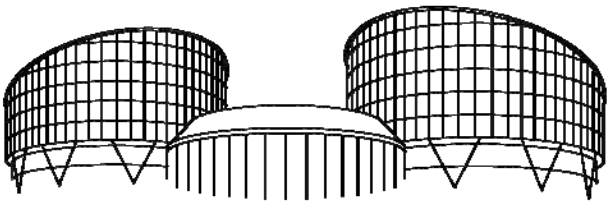

EUROPEAN COURT OF HUMAN RIGHTS
COUR EUROPÉENNE DES DROITS DE L'HOMME

SECOND SECTION

CASE OF MITIĆ v. SERBIA

(Application no. 31963/08)

JUDGMENT

STRASBOURG

22 January 2013

This judgment will become final in the circumstances set out in Article 44 § 2 of the Convention. It may be subject to editorial revision.

In the case of Mitić v. Serbia,

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

Guido Raimondi, *President,*
Peer Lorenzen,
Dragoljub Popović,
András Sajó,
Nebojša Vučinić,
Paulo Pinto de Albuquerque,
Helen Keller, *judges,*

and Stanley Naismith, *Section Registrar,*

Having deliberated in private on 11 December 2012,

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

PROCEDURE

1. The case originated in an application (no. 31963/08) against the Republic of Serbia lodged with the Court under Article 34 of the Convention for the Protection of Human Rights and Fundamental Freedoms ("the Convention") by a Serbian national, Mr Najdan Mitić ("the applicant"), on 20 June 2008.

2. The applicant was represented by Mr M. Cvetanović, a lawyer practising in Leskovac. The Serbian Government ("the Government") were represented by their Agent, Mr S. Carić.

3. The applicant, relying on Article 2 of the Convention, alleged that the authorities had failed to protect the life of his son who committed suicide while in solitary confinement. He further complained that the investigation into his son's death was not adequate and effective under that Article.

4. On 6 December 2010 the application was communicated to the Government. It was also decided to rule on the admissibility and merits of the application at the same time (Article 29 § 1).

THE FACTS

I. THE CIRCUMSTANCES OF THE CASE

5. The applicant was born in 1950 and lives in Manojlovce. He is the father of Jovica Mitić ("JM") who, on 8 October 2007, at the age of 28, hanged himself whilst serving a cumulative prison sentence of one year and nine months at Leskovac District Prison ("the District Prison").

6. On 14 August 2007 JM was arrested by the Leskovac Police Department on suspicion of larceny. The same day the investigating judge of the Leskovac District Court ("the District Court") decided to open an investigation against him on the larceny charge and to detain him for a period of one month.

7. On 15 August 2007, after having been placed in a detention unit of the District Prison, JM was examined by DP, the prison doctor, and a detention medical file was opened at the prison infirmary. During the examination, JM said that he had been involved in four traffic accidents in the past two months in which he had injured sixth cervical vertebra. He denied any other recent injury, surgery or illness. During his detention, JM visited the prison doctor three times complaining of trouble sleeping (17, 22 and 24 August 2007). He was prescribed 10 mg of diazepam and 15 mg of flormidal once a day.

8. On 21 August 2007 the Police Department informed the prison authorities that various District Courts had previously issued several arrest warrants for JM in connection with prison sentences imposed on him earlier by three final judgments (six months ordered on 19 November 2003 for larceny and forgery; three months ordered on 16 May 2005 for enabling substance abuse; and one year ordered on 7 November 2005 for forgery). The prison authorities were thus requested to transfer JM from a detention unit to a prison unit to serve a cumulative prison sentence of one year and nine months. They were also warned that, being a recidivist and a fugitive, he should be placed in the high-security prison unit.

9. On 27 August 2007 JM was placed in the high-security prison unit. On 28 August 2007 he was examined by the prison doctor and by TI, the prison psychologist, as a part of the standard procedure. During the examination JM denied any family history of mental illness and said that prior to imprisonment he had used sedatives for his sleeping problems. In her record of the examination, the prison psychologist described him as introverted, dishonest and dissimulative.

10. JM was examined again on 4 September 2007 for what appears to be muscle pain (the medical file submitted by the Government is partly illegible). On 21 September 2007 he complained of a "twinge" and the prison doctor discovered bruises on his left shoulder, shoulder blades and right upper arm. The doctor considered the bruises to be three days old. JM refused to say how he got these bruises and it would appear that he refused to file a formal complaint with the prison authorities. The doctor observed that he appeared nervous. She prescribed ibuprofen and 10 mg of diazepam twice a day.

