Neutral Citation Number: [2022] EWHC 841 (Admin)

Case Nos: CO/3078/2019; CO/756/2020

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
DIVISIONAL COURT

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 8 April 2022

Before:

LORD JUSTICE STUART-SMITH
MR JUSTICE JAY

- -

Between:

(1) A
(2) MOHAMMED ESMAILI **Appellants**

- and –

(1) DEPUTY GENERAL PUBLIC PROSECUTOR OF THE LYON COURT OF APPEAL
(2) GENERAL PUBLIC PROSECUTOR OF THE ROUEN COURT OF APPEAL **Respondents**

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Hugo Keith QC and Rachel Barnes (instructed by **Sternberg Reed**) for the **Appellant Mr A**
Hugo Keith QC and John Crawford (instructed by **MW Solicitors**) for the **Appellant Mr Esmaili**
Helen Malcolm QC and Richard Evans (instructed by **CPS**) for the **Respondents**

Hearing date: 15 March 2022

Remote hand-down: This judgment was handed down remotely at 10.30am on 15 March 2022 by circulation to the parties or their representatives by email and by release to BAILII and the National Archives.

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Approved Judgment

MR JUSTICE JAY:

Introduction

1. On 22nd September 2021 this Court (Stuart-Smith LJ and Jay J) handed down its judgment in these two extradition appeals ([2021] EWHC 2543 (Admin)). Having decided that *Aranyosi* Stage 1 had been satisfied in various specific respects, supplementary information was sought from the French judicial authorities in line with the procedure laid down in Article 15(2) of the Framework Decision.

2. In the light of the responses that have been provided, the issue for determination in this second judgment is whether, in relation to each Appellant, there is a real risk that he would suffer inhuman or degrading treatment in violation of Article 3 of the ECHR.

3. It is unnecessary to summarise the legal principles, evidence and submissions that have been covered in our first judgment. I will, however, be returning to the medical evidence in the case of Mr A because some of the detail is important.

The Supplementary Information

4. What the Respondents describe as a "preliminary response" to the Court's questions was provided by letter dated 5th November 2021, being the deadline specified in our Order dated 23rd September. The CPS recognised that this response was inadequate and sought a further 14 days for compliance, expiring on 19th November. This first response took issue, albeit entirely courteously, with some of our reasons for concluding that *Aranyosi* Stage 1 was fulfilled. In terms of a substantive response, the point was made that under Law No. 2021-403 of 8th April 2021, a detainee who claims to be held in conditions which are unfit may apply to a judge for redress. The French court has considerable power within an expedited timescale to ensure that appropriate remedial action is taken or, if necessary, for the prisoner to be released. The point was also made that under French legal and administrative arrangements the prison service guarantees the same level of healthcare as is applicable to the general population; and, if necessary, that a detainee be transferred to a local hospital for treatment. The response noted that the quality of healthcare provision was not the subject of criticism in *JMB and others v France* (Application No. 9671/15).

5. On 19th November 2021 the Respondent made a second application for a further 14 days in which to comply with this Court's direction. The application was granted and the Respondent's supplementary response, dated 19th November, was served on 2nd December.

6. The response in relation to the Appellant Mr A provides a certain amount of additional information concerning Villefranche-sur-Saône detention centre and Lyon-Corbas prison.

7. In relation to Villefranche-sur-Saône detention centre, this additional information may be summarised as follows:

   (1) as at 18th November 2021, there were 656 persons incarcerated (as opposed, for example, to serving in the community) in the context of a theoretical capacity of 564 cells and 639 spaces.

(2) the cells (in three buildings, A, B and J) have a surface area of 9m². The in-cell "bathroom" area, comprising a toilet, sink and a mirror) can be estimated as being 1m². The showers are not in the cells and each wing includes an area with several showers accessible to detainees.

(3) as at 18th November 2021, no cells were occupied by three inmates. It follows that all inmates had either 4m² or 8m² of personal space.

(4) the healthcare institutions linked to the Villefranche-sur-Saône detention centre are the Villefranche-sur-Saône hospital centre and the Saint-Cyr-au Mont d'Or hospital centre for psychiatric care.

8. In relation to Lyon-Corbas, this additional information may be summarised as follows:

(1) as at 18th November 2021, there were 1,301 incarcerated persons in the context of 690 cell spaces.

(2) the cells (in three buildings, MAH1, MAH2 and MAH3) vary as between single and double. The area of single cells is 10.5m²; the area of double cells is 13.5m². The surface area of cells for disabled inmates is 21m². All cells have a flat screen TV, a small fridge and a toilet area (estimated to be 1.6m²) with a sink, a toilet and a shower. It follows that the area of the single cells, without toilet area, is 8.9m², providing 4.45m² per detainee when shared by two inmates (none of these cells were occupied by three). The area of double cells, without the toilet area, is 11.9m², therefore amounting to 5.95m² per person when occupied by two inmates and 3.96m² when occupied by three. Within these three buildings, 33 double cells are currently shared by three inmates. Overall, each inmate benefits from personal space of over 3m² and less than 100 inmates have less than 4m² (and then, only by a small margin).

(3) the healthcare institutions linked to Lyon-Corbas prison are the Lyon state hospitals for physical (described as "somatic") care and the Vinatier hospital centre for psychiatric care.

(4) the Lyon-Corbas prison centre benefits from an interregional secure hospital unit, being a healthcare centre linked to this establishment but managed by the local health authorities.

9. Each institution has its own healthcare unit, open from Monday to Friday. Regarding access to treatment, depending on the individual situation and evolution of each unit there is either a pharmacist on site or treatment is provided at the assigned hospital. Such treatments therefore come from the pharmacy of the hospital centre and are administered by the paramedical staff following a doctor's prescription.

10. In relation to the Appellant Mr Esmaili, the additional information regarding Rennes-Vezin prison centre may be summarised as follows:

(1) as at 18th November 2021 there were 997 persons incarcerated in the context of a theoretical capacity of 712 spaces.

(2) Mr Esmaili would be incarcerated either in Detention Centre 1 or Detention Centre 2.

(3) as for Detention Centre 1, the single cells have an area of 10.5m^2, minus the toilet area which has a surface area of 1.6m^2, yielding an available surface area of 8.9m^2. As for double cells, the surface area is 14m^2 and 12.4m^2 without the toilet area.

(4) as at 18th November 2021:

(a) 35 single cells were occupied by one person, which equates to 8.9m² per person.

(b) 48 single cells were occupied by two people, equating to 4.5m² per person.

(c) 8 single cells were occupied by three people, which equates to 2.96m² per person.

(d) 23 double cells were occupied by two people, which equates to 6.2m² person.

(e) 32 double cells were occupied by three people, which equates to 4.13m² per person.

(f) 1 double cell was occupied by one person, equating to 12.4m².

