



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

THIRD SECTION

CASE OF PLOKHOVY v. RUSSIA

(Application no. 45024/07)

JUDGMENT

Art 2 • Positive obligations • Effective investigation • Death of applicant's son by disease during compulsory military service after delayed access to adequate medical treatment, in breach of the duty to safeguard his life (substantive) • Absence of criminal investigation or other remedies capable of comprehensively establishing the circumstances of the death (procedural)

STRASBOURG

22 December 2020

FINAL

22/03/2021

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

In the case of Plokhovy v. Russia,

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

Paul Lemmens, *President*,

Georgios A. Serghides,

Dmitry Dedov,

Georges Ravarani,

María Elósegui,

Darian Pavli,

Peeter Roosma, *judges*,

and Milan Blaško, *Section Registrar*,

Having regard to:

the application (no. 45024/07) against the Russian Federation lodged with the Court under Article 34 of the Convention for the Protection of Human Rights and Fundamental Freedoms (“the Convention”) by two Russian nationals, Ms Tatyana Aleksandrovna Plokhova and Mr Vladimir Mikhaylovich Plokhov (“the applicants”), on 24 September 2007;

the decision to give notice to the Russian Government (“the Government”) of the complaints under Articles 2, 3 and 13 of the Convention concerning the applicants’ son’s death during his military service and the lack of an effective investigation in that regard;

the parties’ observations;

Having deliberated in private on 1 December 2020,

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

INTRODUCTION

1. The case concerns the applicants’ son’s death from a disease during his compulsory military service and the lack of an effective investigation in that regard.

THE FACTS

2. The applicants were both born in 1959 and live in St Petersburg. The applicants were represented by lawyers of the Interregional Group for Military Rights Protection, Ms M. Nosova, Mr M. Bereza, Mr S. Semushin, Ms L. Zhukova, and by a lawyer of the law firm Onegin, Mr D. Bartenev, practising in St Petersburg.

3. The Russian Government (“the Government”) were initially represented by Mr G. Matyushkin, the Representative of the Russian Federation to the European Court of Human Rights, and then by his successor in that office, Mr M. Galperin.

4. The facts of the case, as submitted by the parties, may be summarised as follows.

I. THE APPLICANTS' SON'S CONSCRIPTION FOR MILITARY SERVICE

5. On 17 May 2004 the applicants' son, Mr Maksim Plokhov, was drafted into the army. He was assigned to the reconnaissance detachment of military unit no. 02511 in the village of Kamenka in Leningrad Region.

6. According to the applicants, prior to being drafted their son did not suffer from any illnesses. Having been examined by a military medical panel following his registration for compulsory military service, he was found to be "healthy and fit for military service without any restrictions". During the first year of his military service the applicant's son was diagnosed and received treatment for, among other things, gastritis.

II. MEDICAL ASSISTANCE AND DEATH

A. Medical service in military unit no. 02511

7. At the beginning of August 2005 the reconnaissance detachment was sent out on field manoeuvres. Several days later the applicants' son complained to Sr. Lt. O. of severe stomach pain, asking to be sent to a doctor. Sr. Lt. O. did not give permission, taking the view that the applicants' son was faking his illness because he was unwilling to perform his military service.

8. On 29 August 2005, suffering from severe pain in the left subcostal area, lack of appetite, vomiting and watery stools, the applicants' son again asked to be admitted to the medical service of the military unit. This time the request was addressed to the platoon leader, 1st Sr. Lt. P. However, it was not until 3 September 2005, when the applicants' son's state of health had deteriorated even further, that he was sent to the medical service of military unit no. 02511.

9. On 3 and 5 September 2005 Dr M. and Dr S. diagnosed the applicants' son with an acute episode of chronic gastritis. His medical record also noted that he had already been sick for three days. It appears that urine and blood tests as well as a gastroduodenoscopy were prescribed, but were not performed.

10. While staying at the medical service, on 10 September 2005, at reveille, the applicants' son had an altercation with another soldier, Mr D. A handwritten explanatory statement written by the applicants' son on the same day read as follows:

"In relation to a craniocerebral injury [and] a kidney injury [the applicants' son states] that at 7.30-8 a.m. [I] did not get up at reveille and Mr D. hit me five times, four times in the kidneys and once on the head. After that [I] started having headaches and blood appeared in my urine. Soldier D. is entirely responsible."

11. The applicants' son gave a similar statement to medical service Capt. B. According to that statement, recorded by Capt. B. and addressed to the head of the medical service, the applicants' son started vomiting and experienced severe pain in the right side of his body.

12. According to Mr D.'s statement in respect of the above events, on 9 September 2005, having agreed to the applicants' son's request, he authorised him to serve night duty because the applicants' son did not feel well and did not want to spend the entire night running from a hospital room to a lavatory. In the morning Mr D. discovered the applicants' son sleeping in his bed. In response to Mr D.'s order to get up, the applicants' son asked to be left alone as he wanted to sleep. After the applicants' son disregarded Mr D.'s orders and used offensive language, Mr D. was forced to drag him from the bed. During a minor fight Mr D. hit the applicant's son twice, lightly, in the right lumbar region. After breakfast the applicants' son went back to bed and was taken to hospital in the afternoon.

13. About noon on 10 September 2005 the applicants' son complained to the doctor in charge of his treatment, Dr K., of persistent stomach pain, dizziness, frequent vomiting and watery stools. The doctor palpated his stomach and lumbar region and noted that he was experiencing pain in both sides of that area. An excessive amount of blood was also discovered in the applicants' son's urine. The applicants' son's diagnosis was as follows: "an injury to the soft tissue of the right side of the lumbar region, an injury to the right kidney, a retroperitoneal haematoma, infrequent urination, renal failure, a closed craniocerebral injury, a brain contusion of medium severity, brain oedema and double-sided hypostatic pneumonia".

14. In view of the deterioration of the applicants' son's health, at about 7 p.m. Dr K. brought the applicants' son to Vyborg Military Hospital in his personal car and dropped him near the hospital security checkpoint. The applicants' son walked from the gates to the hospital admissions area.

B. Vyborg Military Hospital

15. Following his admission to Vyborg Military Hospital, the applicants' son was examined by a surgeon. The surgeon concluded that the son's state of health was moderately serious. An ultrasound examination performed on the same day confirmed that he had injuries to the soft tissue of the lumbar region and the right kidney. In addition, the doctors discovered the presence of fluid which was spreading in the abdominal cavity, diffuse kidney changes and enlargement of the liver. The possibility that the kidney injury was traumatic in nature was not excluded.

16. On 11 September 2005 the head of the Military Hospital examined the applicants' son and confirmed the diagnosis of a closed craniocerebral injury and a brain contusion. He also recorded a haematoma on the applicants' son's right cheekbone. In the afternoon a team comprising the

head of the hospital, the chief surgeon and the attending physician examined the applicants' son and recorded that his condition was of moderate severity, as a result of which he was admitted to the hospital resuscitation wing where he was given fluids and haemostatic and antibacterial therapy, and a diagnostic laparoscopy was performed. The applicants' son's health was considered to exhibit a downward trend due to progressive renal failure, the appearance of clear signs of brain oedema and hyperpotassaemia. A plan for the applicants' son treatment and a list of medical procedures were approved.