11. On 25 September 2007 JM failed to show up for a scheduled medical check-up. On 2 October 2007 JM visited the prison doctor concerning a dermato-venereal condition and an appointment was made for him with a specialist outside the prison. Two days later he complained of insomnia and

minor anxiety. He refused to see the prison psychologist and the prison doctor increased the daily dose of diazepam to 10 mg three times per day and again prescribed 15 mg of flormidal once a day.

12. On 3 October 2007 JM attempted to escape together with three other inmates. On 5 October 2007 disciplinary proceedings were initiated against each of them and a disciplinary measure of placement in solitary confinement for a period of 15 days was imposed on each.

13. Before being placed in solitary confinement, JM was examined by the prison doctor, who established that he was fit to undergo solitary confinement with the continuation of previously prescribed daily therapy (paragraph 11 above). During his stay in solitary confinement JM was visited by the prison doctor once a day and was receiving his therapy administered by a member of the prison medical staff. He did not complain of any health problem. The cell in which he was placed was equipped with CCTV which covered the entrance door of the cell and part of the toilet door. It did not make video recordings but only projected images to a screen located in the office of the head of the prison guards.

14. On 7 October 2007 the applicant came to visit his son but was informed that the visit was not allowed because JM had been placed in solitary confinement following disciplinary proceedings against him (paragraph 31 below). He was allowed to leave a package which was given to JM the same day.

15. Early in the morning of 8 October 2007 JM was served with breakfast. At approximately 8.15 a.m. he was visited by the prison doctor and a member of the prison staff. Between 8.45 a.m and 9.00 a.m. a member of the prison medical staff gave him his daily treatment. He later recalled that JM's demeanour was calm and responsive.

16. At around 12 noon the same day JM was discovered by a prison guard and a correctional officer hanging from the heating pipe in his cell by a ligature fashioned out of a bed sheet. At 12.05 p.m. he was pronounced dead.

17. At 12.20 p.m. on the same day the investigating judge of the District Court conducted an on-site investigation during which the cell was secured by two police officers. The deputy public prosecutor was also present. Photographs were taken of the cell and of JM's body. The on-site investigation was closed at 2.00 p.m. The investigating judge made a record of the investigation, including a description of JM's cell and the items found therein, as well as of the reconstruction of the events of that morning based on an interview with the prison warden. The written statements of the prison staff who had contact with JM, given to the prison warden, were also included in the file. JM's family was informed of his death the same day.

18. The same day the police questioned the prison guard and the correctional officer who had discovered JM's body. The prison guard said that he had arrived at work at 7.45 a.m. and had visited all the cells,

including that of JM. Everything appeared normal. He further said that he had seen JM alive in his cell at 10.50 a.m. The correctional officer said that he had last seen JM on 4 October 2007. His impression was that, while JM was an introverted person, there was nothing peculiar in his demeanour.

19. The police also interviewed the prison doctor, the member of the prison medical staff who was giving treatment to JM and two other members of the prison staff who had had contact with him. They maintained that JM had never disclosed any suicidal tendencies and that he had seemed relaxed the last time they had seen him. The official record of all the interviews was made.

20. At 10.00 p.m. that day Dr RK performed an autopsy on JM's body, at the request of the investigating judge. The doctor noted that he had been informed by the investigating authorities that JM's body was discovered at around 10.00 a.m. He went on to describe the external appearance of the body and noted that the ligature had left a twenty-five by thirty millimetres wide trace on the front of JM's neck and a thirty by forty millimetres wide trace on the back and sides of his neck. He further observed an oblong purple bruise on JM's neck; it did not disappear when pressed. The doctor further noted an old bruise, which measured twenty by fifteen millimetres on JM's right upper arm. He concluded, based on its colour and appearance, that it was an old injury. The internal examination did not show, in his opinion, any anomalies. The histopathological examination of JM's internal organs had shown severe blood stasis, particularly in the lungs and kidneys. The microscopic examination of his neck subcutaneous soft tissues revealed fresh bleeding. The toxicology screening revealed no traces of poison; some traces of alcohol were discovered. The autopsy report concluded that JM's death had occurred between 9.00 a.m. and 10.00 a.m. as a result of asphyxia caused by hanging. The report included photographs.

21. Before the autopsy report was received by the court and the applicant, on 9 October 2007 the applicant requested a second autopsy. He was informed the same day by the investigating judge that a second autopsy could not be ordered before the report of the first had been received. JM's body was given to his family the same day.

22. On 9 October 2007 one of the inmates who was also in solitary confinement as a result of the escape attempt (paragraph 12 above) informed the prison doctor and the correctional officer, in two separate visits of which official records were made, that during a daily walk in the prison yard, JM had told him that he planned to stage a suicide attempt in order to be transferred to the Special Prison Hospital in Belgrade. The inmate expressed his regret for failing to inform the prison authorities of JM's intentions.