(5) as for Detention Centre 2, the single cells have an area of 9.5m^2, minus the toilet area which has an area of 1.6m^2, yielding an available area of 7.9m^2. The double cells have a surface area of 13.6m^2 and so 12m^2 without the toilet area.

(6) as at 18th November 2021, in this building:

(a) 36 single cells were occupied by one person, which equates to 7.9m^2 per person.

(b) 45 single cells were occupied by two people, which equates to 3.95m^2 per person.

(c) 1 single cell was occupied by three people, which equates to 2.63m^2 per person.

(d) 23 double cells were occupied by two people, which equates to 6.2m^2 per person.

(e) 32 double cells were occupied by three people, which equates to 4.13m^2 per person,

(f) 1 double cell was occupied by one person, which equates to 12.4m^2.

11. The French judicial authority opined that "it seems unlikely" that if Mr Esmaili were incarcerated in Rennes-Vezin his personal space would be less than 3m². More exactly, 27 prisoners out of 570 had less than 3m² of personal space. I have not used the figure of 997 prisoners because on my arithmetic the sum of §10(4) and (6) above is 570. If a simple mathematical approach were appropriate, this amounts to a probability of just under 5%.

12. An unfortunate complication in Mr Esmaili's case is that the French judicial authority now says that it is very unlikely that he would be held at that institution. Although M. Tricaud, the Appellant's expert, had focused on Rennes-Vezin, and the Court is aware that Rennes is nowhere near Rouen, it is perhaps surprising that his misconception has sought to be corrected only very late in the day. Be that as it may, the parties are agreed that for present purposes the Court should examine the evidence relevant to this institution and make appropriate findings upon it, because it is likely to be representative.

Deficiencies in the Supplementary Information Provided

13. Mr Hugo Keith QC submitted that the French judicial authorities have failed to provide the detailed information which the Court required in Annex A of its September 2021 judgment, in a number of important respects.

14. First, there is no specific information about whether the healthcare units in the two establishments germane to Mr A's case can provide proper treatment for the range of conditions from which Mr A suffers. Although the Respondent has been able to identify the local civilian hospitals to which Mr A would have access should the need arise, no information has been provided as to the range of medical treatments available and whether there are medical practitioners of sufficient expertise in relation to each of the Appellant's conditions. Given, for example, M. Tricaud's evidence that the civilian hospitals attached to Lyon and Villefranche-sur-Saône do not provide kidney dialysis, it is contended that further information of the kind and nature sought should have been supplied.

15. Secondly, there is a lack of information in Mr A's case regarding the dimensions of the in-cell furniture and whether he would be able to move freely between items of furniture in view of his mobility difficulties; whether the in-cell sanitary facilities are or will be partitioned from the rest of the cell; the arrangements that would be made to accommodate his mobility difficulties and medical problems in terms of accessing shower facilities, medical treatment and areas outside his cell for work, exercise and recreation; the daily number of hours allowed out of his cell, heating and temperature; and whether there are serious problems with rats and bed bugs.

Other Evidence

16. In December 2021 the Contrôleur-Général des Lieux de Privation de Liberté ("CGLPL") published its report on Villefranche-sur-Saône prison following an unannounced visit by a team of nine inspectors conducted between 30th November and 7th December 2020. The French authorities were sent a provisional report in April 2021

"with a view to collecting their observations", but the Respondent did not make it available to the Court last June. Given the status of the report at that stage, I cannot accept Mr Keith QC's criticism that it should have been disclosed.

17. The picture painted by the CGLPL report is far from uniform. Mr Keith QC's skeleton argument understandably focuses on the bad, but in a number of important respects the inspectors found an improvement since their previous visit in 2012, particularly in respect of the state of hygiene of the men's accommodation area and the overall "climate of violence". On the other hand, the prison as a whole suffers from chronic understaffing and rapid staff turnover, with all the obvious knock-on impacts. This is in the context of a prison which "is usually permanently overcrowded", although was not at the time of the inspection, owing to the pandemic.

18. It is clear from the CGLPL report that the communal showers and exercise facilities are in generally poor condition. It is common for wastewater to invade the entire shower, and a recommendation was made that "communal showers should be completely renovated to ensure satisfactory hygiene and privacy conditions". None of the exercise yards has a bench for detainees to sit on, and their overall state is described as "deteriorated and under-equip[ped]".

19. Conversely, as Ms Helen Malcolm QC points out at para 31 of her skeleton argument, the CGLPL report also noted the following:

    (1) at the time of the inspectors' visit, no mattresses on the floor were found.

    (2) the toilet areas in buildings A, B and J are separated from their cells by a door.

    (3) inmates have the means to maintain satisfactory personal hygiene.

    (4) no reference is made to inmates with mobility issues being unable to access shower facilities, the medical unit, or the areas outside the cells.

    (5) apart from inadequate lighting, no criticism was made of material conditions within the cells (including of the heating, and the visit was in December).

    (6) in buildings A, B and J prisoners are allowed 2½ hours' exercise a day and those in the "respect module" have access to 25 hours' activity a week.

    (7) apart from breakfast, the food is generally satisfactory.

    (8) monthly rodent controls are in operation, and no criticism is made in relation to bed bugs. (But Mr Keith QC draws attention to the fact that the CGLPL report recognises that these rodent controls are far from completely successful)

20. As for the medical unit, the inspectors found that it was "clean and well-maintained" although the communal premises were "very cramped". The surgeries were equipped with an examination table and "all the equipment necessary for the practice of general medicine". On arrival, every inmate is offered a nursing interview and medical consultation within 24 hours to assess their state of health, current pathologies and continuing treatment needs. Overall:

> "The health unit ensures the permanence and continuity of somatic care in spite of stretched resources.
>
> This unit provides:
>
> - nursing care; general and specialised medical consultations; emergency care during opening hours;
>
> - works on links with the various partners (PA, Saint Cyr psychiatry team, other practitioners …
>
> - other paramedical consultations …
>
> and
>
> - arranges appointments for further examinations, outpatient specialist consultations and hospitalisation, in conjunction with the hospitals and prison escort team;
>
> - offers group education and promotion sessions …"

21. The CGLPL report's observation that resources were stretched was provided more in the context of human resources than the physical state of the medical unit. My impression is that the unit is nurse led with the equivalent of 8.2 full-time filled posts. Nurses are available between 8am and 6:30pm Monday to Friday, and until 3:30pm at weekends. There were three GPs working at 1.6 full-time equivalent ("FTE") for 2 budgeted posts, and by early 2021 (the inspection was in December 2020) the expectation was that the unit would be at full complement. Specialist doctors across a range of disciplines attended the unit on an infrequent basis.

22. Although there appears to be a reasonable system for requesting medical appointments, its operation in practice was unsatisfactory with the rate of missed appointments being as high as 23.9%. The reasons for this were multifarious, ranging from incomplete copying of schedules to failures by supervisors to bring inmates for their appointments to the prisoners themselves preferring to take exercise over their medical appointments, or simply refusing to attend.