17. On 12 September 2005, in view of the continuing deterioration of the applicants' son's health, he was taken by resuscitation ambulance to the Military Clinical Hospital of the 442nd Circuit in St Petersburg (hereinafter "the 442nd Circuit Hospital") for further diagnosis and treatment.

C. 442nd Circuit Hospital

18. On admission to the 442nd Circuit Hospital the applicants' son's state of health was considered to be particularly serious. He was unconscious. A visual examination led to the discovery of a vast haematoma on the left side of the lumbar region, multiple diapedetic haemorrhages on his skin, a bluish bruise under the right eye, a yellowish bruise on the front of the neck and abrasions on the front surface of both shins.

19. At 6.30 p.m. on the same day a medical team comprising the chief surgeon, the chief anaesthetist, the head of the neurosurgical department, the head of the department of haemodialysis and other medical specialists held a meeting to discuss further course of action. The applicants' son was in the intensive care unit under artificial respiration. Following the meeting the medical team made a preliminary diagnosis of "severe associated injuries to the head and stomach, closed craniocerebral injury, severe brain contusion, injuries to the soft tissue of the head, a closed stomach injury, a kidney injury, injuries to the soft tissue of the lumbar region, multiple injuries to the chest and legs, multiple organ failure accompanied by acute renal failure, double-sided pneumonia, poisoning with an unknown toxin and toxic encephalopathy [brain dysfunction]".

20. Two hours later the applicants' son's body fluids were tested for the presence of ethanol and ethylene glycol as possible poisons. The tests came back negative. At the same time the laboratory assistant who had performed the tests noted in his report that, despite the absence of traces of both poisons in the fluids, it was necessary to take into account the fact that the tests had been performed more than two days after the possible poisoning.

21. On 14 September 2005 a second medical panel including among others the head of the hospital, a surgeon, a resuscitation specialist and an infectious diseases specialist examined the applicants' son, having performed computerised tomography scans ("CT scan") of his head and

abdominal and thoracic cavities. At the time of the examination the patient was in a medically induced coma. The medical panel gave the following diagnosis: a multi-system trauma, closed craniocerebral injury, brain contusion, multiple injuries to the chest, legs and soft tissue of the lumbar region, injuries to both kidneys, nephritis syndrome (inflammation of the kidneys), acute kidney failure in the phase of anuria (non-passage of urine), multiple organ failure, polyserositis (inflammation of the serous membranes with effusion), possible acute and serious peroral poisoning with a nephrotoxic substance, and toxic encephalopathy.

22. The applicants' son was transferred to the intensive-care unit of the hospital's nephrology department. He underwent haemodialysis and hormone treatment.

23. On 19 September 2005, at 10 a.m., the applicants' son's heart stopped beating. The time of death was recorded as 10.40 a.m. on the same day. The pathological diagnosis recorded by the hospital read as follows:

"Main illness: severe associated injuries to the head and stomach, closed craniocerebral injury, brain contusion, injuries to the soft tissue of the head and lumbar region, retroperitoneal haematoma, [and] a kidney injury.

Complications of the main illness: acute multiple organ failure, encephalopathy of mixed genesis, myocardiodystrophy, brain oedema, acute respiratory failure and cardiovascular collapse, acute failure of the suprarenal gland, double-sided hypostatic pneumonia, respiratory distress syndrome.

Accompanying illnesses: ulcer in the remission phase, insignificant cicatricial deformity of the duodenal cap".

24. On 22 September 2005 the first applicant was notified of her son's death.

III. INTERNAL INQUIRY INTO THE EVENTS RELATED TO THE APPLICANTS' SON'S DEATH

A. Disciplinary actions

25. On 16 September 2005 the deputy head of military unit no. 02511, Col. Sh., completed an internal inquiry into the events surrounding the applicants' son's admission to the medical service on 3 September 2005. Having studied the applicants' son's medical history and having questioned soldiers who had served in military unit no. 02511, who had stated that for days during the field manoeuvres the applicants' son had refused to eat anything apart from bread, had not washed his cutlery after having used it, had expressed a strong desire to be admitted to hospital and had found military service burdensome, the colonel concluded that the causes of the applicants' son's serious illness and his having been beaten up in the hospital had been: the poor organisation of military service in the reconnaissance detachment under the command of Capt. O.; the lack of

proper guidance of the soldiers by their commanding officers; the poor organisation of work in the medical service of military unit no. 02511.

26. The colonel proposed instituting disciplinary proceedings against the medical personnel of the military unit, discharging Capt. O. and opening a criminal investigation into the applicants' son's beating by Mr D.

27. On 4 October 2005 a deputy military prosecutor of the Vyborg garrison issued two written warnings of identical wording addressed to Capt. O. and the platoon leader, 1st Sr. Lt. P. The warning read as follows:

“In the course of the internal inquiry it was established that on 3 September 2005 [the applicants' son] had been admitted for treatment to the medical service of military unit no. 02511, having been diagnosed with chronic gastritis in the acute stage.

As a result of the internal inquiry by the prosecutor's office it was established that in addition to personal negligence on the part of [the applicants' son], who had not taken proper care of his health (refused to take food) in violation of Article 334 of the Internal Service Statute of the Russian Army, there had been a breach of the requirements of the law on the part of [Capt. O./the platoon leader, 1st Sr. Lt. P.] who ..., having learnt that [the applicants' son] had been refusing to eat, had not determined the cause of those actions and had not enquired whether [the applicants' son] had been ill and whether it had been necessary to provide urgent medical assistance; thus [he] had not taken prompt steps to safeguard [the applicants' son's] health. [The applicants' son] had been admitted for treatment to the medical service of military unit no. 02511 only after an acute attack of the illness. This circumstance confirms that the officer did not duly fulfil his official duty to safeguard soldiers' lives and health.

In order to prevent possible violations, the above-mentioned official should be warned that breaches of the law are unacceptable.”

B. Criminal proceedings

1. Initial stages of the criminal proceedings

28. On 19 September 2005 a military prosecutor instituted criminal proceedings under Article 335 of the Russian Criminal Code (breach of relationship between service personnel of equal rank) in respect of the events of 10 September 2005 between the applicants' son and Mr D. On the same day the investigator entrusted with the case questioned Dr K., who had been on duty on 10 September 2005. The latter stated that the applicants' son had informed him of the fight with Mr D. and had complained of stomach pain. Having noticed redness on the applicants' son's back and having discovered blood in his urine, Dr K. had driven him to Vyborg Military Hospital by private car, as no other cars had been available.

29. On 20 September 2005, following an order from the military prosecutor, military experts performed an autopsy on the applicants' son.

30. On 4 October 2005 the first applicant was granted victim status in the criminal investigation in respect of Mr D.'s beating of her son.

(a) Autopsy no. 56/05

31. On 5 October 2005 the experts issued report no. 56/05, having determined that acute nephritis (renal disease) in combination with double-sided pneumonia and acute renal failure had caused the applicants' son's death. The experts noted that such a renal disease usually developed after an infection. They did not discover any injuries on the applicants' son's body apart from old scars on his shins and two abrasions on the knees which most probably had resulted from the haemorrhagic syndrome. At the same time, having examined the medical documents recording a haematoma under the applicants' son's right eye and an injury to the soft tissue on the bridge of his nose, the experts concluded that those injuries had no causal link to the applicants' son's death, having been caused by a hard blunt object on 10 September 2005.