23. The same day, the applicant lodged a criminal complaint against the prison warden and unspecified prison officers for the alleged murder of his son and abuse of authority. The applicant argued, in particular, that his son

had been unjustly and arbitrarily punished for the alleged escape attempt as he was the only one who had been punished with solitary confinement which had caused psychological suffering and his eventual suicide. On the same day, the public prosecutor requested a report of the events of 8 October 2007 from the prison authorities and that police officers question all persons indicated in the applicant's complaint, in particular about JM's treatment in prison and why he had been placed in solitary confinement.

24. At the request of the public prosecutor, the police again questioned the prison guard and the correctional officer who had discovered JM's body, the prison doctor, the member of the medical staff who had administered treatment to JM and two other prison officers who had had direct contact with him. They all reiterated their earlier statements that, in particular, there had been nothing peculiar in JM's behaviour that would have indicated that he was suicidal.

25. On 16 October 2007 the police report was sent to the prosecutor's office. It also contained a written statement of the prison warden dated 15 October 2007, the record of visits JM had received and decisions concerning disciplinary proceedings against three other inmates who had participated in the escape attempt (paragraph 12 above). The prison warden submitted that JM's treatment was in compliance with the prison rules. JM had visiting rights (he had received eight visits from his family and three from his lawyer) and had received adequate medical treatment. On 19 December 2007 the public prosecutor decided not to prosecute.

26. On 28 December 2007 the applicant filed an indictment with the District Court against the prison, the prison doctor and nine other prison officers for alleged murder, having taken over the prosecution of the case as a "subsidiary prosecutor" (paragraph 30 below). He maintained his allegations in his criminal complaint, adding that the prison doctor had made a wrong assessment in deciding that his son was fit for placement in solitary confinement. On 4 January 2008 the investigating judge of the District Court requested the prison authorities to submit a report on JM's treatment in the prison (in particular, as regards his visiting rights, his medical treatment and any disciplinary proceedings against him). The investigating judge also requested a file from the public prosecutor's office.

27. On 11 January 2008 the prison authorities sent the requested report to the investigating judge. It contained, in particular, the statement of the prison doctor dated 9 January 2008: she gave an account of JM's medical treatment in prison and stated that, while he had not requested medical assistance while in solitary confinement, she had visited him once per day in accordance with prison regulations.

28. On 14 January 2008, after examining all the documents, the investigating judge expressed the opinion that there were not enough elements for an indictment and that the investigation should be discontinued.

29. On 23 January 2008 a chamber of three judges of the District Court accepted that conclusion and decided not to prosecute. That decision was upheld by the Supreme Court of Serbia on 12 March 2008.

II. RELEVANT DOMESTIC LAW AND INTERNATIONAL PRACTICE

30. Code of Criminal Procedure 2001 (*Zakonik o krivičnom postupku*, published in the Official Gazette of the Federal Republic of Yugoslavia nos. 70/01 and 68/02, as well as in the Official Gazette of the Republic of Serbia nos. 58/04, 85/05, 115/05, 46/06, 49/07, 122/08, 20/09, 72/09 and 76/10) entered into force on 28 March 2002.

Articles 19 and 20 of this Code provide, *inter alia*, that formal criminal proceedings can be instituted at the request of an authorised prosecutor. In respect of crimes subject to prosecution *ex officio*, including murder, the authorised prosecutor is the public prosecutor personally. The latter's authority to decide whether to press charges, however, is bound by the principle of legality which requires that he must act whenever there is a reasonable suspicion that a crime subject to prosecution *ex officio* has been committed. Article 61 of this Code provides that should the public prosecutor decide that there is no basis to prosecute, he must inform the victim of this decision, who shall then have the right to take over the prosecution of the case on his own behalf, in the capacity of a "subsidiary prosecutor".

31. Section 81(3) of the Execution of Penal Sanctions Act 2005 (*Zakon o izvršenju krivičnih sankcija*, published in the Official Gazette of the Republic of Serbia no. 85/05) provides that visits are not allowed during placement in solitary confinement. An escape or attempt to escape is qualified as a heavy disciplinary offence (section 145) for which placement in solitary confinement can be ordered (section 146(2)). A prisoner must undergo a medical examination before being placed in solitary confinement (section 151(2) of this Act) and during solitary confinement he must be examined by a prison doctor at least once a day (section 153 of this Act).

