



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

FOURTH SECTION

CASE OF A.P. v. AUSTRIA

(Application no. 1718/21)

JUDGMENT

Art 2 (procedural and substantive) • Effective investigation into the death of the applicant's son during a "heat march" while performing his compulsory military service • Insufficient evidence that the authorities' acts or omissions were responsible for his death • Not shown that the reasonable measures the authorities failed to take would have had a real prospect of altering the outcome or mitigating the harm • Preventive positive obligation under Art 2 not breached

Prepared by the Registry. Does not bind the Court.

STRASBOURG

26 November 2024

FINAL

28/04/2025

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

In the case of A.P. v. Austria,

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

Tim Eicke, *President*,

Gabriele Kucsko-Stadlmayer,

Faris Vehabović,

Branko Lubarda,

Anja Seibert-Fohr,

Ana Maria Guerra Martins,

Anne Louise Bormann, *judges*,

and Andrea Tamietti, *Section Registrar*,

Having regard to:

the application (no. 1718/21) against the Republic of Austria lodged with the Court under Article 34 of the Convention for the Protection of Human Rights and Fundamental Freedoms (“the Convention”) by an Austrian national, Ms A.P. (“the applicant”), on 22 December 2020;

the decision to give notice to the Austrian Government (“the Government”) of the complaints concerning the death of the applicant’s son during his compulsory military service and his treatment prior to his death, the investigation into the events in question and his right to physical and psychological integrity, and to declare inadmissible the remainder of the application;

the decision not to have the applicant’s name disclosed;

the parties’ observations;

Having deliberated in private on 20 February and 15 October 2024,

Delivers the following judgment, which was adopted on the last-mentioned date:

INTRODUCTION

1. This case concerns the death of the applicant’s son while performing his compulsory military service and the criminal investigation into the circumstances leading to his death. It raises primarily issues under Article 2 of the Convention.

THE FACTS

2. The applicant was born in 1971 and lives in Vienna. She was represented by Mr H. Graupner, a lawyer practising in Vienna.

3. The Government were represented by their then Agent, Ambassador H. Tichy, head of the International Law Department at the Federal Ministry for European and International Affairs.

4. The facts of the case, as follows from the material in the case file submitted by the parties to the Court, may be summarised as follows.

I. BACKGROUND TO THE CASE

5. The applicant is the mother of T.P. who was born on 28 August 1997 and died on 3 August 2017.

6. On 30 January 2015 T.P. was declared fit for military service after undergoing the relevant medical examinations.

7. On 10 July 2017 T.P. commenced his compulsory military service, having been assigned to undertake his “basic training 1” (*Basisausbildung 1*) as a member of the guard company in Horn. According to the standard medical examination to which he was subjected that day, he weighed 115 kg, measured 192 cm and had a blood pressure reading of 162 over 86.

8. On 28 July 2017 – that is, after the start of his military service – T.P. received two booster vaccinations (Boostrix against diphtheria, tetanus pertussis, and a second vaccination against polio).

II. THE EVENTS OF 3 AUGUST 2017

A. The morning exercises

9. On the morning of 3 August 2017 T.P. and his fellow conscripts participated in “station training” (*Stationsübungen*) starting at 7.40. They marched a distance of around 2 km to a shaded training location (in an area of forest) where certain skills in which they had been trained were tested; they returned on foot to the barracks at around 11.45 for their lunchbreak, which they spent in the shade. During the lunch break, the platoon commander – Warrant Officer (third class) M.G. – asked the conscripts how they felt and whether they were fit. No one reported any problem to him.

B. The afternoon march

10. A 15-km-long cross-country “heat march” (*Hitzemarsch*) was scheduled to take place in the afternoon, as ordered by the company commander, First Lieutenant K.K., with the conscripts being divided into three different marching groups. T.P. was assigned to the second group.

11. In view of the predicted heat (well over 30°C – see paragraphs 53 and 56 below) K.K. granted a lightening of the uniforms to be worn and equipment to be carried (which weighed a total of 24.73 kg – see paragraph 52 below). Extra water and fruit were also handed out, and water supply stations were set up along the route. Medical support was to be provided by an army emergency medic (Corporal M.S.) and by an army medic (Staff Sergeant O.M.) – with both, however, remaining at the barracks. The reason for M.S. remaining at the barracks was that another platoon was also carrying out a march that same day; O.M. remained at the barracks because he was on call for military ambulance duties that day. The first part of the march route was

set to be in open terrain and the second part in a wooded valley, as cloudy skies had been forecast for late afternoon.

12. Another fourteen conscripts – together with the squad leader, Lance Corporal A.W. – participated in the same marching group as T.P. They were questioned after T.P.’s death and reported the following.

13. The second marching group, including T.P., left the barracks at around 1.05 p.m. As T.S. (one of the conscripts) had indicated that he was having problems walking, he was assigned to the front of the group, and the pace and breaks were adjusted to T.S.’s needs and ability. It appears that T.P., unlike T.S., had not mentioned any problems.

14. During a break at around 2.00 p.m. after marching for approximately 3.4 km in direct sunshine, T.P. suddenly sat or lay down on the ground and complained that his feet and skin were burning. A.W. and some of his fellow conscripts urged T.P. to continue. According to the witness testimony of one conscript (T.Z. – see paragraph 47 below), A.W. was shouting at T.P., and the group of fellow conscripts was also talking to T.P. in a loud manner, with some being “on the edge” (*gereizt*) and some remaining passive. According to the witness testimony of another conscript (J.R. – see paragraph 48 below), the group became frustrated when the third marching group overtook them, and they consequently somewhat “escalated” their tone. Other conscripts then took T.P.’s weapon and rucksack so that he would not have to carry it. T.P. got up and continued walking – this time at the front of the group together with conscript T.S., so the marching pace was adjusted to suit those two conscripts. The group stopped again a short distance further on when T.P. again lay down on the ground, once more complaining that his feet and skin were burning. He said that he had already “given 120%” and could not go on. According to the witness testimony of one conscript (A.M. – see paragraph 41 below), T.P. asked A.W. why he did not believe him; he also asked for a doctor to be called. A.W. told the other conscripts to stand around T.P. to provide him with shade and to sprinkle him with water. T.P. became confused and disoriented, asking the other conscripts why they were spitting at him, before suddenly getting up and continuing walking while saying ‘let’s go on’ to his fellow conscripts. After walking about 20 to 40 meters, he fell to the ground, shaking and with his eyes rolling back into his head.

15. At first A.W. thought that T.P. was shamming, but he then realised that T.P. was not feigning distress and called his superior – the deputy platoon commander, Staff Sergeant M.R. – at 2.19 p.m. on his mobile telephone. M.R. arrived together with M.G. at around 2.45 p.m. in a pickup (*Pritschenwagen*) to collect T.P. and to take him back to the barracks, where the army emergency medic and the army medic were. M.R. several times showed T.P. differing numbers of fingers and asked him how many he could see. Each time T.P. gave the correct answer. M.R. then telephoned M.S., the emergency medic (see paragraph 11 above), at 2.48 p.m. to inform him of the state that T.S. was in. M.S. requested information regarding T.P.’s condition; when told

that the latter was responsive and able to get into the vehicle on his own, he ordered that T.P. be brought back to the barracks.

16. On the way back to the barracks, T.P.'s condition worsened: he became more listless (*apathisch*) and eventually collapsed while still in the vehicle. M.R. called M.S. again, shortly after the first telephone call (around ten minutes later, according to M.S.) to inform him of T.P.'s collapse and also to ask him to call an emergency doctor.

17. The Horn Red Cross was informed at 3 p.m. of a medical emergency at the barracks, and a (civilian) emergency doctor was telephoned at 3.03 p.m.

18. When the pickup arrived at the barracks at around 3.05 p.m., T.P. was no longer responsive. The security barriers were already open. M.S. was standing ready in front of the company building and pulled T.P. out of the vehicle using the Rautek manoeuvre (*Rautekgriff*), laid him down on the ground and checked his blood pressure which was no longer measurable. T.P.'s pulse was increased. M.S. could not apply an intravenous line, as he could not gain access to T.P.'s veins. At first, other servicemen were asked to bring a table to provide shade for T.P., which they did (placing it on its side against the sun); however, M.S. told them to remove it, as it was hindering his first-aid measures, and T.P. lay once more in the sun.

C. Intervention by the civilian medical emergency services

19. A Red Cross ambulance arrived at the barracks at 3.07 p.m. The Red Cross medics, G.P. and C.K., later testified (see paragraph 31 below) that they had found T.P. lying in a stable lateral position on the hot asphalt in the bright sunshine, without any shade, with a body temperature measured at over 42°C and over 43.5°C (the maximum levels) on their respective thermometers (that is, too high to measure). They tried to cool T.P. down and checked his medical data (which was to be provided to the emergency doctor, S.P., who arrived at 3.09 p.m.). S.P. performed first-aid (*Erste Hilfe*) measures and immediately took him to the next hospital, further trying to cool T.P. down during the journey.

20. The ambulance arrived at the hospital at 3.29 p.m. T.P. was taken to the cardiac intensive care unit, where attempts were made to cool him down. However, those attempts failed, and T.P.'s oxygen saturation level fell, prompting doctors to intubate him. Despite all further possible medical measures being taken, his blood circulation ceased. Attempts at resuscitation were made for over one hour, but he was eventually pronounced dead at 5.13 p.m.

21. As it could not be excluded that T.P.'s death had been caused by an infection, all persons who had come into close contact with him were ordered to take antibiotics as a precautionary measure.

III. CRIMINAL INVESTIGATION INTO T.P.'S DEATH

22. On the same day, both the Krems public prosecutor's office (*Staatsanwaltschaft*) and the Austrian Federal Armed Forces instituted investigations into T.P.'s death under Articles 80 and 81 of the Criminal Code (negligent manslaughter and grossly negligent manslaughter – see paragraphs 116-117 below) and Article 33 § 1 of the Military Criminal Code (neglect of the duty of care by superiors and higher-ranking officers – see paragraph 122 below).

A. The autopsy

23. On the same day the public prosecutor's office also ordered a forensic autopsy on the corpse, appointing as expert Dr D., a specialist in forensic medicine (*Facharzt für gerichtliche Medizin*) and a sworn and court-certified expert (*allgemein beeideter und gerichtlich zertifizierter Sachverständiger*). Dr D. was further requested to submit an expert report on the cause of death and on any third-party responsibility (*Fremdverschulden*).

24. On 7 August 2017 – that is to say four days after T.P.'s death – Dr D. performed the autopsy.

25. On 8 August 2017 Dr D. informed the public prosecutor's office of his preliminary autopsy finding (which was subject to further investigations), according to which T.P. had died from cardiac arrest caused by overheating of the body brought about by a foot march (*Herzstillstand durch eine Überhitzung des Körpers, die durch einen Fußmarsch herbeigeführt wurde*). The applicant was also informed of that preliminary finding.

26. Between 8 August and 10 September 2017 four additional tests were performed by other specialised doctors and laboratories – namely, a PCR test and blood alcohol, toxicological, virological tests.

B. Testimony given by those present on 3 August 2017

27. Between 9 and 11 August 2017 the police questioned the three military commanders who had been present on the ground on the day of the events in question (M.G., M.R. and A.W.), the army emergency medic, the army medic and the paramedic (M.S., O.M. and F.R., respectively), the two Red Cross medics (G.P. and C.K.) and thirteen of the fourteen conscripts who had taken part in the same marching group as T.P. The fourteenth and last conscript (J.R.) was questioned on 18 August 2017.