32. The experts further noted that a closed stomach injury, injuries to the right kidney and the frontal abdominal wall, injuries to the soft tissue in the right lumbar region and a retroperitoneal haematoma diagnosed during medical examinations while the applicants' son had been alive were not confirmed by "objective medical data, instrumental and surgical analysis, the results of the autopsy of the body and the histological data".

33. In addition, the experts found that the clinical symptoms of headaches, vomiting, motor dysfunctions and other neurological symptoms exhibited by the applicants' son and diagnosed by medical specialists first as concussion and later, when the applicants' son's state of health had deteriorated, as brain contusion and craniocerebral injury, had resulted from the development of cerebral oedema and a secondary haemorrhage of the brainstem.

34. Lastly, the experts considered that owing to the contradictory information contained in the applicants' son's medical records they were unable to identify with certainty the source of a vast haematoma on the left side of the lumbar region, a yellowish abrasion on the front of the neck and injuries to the front surface of both shins.

(b) Forensic medical expert report of 2 November 2005

35. On 2 November 2005 a medical panel comprised of a number of leading military medical specialists, including the head of the 442nd Circuit Hospital and a forensic medical expert who had participated in the autopsy, held a hearing devoted to the examination of the causes of the applicants' son's death. The medical panel identified the following defects in the applicants' son's treatment at its various stages.

36. Firstly, concerning the period preceding his admission to Vyborg Military Hospital, the medical panel found a failure to diagnose the main illness due to the responding medical personnel's inadequate qualifications and the incomplete examination of the applicants' son, in particular the

failure to perform general tests on his blood, urine, and so forth. The medical panel concluded that those defects had been contributory factors towards the applicants' son's death.

37. Furthermore, concerning the period in Vyborg Military Hospital, the medical panel established a failure to diagnose the main illness owing to objective difficulties of diagnosis related to the seriousness of the patient's condition and the short duration of his stay (less than two days) there. In the medical panel's opinion, that defect did not influence the outcome of the illness.

38. Lastly, during the period in the 442nd Circuit Hospital, the medical panel noted a failure to duly draw up medical documents (the ultimate diagnosis included two "competing" illnesses, namely associated injuries to the head and stomach with concussion and acute nephritis syndrome). This defect, which did not cause the applicants' son's death, occurred as a result of objective difficulties in diagnosis on account of the patient's serious condition and defects in the previous stages of the treatment.

(c) Disjoinder of the criminal proceedings

39. On a number of occasions the first applicant complained to various military and prosecution authorities of her son's death, asking for criminal proceedings to be instituted against Mr O., Mr D. and the doctors who had treated her son between 3 and 19 September 2005. In particular, she argued that Mr O.'s refusal to permit her son to visit a doctor before 3 September 2005, her son's beating in the hospital on 10 September 2005 and the subsequent ineffective medical assistance had caused her son's death.

40. On 10 November 2005 a senior investigator of the military prosecutor's office of the Vyborg garrison questioned Dr Ko., a surgeon who had been on duty in the A&E unit of the 442nd Circuit Hospital when the applicants' son had been brought there on 12 September 2005. Dr Ko. stated that the applicants' son had been in a very serious condition: he had been unconscious and had had difficulties breathing. During an examination on admission to the hospital a haematoma on the lumbar region and puffiness of the face had been recorded in the medical documents. No other injuries had been discovered. At the same time Dr Ko. noted that the applicants' son's craniocerebral injury listed in his medical record had not been confirmed during subsequent medical examinations.

41. On 18 November 2005 the military prosecutor disjoined from the criminal case concerning the applicants' son beating by Mr D. material pertaining to the applicants' son's death. Relying on the results of the autopsy, the military prosecutor reasoned that there was no causal link between the applicants' son's death and his injuries from the beating (a haematoma under the applicants' son's eye and a bruise on the bridge of the nose). In addition, the senior investigator stressed that the objective medical data, the instrumental and surgical analysis, the autopsy and the histological

examinations did not confirm that the applicants' son had sustained a closed stomach injury, injuries to the right kidney and the frontal abdominal wall, an injury to the soft tissue on the right side of the lumbar region or a retroperitoneal haematoma. The disjoined material was sent to another military prosecutor.

(d) Criminal proceedings concerning the beating by Mr D.

42. On 13 December 2005 the Military Court of the Vyborg garrison, having heard evidence from witnesses who had confirmed that on 10 September 2005 Mr D. had hit the applicants' son several times on the back and head, and having studied medical documents recording a haematoma under the applicants' son's right eye and a bruise on the bridge of his nose, found Mr D. guilty of breaches of the rules in his military relations with the applicant's son and of having caused damage to the latter's dignity and honour. The Military Court sentenced Mr D. to one year's imprisonment and suspended the sentence, replacing it with two years' probation. At the trial Mr D. testified that he had hit the applicants' son several times on the back, but denied hitting him on the head.

43. The Military Court also partly allowed the applicants' action for damages and awarded them 5,000 Russian roubles in compensation for non-pecuniary damage.

44. In the absence of an appeal the judgment became final on 24 December 2005. The applicants explained their failure to appeal against the judgment of 13 December 2005 by the absence before 8 November 2006 of any scientific data confirming that the injuries sustained by their son at the hands of Mr D. had affected the course of his illness.

2. Pre-investigation inquiry into the cause of the applicants' son's death

45. After the disjoinder of the relevant material (see paragraph 41 above), a military prosecutor began a pre-investigation inquiry into the cause of the applicants' son's death. He requested an additional complex forensic examination of the applicants' son's medical records.

(a) Forensic medical expert report no. 1 m/d

46. A forensic expert panel comprising five military specialists, leading experts in various fields of medicine, was asked to assess the quality of the medical assistance afforded to the applicants' son when he had contacted medical specialists during his military service.

47. A week later the expert panel issued report no. 1 m/d, confirming the cause of the applicant's son's death as stated in autopsy report no. 56/05 and noting that there was no evidence of insufficient or incorrect medical

assistance which could have influenced the course of the applicants' son's illness and led to his death.

(b) Refusal to initiate criminal proceedings of 19 December 2005

48. On 19 December 2005 the prosecutor, having cited a long list of medical evidence including expert report no. 1 m/d and a certain expert report no. 13 m/d, which was not submitted to the Court, decided not to institute criminal proceedings against the medical specialists who had participated in the applicants' son's treatment after 3 September 2005. The investigator found that there was no evidence of a crime, reasoning as follows:

“According to expert report no. 13 m/d (concerning a complex forensic autopsy performed on the basis of the medical documents), during [the applicants' son's] treatment in the medical service of military unit no. 02511 from 3 to 10 September 2005, a defect occurred in the diagnosis in the form of a failure to identify the main illness.

One contributory factor was the failure of the treating doctors, Dr S. and Dr M., to perform a clinical urine analysis.

When signs of acute renal failure emerged on 10 September 2005, the patient was transferred on the same day to Vyborg Military Hospital in military unit no. 52193.