32. The European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment provides non-judicial preventive machinery to protect persons deprived of their liberty. It is based on a system of visits by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment ("the CPT"). During its years of activity in the field, the CPT has developed standards relating to the treatment of persons deprived of their liberty. The following are its standards concerning the material conditions in solitary confinement (see the CPT standards, document no. CPT/Inf/E (2002) 1 - Rev. 2011, p. 35):

> "The cells used for solitary confinement should meet the same minimum standards as those applicable to other prisoner accommodation. Thus, they should be of an

adequate size, enjoy access to natural light and be equipped with artificial lighting (in both cases sufficient to read by), and have adequate heating and ventilation. They should also be equipped with a means of communication with prison staff. Proper arrangements should be made for the prisoners to meet the needs of nature in a decent fashion at all times and to shower at least as often as prisoners in normal regime. Prisoners held in solitary confinement should be allowed to wear normal prison clothing and the food provided to them should be the normal prison diet, including special diets when required. As for the exercise area used by such prisoners, it should be sufficiently large to enable them genuinely to exert themselves and should have some means of protection from the elements.

All too often, CPT delegations find that one or more of these basic requirements are not met, in particular in respect of prisoners undergoing solitary confinement as a disciplinary sanction. For example, the cells designed for this type of solitary confinement are sometimes located in basement areas, with inadequate access to natural light and ventilation and prone to dampness. And it is not unusual for the cells to be too small, sometimes measuring as little as 3 to 4m²; in this connection, the CPT wishes to stress that any cell measuring less than 6m² should be withdrawn from service as prisoner accommodation. The exercise areas used by the prisoners concerned are also frequently inadequate.

It is common practice for cells accommodating prisoners undergoing solitary confinement as a punishment to have a limited amount of furniture, which is often secured to the floor. Nevertheless, such cells should be equipped, as a minimum, with a table, adequate seating for the daytime (i.e. a chair or bench), and a proper bed and bedding at night.

As regards the cells used to accommodate prisoners undergoing other types of solitary confinement, the CPT considers that they should be furnished in the same manner as cells used by prisoners on normal location."

As regards suicide prevention, the CPT standards (cited above, p. 44) provide as following:

"A person identified as a suicide risk should, for as long as necessary, be kept under a special observation scheme. Further, such persons should not have easy access to means of killing themselves (cell window bars, broken glass, belts or ties, etc.)."

In the Report on the visit to Austria carried out from 14 to 23 April 2004 (see document no. CPT/Inf (2005) 13, §§ 53 and 55) the CPT made the following comments in relation to placement of suicide-risk prisoners in a segregation unit:

"At the PAZ in Vienna-Hernalser Gürtel, there was a segregation unit with 24 single cells, including two security cells and one padded cell; conditions in these cells call for no particular comment. The PAZ in Innsbruck had one padded cell in the basement, which had no access to natural light. At Linz, there was one padded cell and three other cells used for segregation purposes; all the cells had many ligature points and could not safely be used for the accommodation of detainees representing a suicide risk without constant supervision. At the PAZ in Wels, the segregation cells were of a good standard, with adequate access to natural light and ventilation.

...

Further, the CPT invites the Austrian authorities to provide suicide-proof clothing for use in appropriate circumstances."

In the Report on the visit to Malta carried out from 19 to 26 May 2008 (see document no. CPT/Inf (2011) 5, §§ 135 and 136), the CPT made the following remarks concerning the treatment of suicide-risk prisoners:

"A "suicide watch" cell has been installed at the entrance of the YOURS building. The cell with very high bare walls and a transparent ceiling, is equipped only with a mattress. Inmates can be placed there after having attempted to commit suicide or after displaying (auto)-aggressive behaviour; they are subject to reinforced staff monitoring (in emergency circumstances, in "one to one" constant direct supervision). A recording clock is also installed, to check staff presence. Placement in the cell is under the sole responsibility of the CCF psychiatrist, who informed the delegation that inmates were usually placed there for an observation period of two weeks, but that they could be discharged earlier on his decision. A special register was kept, recording the stay in the cell. The delegation was informed that on occasion prisoners had been kept in their underwear or, exceptionally, left naked in the cell (with a Luna blanket).

The delegation was of the opinion that the practice of keeping a prisoner naked in a cell can be considered to amount to degrading treatment and, in pursuance of Article 8, paragraph 5, of the Convention, requested the Maltese authorities to discontinue this practice immediately, indicating that prisoners at risk of suicide should instead benefit from clothing appropriate to their specific needs."

Furthermore, in the Report on the visit to Italy carried out from 14 to 26 September 2008 (see document no. CPT/Inf (2010) 12, §§ 107 and 108), concerning the psychiatric care, the CPT made the following observations:

"Further, in particular at Brescia and Cagliari Prisons the delegation observed serious problems in the handling of prisoners with severe psychiatric disorders or acute episodes of agitation. Delays often arose when arranging transfers to psychiatric establishments (such as an OPG or a psychiatric service in a general hospital - SPDC). This led to very disturbed prisoners being placed in bare cells, sometimes for prolonged periods (as was observed at Cagliari); in some cases, the prisoners concerned were held in such cells while handcuffed (as was the case at Brescia) or stripped of their clothes (as was the case at Cagliari). Thus, acutely ill prisoners with psychiatric disorders did not receive adequate care and were subjected to treatment which can easily be considered as inhuman and degrading. It is all the more worrying that some of the prisoners concerned had allegedly been subjected to physical ill-treatment by staff.