23. As for the quality of psychiatric care, the CGLPL report concluded that "the chronic lack of resources is affecting the level of psychiatric care". Specifically:

> "This team remains notoriously under-resourced in terms of staff and premises. It has:
>
> - a 0.5 FTE manager who started in June 2020 …;
>
> - four FTE nurses in service for five budgeted, i.e. one unfilled post;
>
> - a psychiatrist at FTE 0.8 since September 2020 for two budgeted positions. The position remained vacant from February 2020 until that date and previously from September 2019 to February 2020 it was only filled at FTE 0.6;

- 1.8 FTE psychologist for two budgeted posts;
- 0.2 FTE for an addiction psychologist."

24. Following the advent of a new head of department in September 2020, an "expeditious reorganisation" was effectuated, "without consultation with the somatic care team". This placed greater responsibilities on the general nurses. This reorganisation has also drastically reduced the opportunity for communication and coordination with the physical medical health team.

25. There is no recent CGLPL report for Lyon-Corbas, and the expert evidence from M. Tricaud on which A relies is somewhat out-of-date. If, however, it is reasonable, as the Respondents suggest it is, to read across from Rennes-Vezin to other prisons in the case of Mr Esmaili, a similar approach may presumptively be adopted *à propos* the CGLPL's conclusions for Villefranche-sur-Saône. I am not overlooking the fact that at Lyon-Corbas the route to the medical unit is either up a flight of 20 stairs or a lift, and that in CGLPL's report dated December 2014 inspectors observed inmates on crutches having to climb the stairs rather than take the lift. This, giving it appropriate weight for its age, is specific evidence that displaces this presumptive approach.

The Appellants' Submissions in Outline

26. At this stage I propose to summarise the parties' respective submissions on the evidence. Their submissions on the relevant legal framework will be addressed separately.

27. Mr Keith QC submitted that it was the cumulative effect of all the various failings and deficiencies which should draw the Court to conclusion that there is a real risk that both Appellants would suffer ill treatment in violation of Article 3. In circumstances where the Court has decided that *Aranyosi* Stage 1 has been met, it was incumbent on the French judicial authorities to provide sufficient information by way of supplementary material to enable the Court to be satisfied that the real risk that has been presumptively identified can been discounted. Given the inadequacy of the information furnished, the Court could not be satisfied to the relevant standard that the risk has not fallen below the level of acceptability.

28. In Mr Esmaili's case, Mr Keith QC reiterated that the Court's determination on *Aranyosi* Stage 1 meant that the onus of persuasion, if not of proof, fell on the Respondent to show that there would not be a real risk. A statistical probability of 5% was sufficient; in the alternative, there was also an unacceptable risk that Mr Esmaili's personal space would fall in the bracket of 3-4m² which was a weighty albeit not a presumptive factor in his favour. Given the failure of the French judicial authority to answer the Court's questions other than perfunctorily, the conclusion should be reached at *Aranyosi* Stage 3 that a violation of Article 3 could not be fairly discounted.

29. As for Mr A, Mr Keith QC reminded us of the medical evidence in his complex case and of the evidence of M. Tricaud, and submitted that in the light of the CGLPL report and the failure of the French judicial authority to engage with the Court's entirely proper questions, the conclusion should now be reached that Mr A faces a real risk of ill-treatment that would violate Article 3.

The Respondent's Submissions in Outline

30. Ms Malcolm QC accepted that the French judicial authorities have been slow to answer the Court's questions, and have done so far from comprehensively. However, she submitted that the Court now has evidence from more than one source which should enable it to conclude that there is no real risk of a violation of Article 3.

31. In relation to Mr Esmaili, the focus should be on the personal space issue and nothing else. The Court had not identified any other concerns at *Aranyosi* Stage 1 which fell to be placed in the balance. Ms Malcolm's submission was that the 3m² figure for personal space was not an absolute watershed, and that in all the circumstances the (slight) statistical probability that Mr Esmaili's personal space might be either 2.96m² or 2.63m² could not justify a finding of violation of his Article 3 rights.

32. In relation to Mr A, Ms Malcolm drew attention to his current employment and his evident ability to work long hours. There was no risk that his personal space would fall below 3m², and the chance that it might fall in the bracket of 3-4m² was sufficiently low to be capable of being discounted.

33. As regards Mr A's medical needs, Ms Malcolm's headline submission was that his physical and psychiatric conditions would be adequately addressed within the two penal institutions in question, alternatively within a local hospital. Ms Malcolm relied on the provisions of French law establishing a right to equivalence as between the French NHS and its prison estate.

Relevant Legal Framework

34. In the light of the parties' submissions, the following three issues arise for our determination. Much of the ground has already been covered in our first judgment and will not be repeated.

35. The first issue is the approach we must take to the supplementary information provided by the Respondent, and the additional material lodged by the Appellants, in the light of our earlier conclusion that there was a sufficient basis to seek such information under Article 15(2) of the Framework Decision.

36. The second issue is the approach we should take to the issue of overcrowding (relevant only to the case of Mr Esmaili) in the context of the 3m² benchmark for prisoner personal space.

37. The third issue is whether all aspects of the approach governing Article 3 of the ECHR in deportation and expulsion cases, including the threshold for engagement, should be read across to extradition.

The First Issue: the Supplementary Information

38. In our first judgment, we concluded that the information provided by the "issuing Member State" (here, the French judicial authorities) was insufficient to enable us to decide on the issue of surrender (see the opening words of Article 15(2) of the Framework Decision). It was for that reason that we sought supplemental information from the French judicial authorities, not least because a decision to discharge an

Appellant is impermissible without taking that step. That much is clear from para 104 of the decision of the Grand Chamber in *Aranyosi* [2016] QB 921, which provides:

> "It follows from all the foregoing that the answer to the questions referred is that articles 1(3), 5 and 6(1) of the Framework Decision must be interpreted as meaning that where there is objective, reliable, specific and properly updated evidence with respect to detention conditions in the issuing member state that demonstrates that there are deficiencies, which may be systemic or generalised, or which may affect certain groups of people, or which may affect certain places of detention, the executing judicial authority must determine, specifically and precisely, whether there are substantial grounds to believe that the individual concerned by a European arrest warrant, issued for the purposes of conducting a criminal prosecution or executing a custodial sentence, will be exposed, because of the conditions for his detention in the issuing member state, to a real risk of inhuman or degrading treatment, within the meaning of article 4 of the Charter, in the event of his surrender to that member state. To that end, the executing judicial authority must request that supplementary information be provided by the issuing judicial authority, which, after seeking, if necessary, the assistance of the central authority or one of the central authorities of the issuing member state, under article 7 of the Framework Decision, must send that information within the time limit specified in the request. The executing judicial authority must postpone its decision on the surrender of the individual concerned until it obtains the supplementary information that allows it to discount the existence of such a risk. If the existence of that risk cannot be discounted within a reasonable time, the executing judicial authority must decide whether the surrender procedure should be brought to an end."