In view of the above-mentioned [facts] the expert panel considers that the inadequate medical assistance provided in the medical service of military unit no. 02511 did not affect the clinical outcome and does not have a direct causal link with [the applicants' son's] death.

While [the applicants' son] was undergoing inpatient treatment in Vyborg Military Hospital ... from 10 to 12 September 2005 another diagnostic error was committed by the doctor who had been in charge of his treatment, Dr F., specifically a failure to identify the main illness (acute tubulointerstitial nephritis [a disease when the spaces between tubules (small tubes) inside the kidney become inflamed which reduces the kidneys' ability to filter properly]).

At the same time, while the main illness was not diagnosed, its complications (acute renal failure and double-sided pneumonia) were identified. An entire series of diagnostic steps were taken. An incorrect diagnosis of a closed craniocerebral injury was made in view of the presence of neurological symptoms caused not by traumatic changes but by the intoxication which had developed against the background of acute renal failure and accompanying pneumonia. When the patient's state of health deteriorated as a result of progressive acute renal failure, he was transferred within twenty-four hours to the 442nd Circuit Hospital for further treatment. Despite the fact that the main illness was not diagnosed [in Vyborg Military Hospital], the expert panel considers that the above-mentioned diagnostic defect did not affect the outcome of the illness and did not have a causal link to [the applicants' son's] death.

When [the applicants' son] was in the 442nd Circuit Hospital from 12 to 19 September 2005, the doctors who were treating him, Dr A., Dr K. and Dr Ch., committed a diagnostic error, as [they] did not identify the main illness; however, [the applicants' son's] treatment was carried out correctly (as the complications had been diagnosed); the patient was placed in the intensive care unit and haemodialysis, which is considered to be the main [procedure] in the treatment of acute renal failure, was

performed twice (on 12 and 13 September 2005). Thus, the expert panel considers that despite the fact that the main illness had not been diagnosed, the patient's treatment in the 442nd Circuit Hospital was carried out correctly. The diagnostic error in the form of failure to identify the main illness in the 442nd Circuit Hospital did not affect the outcome and did not have a causal link to the death.

The treatment performed at each stage had no contraindications and was correct. However, taking into account the general state of the patient's health when he was admitted for treatment to Vyborg Military Hospital ... on 10 September 2005, it is necessary to stress that indications for haemodialysis already existed on 10 September 2005, that is to say two days before haemodialysis was in fact carried out.

In assessing the shortcomings in the medical assistance provided, it is necessary to take into account the fact that [the applicants' son] had a rare kidney disease, which had an atypical and difficult development; the acute tubulointerstitial nephritis was accompanied by necrosis of the epithelium of the kidney tubules and acute renal failure. Moreover, there was a serious complication in the form of acute double-sided fibroid septic pneumonia and a compromised medical history (as reported by the patient himself) which was emphasised by the doctors (an alleged kidney injury which was not confirmed subsequently). It is also necessary to stress that even in uncomplicated cases of acute tubulointerstitial nephritis the correct diagnosis is usually made on the basis of a biopsy (during a microscopic examination of a kidney puncture sample taken while the patient is still alive). In the present case, taking into account the seriousness of the patient's condition, it was difficult to perform the above-mentioned diagnostic procedure as it could have led to a further deterioration in the state of the patient's health.

None of the medicines which were given to [the applicants' son] during his inpatient treatment could have caused his acute interstitial nephritis, as more than three months passed between their administration and the development of the condition.

Therefore, during the diagnosis and treatment of [the applicants' son] the medical specialists Dr S., Dr M., Dr F., Dr A., Dr K. and Dr Ch. were responsible for the above-mentioned defects, which were identified in the course of the expert examinations; hence, [they] improperly performed their official duties and their actions contain indications of a criminal offence set down in Article 293 § 2 of the Russian Criminal Code. However, taking into account the fact that those defects did not have a causal link to [the applicants' son's] death, which resulted from the acute tubulointerstitial nephritis, it is necessary to conclude that the doctors' negligence did not cause the negative consequences within the meaning of Article 293 of the Russian Criminal Code, namely the death of an individual; therefore, there are no indications of a criminal offence in their actions."

49. On 27 December 2005 the applicants received a letter from the acting deputy head of the Leningrad Military Circuit, informing them of the disciplinary steps taken against Capt. O. and medical service Capt. B. The deputy head stressed that both officers had been stripped of their rank in view of their negligence and their failure to properly organise military service in the military unit under their command. In addition, Capt. O. had been forbidden to work with personnel.

(c) Reopening of the pre-investigation inquiry

50. On 17 January 2006 the applicants were informed that the decision of 19 December 2005 had been set aside on 13 January 2006 and that a new pre-investigation inquiry had been authorised. That decision was taken because the previous inquiry had been incomplete as no assessment had been made of the quality of medical assistance rendered to their son in the medical services of military units nos. 02511 and 33568.

51. At the end of January 2006 another additional forensic medical examination was authorised.

(d) Forensic medical expert report of 17 March 2006 and the second refusal to initiate criminal proceedings

52. On 17 March 2006 eight medical specialists of the Main State Forensic Medical Centre of the Ministry of Defence of Russia issued a joint opinion supporting, in general, the findings laid down in expert report no. 13 m/d. In particular, having once again noted diagnostic defects at each stage of the applicants' son's treatment after 3 September 2005, the experts concluded that the failure to diagnose the main illness had not caused his death because the treatment had been "adequate, correct and pathogenically and symptomatically directed at elimination of the complications of the kidney illness (acute renal failure and pneumonia) which [had] threatened [the applicants' son's] life". At the same time the experts noted that it was for the investigating authorities to establish why a general analysis of the applicants' son's blood and urine had not been performed immediately after his admission to the medical unit on 3 September 2005. The experts declined to answer the investigator's questions as to whether the applicants' son's death could have been avoided had his illness been diagnosed correctly and in good time by a medical specialist and had there been no defects in the treatment. The experts considered those questions to be hypothetical and outside their competence.

53. The main findings made by the experts read as follows:

"Acute nephritis developed not later than 11 September 2005, which is evidenced by medical data about appearance of oliguria at that period of time (the volume of urination fell down to 100 ml during 12 hours).

No objective ... signs of a kidney trauma were established during the examination. This is confirmed by lack of morphological macroscopic and microscopic signs of injuries of kidneys (bruises, ruptures of kidneys), lack of haemorrhages in the perinephric body, and soft tissue of the back, which could correspond in maturity to the episode of the trauma of 10 September 2005 ...).

The fact that the changes in the [applicants' son's] kidneys had originated not from a trauma but from a disease is demonstrated by:

results of laboratory and instrumental examinations (analyses of blood and urine, echography, spiral computed tomography ...) performed between 9 and

19 September 2005, which indicated an ... increase of the size of kidneys, failure of their function ...;

morphologic data – macroscopic (white kidneys with a sharp deficiency of blood in the cortical layer and plethora of kidney cones).

...

The cause of [the applicants' son's] death was the disease – acute tubular interstitial nephritis, aggravated by the development of an acute renal disease and ... pneumonia, which were the direct cause of his death. The reason of the acute tubular interstitial nephritis was impossible to determine in view of the lack of any objective medical signs. It is impossible to exclude the infectious nature of this disease in view of clinical data about complaints about stomach pains, vomiting and diarrhoea.