...

In the light of the above, the CPT recommends that urgent steps be taken to review the provision of psychiatric care in the establishments visited. In particular, steps should be taken to:

- increase the presence of psychiatrists and ensure that prisoners suffering from severe disturbances are transferred without delay to an appropriate psychiatric establishment (if necessary a civil psychiatric institution);

- provide suicide-proof clothing for use in appropriate circumstances;

- ensure that patients are not handcuffed inside a cell."

In the Report on the visit to Ireland carried out from 25 January to 5 February 2010 (see document no. CPT/Inf (2011) 3, §§ 79-82), concerning the use of special observation cells, the CPT made the following observations (footnotes omitted):

"According to Rule 64 of the Prison Rules 2007, a prisoner shall be accommodated in a special observation cell only if "it is necessary to prevent the prisoner from causing imminent injury to himself or herself, or others and all other less restrictive methods of control have been or would, in the opinion of the Governor, be inadequate in the circumstances". Placement in such a cell should not exceed 24 hours unless the Governor receives authorisation from the Director General of Prisons to extend the placement for a maximum of four further periods of 24 hours.

Paragraph 8 of Rule 64 states that the Governor may require a prisoner's clothing to be removed prior to placement if it is considered that "items or parts of prisoner's clothing may be used by the prisoner to harm himself or herself, or others, or to cause significant damage to property". However, paragraph 9 states that no prisoner should be left unclothed. Also, a prisoner placed in a special observation cell should be visited at least daily by the Governor and by the doctor.

...

In the course of the 2010 visit, the CPT's delegation was deeply concerned by the situation of prisoners placed in special observation cells, which resulted in it making an immediate observation (see paragraph 6 above). To begin with, prisoners who had been placed in a special observation cell complained of the cold temperature and the delegation observed for itself the cells were generally cold (for example, the special observation cell in B Wing of Midlands Prison measured 12°C at the time of the visit). It should be noted that in most instances an inmate's clothes were removed and that only one, maybe two, small blankets were issued; at times, an inmate was permitted to keep his underwear.

Prison Rule 64 is designed to enable management to remove a prisoner in an emergency to a cell where he or she will be safe and can be closely observed by staff. However, in the prisons visited, inmates were being placed in special observation cells not only in such situations but also for accommodation, disciplinary and good order purposes; further, regardless of the reason for the placement, prisoners were in most cases being subjected to the same procedures.

In a number of instances documented by the CPT's delegation, prisoners judged to have disobeyed a legitimate order or who were being refractory, were transferred to a special observation cell, sometimes using control and restraint measures. On each occasion the prisoner's clothing was removed; in many instances, it was apparently either ripped off or cut off, while the inmate was restrained lying prostrate on the floor of the cell. Other than being provided with a rip-proof blanket or poncho, these prisoners were in each instance kept naked (apart from prison-issue underpants) in the special observation cell for 24 hours or longer, they were not offered outdoor exercise or provided with any reading material or permitted to watch television. Such placement could not be described as other than for the purpose of punishment.

...

If a prisoner is placed in a special observation cell for medical reasons, rip-proof clothing should only be provided where necessary (e.g. in cases of self-harm but not

for someone who initiates a hunger-strike). Such a placement and its continuation should only be made upon the authorisation of the medical doctor, when all other measures are inadequate; and the removal of clothes should follow an individual risk assessment, and be authorised by the doctor. Further, the doctor should attend prisoners placed in observation on a daily basis as required by the Prison Rules 2007 (see also section e. below) and record his findings; this was often not the case in most of the prisons visited, notably at Cork Prison. Likewise, the standard 15 minute observation by prison officers of persons placed in a special observation cell should be clearly recorded in the register.

Where there is a need for a disruptive or violent prisoner to be rapidly transferred to a special observation cell, the person concerned should only be kept in such a cell until such time as he has calmed down, whereupon he should be placed in an ordinary cell and, if appropriate, managed through the disciplinary process or Rule 62 governing removal from association. Further, the prisoner's clothing should not be removed unless this is found to be justified following an individual risk assessment."

THE LAW

I. ALLEGED VIOLATION OF ARTICLE 2 OF THE CONVENTION

33. The first sentence of Article 2 of the Convention provides:

"1. Everyone's right to life shall be protected by law."