1. Statements given by the three military commanders present at the events

28. A.W. testified, *inter alia*, that he had noticed only after some time that T.P.'s condition had not improved and that, in addition to his physical

problems, T.P. had manifested mental problems when the latter had thought that he was being spat at when the other conscripts had poured water on him. A.W. had then telephoned M.R. at 2.19 p.m. (see paragraph 15 above).

29. M.R., who was questioned twice, testified that upon his and M.G.'s arrival at the scene of T.P.'s breakdown (*Zusammenbruch*), he had checked his vital signs and had found T.P. to be conscious and lucid. T.P. had been exhausted and sweaty but had been able to talk and count the fingers that M.R. had flashed at him. Furthermore, M.G. and he had helped T.P. to stand up, and T.P. had then got into the vehicle on his own. M.R. had continued to talk to T.P. during the drive. T.P. had become more and more listless and had slowly lost consciousness. At this point M.R. had realised the seriousness of the situation and had called M.S.

30. M.G. testified that on the day of the events in question, he had spent the whole lunch break with the conscripts, who had all seemed fit to him and none of whom had reported any problem to him. He had been standing near M.R. when the latter had been telephoned by A.W. at 2.19 p.m., saying that T.P. "could go on no longer" (*dass T.P. nicht mehr könne*). There was no mention of T.P. having lost consciousness or suffering from some other serious complaint. When he and M.R. had reached the marching group, T.P. had been responsive and conscious. They had helped T.P. get up and had taken him to the vehicle, supporting him to take the few steps to the vehicle; T.P. had got into the vehicle on his own. After T.P.'s condition had started to deteriorate during the journey, they had called M.S., who had been waiting for them when they had arrived at the barracks a few minutes later. T.P. had no longer been responsive. M.S. had had to pull T.P. from the vehicle with a special rescue grip. During this manoeuvre, T.P. had thrown up. M.G. also stated that on the day in question, the temperature had been higher than normal but not extreme, and that no other participants of the march had had any problems.

2. Statements by the Red Cross medical personnel

31. The two Red Cross medics, G.P. and C.K., testified that upon their arrival at the barracks, they had found T.P. lying on the ground in the bright sunshine, without any shade, with a body temperature of over 43.5°C that could no longer be measured (see paragraph 19 above).

3. Statements by the army medical personnel

32. M.S. testified, *inter alia*, that on 2 August 2017 – that is to say the day before the events in question – he had been in the area of the march route in a vehicle for the whole time that another platoon had been undertaking the same march. There had been minor complaints from some conscripts, and two others had been unable to continue the march for physical reasons and had had to be driven back to the barracks in a vehicle. On 3 August 2017 –

that is, on the day of the events in question – M.S. had remained in the barracks, it having been agreed that he would be informed via radio or telephone call in the event of need. At 2.48 p.m. he had been called by M.R., who had informed him that T.P. could no longer continue and that he would be brought back. When he had asked about the state that T.P. was in, M.S. had been told that T.P. was responsive and had got into the vehicle on his own. M.S. had received another call at around 2.57 p.m. T.P. had no longer been responsive when the pickup had arrived at the barracks.

33. F.R. testified that two servicemen had placed a table on its side in front of T.P. when the latter had been brought to the barracks so that T.P. could lie in the shade.

4. Statements by the other conscripts

34. When questioning the other conscripts who had been in the same marching group as T.P., the police verified the statements that they had given to the military investigating committee (see paragraphs 100-101 below). All upheld their previous statements, and no one indicated that they had been subjected to pressure when testifying before the military investigating committee.

(a) T.S.

35. T.S. testified, *inter alia*, that at times during the march T.P. had said incomprehensible things. Suddenly the latter had had a breakdown, saying that his skin and lungs were burning. Overall T.P. had seemed to be confused.

(b) L.R.

36. L.R. testified, *inter alia*, that T.P. had stated that he could no longer march and that T.P. had kept saying “I am burning – I cannot go on; I have given everything – I have already given 120%”. While at first it had not seemed to be an emergency, at some point it had no longer been possible to talk normally with T.P., who had started to talk incoherently and who had become obviously confused. When M.G. and M.R. had arrived, T.P. had been rather confused and shaking. Although T.P. had correctly answered questions about the numbers of fingers he had been shown, he had not been looking well.

(c) A.Pr.

37. A.Pr. testified, *inter alia*, that T.P. had been saying “I cannot go on; you know I always give 120% – I am on fire”. At first A.Pr. had thought that T.P. was shamming; he had only realised that T.P. really did have a health problem when he had started to talk more and more incoherently. A.Pr. had thought that it was a simple case of sunstroke. By the time that M.G. and M.R. had arrived, T.P. had been quite out of it. Although T.P. had answered the

above-mentioned test questions correctly, he had not given a good impression of his well-being.

(d) N.Z.

38. N.Z. testified, *inter alia*, that T.P. had stated that he had already “given 120%”. T.P. had been talking in an ever more crazy manner – among other things calling them bad names. Although T.P.’s answers to the above-mentioned test questions had been correct, he had given a bad impression of his state of health. T.P. had only been able to stand up with the help of M.G. and M.R., and when walking to the above-mentioned vehicle had been supported by them.

(e) R.R.

39. R.R. testified, *inter alia*, that when T.P. had sat down, they had loudly tried to get him to keep moving and that when the third marching group had overtaken them, they had become quite indignant. T.P. had loudly refused to move and had become more aggressive. At that point the first doubts had arisen as to whether T.P. was faking. T.P. had kept on saying “I am on fire – I cannot go on; I have given everything”. T.P. had then become increasingly confused. By the time that A.W. had called his superior it had not been possible anymore to talk normally with T.P. Although T.P. had answered the above-mentioned test questions correctly, he had not given a good impression of his state of health.

(f) A.N.

40. A.N. testified, *inter alia*, that at the beginning he and his comrades had thought that T.P. was shamming. When T.P. had started to talk in a confused manner, they had realised that something was wrong with him. Owing to their keenness to beat the other marching groups, the attitude of A.W. and his fellow conscripts had become more aggressive when T.P. had become unwilling or unable to continue, as they had felt that he was holding them back.

(g) A.M.

41. A.M. testified, *inter alia*, that it had taken about twenty minutes for A.W. to call someone to come and pick up T.P. During those twenty minutes, T.P. had said several times that a doctor should be called. A.M. stated that he could very well remember that T.P. had said to A.W. “I am burning – I cannot go on; I have given 120%, call a doctor – why do you not believe me? Call a doctor!” (“*Ich brenne, ich kann nicht mehr, ich habe 120% gegeben, rufen sie den Arzt, warum glauben sie mir nicht, rufen sie den Doktor!*”). A.M. further noted that A.W. had, however, wanted them to continue and at first had not called anyone, although he had had his mobile telephone in his hand.

(h) C.S.

42. C.S. testified, *inter alia*, that T.P. had said to A.W. “You know I always give 100% – I am already at 120%; I really cannot go on anymore”. At first, T.P.’s behaviour had seemed exaggerated. But then T.P.’s answers to their questions had ceased to make any sense, T.P. had been saying incoherent things. When they had sprinkled water on him, T.P. had asked why they were spitting at him. They had shouted at him that he should get up. Suddenly he had got up and had started walking again. Three of the group had followed him; T.P. had then swung his bag (containing his gasmask) around and had sat down again. They had sat him up; T.P. had been shaking all over his body and had rolled his eyes. C.S. had then left the scene as he could not stand what he was seeing.

(i) M.O.

43. M.O. testified, *inter alia*, that T.P. had lain down on the ground, saying that he could not continue and that he had “given 120%”. The group had encouraged him to continue until the next shady spot, and other conscripts had carried T.P.’s rucksack for him. After about another 100 metres, T.P. had lain down again and had said that his body was “burning”. Eventually T.P. had begun to talk strangely and had no longer been able to say a coherent sentence. Although T.P. had answered the test questions given to him correctly, M.O. had known that something was wrong because T.P. had been looking very strange. M.O. added that the evening before, K.K. had told the conscripts, as regards the march, that those “who can moan, can also walk”.

(j) T.Sa.

44. T.Sa. testified, *inter alia*, that it had been rather unusual for T.P. to show that he had problems, as T.P. had until that march not indicated that he had any problems during his military service, nor during the first march that he had undertaken. T.P. had said “I cannot [walk] anymore – you know I always give 120%”. They had not thought that it was an emergency; some in the group had thought T.P. was shamming. When A.W. had called his superior, T.Sa. had heard A.W. saying that T.P. could not walk anymore. Looking back, T.Sa. remembered that T.P.’s forehead had been very hot.

(k) S.S.

45. S.S. testified, *inter alia*, that T.P. had seemed to be less focused in the morning than he was normally: for example, while conducting a safety check of his rifle he had dropped the barrel several times on the floor. When T.P.’s problems during the march had started, T.P. had said that he could not go on anymore, but that he had “given 120%”. The group had tried to motivate T.P. to continue but T.P. had remained sitting on the ground and had said “my skin

is burning, I am burning, I am so hot”. S.S. had then realised that T.P. was not shamming.

(l) D.S.

46. D.S. testified, *inter alia*, that T.P. had said several times “I cannot anymore; I do not want to anymore – I have already given 120%”, and later other things such as “I am burning, I am dying”. In approximately the last ten minutes before the arrival of the conscripts’ superiors, T.P. had been speaking in an extremely incoherent manner and had undertaken senseless actions (such as swinging his bag [containing his gas mask] around). It had been clear to D.S. that T.P. had required medical assistance.

(m) T.Z.

47. T.Z. testified, *inter alia*, that when T.P. had lain down next to a bush where there had been a bit of shade, A.W. had shouted at him “What are you doing? Get up!”, to which T.P. had replied several times that he could not anymore. The group had also tried loudly to motivate T.P. to continue marching. At the next break T.P. had again lain down on the ground, saying several times “I cannot anymore”. A.W. had shouted at him several times to get up. Most of the rest of the group had been “on the edge” at that point, and some had been passive. Another five to ten minutes later, T.P.’s condition had begun to worsen. A.W. had continued to ask him to get up. T.P. had then begun to be visibly less calm, repeating constantly “I am burning; I am burning”. A.W. had ordered others to give T.P. water. T.Z. had supported T.P.’s head, which had felt burning hot. T.P. had spat out most of the water. After A.W. had realised T.P.’s condition, he had telephoned his superior for help. It had felt as though about fifteen minutes had passed between T.P. lying on the ground and A.W.’s call for help. T.P.’s condition had then deteriorated rapidly. After suddenly getting up and continuing walking, T.P. had swung his bag (containing his gasmask) around and had gone to ground again. When T.Z. had reached him, T.P.’s eyes had been rolled back into his head (*T.P. hatte verdrehte Augen*): it had only been possible to see the whites of his eyes (*man sah nur mehr das “Weiße”*), and T.P. had been shaking. T.Z. had supported T.P.’s head and had again felt the extreme heat of his body. T.Z. added that before the march, K.K. had said that if they were capable of moaning, grumbling and complaining of pain, they were also capable of continuing to march.

(n) J.R.