39. In a domestic context, the leading authority on the practical application of *Aranyosi* is the decision of this Court (Beatson LJ and Williams J) in *Mohammed v Portugal* [2017] EWHC 3237 (Admin), at para 15:

> "Stage 1 of the procedure involves determining whether there is such a risk by assessing objective, reliable, specific and properly updated evidence … A finding of such a risk cannot lead, in itself, to a refusal to execute the EAW. Where such a risk is identified, the court is required to proceed to stage 2.
>
> Stage 2 requires the executing judicial authority to make a specific assessment of whether there are substantial grounds to believe that the individual concerned will be exposed to that risk. To that end it must request the issuing authority to provide as a matter of urgency all necessary supplementary information on the conditions in which it is envisaged that the individual concerned will be detained.

> Stage 3 deals with the position after the information is provided. If in light of that, and of any other available information, the executing authority finds that, for the individual concerned, there is a real risk of inhuman or degrading treatment, execution of the warrant must be postponed but cannot be abandoned."

40. It is common ground that the French judicial authorities have not provided comprehensive answers to all the questions we posed, and that some questions have simply not been addressed. However, this is not a situation where a judicial authority has wholly failed to engage, and it is also common ground that the deficiencies in the information supplied cannot, without more, justify an order for the discharge of either or both Appellants. Mr Keith QC accepted that the present cases do not fall within such an exceptional category: c.f. *Mohammed v Portugal (No. 2)* [2018] EWHC 225 (Admin) where such an order was made in a case of a wholesale failure to address the questions posed, leaving the Court without the material to perform the requisite Stage 3 evaluation.

41. We have now reached Stage 3 in a situation where the French judicial authorities have provided some supplementary information and Mr A in particular has filed further evidence which, on the face of it, is "objective, reliable, specific and properly updated". The CGLPL report of December 2021 may be accurately characterised in these terms. In such circumstances, it is incumbent on the Court to carry out the evaluative exercise predicated by Stage 3 on the basis of all the material it has as its disposal. The ultimate question is whether, in the light of all that information, the relevant Article 3 risk may be discounted.

42. In this context I should address one of the contentions made by the French judicial authorities, which is that the ECtHR in *JMB* made no criticism of healthcare provision in any of the six penal institutions there under scrutiny. That comes close to saying that we were wrong to invoke the Article 15(2) procedure in the case of Mr A. In response, we make three observations. First, although Mr Keith QC was right to submit that the quality of healthcare provision was not in issue in *JMB*, there is an evidential burden on an appellant to adduce "objective, reliable, specific and properly updated evidence" indicative of a violation. Secondly, the case of Mr A is somewhat atypical in that he has a constellation of medical conditions which have been addressed in some detail in his medical evidence. It was, and remains, appropriate for this Court to investigate his case with the appropriate degree of concern. Thirdly, in performing the Stage 3 evaluation I will naturally take into account the mutual respect and confidence that is due to a co-signatory to the ECHR and the presumption that it will comply with its obligations under Article 3.

The Second Issue: the 3m² Figure for Personal Space

43. There was some discussion before us as to the saliency of the 3m² benchmark in the context of prison overcrowding. The relevant principles have been set out by the Grand Chamber in *Mursic v Croatia* [2017] 65 EHRR 1. Although a domestic and not an extradition case, it is not in dispute that these principles are applicable to the latter context. These may be summarised as follows, with the relevant references to *Mursic* being provided in parentheses:

(1) 3m² of floorspace per detainee is the relevant minimum standard under Article 3 (paras 110 and 136).

(2) the in-cell sanitary facility should not be counted in the overall surface area of the cell, but the space occupied by furniture should be included. In relation to the latter, what is important is whether detainees have the possibility to move around within the cell normally (para 114).

(3) although a violation of Article 3 "cannot be reduced to a numerical calculation of square metres allocated to a detainee", "a strong presumption of a violation of Article 3 arises where the personal space available to a detainee falls below 3m² in multi-occupancy accommodation" (para 123).

(4) where the presumption applies, the burden shifts to the Respondent to show that the cumulative effects of detention serve to rebut it. It is incumbent on the Respondent to demonstrate convincingly that there are adequate compensating factors (para 125 and 137).

(5) ordinarily, the presumption will be capable of rebuttal only if the following factors are cumulatively met, viz. (i) the reductions in the required minimum personal space of 3m² are short, occasional and minor; (ii) such reductions are accompanied by sufficient freedom of movement outside the cell and adequate out-of-cell activities; and (iii) the applicant is being held in what is, when viewed generally, an appropriate detention facility, and there are no other aggravating aspects of the conditions of his or her detention (para 138).

(6) in cases where the personal space per detainee falls between 3-4m², the space factor remains a weighty one in the court's overall assessment under the rubric of Article 3 but there is no presumption as such. A violation of Article 3 will be found if the space factor is coupled with other aspects of inappropriate physical conditions of detention – e.g. access to outdoor exercise, natural light or air, availability of ventilation, adequacy of room temperature, the possibility of using the toilet in private, and compliance with basic sanitary and hygienic requirements (para 139).

44. It is clear that the 3m² figure is not an absolute tipping point between violation and non-violation of Article 3 notwithstanding the latter's character as an absolute right. Anything below this figure generates a strong presumption, but matters of extent, fact and degree must, in this particular context, remain relevant. Further, there must be a difference between, for example, 1.96m² and 2.96m², noting as we do that 0.04m² represents the surface area of a sheet of A4 paper. On a related point, the ascertainment of real risk of an Article 3 violation in this case may properly take into account the chance (less than 5% on a simple mathematical approach) that Mr Esmaili would find himself with under 3m² of personal space. If that threshold constituted an absolute, binary standard, there would be force in Mr Keith's submission that there cannot be degrees of torture; but the position here is not black and white.

45. As Lord Brown of Eaton-Under-Heywood explained in *R (oao Wellington) v Secretary of State for the Home Department* [2008] UKHL 72; [2009], 1 AC 335, at para 86:

> "… there is a good deal of flexibility in the concept of inhuman and degrading treatment and punishment with many factors in

> play in determining whether it attains the minimum standard required and whether the risk of such ill-treatment is satisfied …"

There was a difference of opinion in the House of Lords as to whether what were described as "relativist" factors, for instance the public interest in favour of extraditing foreign criminals, should be placed in the Article 3 balance. Although that difference was noted in passing by Mr Keith QC in the course of his submissions, it is unnecessary for us to enter that debate.