34. The applicant complained under Article 2 that the authorities were responsible for his son's death and/or that they failed to protect his life. He also complained that the investigation into his son's death had not been adequate or effective, as required by the procedural obligation imposed by that Article.

A. Submissions of the parties

1. The applicant

35. The applicant alleged, without more, that his son was killed by the prison authorities. He also alleged that, if his son had indeed committed suicide, it was the fault of the prison authorities who had failed to protect him: his son had been beaten by other inmates; he should not have been placed in solitary confinement and the disciplinary proceedings against him were a set-up manufactured by the prison authorities. He also claimed his son's medication was too strong.

36. The applicant further argued that the circumstances of his son's death were neither properly investigated nor established. There were discrepancies between the report of the investigating judge and the autopsy report (as to the time JM's body was discovered) and between the prison guard's statement and the time of death established by the autopsy

(paragraphs 16, 18 and 20 above). He also claimed that the prison authorities had refused to give him the CCTV tape recordings of his son's cell.

2. The Government

37. The Government argued that the authoritites could not have been aware that JM was a suicide risk. He had no history of mental health problems or of suicidal tendencies. Upon his arrest, he was examined by the prison doctor and was thereafter under constant medical care by the same doctor. JM had never shown any sign of mental distress that could be interpreted as alarming. The applicant had not indicated in his submissions that his son had suffered from mental illness and none of his relatives, who visited him in prison, including the applicant, had alerted the authorities to any unusual or worrying behaviour. Furthermore, solitary confinement could not have adversely affected his mental state because he was not in total isolation: he had contacts with the prison staff, was visited regularly by the prison doctor and had one-hour daily exercise together with other inmates who were also placed in solitary confinement. He also had contact with the outside world through letters.

38. The Government further maintained that JM had never complained about his treatment in prison. The applicant's claim that his son was the only one placed in solitary confinement after the disciplinary proceedings was untrue: all inmates who attempted to escape were punished in the same manner. Copies of the relevant decisions were submitted.

39. The Government submitted that the investigation into JM's death met the Convention requirement of effectiveness. The decision to discontinue the proceedings had been based on an objective, impartial and comprehensive analysis of all the evidence. As regards the discrepancy between the prison guard's statement and the time of death established in the autopsy report (paragraphs 18 and 20 above), the Government submitted that it did not undermine the findings of the autopsy because the forensic expert's task was not to establish the precise minute of JM's death (that was not the focus of the investigation) but rather to determine the cause of his death. Furthermore, the inconsistency could simply have been the result of a mistake.

40. The Government also submitted that the investigation fulfilled the condition of public scrutiny: the applicant was in constant contact with the investigators; he had been informed in a timely manner about his son's death; he had full access to documents in the file; and he was informed of the public prosecutor's decision not to initiate criminal proceedings as well as of the courts' decisions.

B. The Court's assessment

1. Admissibility

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

2. Merits

(a) The substantive protection

i. The cause of death: the alleged involvement of State agents in JM's death

42. The Court reiterates that Article 2, which safeguards the right to life and sets out the circumstances when deprivation of life may be justified, ranks as one of the most fundamental provisions in the Convention, from which no derogation is permitted. In the light of the importance of the protection afforded by Article 2, the Court must subject deprivation of life to the most careful scrutiny, taking into consideration not only the actions of State agents but also all the surrounding circumstances (see, among other authorities, *McCann and Others v. the United Kingdom*, 27 September 1995, §§ 146-47, Series A no. 324).

43. The applicant alleged that his son was killed by the prison authorities but did not develop this argument at all. The Court observes that voluminous investigation documents were unanimous as to the cause of JM's death. The applicant merely reiterated his allegations from the criminal complaint. However, this remains a vague and undeveloped submission, in respect of which the case-file, including the domestic investigation, reveals no sufficient elements. The Court will thus proceed on the basis of a suicide.

44. In such circumstances, the Court finds that the applicant has not substantiated any violation of the substantive limb of Article 2 of the Convention.

ii. Failure of the State to protect JM's life

45. The Court reiterates that the first sentence of Article 2 § 1 enjoins the State not only to refrain from the intentional and unlawful taking of life, but also to take appropriate steps to safeguard the lives of those within its jurisdiction (see *L.C.B. v. the United Kingdom*, judgment of 9 June 1998, § 36, *Reports* 1998-III). In the context of prisoners, the Court has had previous occasion to emphasise that persons in custody are in a vulnerable position and that the authorities are under a duty to protect them. It is incumbent on the State to account for any injuries suffered in custody,

which obligation is particularly stringent when an individual dies (see, for example, *Salman v. Turkey* [GC], no. 21986/93, § 99, ECHR 2000-VII).