48. J.R. testified, *inter alia*, that T.P. had said that he could not go on anymore and that T.P. had wanted to be driven back to base. When the third marching group had overtaken them, the group had become frustrated because T.P. and T.S. had been holding them back. J.R. and the rest of the

group had been very motivated to finish the march, which was why they had “escalated” their tone somewhat. It had only been after A.W.’s telephone call to his superiors and when waiting for their arrival that J.R. had realised that T.P. was not shamming.

C. Other developments (from August until October 2017) in the investigation

49. On 10 August 2017 the public prosecutor’s office took possession of all medical files relating to T.P., together with extracts from the general ledger of the barracks for 2 and 3 August 2017.

50. On 11 August 2017 Dr D. informed the public prosecutor’s office that during an examination of T.P.’s blood conducted by a specialised medical laboratory (see paragraph 26 above), two germs (*haemophilus influenzae* and *streptococcus pneumoniae*) had been found in his blood although no signs of infection on the organs had been found during the autopsy. It had been an acute infection. The introduction of germs into the blood had caused the high fever and had been capable of causing sepsis. This form of the disease was extremely rare, Dr D. having seen so far only two or three such cases. The applicant was also informed of these preliminary toxicological findings.

51. On 17 August 2017, following media reports claiming that during the march held one day before the events in question, some 20 conscripts had allegedly lost consciousness, the police inspected the medical records of the barracks. They found medical notes concerning two conscripts who had participated in the march. Both had been brought back to the barracks in a vehicle after having reported their health problems (see also paragraph 32 above).

52. On 21 August 2017 the police weighed the material which the conscripts had had to carry during the march, making up a total of 24.73 kg together with the assault rifle. They also documented the route of the march until T.P.’s breakdown and the way back to the barracks.

53. On 22 August 2017 the Central Institute for Meteorology and Geodynamics reported to the police that the temperatures in Horn on 3 August 2017 had been between 34 and 35°C at 1 p.m. and 36°C at 3 p.m.

54. On 25 August 2017 the applicant declared to join the criminal proceedings as a private party in accordance with Article 67 of the Code of Criminal Procedure (see paragraph 125 below).

55. On 5 September 2017 the police reported to the public prosecutor’s office that the only two time references that could be established with absolute certainty were 2.19 p.m. for A.W.’s telephone call to M.R. and 3 p.m. for the telephone call to the medical emergency number (144) concerning an emergency at the barracks. The other time references mentioned by the witnesses could not be objectively ascertained.

56. On 6 October 2017 the applicant lodged an application with the public prosecutor's office requesting that certain further investigative steps be undertaken. She also submitted information that she had received from the Central Institute for Meteorology and Geodynamics attesting to the following temperatures in Horn for 3 August 2017: 29.2°C at 9 a.m., 35.9°C at 1 p.m., 36.1°C at 2 p.m. and 35.6°C at 3 p.m. The information given by the Central Institute for Meteorology and Geodynamics to the police concerning temperature levels on 3 August 2017 differed slightly (see paragraph 53 above). Furthermore, the highest temperatures recorded on each of the days between 31 July and 2 August 2017 varied from over 32 to over 35°C.

57. On 14 October 2017 the applicant requested that further specific items of evidence be gathered.

D. Dr D.'s expert report of 20 October 2017

58. On 20 October 2017 Dr D. submitted the expert report requested by the public prosecutor's office (see paragraph 23 above), containing twenty-two-pages. The report concluded that the cause of T.P.'s death had been heart failure caused by the overheating of his body, in conjunction with an acute septic inflammation (*infolge einer akuten, septischen Entzündung und Überwärmung im Herz-Kreislaufversagen gestorben*) – two different bacteria were found in his blood – and that it had not been possible for others to recognise the signs of bacterial infection before the point at which T.P. broke down, as he had not complained previously of feeling unwell or ill. The relevant parts of Dr D.'s expert report read as follows.

“T.P. died as a result of acute septic inflammation and hyperthermia [leading to] cardiovascular failure.

...

In summary, according to the results of the post-mortem and associated examinations, T.P. ultimately died from cardiovascular failure caused by an acute, septic inflammation following infection by two pathogenic germs which – combined with overheating due to physical exertion, high outside temperatures and sunlight – led to an increase in body temperature to over 43°C and consequently to a state of collapse [*Kollapszustand*] with respiratory and circulatory failure.

The high outside temperature of about 35°C at the time of the incident, a physically strenuous walk (partly in the sun, and carrying a load of almost 25 kg), [the fact that T.P. was] already exhausted from physical exertion ... in the morning, and the fact that T.P. [was] significantly overweight may [all] have contributed to T.P. being massively overheated ... both from outside and by exertion [combined with] a reduced [level of natural] heat dissipation and by fever due to illness.

The fact that no inflammatory foci had thus far developed in the internal organs ... indicates [that] a peracute event [*perakutes Geschehen*] [took place].

...

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It was not possible – without a medical examination – for outsiders [*Aussenstehende*] to recognise the illness and the threatening nature of the condition until the time of [T.P.’s] breakdown [*Zusammenbruch*] during the march – especially given that symptoms of illness were also masked by the appearance of exhaustion, which initially appeared harmless in view of the external stress [to which T.P. was subjected] and which was, moreover, tolerable in a [person] in good health.

[By the time] the symptoms were noticed by outsiders, T.P. was already in a state of confusion and circulatory failure, symptoms which, given the external circumstances, indicated heat stroke.

... summoning help [should have been done] as an initial measure.

In view of the fact that [T.P. was both] confused and exhausted, an immediate emergency medical intervention should have been initiated (even without knowledge [that he was suffering from] a febrile illness), on suspicion [that he had] heat stroke, in order to counteract as quickly as possible an acutely life-threatening increase in intracranial pressure or circulatory failure, which [typically] arose during such emergencies.

Transporting [T.P.] by army vehicle to the barracks instead of immediately calling an ambulance and an emergency doctor thus delayed the initiation of the necessary medical measures by about the time that it took [to wait for] the emergency doctor from the barracks to arrive and intervene.

The medical measures subsequently initiated (and ultimately, also the resuscitation attempts) were unsuccessful owing to [T.P.’s] extremely high core body temperature.

In view of the [very swift] onset of symptoms [*perakut einsetzende Symptomatik*] of irreversible circulatory failure owing to heat or infection shortly after [T.P.’s] physical breakdown, no other eventuality could have been expected – even if T.P. had been brought directly from the place of his breakdown to the hospital, and [it cannot be said] with the [degree of] certainty or even probability required in criminal proceedings that the occurrence of [T.P.’s] death could have been prevented.

In conclusion, the occurrence of T.P.’s overheating and the recognition of the underlying clinical picture (apart from the heat stress due to the outside temperature, solar radiation and physical exertion) could not have been recognised by outsiders without a clinical medical examination, given that [T.P. had not] complained [of such a problem]; such an examination was not called for in the absence of any complaints [from T.P.].

...

The appearance of breakdown and states of confusion would have prompted the immediate notification of an emergency doctor and the ambulance service [in order to secure] the fastest possible professional care for [what was] a life-threatening condition.

...

However, owing to [T.P.’s] high body temperature and the introduction of germs into [his] bloodstream (which took foudroyant effect) [*foudroyanter Verlauf*], death ... could not have been prevented even if an emergency doctor had intervened at the site of the breakdown.

Firm indications of a third-party’s responsibility for T.P.’s death have accordingly not emerged.”

E. Further developments (from October 2017 until March 2018) in the investigation

59. On 24 October 2017 the police questioned K.K. in respect of the applicant's request that further evidence be gathered (see paragraph 57 above).

60. On 28 October 2017 the applicant again requested that further specific evidence be gathered.

61. On 1 November 2017 the public prosecutor's office requested the final reports drafted by the investigating committee and the special commission set up by the Federal Ministry of Defence and Sport following T.P.'s death (see paragraphs 100 and 113 below); the Ministry submitted those reports to the public prosecutor's office on 4 January 2018.

1. Additional questions put to Dr D.

62. On 6 December 2017 the public prosecutor's office requested Dr D. to supplement his expert report (see paragraph 58 above) with a view to answering several additional questions – notably (i) whether T.P. would have suffered a breakdown leading to death even if he had taken physical rest and received timely medical treatment, and (ii) whether his death could have been prevented if he had not participated in the march.

2. Taking of further testimony

63. Also on 6 December 2017 the public prosecutor's office requested the police to put further specific questions to (i) K.K., M.G., M.R., O.M. and F.R. – who by then were all regarded as suspects (K.K., M.G. and M.R. in respect of the crimes of manslaughter and neglecting their duty of care under Articles 80 and 81 of the Criminal Code and Article 33 § 1 of the Military Criminal Code, and O.M. and F.R. in respect of the crimes of false testimony and obstruction of prosecution – on account of their witness statements according to which T.P. had lain in the shade after being brought back to the barracks whereas other witnesses had stated that T.P. had lain in the blazing sunshine – under Article 288 §§ 1 and 4 and Article 299 of the Criminal Code – see paragraphs 116-117 and 120-122 below), and to (ii) the civilian emergency doctor S.P. as a witness. The police carried out that additional questioning between 9 January and 7 February 2018.

(a) Statements by army and civilian medical personnel

64. S.P. testified as a witness that when he had arrived at the barracks on 3 August 2017, T.P. had been lying in the blazing sunshine, without any shade being provided for him. S.P. had also not seen any table nearby.

65. O.M., one of the suspects (see paragraph 63 above), testified that M.S. could confirm his earlier statement that some soldiers had placed a table on

its side in order to provide shade for T.P. while the latter had been administered first aid at the barracks. O.M. could, however, not indicate for how long the table had remained set up in that manner.

66. F.R., another of the suspects (see paragraph 63 above), gave the same testimony as O.M. – namely, that one or two soldiers had placed a table on its side in order to provide shade for T.P. However, F.R., too, could not indicate for how long the table had remained set up in that manner or whether the table had remained in that position when the Red Cross ambulance and S.P. had arrived at the scene.

67. M.S., the army emergency medic, testified as a witness that some soldiers had indeed placed a table on its side in order to provide shade for T.P. at the barracks but that he had afterwards requested that the table be removed, as he had needed more space to provide medical aid. It was therefore possible that the table had no longer been there when the Red Cross ambulance and S.P. had arrived at the scene (see paragraph 18 above).

(b) Statements made by three of the military commanders (K.K., M.G. and M.R.)

68. M.R. testified (as a suspect – see paragraph 63 above) that in principle, the march would normally have lasted a whole day, with several halts for targeted training. Because of the expected heat, the station training sessions had all been conducted in the morning; for the afternoon, only the foot march had remained scheduled. M.R. further confirmed that he had been aware of the below-mentioned decree on the performance of military-service duties during extreme outside temperatures (see paragraph 130 below). According to him, the command had not considered postponing the march for another day. Furthermore, he had been of the view that no medical emergency had been underway when he had received the above-mentioned telephone call from A.W. He also confirmed that several soldiers had placed a table on its side to provide shade for T.P. once they had arrived at the barracks.

69. M.G., too, testified (as a suspect – see paragraph 63 above) that originally the march should have lasted the whole day, from about 8 a.m. until 10 p.m., but that its scheduling had been changed because of the heat. Furthermore, M.G. had been with the conscripts for the whole of the lunch break and had noted that all were fit and motivated to undertake the march. Only one conscript had been excluded from the march by M.S. on account of blisters on his feet. M.G. also confirmed that he had been aware of the decree on the performance of military-service duties during extreme outside temperatures (see paragraph 130 below). The possibility of postponing the march for another day had not been considered by the command; moreover, schedule-wise it would not have been possible. M.G. also confirmed that several soldiers had set up a table vertically to provide shade for T.P. once they had arrived at the barracks.