The Third Issue: the Overarching Approach to the Issue of "Real Risk" in the Context of Extradition

46. Ms Malcolm QC boldly submitted that the principles articulated both in Strasbourg and the Supreme Court for defining the threshold for the engagement of Article 3 in the specific contexts of deportation and expulsion are equally applicable to the present context of extradition. This was not a submission that had been prefigured in her skeleton argument filed for the purposes of the first hearing of these appeals in June last year.

47. The cases to which she was referring include *Paposhvili v Belgium* [2017] Imm AR 867, *AM (Zimbabwe) v Secretary of State for the Home Department* [2020] UKHL 17; [2021] AC 633 and *Savran v Denmark* [2021] ECHR 1025 (Application No 57467/15 decided by the Grand Chamber on 7th December 2021).

48. The facts of these three cases require brief encapsulation. All three cases concerned foreign criminals whom Belgium, the United Kingdom and Denmark sought to deport. In *Paposhvili* the issue was whether he would receive appropriate treatment in Georgia for his chronic lymphocytic leukaemia; in *AM (Zimbabwe)*, it was whether the HIV positive appellant would have access to medication which would prevent his relapse into full-blow AIDS; and in *Savran*, it was whether he would receive necessary psychiatric treatment in Turkey for his paranoid schizophrenia.

49. The precise articulation of the Article 3 threshold in deportation and expulsion cases was subject to close analysis by Lord Wilson JSC in *AM (Zimbabwe)*, critical as he was of certain aspects of the Grand Chamber's reasoning in *Paposhvili*. It is sufficient for present purposes to set out parts of two paragraphs of the Grand Chamber's judgment in *Savran*, being the most recent authority on this topic:

> "131. The Court stressed in the above connection that the benchmark was not the level of care existing in the returning State; it was not a question of ascertaining whether the care in the receiving State would be equivalent or inferior to that provided by the healthcare system in the returning State. Nor was it possible to derive from Article 3 a right to receive specific treatment in the receiving State which was not available to the rest of the population (ibid., § 189). In cases concerning the removal of seriously ill persons, the event which triggered the inhuman and degrading treatment, and which engaged the responsibility of the returning State under Article 3, was not the lack of medical infrastructure in the receiving State. Likewise,

> the issue was not one of any obligation for the returning State to alleviate the disparities between its healthcare system and the level of treatment existing in the receiving State through the provision of free and unlimited healthcare to all aliens without a right to stay within its jurisdiction. The responsibility that was engaged under the Convention in cases of this type was that of the returning State, on account of an act - in this instance, expulsion - which would result in an individual being exposed to a risk of treatment prohibited by Article 3 (ibid., § 192). Lastly, the Court pointed out that whether the receiving State was a Contracting Party to the Convention was not decisive.
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> …
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> 134. Firstly, the Court reiterates that the evidence adduced must be "capable of demonstrating that there are substantial grounds" for believing that as a "seriously ill person", the applicant "would face a real risk, on account of the absence of appropriate treatment in the receiving country or the lack of access to such treatment, of being exposed to a serious, rapid and irreversible decline in his or her state of health resulting in intense suffering or to a significant reduction in life expectancy" (ibid., § 183)."

50. In my judgment, the following principles may be derived from these authorities:

(1) A returning state (*qua* signatory to the ECHR) has a general right to control the entry, deportation and expulsion of aliens.

(2) A returning State is under no general obligation to consider the level of care available in the receiving state.

(3) A returning state may be under an obligation to refrain from acts which may place it in violation of Article 3.

(4) The threshold for engagement and violation of Article 3 in very high: see the exacting formulation in para 134 of *Savran*.

51. Some modest support for Ms Malcolm QC's contention that these principles may be read across to extradition cases may be derived from two sources.

52. In the first place, in para 124 of its judgment in *Savran* the Grand Chamber referred generally and without differentiation to "its case-law concerning the extradition, expulsion or deportation of individuals". That was in the context of States Parties having "the right to control the residence, entry and expulsion of aliens". However, the Grand Chamber identified no extradition case within its jurisprudence in which this principle was applied, and it may be pointed out that extradition arrangements within the EU (and, so far as concerns the UK, post-Brexit) are not concerned with the "residence, entry and expulsion of aliens".

53. Secondly, at para 6 of his judgment in *Speraukas v Lithuania* [2020] EWHC 3543 (Admin), Fordham J stated:

> "Mr Henley accepts that section 25 is a "high threshold". It was not necessary at the hearing and is not necessary in this judgment to trawl the lines of authority in relation to it or the other grounds of appeal: they are well-trodden paths. So far as Article 3 ECHR is concerned the parties made submissions on AM (Zimbabwe). In that case, Lord Wilson's judgment at paragraph 31 identified in the Article 3 and health context the relevant threshold by reference to whether the individual being removed (that was in immigration rather than an extradition case) would, by reason of their medical condition and any response or lack of response to it, be exposed to a "serious rapid and irreversible decline in the state of [their] health resulting in intense suffering" or a "significant" (meaning "substantial") "reduction in life expectancy". Lord Wilson at paragraph 23 also dealt with the "procedural requirements" and the position where concerns are raised and when the focus then turns to the position in the receiving state (in an immigration case) or requesting state (in an extradition case)."

The submissions advanced on *AM (Zimbabwe)* were not set out, but I do not read Fordham J's judgment as endorsing the application of that authority to an extradition context. Indeed, he made it clear that it was an immigration and not an extradition case.

54. I accept the submission of Mr Keith QC that there is a straightforward and fundamental difference between immigration and extradition cases: that Contracting States owe a duty of care to its prisoners, and no such duty is owed in relation to healthcare provision generally. If, for example, the evidence were that a particular country systematically failed to provide dialysis for those with kidney failure, and there was a significant risk that the proposed extradited person might suffer such failure, I do not think that extradition to such a country would be ordered. It would not matter for this purpose whether the argument was advanced under section 25 of the Extradition Act (whether the physical or mental condition of the appellant is such that it would be unjust or oppressive to extradite him) or under section 21A(1)(a) (whether extradition would be incompatible with the appellant's Article 3 rights on the basis of substantial grounds for considering that, if extradited, he will suffer treatment crossing the Article 3 threshold or that there is a real risk he will suffer such treatment).

55. In Mr Keith QC's skeleton argument filed for the purposes of the June 2021 appeal hearing he drew our attention to a number of authorities. I may summarise the position quite briefly as follows.

56. Authority for the proposition that Contracting States are subject to a duty of care towards prisoners is to be found in *Helhal v France* (App no 10401/12, ECtHR, 19 February 2015), at para 47. The duty is:

> ".. [t]o verify that prisoners are fit to serve their sentence, to provide them with the necessary medical treatment and, where appropriate, to adapt the general conditions of detention to their particular state of health."