46. Bearing in mind the difficulties in policing modern societies, the unpredictability of human conduct and the operational choices which must be made in terms of priorities and resources, the scope of the positive obligation must be interpreted in a way which does not impose an impossible or disproportionate burden on the authorities. Accordingly, not every claimed risk to life can entail for the authorities a Convention requirement to take operational measures to prevent that risk from materialising. For a positive obligation to arise regarding a prisoner with suicidal tendencies, it must be established that the authorities knew, or ought to have known at the time, of the existence of a real and immediate risk to the life of an identified individual and, if so, that they failed to take measures within the scope of their powers which, judged reasonably, might have been expected to avoid that risk (see *Keenan v. the United Kingdom*, no. 27229/95, §§ 89 and 92, ECHR 2001-III).

47. The Court has recognised that the prison authorities must discharge their duties in a manner compatible with the rights and freedoms of the individual prisoner concerned. There are general measures and precautions which ought to be available to diminish the opportunities for self-harm, without infringing personal autonomy. Whether any more stringent measures are necessary in respect of a prisoner and whether it is reasonable to apply them will depend on the circumstances of the case (see *Keenan*, cited above, § 91).

48. In the light of the above, the Court will examine whether the authorities knew or ought to have known that JM posed a real and immediate risk of suicide and, if so, whether they did all that could reasonably have been expected of them to prevent that risk.

49. The Court notes that JM did not have any known history of mental health problems or suicidal tendencies (compare *Keenan*, cited above, §§ 94 and 95). All the time during imprisonment he acted in a normal fashion, showing no particular signs of physical or mental distress. He had constant access to medical assistance, was always examined by the same prison doctor and had contact with other prison officers and inmates, none of whom ever reported anything unusual in his behaviour. JM's medical record shows that he complained of insomnia and mild anxiety for which he was treated. On the morning of the day he killed himself, he was seen by the prison doctor and two other prison officers (paragraph 15 above). According to their statements given during the investigation, there was nothing strange in his demeanour. Neither did JM's relatives ever alert the prison authorities to any risk of suicide. For these reasons, the Court does not find that the authorities could have reasonably foreseen JM's decision to hang himself.

The Court recalls at this point that the CPT has recommended that persons identified as a suicide risk should be subject to special precautions.

In particular, they should not be placed alone in a cell with easy access to means of killing themselves, such as, cell window bars, broken glass, belts or ties (see the CPT Standards, cited above). Furthermore, suicide-proof clothing should be used in appropriate circumstances, such as in the case of mentally-ill prisoners and prisoners who were placed in suicide watch cells after having attempted to commit suicide or after displaying auto-aggressive behaviour (see the Reports in the "Relevant domestic law and international practice" above). However, it is clear from the circumstances of the present case that JM's mental state during imprisonment had never called for such special protective measures.

50. As regards the applicant's complaint that the authorities failed to protect his son from being beaten by other inmates, the Court notes that JM's medical file indicates that, during the examination on 21 September 2007, the prison doctor discovered three-day old bruises on his left shoulder, shoulder blades and right upper arm (paragraph 10 above). However, JM refused to reveal the origin of the bruises or to submit a formal complaint to the prison authorities. In these circumstances, the Court finds it unreasonable to consider that prison authorities failed to take necessary measures to protect the applicant's son.

51. Furthermore, as regards the applicant's claim that his son's medical treatment was inadequate, the Court notes that JM was prescribed sedatives for insomnia and mild anxiety. He never raised any serious mental health issue which could be considered to have required special psychiatric examination. Furthermore, he never complained about the quality of the medical assistance or the therapy received nor was he refused access to a specialist (compare *Younger v. the United Kingdom* (dec.), no. 57420/00, ECHR 2003-I). The Court finds no evidence that JM's medical treatment was inadequate.

52. Lastly, as regards the applicant's claim that his son was unjustly placed in solitary confinement following arbitrary disciplinary proceedings, the Court notes that other inmates involved in the escape attempt were punished in the same way (paragraph 12 above) and that the ordered disciplinary measure was prescribed by domestic law (paragraph 31 above).

53. Having regard to the above, the Court does not find any manifest omission on the part of the domestic authorities allowing a finding that the Serbian authorities failed to prevent a real and immediate risk of suicide or that they otherwise acted in a way incompatible with their positive obligations to guarantee the right to life.

Accordingly, there has been no violation of Article 2 of the Convention in this respect.