70. K.K. testified (as a suspect – see paragraph 63 above) that he had been aware of the decree on the performance of military-service duties during

extreme outside temperatures (see paragraph 130 below), and that he had ordered the march after securing prior approval from the battalion command. He had not cancelled the march because another platoon had successfully completed the same march one day before. Furthermore, both the implementing regulation governing basic training and the above-mentioned decree had provided that training goals should be achieved by all means necessary.

3. Dr V.'s internal pulmonological expert report of 5 March 2018

71. On 5 March 2018 Dr V., another medical specialist (in lung diseases and internal medicine, *Lungenkrankheiten und innere Medizin*) and a sworn and court-certified expert, submitted an internal pulmonological expert report (*Intern-Pulmologisches Gutachten*) to Dr D. at the latter's request with a view to his being able to answer some of the additional questions posed to him by the investigators, which had been asked by the public prosecutor's office (see paragraph 62 above). According to Dr V., T.P.'s elevated blood pressure reading of 162/86 on 10 July 2017 (see paragraph 7 above) had had no bearing on his death because juvenile hypertension could not cause death – even under the kind of stressful conditions that had pertained on the day of his death. T.P.'s high blood pressure had to be viewed in the light of T.P.'s constitution: that is, he had been overweight. Furthermore, T.P. had not had any kind of heart disease which had gone undetected during the medical examination conducted to determine his fitness for military service (see paragraph 6 above) and which would have restricted his performance and required treatment. Consequently, the decision to declare T.P. fit for military service had been medically coherent and appropriate.

F. Dr D.'s (first) supplementary expert report of 5 April 2018

72. On 5 April 2018, referring to Dr V.'s findings of 5 March 2018 (see paragraph 71 above), Dr D. submitted his seven-page (first) supplementary expert report on the question of the avoidability (*Vermeidbarkeit*) of T.P.'s death which read, in so far as relevant, as follows.

“From a medical point of view, the additional factors of the march and the external stress caused by heat contributed significantly to the [very swift] onset of death [*perakuter Todeseintritt*].

However, it can by no means be ruled out that even [if T.P. had simply] rested on 3 August 2017, and not participated in the march in question, death would have occurred solely as a result of germs being washed into the bloodstream.

By contrast, given timely or early medical treatment, the occurrence of death could have been prevented with a high degree of probability by the administration of germicidal medication ([in the form of] antibiotics).

However, medical treatment could only have taken place after [the manifestation of a] subjective feeling of illness and the presentation [of symptoms], as there were no externally perceptible signs of illness.

...

The vaccination administered six days before death [see paragraph 8 above] can be seen as a further factor weakening the immune system and thus favouring the occurrence of the disease in the form described.”

G. Application by K.K. for the discontinuation of the proceedings against him

73. On 4 June 2018 K.K. lodged (on the basis of Dr D.’s first supplementary expert report – see paragraph 72 above) with the public prosecutor’s office an application requesting the discontinuation of the proceedings against him.

H. Dr K.’s private expert report of 14 June 2018

74. On 1 July 2018 the applicant submitted to the public prosecutor’s office a thirty-seven-page-long privately-commissioned expert report (which was based on the case-file material, without an examination of the corpse) dated 14 June 2018 (see paragraph 75 below); the report was produced by Dr K., a specialist in infectiology and tropical medicine (*Infektiologie und Tropenmedizin*), in internal intensive-care medicine (*Internistische Intensivmedizin*) and in internal medicine (*Innere Medizin*) who is also a professor at the Medical University of Graz (*Medizinische Universität Graz*).

75. According to Dr K., bacterial infection had not been the cause of death, as an examination of T.P.’s blood (see paragraph 50 above) had not been carried out *lege artis*. He further stated that only bacterial DNA had been found and that blood had been taken from T.P. only after four days had elapsed following his death, and that the results of the blood test should therefore be regarded from that perspective. Only a blood sample taken while T.P. had still been alive could have shed light on whether a bacterial infection had been the cause of his death. It was possible that T.P.’s body had been contaminated by bacteria during resuscitation efforts or post mortem. Dr K. concluded that the only cause of death – given the circumstances surrounding T.P.’s death – could have been overheating of the body, and that T.P.’s chances of survival rate would have been higher if he had been taken to hospital promptly.

The relevant parts of his expert report read as follows.

“Dr D. bases his summary on the molecular biological evidence of [the presence of] *haemophilus influenzae* and *streptococcus pneumoniae* (a positive PCR test result from blood taken on 7 August 2017) but finds no evidence of inflammation in [the findings of] the post-mortem examination and the histological examinations. In the culture smears taken from the brain and the heart, these two pathogens are **not** found (but others

[were] ...), which means that the positive PCR test can only be regarded as evidence of haemophilus influenzae [DNA] and streptococcus pneumoniae DNA ... – (that is, genetic information regarding [the presence of] these pathogens in the blood, without these pathogens having been detected alive in the blood). The mere detection of ... DNA in the absence of histological (fine-tissue) signs of inflammation in the organs and symptoms and signs which clinically do not fit (including the laboratory examinations in the hospital) ... is thus not compatible with the findings and the summary [provided by the expert, Dr D.], according to which T.P. died of acute septic inflammation and consequent hyperthermia [ending] in cardiovascular failure.

Molecular biological evidence alone is not sufficient to establish blood poisoning through these pathogens, since DNA of these pathogens (which also colonise the upper and lower respiratory tract) may have entered the bloodstream during resuscitation, without this transfer during resuscitation or afterwards indicating a disease value in the sense of sepsis ... Furthermore, the pathogens ... were not detected in the conventional culture of one of the smears taken from the heart or brain, where they should have been found in the event of a case of bacterial blood poisoning. Furthermore, cadaveric putrefaction was already present, in which case colonising microorganisms on mucous membranes (such as those in the gastrointestinal tract or the lungs and respiratory tract) can break through the mucosal barrier and enter the blood. Taking a blood sample for the purpose of detecting germs four days after death is not a suitable [method] of detecting a case of blood poisoning [caused by] these pathogens. The detection ... by means of [a] PCR [test] when taking a blood sample four days after death is therefore unsuitable for the detection of blood poisoning [caused by] these pathogens.

The [collection] of blood culture in blood culture bottles ... or other techniques during the autopsy is not described by the expert, Dr D., in his expert report. The taking of blood culture is considered to constitute the gold standard for the detection of bacterial blood poisoning ... Such blood culture should be taken as soon as possible after the patient's death in order to avoid that blood culture being influenced by the translocation ... of colonising germs into the bloodstream and organs [in the course of] of the putrefaction of the corpse – and thus prevent a falsification of the results. Furthermore, blood culture should be taken during the patient's lifetime if sepsis was suspected, although the attending physicians [did not harbour] such a suspicion when T.P. was admitted to hospital.

The expert, Dr D., found '... about 300 ml of slightly discoloured, already putrefactive, discoloured fluid' on both sides when opening the corpse's chest cavity ... This [was] primarily triggered by the post-mortem influx of pathogens into this body region, as T.P. had not shown any clinical symptoms or signs of pleurisy before death. A microbiological examination of this secretion immediately after the opening of the corpse was not carried out ... The cause of the ... fluid in the chest cavity ... is therefore not sufficiently ascertainable owing to the failure to subject this fluid to a microbiological examination ...; the examination of this body region is therefore deficient.

...

The fine tissue examination

- of the heart did not show any evidence of inflammation
- of the lungs did not show any evidence of inflammation
- of the liver did not show any evidence of inflammation
- of the spleen did not show any evidence of inflammation

- of the cerebrum did not show any evidence of inflammation

All findings indicate a putrefactive alteration of the corpse four days after the patient's death. The microbiological findings must therefore be considered from the point of view of the putrefaction that had already occurred. Thus, microorganisms of the gastrointestinal tract, the skin, the oral pharynx and the respiratory tract were found in the heart and brain ...

Expert Dr D. found in the bacteriological examinations ...

- of the brain:

‘... The germs detected correspond at least in part to germs [arising from] contamination.

- of the heart:

‘... The germs detected correspond at least in part to germs [arising from] contamination’.

... Since the germs detected are judged by the expert to be ‘in part’ germs [arising from] contamination, the other part, which is not specified, need not correspond to any germs [arising from] contamination and thus have had any significance. There is no further argumentation or justification of the assessment in this regard in the expert report. Pneumococci or haemophilus influenzae were **not** culturally detected.

The assessment that the culturally detected pathogens correspond at least in part to [germs arising from] contamination is an undifferentiated interpretation [*undifferenzierte Interpretation*] of the germ evidence [that is] not compatible with the histological findings and therefore not conclusive.

...

However, there was no evidence of pus accumulation or gas gangrene either in the area of the brain or in the area of the heart when the corpse was opened or in other organs; the heart valves showed no evidence of valvular inflammation. In the histological examinations, no inflammation was found in any of the organs examined. Thus, the cultural evidence of germs corresponding to a flora of the oral pharyngeal cavity, the respiratory tract, the gastrointestinal tract and the skin are to be regarded as post-mortem events within the context of corpse putrefaction (as described by the expert in the area of the thoracic cavity and the liver during the opening of the corpse and during the new formation of alcohol). The bacterial evidence therefore does not ‘... correspond, at least [wholly], to [germs arising] from contamination ...’; moreover – owing to the lack of macroscopic ... and/or microscopic ... indications of an inflammation – [it is] **not** to be regarded as [pointing to the presence of] pathogens [attributable to] infectious diseases. The bacterial pathogens detected in the culture are thus **all** to be regarded as [germs arising from] contamination or as signs of putrefaction. The expert's assessment ... is therefore **not** conclusive.

... The laboratory examinations [conducted by] the hospital providing initial care did not reveal any indication of a bacterial infection ...

The findings cited in Dr D.'s expert report and the summary are therefore **not** conclusive overall.

...

For acute septic inflammation [caused by] the two pathogens ... there is neither clinical nor microbiological evidence that is reliable or can be cited with a probability bordering on certainty. The positive PCR result alone is ... insufficient for this and, on top of that,

was carried out too late. Furthermore, a PCR test cannot be used to make any statement about the acute nature of any blood poisoning [caused by] *haemophilus influenzae* and *streptococcus pneumoniae*, since a PCR test only detects the presence of DNA from these pathogens, irrespective of the length of an illness ...

...

The laboratory found no evidence of bacterial inflammation ... The microbiological uncertainty of the DNA evidence ... has ... already been explained. A deficiency of blood flow due to circulatory failure at the time of the first blood gas analysis in the intensive care unit of the hospital ... was ... not [indicated]. Therefore, a sepsis-related circulatory failure cannot be inferred.

... T.P. [was administered] a pneumococcal vaccine [which helps protect against certain types of bacterial infections, such as meningitis, sepsis and pneumonia] on 4 March 2008; this clearly lessens the probability of a pneumococcal infection and contradicts the expert's statement (T.P. was also [administered] vaccinations against *haemophilus influenzae*).

...