57. Further, in *Helhal* the ECtHR confirmed, at para 48, that a "lack of appropriate medical care may in principle amount to treatment contrary to Article 3". The Court continued, in the same para:

> "The Court requires, firstly, the provision of relevant medical support for sick detainees and appropriate medical treatment for their specific ailments. The promptness and frequency with which medical care is provided to such prisoners are two factors to be taken into account in assessing whether they are being treated in a manner compatible with the requirements of Article 3. In particular, these two factors are not assessed by the Court in absolute terms, but with due regard for the prisoner's particular state of health in each case … As regards the third obligation [adapting general conditions to the prisoner's particular state of health], the Court requires the prison environment to be adapted, where necessary, to the prisoner's specific needs so that he or she can serve the sentence in conditions that do not undermine his or her psychological well-being."

58. Where an individual suffers from a medical condition, a deterioration of that condition in custody can constitute a breach of Article 3 (see *Pretty v United Kingdom*, App no 2346/02 (ECtHR, 29 July 2002), at para 52:

> "The suffering which flows from naturally occurring illness, physical or mental, may be covered by Article 3, where it is, or risks being, by treatment, whether flowing from conditions of detention, expulsion or other measures, for which the authorities can be held responsible."

59. At the hearing last year the parties were unable, on account of the timing, to draw our attention to the decision of the First Section of the ECtHR in *Khachaturov v Armenia* (Application No. 59687/17), handed down on 24th June 2021. Paras 82-85 are relevant:

> "82. Nevertheless, according to the Court's well-established case-law, ill-treatment must attain a minimum level of severity if it is to fall within the scope of Article 3. The assessment of this minimum is relative; it depends on all the circumstances of the case, such as the duration of the treatment, its physical and mental effects and, in some cases, the sex, age and state of health of the victim (see, among other authorities, *Khlaifia and Others v. Italy* [GC], no. 16483/12, § 159, 15 December 2016, and *Kudła v. Poland* [GC], no. 30210/96, § 91, ECHR 2000-XI). In order to determine whether the threshold of severity has been reached, the Court may also take other factors into consideration, in particular: the purpose for which the ill-treatment was inflicted, together with the intention or motivation behind it, although the absence of an intention to humiliate or debase the victim cannot conclusively rule out a finding of a violation of Article 3; the context in which the ill-treatment was inflicted, such as an atmosphere of heightened tension and emotions; and

> whether the victim was in a vulnerable situation (see *Nicolae Virgiliu Tănase v. Romania* [GC], no. 41720/13, § 117, 25 June 2019).
>
> 83. The Court has held that the suffering which flows from naturally occurring illness may be covered by Article 3, where it is, or risks being, exacerbated by treatment, whether flowing from conditions of detention, expulsion or other measures, for which the authorities can be held responsible (see *Pretty v. the United Kingdom*, no. 2346/02, § 52, ECHR 2002-III).
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> 84. It is the settled case-law of the Court that extradition by a Contracting State may give rise to an issue under Article 3, and hence engage the responsibility of that State under the Convention, where substantial grounds have been shown for believing that the individual concerned, if extradited, faces a real risk of being subjected to treatment contrary to Article 3 (see, *mutatis mutandis***,** *Soering v. the United Kingdom*, 7 July 1989, § 91, Series A no. 161).
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> 85. In the context of the removal of seriously ill individuals, the Court has held that the authorities of the returning State have an obligation, under Article 3, to protect the integrity of the individuals concerned - an obligation which is fulfilled primarily through appropriate procedures allowing the risks relied upon to be assessed. In the context of these procedures, it is for the applicants to adduce evidence capable of demonstrating that there are substantial grounds for believing that, if the measure complained of were to be implemented, they would be exposed to a real risk of being subjected to treatment contrary to Article 3. In this connection it should be observed that a certain degree of speculation is inherent in the preventive purpose of Article 3 and that it is not a matter of requiring the individuals concerned to provide clear proof of their claim that they would be exposed to proscribed treatment. Where such evidence is adduced, it is for the authorities of the returning State, in the context of domestic procedures, to dispel any doubts raised by it (see *Paposhvili v. Belgium* [GC], no. 41738/10, §§ 185-87, 13 December 2016)."

60. *Khachaturov* was a case concerning the extradition of a seriously ill individual from Armenia to Russia. The ECtHR did not define the threshold for the engagement of Article 3 to his case beyond saying that there had to be a "minimum level of severity" (which I understand to mean a relatively high threshold) and that a range of factors fell to be taken into consideration. What the ECtHR did not do was to apply the stringent test set out in para 183 of *Paposhvili*. The reference to paras 185-187 of that case bring into play only the procedural obligations we have already outlined, including the need for the returning State, in the context of its domestic procedures, to dispel any doubts raised by the evidence adduced by the putative returnee indicating the existence of substantial grounds to believe that there would be a real risk of ill-treatment. In our

view, the reference to *Khachaturov* merely serves to confirm the validity of Mr Keith QC's overarching submission.

61. Mr Keith QC also relied on para 173 of the recent decision of the ECtHR in *Shirkhanyan v Armenia* (Application No. 54547/16), handed down on 22nd February 2022. This was a domestic rather than an extradition case, and the test that the ECtHR applied to Article 3 was the same as that germane to extradition cases: where "the cumulation of those factors results in [the detainee] having been exposed to prolonged mental and physical suffering which went beyond the unavoidable level of suffering inherent in detention". Viewed in this way, *Skirkhanyan* is no more than an uncontroversial application by the ECtHR of its decision in the *locus classicus* of *Mursic*. That too was a domestic case, but that too has been applied in the same terms to the context of extradition. Ms Malcolm QC did not submit that what the ECtHR had to say in *Mursic* about personal space was inapplicable to extradition, and/or that there was a different threshold requirement for the engagement of Article 3 in a domestic as opposed to an extradition context. In the same way as State Parties must safeguard their own prisoners from ill-treatment which would create a serious risk of a violation of this Article, State Parties must also ensure (as made explicit in item 13 of the Preamble to the Framework Decision) that another Contracting Party would not expose the extradited person to the self-same risk.

