under Article 2 of the Convention, the Court has no doubt that the applicants suffered distress and frustration on account of the respondent State's failure to protect the first applicant's health and life in prison. Making its assessment on an equitable basis, the Court awards the second applicant, Mrs Dali Sikharulidze, EUR 15,000 under this head.

B. Costs and expenses

112. In the absence of a claim for costs and expenses, the Court notes that there is no call to make any award under this head.

C. Default interest

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

FOR THESE REASONS, THE COURT UNANIMOUSLY

1. *Declares* the complaints under Articles 2 and 3 of the Convention admissible and the remainder of the application inadmissible;

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

3. *Holds* that there is no need to examine separately the complaint under Article 3 of the Convention;

4. *Holds* that there has been a violation of Article 34 of the Convention;

5. *Holds*
   (a) that the respondent State is to pay the second applicant, within three months from the date on which the judgment becomes final in accordance with Article 44 § 2 of the Convention, EUR 15,000 (fifteen thousand euros), plus any tax that may be chargeable, in respect of non-pecuniary damage, to be converted into the national currency of the respondent State 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;

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

Done in English, and notified in writing on 22 November 2011, pursuant to Rule 77 §§ 2 and 3 of the Rules of Court.

Marialena Tsirli	Josep Casadevall
Deputy Registrar	President