The sole molecular biological evidence is not sufficient to indicate blood poisoning caused by pathogens such as pneumococci or *haemophilus influenzae*, since DNA from these pathogens (which also colonise the upper and lower respiratory tract) may have entered the bloodstream during resuscitation, without this transfer during resuscitation or afterwards indicating a disease value in the sense of sepsis ... in relation to the DNA evidence ... in the blood of T.P. (who died on 3 August 2017) [contained in] a blood sample [taken on] 7 August 2017 ... it cannot be established beyond doubt or with probability bordering on certainty that these two pathogens were actually present in the blood of the deceased before his death and caused blood poisoning, since

1. the two pathogens could have entered the blood during resuscitation ...
2. the two pathogens ... could have entered the bloodstream post mortem from the respiratory tract and/or the lungs by the time the autopsy was carried out
3. at the time the sample was taken, contamination of the blood had already occurred, since highly pathogenic bacteria from the intestine and skin and the respiratory tract could also be detected in other regions of the body (brain, heart)
4. only DNA from the two pathogens ... (and not the pathogens themselves) could be culturally detected; however, other pathogens from the intestine and from the skin and respiratory tract [could certainly be detected], although no clinical or morphological correlate (and thus no infectious disease) could be detected in respect of any of the pathogens.

Haemophilus influenzae and *streptococcus pneumoniae* are by no means extremely rare pathogens causing sepsis, as noted by the expert, Dr D. ...

...

Physical exertion can lead to temporarily reduced activity on the part of the body's own defence cells ..., but this reduction is not associated with an increased occurrence of blood poisoning. Rather, increased viral infections may occur after (rather than during) physical exertion ... The reactions that may occur after vaccination with Boostrix ... are known side effects of that vaccination and ... usually occur within the first forty-eight hours. These side effects are to be regarded as reactions on the part of vaccination recipients, but not as simultaneously occurring immune deficiencies brought about by the vaccination. In the documents, no ... side effects are noted

immediately or up to two days after T.P.'s vaccination, [which] was carried out six days before the occurrence of the event in question. There is therefore no evidence whatsoever for an exertion-related immunodeficiency or an immuno-weakening effect of the Boostrix polio vaccination with regard to the event which occurred in respect of T.P. during the march and which ended fatally.

...

Overall, the finding that blood poisoning was the cause of T.P.'s death – as cited in Dr D.'s expert report – which is based on the molecular biological DNA evidence of haemophilus influenzae and streptococcus pneumoniae, is therefore **not** conclusive and **not** established without defects. [A case of] sepsis or an infection by pneumococci and/or haemophilus influenzae **cannot** be deduced from the available documents and examination results.

...

The expert, Dr D., writes: '... but even if T.P. had been brought directly from the place of his breakdown to the hospital, no other course could have been expected and death ... could not have been prevented'. In the supplementary expert report of 5 April 2018, Dr D. writes that with 'timely or early medical treatment, on the other hand, the administration of germicidal medication (antibiotics) would very likely have prevented death'. The two statements in the expert report and supplementary expert report therefore contradict each other.

...

Blood pressure was 110 systolic during the initial examination carried out by the emergency doctor, S.P., and 120 systolic, as noted in the Red Cross's treatment logbook ...; it was thus normal. Therefore, during the initial examination by the emergency doctor and also [the examination conducted] before that by the army medic, no circulatory failure occurred that could be held responsible for the neurological impairment ... Rather, the circulatory failure occurred immediately after intubation – that is to say in the cardiac intensive care unit.

The heart rate and respiratory rate were elevated, which, however, can also occur in the case of externally applied heat and the resulting hyperthermia. Thus, the neurological abnormality or neurological impairment was at the forefront, and was not due to a circulatory failure, whereas these neurological symptoms may have been primarily caused by the brain swelling due to heat later on during the post-mortem examination.

... If one were to follow the assessment of the expert, Dr D., and assume that bacterial blood poisoning was the cause of the patient's symptoms, then transporting [T.P.] more rapidly [to hospital] might very well have had an effect on the probability of survival. Thus, the probability of survival decreases by 8% every hour from the time that severe bacterial sepsis is detected, starting from a probability of survival of around 80% in the absence of adequate care. Conversely, the probability of survival increases every half hour to every hour if the patient is transported more quickly ... The period between the onset of the first symptoms at about 2 p.m. and [T.P.'s] arrival at the hospital at 3.23 p.m. was about one hour and twenty-three minutes. If the patient had been brought [immediately and] directly to the hospital ... from [the scene of] the incident, a period of about eighty-three minutes could have been gained; ... this would have resulted in an 8-16% increase in his chances of survival in the presence of bacterial sepsis ... The survival rate in the event that septic shock [arises] and adequate treatment is administered within the first hour is 80% – a long way from the assessment of the expert, Dr D., according to whom, in the event of bacterial sepsis with circulatory

failure, death would occur anyway, and rapid treatment would not change the probability of survival.

In the event of bacterial sepsis, quicker transport [to hospital] will increase the probability of survival. The assessment of the expert, Dr D., ... is therefore not compatible with the scientific literature and is **not** conclusive ...

...

The “quick SOFA score” [Sequential Organ Failure Assessment score] is used to assess the risk of death in a patient with suspected sepsis, but it cannot be used to diagnose sepsis. The quick SOFA score evaluates 1. the respiratory rate ... 2. the systolic blood pressure ..., and 3. any change in consciousness ... If the quick SOFA score is positive and infection is suspected, a patient should be further diagnosed (given that there is a risk of death) and transferred to a hospital, for example. The clinical signs – a change in [the degree of] consciousness, respiratory rate and blood pressure – can be determined by any medic and doctor, and so the risk assessment can be made by means of the quick SOFA score. The patient had met two out of three criteria of the quick SOFA score (the blood pressure was initially normal) and should therefore have been transferred immediately to a hospital for further examination.

This does not mean, ... however, that at this point in time sepsis had already been confirmed by the [results of] the quick SOFA score; for this, further diagnostic measures should have been carried out. Had a medic been present at the scene, he would therefore have recognised the symptoms that can occur in sepsis and serve to assess the risk of death from sepsis.

Dr D. writes in his supplementary expert report of 5 April 2018: ‘However, medical treatment could only have taken place after [the manifestation of a] subjective feeling of illness and the presentation of [symptoms], as there were no externally perceptible signs of illness’. This statement is inaccurate, since in the case of many diseases it is not only the patient’s subjective perception and his description of his symptoms (that is, the disturbances and discomforts perceivable by patients), but also the signs perceivable by laypersons as well as medically trained staff (that is, the changes and abnormalities in a patient that are perceived by other persons) which are decisive for the suspicion and diagnosis of a disease. For example, in the event of neurological impairment, the patient’s subjective perception and [power of] expression are limited or [non-existent], and so [there is a need for] other (that is, medically trained) persons to assess the [degree of] neurological impairment in order [to achieve] an adequate diagnosis and [administer adequate] treatment.

IV Summary of the questions and answers

1. whether the findings and summary cited in Dr D.’s expert report are conclusive

The findings cited and the summary in Dr D.’s expert report are **not** conclusive.

2. whether the blood poisoning cited in Dr D.’s expert report as the cause of T.P.’s death is established conclusively and without deficiencies

The blood poisoning cited in Dr D.’s expert report as the cause of T.P.’s death is **not** established conclusively and **not** without deficiencies. Blood poisoning **cannot** be established beyond doubt or with probability bordering on certainty. Sepsis or an infection from pneumococci and/or haemophilus influenzae **cannot** be inferred from the available documents and examination results.

3. whether the time periods [pertaining to the events in question] were relevant to [the question of] whether adequate care was administered to T.P. and to the fatal outcome

If – contrary to the opinion of the expert, Dr D. – sepsis was present, then the time periods were relevant to [the question of] whether adequate care was administered to T.P. and to the fatal outcome.

4. whether a medic could have recognised possible sepsis in T.P. and what should have been done if this had indeed been the case

A paramedic could have recognised the signs of a possible sepsis in T.P. [In such an event], T.P. should then have been taken to hospital immediately. However, sepsis or an infection by pneumococci and/or haemophilus influenzae **cannot** be deduced from the available documents and examination results.”

76. Dr K. further pointed out some factual mistakes in Dr D.’s expert report; for example, he noted (i) that T.P. had been taken directly to the cardiac intensive care unit, where he had then been intubated (and not taken there only after intubation, as asserted in Dr D.’s expert report – see also paragraph 20 above), and (ii) T.P. had been vaccinated with Boostrix and polio (and not simply Boostrix, as noted in Dr D.’s expert report; see also paragraph 8 above).

77. Relying on Dr K.’s findings and the fact that Dr D. was not a specialist in infectious diseases, the applicant also lodged an application to obtain an expert report from an expert in the fields of infectious diseases and internal intensive-care medicine (*Fachgebieten der Infektiologie und der internistischen Intensivmedizin*), with a view to proving that (i) it had not been an infectious event which had led to T.P.’s death, but rather that his death had been caused by overheating due to external circumstances, and (ii) T.P. would not have died if he had been taken directly to hospital immediately. The applicant further argued that the decree on the performance of military-service duties during extreme outside temperatures (see paragraph 130 below) had been breached: specifically, she emphasised, among other things, the obligation contained therein that a complaint made by a subordinate about his or her own physical condition was to be believed without reservation and that that subordinate was to be afforded the services of a doctor.

I. Further developments (from August 2018 until June 2019) in the investigation

78. On 24 August 2018 the applicant submitted a statement (*Äußerung*) to the Krems Regional Court (*Landesgericht*) regarding K.K.’s request for the discontinuation of the proceedings against him (see paragraph 73 above). She referred again to Dr K.’s expert report (see paragraph 75 above) and submitted that the case against K.K. was ready for indictment. As an alternative to the indictment, she requested (i) that an expert report from an expert in the fields of infectious diseases and internal intensive-care medicine be ordered, and (ii) the refusal of a request lodged by K.K. for the proceedings to be discontinued.

1. Application lodged by M.R. for the discontinuation of the proceedings against him

79. On 6 September 2018 M.R. also lodged with the public prosecutor's office an application requesting the discontinuation of the proceedings against him.

2. Instructions by the Office of the Attorney General

80. On 18 December 2018 the Vienna Office of the Attorney General (*Oberstaatsanwaltschaft*) requested the Krems public prosecutor's office to obtain a (second) supplementary expert report from Dr D. in view of the questions raised by Dr K.'s private expert report (see paragraph 75 above). It deemed that the facts had not been completely elucidated and that the cause of death could not yet be assessed conclusively (as the hypothesis of sepsis as the cause of death still needed to be reviewed, and the question of T.P.'s survival chances also still needed to be clarified). The hypothesis of overheating as the cause of death – as posited by the privately-commissioned expert Dr K. – would lead to a different legal assessment than would an infectious event as cause of death, because the ordering of the march would constitute a relevant breach of the required due diligence. It was thus necessary to obtain a (second) supplementary expert report from Dr D. and subsequently, if still appropriate, an expert report from an expert in the fields of infectious diseases and internal intensive-care medicine.

3. Further additional questions put to Dr D.

81. On 14 January 2019 the Krems public prosecutor's office requested that Dr D. once again supplement his expert report with a view to answering several additional questions, including: how long after a person's death could (live) pathogens of *haemophilus influenzae* and *streptococcus pneumoniae* be detected in the blood; when blood culture to detect bacterial blood poisoning should be taken using blood culture bottles, and whether that was still possible (days) after the death of the person in question; whether there was in existence a blood sample taken from T.P. while he had still been alive; whether the two above-mentioned pathogens could have entered his blood during resuscitation or (post mortem) during the autopsy; whether T.P. would have survived if an ambulance had been called to the site of his breakdown and if it had been recognised there (on the spot) that he was suffering from sepsis; whether T.P. would have survived if he had been taken by ambulance directly from the place of breakdown to hospital; whether a medical layman could have determined whether T.P. was suffering from sepsis or whether he was suffering from overheating; whether, if sepsis was not sufficiently demonstrable as the cause of death, all the necessary findings for a reliable diagnosis of overheating as the cause of death had been realised; and whether M.G. and M.R. could have recognised after T.P.'s breakdown that his

condition required immediate medical intervention – both immediately after his breakdown and during his transportation by vehicle.