...

Between 3 and 10 September 2005 [the applicants' son] ... was diagnosed with an attack of chronic gastritis.

Acute tubular interstitial nephritis was not diagnosed at that stage either because at that moment that disease had not yet developed or as a result of the failure to make a clinical analysis of urine.

It should be noted that ... there are data that blood and urine analysis had been ordered. Why those analysis were not performed can be determined only by the investigation.

...

The medical assistance which was afforded to [the applicants'] son] at all stages of his treatment in the medical service of military unit no. 02511, in [Vyborg Military Hospital] and [in the 442nd Circuit Hospital] was not contraindicated and did not negatively affect his state of [health]; [it] did not cause the deterioration of his condition and was not the cause of his death. However, that treatment could not prevent the fatal outcome due to the development of serious complications of the main illness, acute tubulointerstitial nephritis.

...

The sole cause of [the applicants' son's] death was acute tubular interstitial nephritis complicated by the development of acute renal failure and acute double-sided fibroid septic pneumonia, which acted as the direct cause of death.

The main [factors] in the outcome of the illness were the character and severity of the rapidly progressing illness itself (acute tubulointerstitial nephritis) and the serious complications which developed.”

54. On 3 February 2006 a military investigator questioned Mr B., who had been the head of the medical service of military unit no. 02511 in September 2005. Mr B. stated that between 3 and 10 September 2005, when the applicants' son had been kept under supervision in the medical service, no general blood and urine tests had been performed because the laboratory technician had been on annual leave and the tests had not been urgent in view of the applicants' son's diagnosis at that time. At the same time, Mr B. admitted that following the applicants' son's admission the doctor who had initially seen him had included those tests in the lists of procedures to be

performed. Mr B. further noted that on 7 September 2005 the applicants' son had been taken to a hospital in another military unit for a gastroduodenoscopy. However, it had never been performed for unknown reasons. According to Mr B., the doctor who had been in charge of the applicants' son's treatment had examined him on 5, 7 and 9 September 2005 and prescribed treatment which had only included a special diet, multivitamins and drotaverine (an antispasmodic drug).

55. On an unspecified date the military authorities refused to open a criminal investigation into the applicants' son's death.

(e) Second reopening of the pre-investigation inquiry

56. In May 2006 the applicants were informed that following their complaints the pre-investigation inquiry had been reopened on 28 April 2006 and another forensic expert examination of their son's medical records was ordered.

(f) Forensic civil medical expert examination of 8 November 2006 and third termination of the pre-investigation inquiry

57. On 8 November 2006, having studied the entire criminal case file, including the results of the disciplinary proceedings, the investigators' decisions and the complete set of medical documents including the previous expert reports, the State Forensic Medical Bureau of the Health Committee in the Leningrad Regional Authority completed its examination in which eight experts, leading civilian specialists working in various medical academies and institutions in St Petersburg, participated. Expert report no. 451/k contained the following conclusions:

"The above allows the expert panel to conclude that the beginning of the final disease of [the applicants' son] was in late August 2005 ...

In the present case it is impossible to establish what damaged [the applicants' son's] kidneys as there is no evidence of his having been in contact with aggressive chemicals (solvents, antifreeze, [or] heavy metals), sources of radiation, and so forth; no extensive forensic chemical examination of biological samples from [the applicant's son] was performed either during his lifetime (in the initial stages of the illness) or after his death; the development of serious renal failure and the haemodialysis substantially undermined the initial morphological picture of changes in the kidneys which are usually identified during biopsy in the early stages while the patient is still alive; monitoring of the urine and biochemical characteristics of the blood was only established after 10 September 2005 ...

The expert panel considers it counterproductive to seek to refute or cast doubt on the fact that [the applicants' son] had been injured during the morning of 10 September 2005. This fact is objectively confirmed by the history of the case (statements by [the applicants' son], [results] of the disciplinary proceedings), the clinical data (numerous records in the medical documents showing the presence of an injury, results of the X-ray), the macromorphological data (a haemorrhage measuring 7 by 6 [centimetres] on the back surface of the lower side of the left kidney) and the micromorphological data (erythrocytes and lymphocytes in the pararenal cellular tissue on the left side). A

trauma to the patient's lumbar region ... was accompanied by a haemorrhage in the pararenal cellular tissue with subsequent swelling, disturbance of the blood supply to the kidneys and leakage of urine resulting from external squeezing of the urethra. That circumstance (a trauma to the lumbar region) aggravated the development of acute renal failure (it was after the events on the morning of 10 September 2005 that [the applicants' son's] state of [health] deteriorated drastically and macrohaematuria appeared for the first time) and affected the subsequent fatal outcome ...

The [applicants' son's] death resulted from a kidney condition similar to acute tubulointerstitial nephritis ...; a trauma to the lumbar region sustained on 10 September 2005 was a negative factor which aggravated the kidney condition.

...

1. At the stage of [the applicants' son's] stay in the medical service from 3 to 10 September 2005 the main illness (kidney failure) was not suspected; it was not diagnosed until on 10 September 2005, when a large amount of blood appeared in the patient's urine (macrohaematuria) which was visible to the naked eye. At the subsequent stages of the inpatient examinations and treatment the main focus of attention was the kidneys which, in general, corresponded to the patient's pathology. The mistake in diagnosis resulted from insufficient examination of the patient (in military unit no. 02511) and subsequently from the seriousness of the associated complications, which appeared quickly, and the difficulty of diagnosing the acute tubulointerstitial nephritis in their presence, as the diagnosis of [that illness] usually requires a kidney biopsy. It is worth noting that the initial diagnosis of acute pancreatitis which was recorded in the patient's medical history on 3 September 2005 called for immediate admission of the patient to hospital and the performance of extensive examinations (in the first place of the blood and urine); that was not done. The lengthy, eight-day, delay in diagnosing the pathological process and the consequent failure to perform the necessary treatment negatively affected the outcome of [the illness].

2. There was no adequate examination of [the applicants' son] in the medical service of military unit [no. 02511]. ... The patient's examination in [Vyborg Military Hospital] and in the [442nd Circuit Hospital] do not warrant criticism.

3. The treatment which was provided to [the applicants' son] in the medical service corresponded to a mistaken diagnosis of gastritis which was accompanied by the manifestation of the main illness (renal failure). That treatment was not contraindicated, but it could not prevent the progression of kidney failure ...

...

6. The treatment afforded to the [applicants' son] from 3 to 19 September 2005 did not cause the deterioration of his health and did not cause his death.

7. The main [factor] in the outcome of [the applicants' son's] illness was the gravity and malignant character of the pathological process in the kidneys which was aggravated by an injury to the lumbar region. The belated provision of medical assistance should be considered as an attendant negative factor in the history of the illness."

58. The expert panel was unable to answer the investigator's questions concerning the applicants' son's prognosis had the medical assistance afforded to him been adequate and timely.

59. Having been informed of the expert examination the first applicant applied to the investigating authorities, asking them to provide her with a copy of the expert report. In a letter of 21 November 2006 she was informed that no copies of procedural documents could be made available to her as she was not a party to the proceedings. That right could only be invoked in the course of criminal proceedings – which had not been instituted in respect of the applicants' son's death – and only by parties to those proceedings and their representatives.