62. In *Magiera v District Court of Kracow, Poland* [2017] EWHC 2757 (Admin) at paras 32-36 Julian Knowles J stated what the approach of this Court should be in a case involving section 25 of the 2003 Act:

> "32. Where an extradition defendant maintains that it would violate Article 8 to extradite him because of his medical condition, or that extradition is barred by s 25 for the same reason, there must be an intense focus on what that medical condition is and what it means for him in terms of his daily living, so that a proper assessment can be made of what effects upon him and his condition extradition and incarceration would have. Once that exercise has been carried out the court must assess the extent to which any adverse effects or hardship can be met by the requesting state providing medical care or other arrangements. Once that has been done, then the Court must finally make the assessment required by Article 8 and s 25 in the manner described in the authorities which I have set out above to determine whether the bar is made out. This is consistent with the approach of the Divisional Court in *Dewani v. Government of South Africa* [2014] EWHC 153 (Admin):
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> "50. …. We must take into account all such matters, including the consequences to the requested person's state of health and age. We accept that this entails a court taking into account the question as to whether ordering extradition would make the person's condition worse and whether there are sufficient safeguards in place in the requesting state."
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> 33. This exercise requires an intensely fact specific approach (something which the Court in *Dewani*, supra, also emphasised

at para 51 ('… each case must be specifically examined by reference to its facts and circumstances.')) It is obvious that medical conditions range in their nature, severity and scope. At one end of the spectrum are those diseases and illnesses such as diabetes, a chronic long-term illness which can, if not properly treated, have very serious consequences, but which is common, well–understood and in the vast majority of cases easily treatable by diet, tablets or insulin, even in the prison environment. At the other end of the spectrum are illnesses and diseases which are more complex (not necessarily more serious, although they may be) whose management cannot be so easily achieved, and certainly not where the person affected is a serving prisoner. An example might be cystic fibrosis which, as well as being life-limiting, can raise a variety of complications which require frequent hospitalisation, intravenous use of drugs, and other techniques and preventative measures to enable the patient to avoid and/or recover from lung infections.

34. This means, in turn, that where a requesting state is asked to respond to concerns about the health of a person whose extradition from the UK they have requested, and to supply details of how they would propose to manage that person in a prison environment to assuage legitimate concerns about the person's health were he to be extradited and incarcerated that are supported by detailed medical opinions, they must provide, so far as is reasonably practicable, a response which meets the concerns in respect of that specific individual. That is not to say that very lengthy documents or care plans need always be provided by way of reply. The starting point must be that in the case of an EU member state there is a rebuttable presumption that there will be medical facilities available of a type to be expected in a prison: *Kowalski v. Regional Court in Bielsko-Biala, Poland* [2017] EWHC 1044, para 20. From that starting point it might not be necessary to say very much more. In the case of an insulin dependent diabetic prisoner, for example, it might merely be necessary for the requesting state to indicate that the management of diabetes is understood, that insulin is available, and that arrangements can be made for the defendant's blood sugar to be appropriately monitored.

35. However, in other cases, where the treatment or management of the illness or condition is more complex, more detail may be required before the court considering matters under Part 1 of the EA 2003 can be satisfied that concerns arising from the defendant's medical condition have been met such that there are no bars to extradition. The reason is that it is self-evident that the range of medical care that is provided in prisons is necessarily and inevitably more limited than that which is available in the outside world (as the Polish authorities in this case have expressly stated), and it is also obvious that the sort of medical

> care which can be provided in prisons is subject to constraints arising from security requirements and the like. Thus, in some cases it may be necessary for the requesting state to provide specific details of what concrete steps will be taken to address the specific issues arising from the defendant's illness to ensure that he does not suffer severe hardship or oppression by reason of his incarceration resultant on extradition. In such a case, broad generalised assertions to the effect that the prison has a clinic, or that prisoners are entitled to health care, or that (unspecified) medicines are available, may not be enough.
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> 36. In all cases, however, I would expect the authorities in the requesting state to be provided with the defendant's medical records so that they have a proper understanding of what the health issues are. Without these records anything they say will likely be only of a general nature and, in many cases, such general information may not be of much assistance to whichever court in this country is considering matters."

63. I agree, and conclude that the same approach should be applied to cases involving an issue under Article 3. The application of an "intensely fact-specific approach" carries with it the consequence that the guidance provided in paras 34-36 of this judgment must be understood as operating at a high level of generality.

Analysis and Conclusions

64. The case of Mr Esmaili raises a narrower issue than the case of Mr A, and for that reason I may address his case first.

65. The purpose of seeking supplementary information from the French judicial authority was to endeavour to understand how personal space was calculated in relation to Rennes-Vezin prison. As para 145 of the Court's first judgment had pointed out, counsel had carried out different calculations using different premises and assumptions. Given that there were no concerns about Mr Esmaili's mobility or health, the Court did not seek supplementary information about furniture items in the cells and whether he would be able to move freely between them.

66. In my judgment, the supplementary information served on 3rd December 2021 is sufficient to enable a reasonable judgment to be made on the personal space issue. I have summarised the position at §§10-11 above. The question this Court posed in September 2021 was brief and focused, and the information provided may be similarly characterised.

67. In short, as at 18th November 2021 the evidence is that three inmates had 2.63m² of personal space and another 24 inmates had 2.96m². If the 3m² benchmark represented an absolute threshold or dividing-line, evidence of this sort would give rise to more than a modicum of concern. There would never, of course, be evidence in the real world to the effect that in country X the risk of torture at the hands of the police or prison service was 5%, but the point I am making is that even a relatively low risk of physical and/or mental abuse wreaked in this way would surely raise a serious issue in the context of Article 3. But that is not the position here. Personal space falling below 3m² per inmate

generates a strong presumption of violation, but the issue is neither stark nor binary. As Lord Brown has observed, a good deal of flexibility is required, and the overall picture needs to be considered. Questions of statistical probability and of fact and degree are also germane. I am not overlooking the 0.04m² shortfall for the 24 inmates, but the modesty of the deficit is a factor to be borne in mind, as well as the fact that a shortfall of 0.37m² only applies to three inmates.

68. Mr Keith QC also relied on the fact that the action plan following the ECtHR ruling in *JMB* does not appear to have had much positive effect. The overcrowding level at Rennes-Vezin prison was 133.8% in May 2021 and had risen to 146.8% by December. No doubt the inference may be drawn that the May figure was artificially lowered by the impact of the pandemic. However, overcrowding levels are no more than a proxy for personal space, and in my view are too blunt an instrument to take the argument any further.

69. I am also not overlooking the report of M. Tricaud dated 12th November 2019 which was considered by District Judge Goezee. CGLPL published its last report on Rennes-Vezin prison in January 2017. It referred in strong terms to the cumulative effects of overcrowding and understaffing, and stated that more than 10% of the prison population were sleeping on mattresses. M. Tricaud also drew attention to evidence of a more generic nature cataloguing what may be described as endemic and systemic problems within the French prison estate, many of which are reflected in the judgment of the ECtHR in *JMB*. Even so, it is not Mr Keith QC's case that this issue is capable of being addressed at such a high level of generality, and as *Aranoysi* and other cases in the ECtHR have made clear the evidence under scrutiny must be "objective, reliable, specific and properly updated". M. Tricaud's evidence, as well as the CGLPL report of January 2017, does not satisfy this composite criterion.

70. For all these reasons, I conclude that a risk of a violation of Article 3 of the Convention on the ground of paucity of personal space may properly be discounted in the case of Mr Esmaili, and his appeal must be dismissed.

71. I turn to consider the case of Mr A, which is undoubtedly more complex and, on a human level, more troubling.

72. The Court's first judgment did not deal in much detail with Mr A's medical history and conditions. That exercise will now be undertaken.