4. *Application to institute proceedings against A.W.*

82. On 27 January 2019 the applicant lodged an application with the public prosecutor's office requesting the opening of investigative proceedings (*Ermittlungsverfahren*) against A.W. under Articles 80 and 81 of the Criminal Code and Article 33 § 1 of the Military Criminal Code (see paragraphs 116-117 and 122 below).

5. *Discontinuation of proceedings against O.M. and F.R.*

83. On 8 February 2019 the public prosecutor's office explained its grounds for discontinuing (*Einstellungsbegründung*) the investigative proceedings against O.M. and F.R. It held that their witness statements (according to which T.P. had lain in the shade after being brought back to the barracks) had contradicted other witness statements (according to which T.P. had lain in the blazing sunshine). It further noted that additional investigative steps had been taken: notably, M.S. had been questioned again, and he had confirmed that he had requested that the table set up by other conscripts to provide shade for T.P. be removed, as he had needed more space in which to administer first aid to T.P. (see paragraph 67 above). There was consequently insufficient evidence proving the commission of the offence of giving a false witness statement.

6. *Refusal of the requests for the discontinuation of the proceedings against K.K. and M.R.*

84. On 8 June 2019 the Krems Regional Court (*Landesgericht*) issued a decision (*Beschluss*) refusing the requests lodged by K.K. and M.R. for the discontinuation of the proceedings against them (see paragraphs 73 and 79 above). The court held that the facts had not yet been elucidated sufficiently as to be able to assess conclusively whether a continuation of the proceedings against them was justified. Dr K.'s private expert report had raised certain questions that required a (second) supplementary report by Dr D., as had been requested by the public prosecutor's office. Only afterwards could the cause of T.P.'s death be clarified, which in turn would determine the punishability of K.K.'s and M.R.'s conduct.

85. The court also referred to the decree on the performance of military-service duties during extreme outside temperatures (see paragraph 130 below) and considered that in the light of the evidence gathered thus far, it could reasonably be considered that ordering the march to go ahead had constituted an objective breach of the requirement that due diligence be exercised (*objektive Sorgfaltswidrigkeit*). Furthermore, it could objectively be considered that M.R. had breached the requirement that due

diligence be exercised – whether T.P.’s death had been caused by overheating or whether the cause of his death had been bacterial infection – by failing to organise an immediate medical intervention.

J. Dr D.’s (second) supplementary expert report of 19 August 2019

86. On 19 August 2019 Dr D. submitted his ten-page (second) supplementary expert report, as requested by the public prosecutor’s office (see paragraph 81 above), the relevant parts of which read as follows.

“Following the occurrence of T.P.’s death on 3 August 2017 ... the body was opened in the afternoon of 7 August 2017, approximately ninety hours after the death had occurred.

...

The live detection [*Lebendnachweis*] of pneumococci or haemophilus influenzae pathogens four days after death would no longer have been possible in view of the described condition of the corpse. Examinations aimed at the detection of live germs in the blood after death [involve] taking blood samples within a few hours of death ... [A] blood culture examination conducted days after death would therefore not have been capable of detecting germs.

A live blood sample from T.P. that could have been used for a blood culture was also not available at the time of the autopsy.

...

The detection of the presence of pathogenic germs in the blood had therefore to be expediently attempted exclusively by means of a DNA examination ...

Blood was taken from the femoral vein for [the purposes of] the toxicological examination and the alcohol and bacterial examination, since experience has shown that there is the lowest probability of post-mortem contamination (for example, through germ migration) compared to a blood sample taken from the large vessels near the lungs.

...

With regard to the temporal sequence, reference is made to the description in the expert report ...; an earlier emergency medical intervention between the time of notification [2.19 p.m.] and the subsequent period until the actual arrival of the emergency doctor at [3.07 p.m.] would have been possible if the emergency doctor had been called at the same time that the commander was first notified.

In this fifty-minute period, the required travel time must also be taken into account, so that the time [that would have been] gained is further narrowed.

Taking into account [T.P.’s] clinical condition and the subsequent short time (of about one hour) until [the occurrence of] cardiovascular arrest (within which time the body temperature could not be cooled down to below 42.7°C, despite [efforts to do so]), the occurrence of death could not have been prevented with certainty or even a high probability, even if the emergency doctor had been notified immediately and intervention had taken place on the spot – especially given the fact that a body temperature of over 43.5°C was determined during the first examinations, and that subsequently (in the hospital) a temperature of 42.5°C was also measured in the urinary bladder; thus, an immediately life-threatening condition existed.

Life-threatening complications due to organ damage caused by a disturbed cell metabolism are to be expected at temperatures above 40°C, at which point – largely independent of the cause of the overheating – a cooling of the body-core temperature should be sought as quickly as possible.

In the [relevant] literature, the time window for [action to be taken in respect of] heatstroke caused by exertion is given as less than thirty minutes [if worsening] leading to death is to be avoided ...

The improvement in the chances of survival of 8% per hour cited by the private expert also reflects the fact that – given that the transport times still have to be taken into account and that less than one hour of time could therefore only have been gained in any event – the chance of survival would only have been increased by a few per cent.

Owing to the short time window for achieving a reduction in the core body temperature, it can therefore not be safely assumed that T.P. would have survived if he had been taken directly to hospital by the ambulance service.

Differentiating between [a case of] heat stroke and a septic condition is not possible for a medical layman; the decisive factor is the [ability to] recognise an overall condition that is life-threatening.

With regard to the predisposing factors for the occurrence of exertion-related overheating in T.P., reference should be made to the statements in the expert report ...; particular reference should be made here to [T.P.'s] overweight [and], owing to [T.P.'s] overweight, the reduced heat dissipation [combined] with the concomitant need for increased muscular work [when compared to the demands placed on] other conscripts and the fact that [T.P.] had already [exerted himself] earlier on the same day, which may have led to [his] becoming exhausted.

The risk of a heat-related incident is increased by a factor of four in fit overweight people and by a factor of eight in unfit overweight people compared to people of normal weight.

Acute (especially febrile) illnesses are further predisposing factors for [suffering from] heat stroke.

The overheating of [T.P.'s] body had been clinically diagnosed several times.

... [a] finding of a heat-related death is generally to be arrived at within the framework of a post-mortem examination by excluding other causes of death, taking into account the circumstances of the occurrence of death and the situation in which it occurred.

The possible post-mortem findings in this regard were found in T.P. in the form of haemorrhaging under the serous membranes, which is also to be expected in a case of acute septicaemia.

The fact that the acute course [of the illness] occurred during a physical strain that was well tolerated by the other conscripts, together with the findings of the blood test, speaks in favour of the vital and acute onset of germs [*vital und akut einsetzende Keimeinschwemmung*] being flushed into [T.P.'s] bloodstream.

As stated in the expert report ..., a life-threatening condition is recognisable – even to a medical layman – [if the person concerned is in a] state of exhaustion and confusion, regardless of the cause.

...

The administration of antibiotics [to T.P.] – in conjunction with [his] non-participation in the march – would have been sufficient to prevent T.P.'s death. However, according

to the file, complaints that could have led to decisions in this regard [being taken] were not voiced [by T.P.].”

K. Dr K.’s supplementary private expert report of 21 October 2019

87. On 9 November 2019 the applicant submitted a supplementary expert report of 21 October 2019 by Dr K., containing six pages, with comments on Dr D.’s (second) supplementary expert report (see paragraph 86 above). The relevant parts of this report read as follows.

“The live detection [*Lebendnachweis*] of pneumococci and haemophilus would have been feasible if appropriate samples (for example blood cultures, lung cultures, etc.) had been taken ... However, live detection and a positive PCR result would not have allowed a conclusion to be drawn about sepsis, as the corpse was examined around ninety hours after death ...

... The expert Dr D. picks out interpretations indiscriminately from all possibilities and interprets the germs in the brain and heart as [constituting] contamination, but the PCR evidence in the blood as relevant and indicating an infection; this is arbitrary and scientifically completely untenable and not supported by any of the findings of the expert.

The detection of pneumococci and haemophilus influenzae by a PCR test, as described above, is to be regarded in any case as an expression of translocation (and thus as putrefaction of the corpse) – and not as a pathogenic finding indicating sepsis – in the event that samples are taken from the corpse about ninety hours after death. As already stated above, the detection of bacteria in the brain and heart proves that putrefaction has already occurred.

In summary, it is not possible to determine bacterial sepsis by means of the PCR method ninety hours after death. The expert’s conclusions that the positive PCR result for pneumococci and haemophilus influenzae would indicate sepsis are in no way comprehensible and cannot be substantiated by any of the examinations. There were also no clinical or anamnestic indications that would have been compatible with sepsis before T.P.’s death.

...

The expert does not justify in any way why the bacteria in the brain should be a contamination, but the PCR findings from the blood should be relevant ...

Overall, everything points to a bacterial translocation (due to putrefaction) and not to pneumococcal and haemophilus sepsis.

...

[I] indicated the increase in the probability of survival in the event of septic shock because this information had been requested by [the applicant’s representative]. All findings indicate that T.P. did not have sepsis. The theoretical improvement in the chances of survival through earlier intervention is therefore only relevant in so far as ... The two statements in the expert report and supplementary expert report contradict each other and cannot be substantiated by [the relevant] scientific literature, since in addition to antibiotic therapy in the case of septic shock (which, however, was not present), other measures would also have had to be carried out (circulatory therapy, ensuring oxygen supply, electrolyte compensation, antibiotic therapy etc.).

...

Citing bleeding from the serous membranes as an indicator of sepsis is an insufficient argument, as such bleeding can be present in respect of a variety of causes of death.

...

T.P. had risk factors in respect of death from overheating; the tolerance of stress among the other march participants does not exclude death from overheating.

...

Lastly, I would like to note once again that parts of my expert report of 14 June 2018 were aimed at justifying what would have had to be done if sepsis had actually been present and whether a better course of care could have been achieved. However, I am of the opinion (and have explained this in detail) that sepsis was NOT present and that there were and are no indications for this.”

88. On the basis of these additional comments by Dr K., the applicant lodged another request that an expert report be ordered from an expert in the fields of infectious diseases and internal intensive-care medicine.

L. Discontinuation of the criminal investigation by the public prosecutor’s office

89. On 27 January 2020, in response to the applicant’s application (see paragraph 82 above), the public prosecutor’s office informed the applicant of its decision under section 35c of the Public Prosecution Act (*Staatsanwaltschaftsgesetz* – see paragraph 129 below) not to initiate investigative proceedings against A.W., and of its decision to discontinue the investigative proceedings against K.K., M.G. and M.R., in accordance with Article 190 of the Code of Criminal Procedure (see paragraph 127 below).

90. On 13 February 2020, at the applicant’s request, the public prosecutor’s office explained its reasons for the discontinuation of proceedings against K.K., M.G. and M.R. and the non-initiation of proceedings against A.W.