(b) The procedural protection: the investigation into JM's death

54. The Court reiterates that whenever a detainee dies in suspicious circumstances, Article 2 requires the authorities to conduct an independent

and impartial official investigation that satisfies certain minimum standards as to effectiveness (see, for example, *Paul and Audrey Edwards v. the United Kingdom*, no. 46477/99, §§ 69-73, ECHR 2002-II, and *Trubnikov v. Russia*, no. 49790/99, § 88, 5 July 2005). Thereby, the competent authorities must act with exemplary diligence and promptness and must of their own motion initiate investigations which would be capable of, firstly, ascertaining the circumstances in which the incident took place and any shortcomings in the operation of the regulatory system and, secondly, identifying the State officials or authorities involved. The nature and degree of scrutiny which satisfy the minimum threshold of effectiveness depend on the circumstances of each particular case. They must be assessed on the basis of all relevant facts and with regard to the practical realities of investigation work (see *Koseva v. Bulgaria* (dec.), no. 6414/02, 22 June 2010). Furthemore, the obligation to investigate is not one of result, but of means only.

55. The requirement of public scrutiny is also relevant in this context. The degree of public scrutiny required may well vary from case to case. In all cases, however, the next-of-kin of the victim must be involved in the procedure to the extent necessary to safeguard his or her legitimate interest (see, for example, *McKerr v. the United Kingdom*, no. 28883/95 , § 148, ECHR 2001-III).

56. The Court finds that a procedural obligation arose to investigate the circumstances of JM's death. He was a prisoner under the care and responsibility of the authorities when he died as a result of what appeared to be a suicide (paragraph 43 above). The investigation was necessary to establish, firstly, the cause of death, and, secondly, once suicide was established, to examine whether the authorities were in any way responsible for failure to prevent it. That investigation had also to fulfil requirements set out above (paragraphs 54 and 55 above).

57. In the present case, the investigation was carried out by the investigating judge with the assistance of the police and later on by the public prosecutor. They were not connected to the prison authorities, either structurally or factually, so that the persons conducting the investigation were independent from the relevant personnel of the prison.

As to whether the investigation was prompt and expeditious, the Court observes that an on-site investigation was conducted immediately after the incident, including photographs of the scene and of the body. An autopsy was performed on the day of the death by a forensic expert (contrast *Tepe v. Turkey*, no. 27244/95, § 181, 9 May 2003). Furthermore, following the applicant's criminal complaint the case was again examined by the public prosecutor, by the investigating judge and by the District Court and the Supreme Court of Serbia, within five months after JM's death.

As regards thoroughness, the Court notes that police officers questioned a number of prison officers, including the prison doctor and the officers who

discovered JM's body. Furthermore, the autopsy report was detailed: it described both the internal and external features of JM's body and took histopathological samples which were analysed in detail (contrast *Tanlı v. Turkey*, no. 26129/95, § 150, ECHR 2001-III (extracts)). It went on to clearly conclude as to suicide by hanging. It is true that certain facts in the autopsy report (the time of discovery of JM's body and the time of death) did not match the report of the investigating judge and the prison guard's statement (paragraphs 16, 18 and 20 above). However, while some effort should have been made to clarify these inconsistencies, the Court does not find this oversight sufficient to conclude that the investigation into JM's death was sufficiently flawed as to undermine its effectiveness, since the precise time of death was not of crucial importance in the present case (contrast *Velikova v. Bulgaria*, no. 41488/98, § 79 *in limine*, ECHR 2000-VI). Moreover, the applicant could have but did not challenge the expert's conclusions after he had received the autopsy report.

Furthermore, following the applicant's criminal complaint, the police again questioned several prison officers and the prison warden also gave a statement to the public prosecutor. Once the public prosecutor decided not to prosecute and the applicant took over the prosecution, the investigating judge requested a new report from the prison authorities and gathered more evidence. However, having examined all documents, he considered that there were not enough elements for indictment and that the investigation should be discontinued. That conclusion was upheld by the District Court and by the Supreme Court of Serbia. This also shows that the applicant has been involved in the procedure to the extent necessary to safeguard his interest as a next-of-kin.

Finally, as regards the applicant's allegation that the prison authorities refused to produce the CCTV recordings, the Court notes that such recordings were never made (paragraph 13 above).

58. In the light of the above, the Court concludes that there has been no violation of the procedural obligation of Article 2 of the Convention.

FOR THESE REASONS, THE COURT UNANIMOUSLY

1. *Declares* the application admissible;

2. *Holds* that there has been no violation of Article 2 of the Convention as regards the authorities' positive obligation to protect the right to life;

3. *Holds* that there has been no violation of Article 2 of the Convention in respect of the respondent State's obligation to conduct an effective investigation.

Done in English, and notified in writing on 22 January 2013, pursuant to Rule 77 §§ 2 and 3 of the Rules of Court.

Stanley Naismith Registrar	Guido Raimondi President