73. A is now aged 56. According to his GP, he was suffering in March 2021 from the following conditions:

(1) anxiety and depression which is moderate to severe in nature. This is exacerbated by the stress of having to wear an electronic tag. He has not responded well to SSRI medication, and was not then receiving treatment.

(2) essential hypertension which "has been tricky to control" but "we have got on top of it with medications and lifestyle advice".

(3) a non-functioning left kidney.

(4) chronic renal disease (C stage 3) which is well-controlled with medications and regular renal review.

(5) impaired hypoglycaemia or prediabetes, which is also well-controlled.

(6) psoriasis, exacerbated by stress, which is difficult to control. It is treated with dose emollients, occasional steroids and vitamin D analogues.

(7) a right central ear perforation with persistent inflammation and recurrent mild left otitis externa.

(8) osteoarthritis in both knees, which is treated conservatively.

(9) gout, for which he takes Allopurinol.

74. A report from the same GP given in 2018 refers to Mr A suffering from asthma since 2008. That condition was then maintained on two inhalers. Asthma is not referred to in the March 2021 report, but whether this is an oversight is not clear.

75. A report from a cognitive behavioural therapist indicates that Mr A is not currently suitable for therapy of this type. The author of the report was concerned about the risk of suicide "should he lose his legal battle".

76. A report from a psychiatrist given in 2020 confirms the diagnosis of moderate depression, currently untreated, which would get worse in the event of his extradition. There is other evidence addressing Mr A's mental state which dates back to 2018 and is likely to be out-of-date.

77. Finally, there is a report from a consultant renal physician whose terms I record in full:

> "To clarify, [A] requires blood pressure lowering medication which must be given each day. If his blood pressure were poorly controlled, as for example would be the case if he regularly missed medications, then he would be at high risk of kidney failure in his one remaining kidney which already is damaged and leaks protein, and of more general complications of high blood pressure which include stroke and heart attack. If [A's] one remaining kidney failed he would require dialysis and/or a kidney transplant and without this treatment he would die."

78. I have been unable to find a reference to Mr A's current treatment regime for his hypertension, although there is nothing to suggest that it would be other than standard. The GP's report from 2018 refers to blood and urine tests at either 6 or 12 monthly intervals.

79. Ms Malcolm QC drew our attention to the following passage in the report from the psychiatrist given in 2020:

> "4.5 [A] works as a HGV driver which is his full-time job. He needs to wake up early in the morning which he does not find difficult because of his poor sleep pattern. He finds his job the most important part of his life which helps him to distract from

> his ongoing extradition worries. His job requires a degree of concentration which helps him to forget other things and he states that he remains able to work as an HGV driver without any incident. He works around 60 hours a week. He looks forward to finishing his work on Friday evening so that he can go home."

80. As Mr Keith QC submitted, there is a danger in a case such as this in taking too atomistic an approach. Whether the Article 3 threshold has been attained in any particular case requires a precise and fact-specific examination of the conditions to which the extradited person would be made subject in the light of his vulnerabilities and physical and medical health. Unsanitary conditions in a shower coupled with mobility difficulties would be more important, and potentially more distressing, for Mr A as compared to someone younger and fitter. The same point applies to personal space, conditions in the exercise yard (i.e. absence of benches), and the overall prison environment. I am content to adopt the approach that Mr Keith QC urges on the Court, but in my judgment the principal concern in Mr A's case surrounds his constellation of medical conditions, both physical and mental.

81. I have reached that conclusion for the following principal reasons.

82. Although the supplementary information does not address a number of the issues where we sought further assistance, it is clear from all the available evidence, including the CGLPL report of December 2021, that there are no real concerns regarding personal space within the prison cells, whether the "bathroom" area is suitably partitioned from the main living area, and whether Mr A would be able to move around freely despite the presence of items of furniture. Although this last matter has not been addressed directly, the inferences to be drawn from the dimensions and surface area of the cells gives sufficient comfort in this regard.

83. Further, I consider that Mr Keith QC may have overstated his client's mobility difficulties. He has had a successful hip replacement procedure. Although he suffers from osteo-arthritis in his knees, he is not severely disabled.

84. The CGLPL report paints a picture of a prison which is overcrowded, understaffed and under-resourced. The system is under considerable pressure. However, putting Mr A's medical problems to one side for the moment, I accept the tenor of Ms Malcolm QC's submissions that a real risk of a violation of Article 3 of the Convention may properly be discounted. The yardstick for such a violation remains a relatively high one, and in my judgment the cumulation of factors in Mr A's case would not lead to prolonged mental and physical suffering.

85. The question therefore remains whether Mr A's panoply of medical conditions brings his case within the ambit of Article 3 so as to suggest a real risk of violation. In this context, the judgment of Julian Knowles J in *Magiera* provides important guidance. There are functioning healthcare units at both of the prisons relevant to Mr A, and even if they are operating in less than ideal circumstances it has to be pointed out that the majority of the conditions from which Mr A suffers are neither so unusual nor so complicated that they should be regarded as falling outside the expertise of the trained nurses working within those units no doubt under the supervision of trained doctors. A will need treatment for his hypertension and his kidney function will need to be monitored by regular blood and urine tests. In the event of a significant deterioration in

the state of Mr A's sole functioning kidney, this Court may safely proceed on the basis that the French national health system would provide dialysis and whatever more sophisticated treatments may be deemed necessary. Even if dialysis were not available in the hospitals that have been identified, Lyon in particular is a large city and there is no reason to think that an appropriate renal unit would not be found.

86. Mr A is not currently receiving treatment for his anxiety and depression. He may well benefit from a non-SSRI anti-depressant, and that would be a matter for the prison authorities in France to consider.

87. It is true, as Mr Keith QC submits, that the French judicial authority has not specifically addressed the questions we posed regarding the facilities and expertise available in the two relevant prisons to address the constellation of Mr A's physical and mental issues. Instead, reliance is placed on the general principle of equivalence between the French prison system and the French NHS. Nonetheless, that principle, together with the information contained in the CGLPL report of December 2021 and the inferences to be drawn from it, enables any evidential lacunae to be filled.

88. Overall, and taking into account all the features of Mr A's case, I have reached the conclusion that any real risk of a violation of Article 3 of the Convention may properly be discounted. A's appeal must therefore be dismissed.

Disposal

89. The appeals of Mr Esmaili and Mr A are dismissed.

90. In Mr A's case, it would be obviously be desirable that at the time of his extradition both he and those receiving him in France be provided, in English and in French, with a list of his current medical conditions and medications. This would be in addition to the medical evidence that was attached to the Article 15(2) request for supplementary information. Brief submissions in writing should be provided before judgment is handed down if the parties are not in agreement about this.

LORD JUSTICE STUART-SMITH

91. I agree.