1. The non-initiation of proceedings against A.W.

91. As regards A.W., the public prosecutor’s office considered that he could not be accused of any objective breach of the requirement to exercise due diligence as he had ordered the appropriate measures (laying T.P. down and taking measures to lower his body temperature). Once T.P. had manifested signs of confusion (which A.W. had recognised), the immediate initiation of medical emergency-aid procedures would have been appropriate. A.W., however, had merely informed his superiors (M.G. and M.R.) by telephone that there was a problem with T.P. This conduct had to be assessed as objectively contrary to the duty to exercise due diligence, as the expert Dr D. had held that a medical layperson should have recognised T.P.’s life-threatening state on account of his state of exhaustion and confusion and

that he should therefore have been immediately afforded the services of a doctor (*das Erfordernis der umgehenden Alarmierung eines Arztes war geboten*).

92. However, according to Dr D., the occurrence of death could not have with certainty or even with a degree of probability been prevented even if the patient had been taken directly to hospital. In view of the distances involved, the time saved would have been less than forty-five minutes. Even judging by the mere probabilities on which the private expert report by Dr K. had been based – which had made no reference to the specifics of T.P.’s case – there had been no significant increase in risk. Since no investigative actions had been taken against A.W. thus far, it was therefore necessary to refrain from initiating proceedings against him.

2. Discontinuation of the proceedings against M.G. and M.R.

93. As regards M.G. and M.R., the public prosecutor’s office considered that they could have initially assumed that T.P. had been merely exhausted when they had been informed by telephone of his difficulties. The intended pick-up and return to barracks of T.P. had therefore not constituted an objective breach of their duty of care. It could not be sufficiently proved that M.G. and M.R. had also fully appreciated T.P.’s confusion (in addition to his exhaustion) when they had arrived on the scene. They had briefly checked T.P.’s mental state by (also) having him count the fingers they had showed to him, as confirmed by witness statements. T.P. had managed to answer correctly and had been responsive (*ansprechbar*). There was no evidence that M.G. and M.R. had been made aware of T.P.’s previous confusion.

94. During the transport, T.P.’s level of consciousness had further faded, and he had ultimately become unconscious. In response, M.G. and M.R. had informed M.S. and had instructed the latter to call the emergency doctor. This behaviour had constituted an adequate reaction that had not led to any further ascertainable delays in the rescue chain and had therefore not constituted an objective breach of the duty of care.

3. Discontinuation of the proceedings against K.K.

95. As regards K.K., the public prosecutor’s office noted that the original march had been ordered one week in advance and had been planned for a full day but had then been adjusted (in consultation with M.G.) in view of the high outdoors temperatures. According to the final report by the military investigating committee (see paragraph 112 below), the decision to hold the march had not been prohibited under the decree on the performance of military-service duties during extreme outside temperatures (see paragraph 130 below) as the decree allowed a certain discretion in respect of action and interpretation; however, the committee deemed that the decision had constituted a leadership decision that had been “problematic” (see

paragraph 111 below). Even though that assessment by the investigating committee had not been binding under law, it nevertheless constituted an indication as to how a conscientious and reasonable person from the relevant circle (*ein gewissenhafter und verständiger Angehöriger aus dem Verkehrskreis des Täters*) had been allowed to interpret the discretion granted in the decree and that that discretion had not been exceeded in the instant case. Therefore, an objective breach of the duty to exercise due diligence could not be sufficiently established.

96. K.K. had been entitled to assume that everyone had been in good health and that the persons present at the site would react adequately in the event of complications. The occurrence of an acute septic inflammation had objectively not been foreseeable. On the other hand, if one were to assume that there had been a negligent and attributable behaviour, then there would have been an increase in risk (*Risikoerhöhung*) – especially since, according to Dr D.’s expert report, the physical exertion in combination with the heat had favoured the spread of germs. The fact that, according to Dr D., it could by no means be ruled out that death would have occurred solely as a result of the spread of germs – even if T.P. had physically rested instead of participating in the march – did not indicate to what extent the risk (or probability) of such a death had changed as a result of T.P.’s participation in the march.

M. Judicial review by the Krems Regional Court of the discontinuation of the criminal investigation

97. On 28 February 2020 the applicant lodged an application (based on Article 195 of the Code of Criminal Procedure – see paragraph 128 below) with the Krems Regional Court requesting the continuation of the investigative proceedings against K.K., M.G. and M.R., and also against A.W. She emphasised that the decree on the performance of military-service duties during extreme outside temperatures (see paragraph 130 below) provided the obligation, in the event of possible danger to the health of servicemen due to extreme temperatures, to believe a complaint made by a subordinate about his or her own physical condition without reservation and to afford that subordinate the services of a doctor. The decree further laid down that rapid transportation to hospital be provided upon the recognition of faintness, dizziness, feelings of anxiety, redness (and sometimes paleness) in the face, and a strong thirst and/or a headache, as such symptoms could be signs of a life-threatening situation (see Appendix 5 to the decree, as reproduced in paragraph 131 below). The applicant further contested the legal assessments made by the public prosecutor’s office in respect of the level of individual responsibility of K.K., M.G., M.R. and A.W. She also argued that not all possible sources of evidence had been exhausted, as the requested additional expert report from an expert in the fields of infectious diseases and

internal intensive-care medicine had not been ordered, despite the deficiencies shown in Dr D.'s expert report.

98. On 30 June 2020 the Regional Court dismissed her application as not justified in respect of K.K., M.G. and M.R. and rejected it as inadmissible in respect of A.W., as no investigative proceedings had been initiated against the latter. The court noted that it was the exclusive decision of the public prosecutor's office whether to bring charges or whether to discontinue the proceedings. The assessment of whether the evidence suggested a conviction was only to consist of a check by the court on whether abuse of power on the part of the prosecution had taken place (*soll lediglich einer Art Missbrauchskontrolle unterworfen werden*); only an unpardonable error in the assessment of evidence (*eine unerträgliche Fehlentscheidung bei der Beweiswürdigung*) could lead to justified criticism of that assessment.

99. The court held that the application for the continuation of the proceedings concerning K.K., M.G. and M.R. was not justified, as the decision of the public prosecutor's office could neither be seen as exceeding its discretionary powers nor as a violation of a legal provision. The reason of the public prosecutor's office for discontinuing the proceedings was not based on an unpardonable error in the assessment of evidence, and the court was not authorised to dictate to the public prosecutor's office how it should assess evidence. The court further noted that the public prosecutor's office had carried out extensive investigations in respect of the present case and had interviewed a large number of witnesses and obtained an expert report, which had been supplemented twice. The public prosecutor's office had determined that a problematic leadership decision had indeed been made and that T.P.'s death had been due to an interplay of several factors, but that no criminally relevant facts could be proved with the level of certainty required for criminal proceedings. The public prosecutor's office had given comprehensive reasons for its decision. There were no significant doubts about the correctness of the facts on which the decision to terminate the proceedings had been based, nor had there been an incorrect application of the law.

IV. MILITARY INVESTIGATION INTO THE EVENTS IN QUESTION

A. Investigating committee (review of the events of 3 August 2017)

100. Following the initiation of an investigation by the Austrian Federal Armed Forces on the day of T.P.'s death (see paragraph 22 above), an investigating committee (*Untersuchungskommission*) was set up by the Federal Ministry of Defence and Sport. It was composed of eight members, including two members with legal knowledge and another two with other special knowledge, as well as one doctor. It was initially led by a colonel of the Military Command of Lower Austria (*Militärkommando*

Niederösterreich) until 9 August 2017, after which it was presided over by the president of the Salzburg Regional Court.

1. Main investigative measures undertaken

101. From 3 until 9 August 2017 the investigating committee questioned the military commanders and medics involved and thirteen of the other fourteen conscripts from the same marching group as T.P. and transmitted their respective testimony to the public prosecutor's office. It is not clear from the case material why the fourteenth conscript (J.R.) was not questioned.

102. As regards the outside temperature on 3 August 2017, K.K. testified that it had been 33°C according to the weather information that he had found on the Internet and 31°C in the shade according to his own thermometer. M.G. testified that according to his estimation it had been around 30°C, while M.R. testified that it had been below 30°C, according to his estimation. A.W. testified that he could not state what the temperature had been.

103. O.M. testified that after T.P. had been brought back to the barracks and he had helped to administer first aid to T.P., he had noticed when holding T.P.'s head that the latter had been red hot (*glühend heiß*). O.M. further stated that M.S. had arranged for T.P. to lie in the shade, and that for this purpose a table had been placed on its side in front of T.P.

104. M.S. testified that before the march he had given each squad leader his mobile telephone number so they could call him in the event of need.

105. The testimony given by the other conscripts who had been part of the same marching group as T.P. is summarised in paragraphs 35-47 above.

106. On 17 August 2017 the presiding member of the investigating committee undertook the same march as that held on 3 August 2017, departing at around the same time in sunshine and at a moderate pace, together with A.W. and another member of the investigating committee. They found that A.W.'s statements were technically plausible in terms of the timing and route (*weg-zeit-technisch nachvollziehbar*).

2. Interim report of 29 August 2017

107. In its interim report of 29 August 2017, the investigating committee described the facts that had been ascertained so far. It also noted that on 3 August 2017, according to the Horn weather measuring station, the temperature at 12 noon had already been 33°C. From 1.20 p.m. until about 4 p.m., the temperature had been over 35°C, with the day's maximum temperature of 36.9°C having been reached by 2.40 p.m. Furthermore, provision had been made for medical care to be administered at the barracks (to those who needed it) by M.S., who had remained behind in the barracks because a third platoon had also been undertaking a march along a different route.

108. According to its preliminary findings, the investigating committee noted that the approval of the Land Forces Command (*Kommando Landstreitkräfte*) for the advancement (*Vorziehen*) of the “training objective march” (which had not been provided for in “basic training 1” for the guard company), had not been obtained because it had been deemed unnecessary by the commander of the guards (*Kommandant der Garde*).

109. Furthermore, the investigating committee recommended that the special commission set up by the Ministry of Defence and Sport (see paragraph 113 below) be tasked with examining the applicable training regulations and making a corresponding recommendation.

3. Statement of 14 September 2017

110. In a statement (*Stellungnahme*) of 14 September 2017 the investigating committee concluded that the march of 3 August 2017 had been in a form for which the training regulations had not provided since 2015. It consequently recommended that the compliance of the guard company with the 2014 implementing regulation for basic training (*Durchführungsbestimmung für die Basisausbildung 2014*) be checked.

111. Furthermore, as regards the decree on the performance of military-service duties during extreme outside temperatures (see paragraph 130 below), the term “avoidance” [in respect of foot marches] allowed commanding officers a certain latitude of discretion in respect of action and interpretation, unlike terms such as “prohibition” or “absolute impermissibility”. The investigating committee considered that in the instant case, to have proceeded with the march in the afternoon – given the prevailing temperatures and in the absence of the predicted cooling down of temperatures – in view of the term “avoidance” (as used in the relevant regulation) – had not been forbidden but should be considered to have constituted a “problematic leadership decision” (*eine problematische Führungsentscheidung*), despite the accompanying measures taken. It noted that the wording in the decree had not been changed, despite an incident in 2007, because in exceptional cases it might be necessary to carry out marches even in extreme outside temperatures (for example, in the event that the weather changed during alpine training, during a descent/march into a valley, or during short marches to and from training locations that could only be reached on foot for the kind of training that could permissibly be carried out in extreme outside temperatures). In carrying out their leadership duties, commanders should only use such room for manoeuvre in necessary and exceptional cases. The committee recommended that the special commission, when evaluating the training regulations, check a possible revision of the decree (see paragraph 130 below) (with a view to a possible reduction of the room for the interpretation of the decree).