60. The following day a senior military prosecution investigator, relying on the expert opinions including report no. 451/k, closed the pre-investigation inquiry, refusing to institute criminal proceedings against the doctors who had treated the applicants' son.

(g) Third reopening of the pre-investigation inquiry

61. On 1 December 2006 the applicants were informed that the decision of 22 November 2006 had been set aside and that an additional pre-investigation inquiry into their son's death was to be carried out. The additional pre-investigation inquiry was to concentrate on the effects on his state of health of the delayed medical assistance in the initial stages of his treatment and of the injury to the lumbar region sustained by him on 10 September 2005. A fresh study of the applicants' son's medical records by military medical experts was ordered for that purpose.

(h) Forensic medical expert report of 19 February 2007 and the final termination of the pre-investigation inquiry of 10 March 2007

62. On 19 February 2007 the 93rd State Forensic Medical Centre of the Leningrad Military Circuit produced expert report no. 7 m/d, which entirely supported the conclusions of the military medical experts in their previous reports. The military experts considered that it was impossible to claim that clinical analyses of blood and urine at an earlier point would have ensured the correct diagnosis of the disease and the applicants' son's recovery. In addition, the military experts disagreed with the civilian experts that the applicants' son had sustained a kidney injury which had affected his disease. They referred to the lack of a bruise on the skin, irregular form of the haemorrhage; the lack of morphologic, macroscopic and microscopic signs of kidney injuries and, on the contrary, presence of signs of an acute renal disease and general haemorrhagic syndrome of internal organs, including brain; timing of haemorrhage (from one to three days prior to death and, thus, too late for the episode of 10 September 2005); objective laboratory and instrumental tests and analysis. They also stressed that the illness had only exhibited itself on 10 September 2005 and not at the end of August 2005 as the civilian experts had considered.

63. On 10 March 2007 a senior investigator of the military prosecutor's office of the Vyborg garrison refused to institute criminal proceedings,

considering that there was no evidence of criminal conduct in the doctors' actions or inactions. The decision was worded identically to that issued by the military prosecution authorities on 1 December 2006, save for an additional page in which the most recent findings of the military experts were restated.

3. Court proceedings against the refusal to initiate criminal proceedings of 10 March 2007

64. Two weeks later the first applicant appealed against the decision of 10 March 2007 to the Military Court of the Vyborg garrison, complaining of the ineffective, incomplete and protracted pre-investigation inquiry into her son's death. In particular, the first applicant stressed that the military investigators had referred exclusively to the findings made by the military experts, disregarding those of the civilian experts. In the first applicant's opinion, the investigators had restricted their pre-investigation inquiry to the restatement of the expert findings without any attempt to resolve the contradictions between the different versions and to take into account other relevant factors which could have affected the outcome of her son's illness.

65. On 11 April 2007 the Military Court of the Vyborg garrison dismissed the first applicant's complaint, finding that the investigator's decision had been lawful and well-founded. The Military Court was convinced by the expert evidence according to which there had been no causal link between the delayed and inadequate medical assistance rendered to the applicants' son in the initial stages of his treatment and his death.

66. On 31 May 2007 the Military Court of the Leningrad Circuit upheld the decision of 11 April 2007.

C. Civil action

67. The applicants brought a civil action against military unit no. 02511.

68. On 24 April 2008 the Primorskiy District Court of St Petersburg dismissed their claims, finding that the applicants had failed to demonstrate the fault on the part of the defendant in their son's death. It referred, in particular, to the refusal to institute criminal proceedings of 10 March 2007 due to lack of *corpus delicti*, as confirmed by the military courts. The court restated that the military investigator had established that there had been a number of defects in the diagnosis and treatment of the applicants' son by medical officers S. and M. They had therefore improperly carried out their official duties. However, the expert examinations performed during the pre-investigative inquiry had considered those defects not to have had a causal relationship with the applicants' son's death. Thus, the applicants' claims were unsubstantiated.

69. The applicants appealed, complaining, in particular, that their son had been healthy when he had been drafted for military service; that he had

been initially denied a possibility to see a doctor in good time; that no laboratory analyses of blood and urine had been performed; that he had received a kidney injury which had negatively affected the disease's outcome; and that the experts had established defects in the medical assistance provided to him, including belatedness of treatment and misdiagnosis. The applicants considered that the above demonstrated the lack of access of their son to timely and adequate medical assistance.

70. On 19 June 2008 the St Petersburg City Court upheld the judgment of 24 April 2008. In particular, the court noted that the defects had not been a direct cause of the applicants' son's death, as established by experts and the refusal to institute criminal proceedings into his death of 10 March 2007.

THE LAW

I. ALLEGED VIOLATION OF ARTICLE 2 OF THE CONVENTION

71. The applicants complained under Article 2 of the Convention of the death of their son during military service and the absence of an effective and prompt investigation into his death. Article 2 of the Convention reads as follows:

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

A. Admissibility

72. The Court notes that this complaint is neither manifestly ill-founded nor inadmissible on any other grounds listed in Article 35 of the Convention. It must therefore be declared admissible.

B. Merits

1. *Submissions by the parties*

(a) **The applicants**

73. The applicants asserted that the State had failed to take appropriate steps to safeguard the life of their son who had been within its jurisdiction, similar to people in detention (citing *Salman v. Turkey* [GC], no. 21986/93, § 99, ECHR 2000-VII, and *Keenan v. the United Kingdom*, no. 27229/95, §§ 89 and 91, ECHR 2001-III). They submitted that their son had been healthy when he had been drafted for military service and had had no kidney disease. When he had fallen ill in August 2005, the State had failed to provide him with prompt access to medical care. Furthermore, for eight days after his admission to the medical unit he had received no proper medical examination and treatment. The medical care had been generally

inadequate, with insufficient nutrition and facilities, such as cars. Moreover, despite already being confined to a hospital bed, the applicants' son had been beaten by another soldier. The applicants doubted the experts' conclusions for a number of reasons. Firstly, no causes of the kidney disease had been eventually established. While the trauma origin of the kidney disease had been dismissed, the experts had not assessed the impact of that trauma on the outcome of the disease. Although the delays and other defects in medical assistance to the applicants' son had been admitted, those theories had been discarded as not having caused the death.

74. The applicants furthermore submitted that the investigation of their son's death had not been effective. In particular, no criminal investigation but only a pre-investigation inquiry had been carried out into his death. There had been a criminal investigation into the alleged breach of the relationship between service personnel of equal rank under Article 335 of the Criminal Code of Russia in respect of Mr D.'s beating of the applicants' son, but that had not encompassed the latter's death. Even the pre-investigation inquiry had been initiated – on 18 November 2005 – a full two months after the death and only following the applicants' complaints. The subsequent forensic examinations had failed to establish the cause of the kidney disease; no chemical examination of biological samples from his body had been done, which could have allowed the cause of the kidney disease to be established. The pre-investigation inquiry had identified a number of defects in the medical case, but the investigator had refused to open criminal proceedings. The pre-investigation inquiry had not been effective because it had not been able to ensure the applicants' rights – they had no victim status, as that status could be granted only within the framework of criminal proceedings. Without victim status the applicants had not been able to access the case file or otherwise avail themselves of rights such as the right to put their questions to experts before forensic examinations. Also, on 21 November 2005 they had been refused a copy of an expert report on the grounds that they had not had victim status.

75. The applicants lastly submitted that, even if criminal prosecution was not always required by the Court in respect of cases of medical negligence, no other effective means for the establishment of the relevant facts and responsibility of those involved had been available to them. So, they had not been aware of any disciplinary proceedings against the medical officers concerned. Furthermore, their civil action against their son's military unit had been unsuccessful with reference, in particular, to the refusal to open criminal proceedings.

(b) The Government

76. The Government submitted that in total seven different medical expert examinations had been carried out in respect of the applicants' son's death. All the experts had concluded that Dr S. and Dr M. had made small

errors, such as, in particular, the failure to perform a clinical urine analysis. The Government considered that while assessing that defect, it should be taken into account that the applicants' son had suffered from a rare kidney disease which had taken an atypical and harmful course. His medical situation had been aggravated by pneumonia and his medical history. The Government submitted that to properly diagnose the applicants' son a biopsy test had been necessary, but it had been impossible to perform it given the patient's worsening condition. Based on the experts' scientifically proven, reasoned and unequivocal conclusions, the Government submitted that the small defects in the diagnosis had not directly caused the applicants' son's death. The treatment he had received at all stages had had no contraindications, had been timely, correct and full. Based on the above the Government asserted that the applicants' son had been provided with proper medical assistance. As established by the pre-investigation inquiry, the applicants' son's death had been caused by a disease and no one had been responsible for that outcome.

77. The Government also submitted that they had complied with the procedural obligation to investigate the applicants' son's death. In particular, on 19 September 2005 a criminal investigation into Mr D.'s beating of the applicants' son had been initiated under Article 335 of the Criminal Code. Two forensic examinations had established no connection between that beating and the latter's death. The experts had examined but dismissed the possible traumatic origin of the kidney disease. There had been no other evidence that the applicants' son had been ill-treated. The material concerning the applicants' son's death had been disjoined from the criminal case against Mr D., and then a separate pre-investigation inquiry into his death had been carried out. That pre-investigation inquiry had been carried out by an independent authority – the military prosecutor's office – and it had been full and objective. Within the framework of the pre-investigation inquiry five forensic examinations had been carried out. According to the experts small misdiagnoses which had occurred had not been a direct cause of the applicants' son's death because the treatment provided to him at all stages had had no contraindications, and had been timely, correct and full. The cause of his death had been acute tubular interstitial nephritis, aggravated by acute renal failure and acute pneumonia.

2. The Court's assessment

(a) Substantive limb

78. The applicable legal principles have been summarised in *Muradyan v. Armenia* (no. 11275/07, §§ 132-133, 24 November 2016), and *Mustafayev v. Azerbaijan* (no. 47095/09, §§ 52-54, 4 May 2017). In those judgments the Court reiterated that Article 2 of the Convention imposes on a State the obligation to protect the life of individuals within its jurisdiction,

such as people in custody and conscripts. That obligation also implies an obligation to provide them with the medical care necessary to safeguard their lives.

79. Turning to the present case the Court notes that the applicants' son was healthy when he was drafted for military service.

80. The Court further notes that according to the applicants their son fell ill in August 2005, and unsuccessfully asked for permission to see a doctor on at least two occasions (see paragraphs 7-8 above). It was not until 3 September 2005 when the applicants' son's state of health had deteriorated even further, that he was allowed to see a doctor. According to the medical records made following the applicants' son's admission to the medical unit on 3 September 2005, he had been ill for the previous three days (see paragraph 9). Based on that record the civilian experts concluded that the applicants' son's illness had begun in late August (see paragraph 57 above). In a later forensic report military experts doubted the above conclusion (see paragraph 62). However, the Court does not need to determine whether the applicants' son fell ill with the kidney disease in early or late August 2005. It was a matter for the State authorities to investigate. The Court observes in this connection that the failure to allow the applicants' son to visit a doctor became the reason for the disciplinary reprimand of the concerned military officers, 1st Sr. Lt. P. and Capt. O. (see paragraph 27 above). Thus, the delay in ensuring the applicants' son's access to medical care was a fact and it was known to the investigating authorities. However, at no point did the investigator or the experts examine the implications of that delay for the outcome of the applicants' son's illness.

81. During the period between the applicants' son's admission to the medical unit from 3 to 10 September 2005 no medical examinations, including the basic tests of blood and urine, were performed. That fact had been established by experts as early as in November 2005. The medical expert panel found that the failure to perform those tests had contributed to the applicants' son's death (see paragraph 36 above). Even if the other experts later doubted that earlier testing or that tests of blood and urine as opposed to a biopsy would have allowed correct diagnosis and successful treatment of the applicants' son's disease (see paragraph 62 above), the fact that no medical tests were carried out for eight days following his admission to the medical unit is undeniable. Whether or not blood and urine tests could have ensured the correct diagnosis and cure is yet again not decisive in terms of the State's obligation to safeguard life, but performing those tests would have been a reasonable step to take in any event. The explanation given by the medical unit's doctor that the tests were not done because the laboratory technician was on leave (see paragraph 54 above) is not acceptable. It only demonstrates that the medical unit was not properly equipped or staffed to provide an adequate level of medical care (see

Magnitskiy and Others v. Russia, nos. 32631/09 and 53799/12, § 261, 27 August 2019). The same is confirmed by the applicants' son's transfer to hospital on 10 September 2005 in a personal car as no other cars were available (see paragraphs 14 and 28 above).

82. The Court further notes that during the same period, between 3 and 10 September 2005 the applicants' son received no treatment except for multivitamins and a medicine for the treatment of gastritis, which he did not have. The experts considered that treatment neither contraindicated, nor useful (see paragraphs 53 and 57 above).

83. Only on the evening of 10 September 2005, when the applicants' son was brought to Vyborg Military Hospital, and during the next day a number of examinations were performed on him: an ultrasound examination, blood and urine tests and a laparoscopy. He was also given fluids and haemostatic and antibacterial therapy. However, on 12 September the applicants' son's state of health deteriorated and he was transferred to the 442nd Circuit Hospital in a state of unconsciousness. He did not regain consciousness and died on 19 September 2005.

84. So, out of the sixteen days the applicants' son spent under medical supervision, for the first eight days no tests were performed and no medication, except for multivitamins and gastritis treatment, was provided to him. A day after the examinations and the treatment began at last, the applicants' son went unconscious and his condition became critical. He died a week later.

85. In such circumstances the Court considers that by delaying the applicants' son's access to medical care and then by delaying his proper examinations, testing and treatment, the authorities put his life in danger and failed to take necessary steps to safeguard his life.

86. As for the Government's assertion that there was no link between the death of the applicants' son and any shortcomings in his medical treatment, the Court notes that the object of its examination in the present case is whether or not the domestic authorities fulfilled their duty to safeguard his life by providing him with proper medical treatment in a timely manner, and not the existence of the causal link doubted by the Government (see *Mustafayev*, cited above, § 65, and *Magnitskiy*, also cited above, § 264).

87. Based on the above the Court concludes that in the absence of timely access to adequate medical care, the domestic authorities unjustifiably put the applicants' son's life in danger. The State has thus failed to comply with its positive obligation under Article 2 of the Convention.

(b) Procedural limb

88. The applicable legal principles have been summarised in *Shumkova v. Russia* (no. 9296/06, §§ 106-09, 14 February 2012), as well as, albeit in a different context, in *Nicolae Virgiliu Tănase v. Romania* [GC]

(no. 41720/13, §§ 161-63, 25 June 2019), and *Vovk and Bogdanov v. Russia* (no. 15613/10, §§ 65 and 66, 11 February 2020).

89. The Court notes that in the present case the pre-investigation inquiry was opened only on 18 November 2005, about two months after the death of the applicants' son. Further, the authorities repeatedly refused to open a criminal investigation into the death of the applicants' son. After the last refusal of 10 March 2007 was confirmed by the national courts, no criminal investigation was ever performed.

90. The Court has previously found that in the context of the Russian legal system a "pre-investigation inquiry" alone is not capable of leading to the punishment of those responsible, since the opening of a criminal case and a criminal investigation are prerequisites for bringing charges against the alleged perpetrators which may then be examined by a court (see *Fanzyeva v. Russia*, no. 41675/08, § 53, with further references, 18 June 2015, and *Trapeznikova and Others v. Russia*, no. 45115/09, §§ 34-36, 1 December 2016). The Court also held that, in the absence of a proper criminal investigation, it is impossible to carry out a whole range of investigative measures such as questioning, confrontations, searches, seizures, reconstructions, and so forth, while ensuring the validity of the collected evidence (see *Fanzyeva*, cited above, § 53, with further references, and *Trapeznikova and Others*, cited above, §§ 34-36). Furthermore, lack of a criminal investigation seriously undermines the procedural rights of the victims with regard to the investigation, such as the right to lodge applications, to put questions to experts or to obtain copies of procedural decisions (see *Kleyn and Aleksandrovich v. Russia*, no. 40657/04, § 57, 3 May 2012). As evidenced by the present case (see paragraph 59 above), the applicants were not granted victim status and, therefore, could not exercise the procedural rights accompanying that status. Thus, the pre-investigation inquiry carried out in the present case did not and could not satisfy the requirements of Article 2 of the Convention to the State's procedural obligation.

91. As for civil, administrative or disciplinary remedies available to the applicants, the Court notes as follows. Although the applicants' son's superior officers, P. and O., were subjected to disciplinary reprimands for the applicants' son's initial delayed access to medical care (see paragraph 27 above), those proceedings did not concern other personnel or subsequent periods of medical assistance to the applicants' son. Thus, the disciplinary proceedings alone did not establish as a whole the circumstances leading to the applicants' son's death. Furthermore, the applicants' civil action seeking to establish civil responsibility on the part of their son's military unit's personnel was dismissed. It should be noted that the national courts mostly referred to the refusal to initiate criminal proceedings of 10 March 2007 as evidence of the lack of fault in the actions of the military unit's personnel (see paragraph 68 and 70 above). It would

thus appear that the refusal to open a criminal investigation also undermined the applicants' chances of success in the civil courts, which did not carry out independent fact finding for the purpose of determining the cause of the death and holding those responsible to account (see *Shovgurov v. Russia* (dec.), no. 17601/12, § 63, 25 August 2015).

92. The absence of a criminal investigation or of other remedies capable to comprehensibly establish the circumstances of the applicants' son's death leads the Court to the conclusion that the authorities failed to comply with their obligation to carry out an effective investigation thereof.

93. There has therefore been a violation of Article 2 of the Convention under its procedural limb.

II. OTHER ALLEGED VIOLATIONS OF THE CONVENTION

94. The Court has examined other complaints submitted by the applicants under Articles 3 and 13 of the Convention in respect of their son's amputated finger and his beating by Mr D. However, having regard to all the material in its possession, and in so far as these complaints fall within the Court's competence, it finds that they do not disclose any appearance of a violation of the rights and freedoms set out in the Convention or its Protocols. This part of the application must therefore be rejected as being manifestly ill-founded, pursuant to Article 35 §§ 3 (a) and 4 of the Convention.

III. APPLICATION OF ARTICLE 41 OF THE CONVENTION

95. Article 41 of the Convention provides:

"If the Court finds that there has been a violation of the Convention or the Protocols thereto, and if the internal law of the High Contracting Party concerned allows only partial reparation to be made, the Court shall, if necessary, afford just satisfaction to the injured party."

A. Damage

96. The applicants jointly claimed 295 euros (EUR) in respect of pecuniary damage (funeral costs) and EUR 100,000 in respect of non-pecuniary damage.

97. The Government asked the Court to reject the applicants' claims as the applicants' rights under the Convention had not been violated.

98. The Court awards the applicants jointly EUR 295 in respect of pecuniary damage and EUR 33,800 in respect of non-pecuniary damage, plus any tax that may be chargeable.

B. Costs and expenses

99. The applicants also claimed EUR 2,489 for the costs and expenses incurred before the domestic courts and before the Court. The full amount of costs and expenses claimed was supported by legal-services agreements and payment receipts.

100. The Government submitted that the applicants' supporting documents had not been itemised and, thus, had not been necessarily and reasonably incurred.

101. According to the Court's case-law, an applicant is entitled to the reimbursement of costs and expenses only in so far as it has been shown that these were actually and necessarily incurred and are reasonable as to quantum. In the present case, regard being had to the documents in its possession and the above criteria, the Court considers it reasonable to award the sum of EUR 2,489 covering costs under all heads, plus any tax that may be chargeable to the applicants.

C. Default interest

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

FOR THESE REASONS, THE COURT, UNANIMOUSLY,

1. *Declares* the complaints under Article 2 of the Convention concerning the applicants' son's death and investigation thereof admissible and the remainder of the application inadmissible;
2. *Holds* that there has been a violation of the substantive limb of Article 2 of the Convention;
3. *Holds* that there has been a violation of the procedural limb of Article 2 of the Convention;
4. *Holds*
 - (a) that the respondent State is to pay the applicants jointly, within three months from the date on which the judgment becomes final in accordance with Article 44 § 2 of the Convention, the following amounts, to be converted into the currency of the respondent State at the rate applicable at the date of settlement:
 - (i) EUR 295 (two hundred and ninety-five euros), plus any tax that may be chargeable, in respect of pecuniary damage;

- (ii) EUR 33,800 (thirty-three thousand eight hundred euros), plus any tax that may be chargeable, in respect of non-pecuniary damage;
- (iii) EUR 2,489 (two thousand four hundred and eighty-nine euros), plus any tax that may be chargeable to the applicants, in respect of costs and expenses;
- (b) that from the expiry of the above-mentioned three months until settlement simple interest shall be payable on the above amounts at a rate equal to the marginal lending rate of the European Central Bank during the default period plus three percentage points;

5. *Dismisses* the remainder of the applicants' claim for just satisfaction.

Done in English, and notified in writing on 22 December 2020, pursuant to Rule 77 §§ 2 and 3 of the Rules of Court.

Milan Blaško
Registrar

Paul Lemmens
President