4. Final report of 30 November 2017

112. In its final report of 30 November 2017, the investigating committee concluded that the exact cause of death was unknown as, under the relevant domestic legislation, it did not have access to the expert report ordered by the public prosecutor's office. The committee thus referred to its statement of 14 September 2017 and to its interim report of 29 August 2017 (see paragraphs 107-109 and 110-111 above), noting that the recommendation made therein that the special commission examine the applicable training regulation was currently being implemented. Furthermore, the compliance of the guard company with that training regulation was being monitored.

B. Special commission (review of the applicable training regulations)

113. On 9 August 2017 the Ministry of Defence and Sport, in addition to the investigating committee (see paragraphs 100-112 above), also set up a special commission (*Sonderkommission*) "to evaluate the training regulations and related decrees" (*zur Evaluierung der Ausbildungsvorschriften und der diesbezüglichen Erlasse*). It was tasked with reviewing all relevant training guidelines and related decrees in order to identify weak areas, review the handling of the relevant training guidelines and related decrees and propose improvements. The commission worked independently of the investigating committee and under a different leadership. Its final report of 5 December 2017 listed several recommendations, including certain amendments that it urged be made to the decree on the performance of military-service duties during extreme outside temperatures (see paragraph 132 below).

C. Disciplinary proceedings

114. The applicant submitted that no disciplinary measures had been taken against any of the commanders or servicemen involved.

115. The Government submitted that disciplinary proceedings had been informally (*formlos* – that is, without any official decision being made) instituted from 9 August 2017 onwards but that the military disciplinary authority was bound by the statement of facts underlying a final court judgment. It had therefore been necessary to await the outcome of the criminal proceedings. Once the decision of the Regional Court of 30 June 2020 (see paragraphs 98-99 above) had been delivered, the commander of the guard, acting as the disciplinary authority, had carried out a disciplinary assessment in August 2020 and had found that no culpability could be established and therefore had (without any formal decision being made) discontinued the disciplinary proceedings. The Government did not submit any documents related to the disciplinary assessment carried out by the commander of the guard.

RELEVANT LEGAL FRAMEWORK AND PRACTICE

I. CRIMINAL CODE

116. Article 80 § 1 of the Criminal Code (*Strafgesetzbuch*) defines negligent manslaughter (*fahrlässige Tötung*) as negligently causing the death of another person.

117. Article 81 § 1 defines grossly negligent manslaughter (*grob fahrlässige Tötung*) as causing the death of another person by gross negligence.

118. Article 92 defines the torture or neglect of minor, younger or defenceless persons (*Quälen oder Vernachlässigen unmündiger, jüngerer oder wehrloser Personen*) as inflicting physical or mental torture on another person who is subject to the perpetrator's care or custody and who is defenceless because of infirmity (*Gebrechlichkeit*), illness or mental disability.

119. Article 93 defines the over-exertion of minors, younger persons or persons in need of care (*Überanstrengung unmündiger, jüngerer oder schonungsbedürftiger Personen*) as overexerting, through malice or recklessness, another person who is dependent on the perpetrator or is subject to the perpetrator's care or custody and who, because of his or her state of health, obviously needs to be spared – thereby causing, even if only negligently, the risk of death or of considerable bodily injury or damage to the health of the overexerted person.

120. Article 288 defines the offence of false testimony (*falsche Beweisaussage*) as giving false testimony as a person providing information during his or her formal examination on the merits of a case (paragraph 1) or as a witness before the criminal police or the public prosecutor's office (paragraph 4).

121. Article 299 defines the obstruction of prosecution or punishment (*Begünstigung*) as intentionally preventing another person, who has committed an offence punishable by a penalty, from being prosecuted or preventing the execution of the respective penalty or preventive measure in whole or in part.

II. MILITARY CRIMINAL CODE

122. Article 33 § 1 of the Military Criminal Code (*Militärstrafgesetz*) defines the neglect of the duty of care (*Vernachlässigung der Obsorgepflicht*) by superiors and higher-ranking officers (*Vorgesetzte und Ranghöhere*) as grossly neglecting, even if only negligently, the duty incumbent on the perpetrator of care for the preservation and protection of the soldiers under his or her command and thereby negligently causing the death of a soldier or

serious bodily injury or bodily injury with permanent consequences to a soldier.

123. Article 35 defines degrading treatment (*entwürdigende Behandlung*) as treating a subordinate or lower-ranking person in a manner that violates human dignity or, out of malice, making the service of a subordinate more difficult and thereby placing him or her in an agonising condition.

III. CODE OF CRIMINAL PROCEDURE

124. Article 1 § 3 of the Code of Criminal Procedure (*Strafprozeßordnung*) defines an initial suspicion (*Anfangsverdacht*) as an assumption, on the basis of certain indications, that a criminal offence has been committed.

125. The participation of private parties (*Privatbeteiligung*) in criminal proceedings is regulated by Article 67, which provides that victims become private parties by declaration (that is, simply by declaring that they are parties to those proceedings) and that in such a declaration, they shall, unless it is obvious, state their entitlement to participate in the proceedings in question and their claims for damages (paragraph 2). In addition to the rights of victims, private parties have the right, *inter alia*, to request that evidence be gathered; they may also bring charges if the public prosecutor withdraws from it and lodge a complaint against the judicial discontinuation of the proceedings in question (paragraph 6).

126. Article 127 concerns expert reports and provides that a further expert report shall be ordered if the findings of the first expert report are inconclusive or contradictory or otherwise deficient, or if the statements of two experts regarding the facts of the case or the conclusions drawn from their observations are significantly contradictory, and the concerns cannot be resolved through questioning (paragraph 3).

127. Article 190 regulates the discontinuation of investigative proceedings and provides that the public prosecutor shall refrain from prosecuting a criminal offence and shall discontinue the preliminary investigation in so far as the offence on which the investigative proceedings are based is not punishable by a sentence delivered by a court (paragraph 1).

128. Article 195 regulates the possibility to request the continuation (*Antrag auf Fortführung*) of investigative proceedings and states that as long as the punishability (*Strafbarkeit*) of the offence is not statute-barred, the court shall, upon an application being lodged by the victim, order the continuation (*Fortführung*) by the public prosecutor of terminated investigative proceedings if the law has been violated or incorrectly applied, or if there are substantial doubts about the correctness of the facts on which the decision on termination was based, or if new facts or evidence are submitted which, on their own or together with other findings of the

investigation, appear sufficient to clarify the facts of the case to such an extent that action can be taken (paragraph 1).

IV. PUBLIC PROSECUTION ACT

129. Section 35c of the Public Prosecution Act (*Staatsanwaltschaftsgesetz*) regulates the non-initiation of investigative proceedings (*Absehen von der Einleitung eines Ermittlungsverfahren*) and provides that the public prosecutor shall refrain from initiating investigative proceedings if there is no initial suspicion (see paragraph 124 above). The person who reported the (alleged) offence in question (*der Anzeiger*) shall be informed of this, and it shall be pointed out to him or her that he or she is not entitled to lodge an application (under Article 195 of the Code of Criminal Procedure – see paragraph 128 above) for the continuation of the proceedings.

V. MILITARY SERVICE REGULATIONS

130. The decree (*Erlass*) of the Federal Ministry of Defence and Sport of 15 September 2014 on the time regulations for subordinate departments/guidelines (*Zeitordnung für den nachgeordneten Bereich/Richtlinien*; VBl. I Nr. 45/2014) regulated general working hours for servicemen and granted the power to set special regulations – for example, in the interests of the well-being of individual service personnel. It contained a specific chapter on the performance of military-service duties during extreme outside temperatures, the relevant parts of which at the time of the events read as follows.

“D) Service in extreme outside temperatures and/or increased environmental pollution

1. Service in exceptional heat or extreme cold [performed by] troops, academies and schools

In the event of extreme temperatures, field service in the barracks or a training area is to be carried out in a manner that deviates from the valid regulations with the aim of reducing heat- or cold-related stress on the soldiers as follows.

a) Extreme temperatures exist when the following values are reached:

- at 12 noon, above 28°C (in the shade).
- at 07 a.m., minus 15°C.

These values are to be regarded as guideline figures. In addition, humidity, *foehn* [a warm, dry, southerly wind], wind conditions and precipitation must be taken into account. The measurement of and the dissemination [of information regarding] temperatures in the event of extreme weather conditions is generally the responsibility of the barracks commander. Where this is not possible (for example, in the case of relocation [*zB bei Verlegungen*]), the assessment is the responsibility of the commander in charge.

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The assessment of the other above-mentioned components is usually the responsibility of the unit commander or the local heads of training.

b) In addition, the troop commanders shall ensure the timely communication of the detection of extreme outside temperatures for their area.

c) Unit commanders shall be responsible for organising training ... under extreme temperature conditions that are in accordance with the following guidelines:

aa) If extreme temperatures are expected, the appropriate uniform and equipment shall be ordered before the start of service.

bb) The lightening of clothing, the interruption of training in very hot weather, and the carrying out of warm-up exercises in extremely cold weather or other weather conditions that appear to render cold-induced injury [*Kälteschädigungen*] a possibility are anticipatory measures that should be taken in order to maintain physical performance. In such cases, the decision shall be made by the on-site training leader (possibly also the platoon commander, squad leader, team leader or the equivalent thereof).

cc) **Additional measures:**

- The use of cool rooms and shady places outdoors when it is very hot.
- The avoidance of foot marches, especially in open and uncovered areas during the hot hours of the day.
- A sufficient supply of liquids so that no soldier suffers from thirst.
- The avoidance of wind-exposed places in winter.
- The incorporation of exercise and warm-up exercises when there is a risk of cold-induced injury.

d) If available, the participation of trained medical personnel to the extent necessary shall be ensured during training outside the barracks.

e) In the event of a danger posed by extreme temperatures to the health of members of a troop unit that is on a training exercise (a complaint made by a subordinate about his or her own physical condition should be believed without reservation for the time being; the subordinate should be brought before a doctor and be held responsible if any of the information [that he or she has] given is found to be untrue); training is to be terminated prematurely under the responsibility of the highest-ranking person in charge of the training (as a rule the unit commander, but under certain circumstances the team leader). In such a case, more suitable training exercises are to be carried out [and] the relevant daily column of the duty roster amended accordingly.

f) The possibility of avoiding heat forecast for the day ahead by moving [scheduled] training forwards is to be employed to a large extent ... In the event of extreme cold, training shall be conducted in the barracks area or in the accommodation area, if possible.

g) The achievement of training objectives is to be striven for by all means available, despite any restrictions placed on or deviations from [the original schedule]. If these objectives cannot be achieved – even with the addition of more post-training time – the commander of the unit in question (after being notified by the unit commander) shall decide on how to arrange the daily duty roster during the period of extreme temperatures ...”

131. Appendix 5 to the above-mentioned decree contained detailed information on the symptoms and treatment of heat stroke and sunstroke, as follows.

Heat stroke was described as heat accumulation (*Wärmestauung*) in the body, which could occur during excessively muggy heat and periods of physical exertion. It was a life-threatening condition. The first signs of the onset of heat stroke were faintness, dizziness (staggering when walking), a feeling of anxiety, redness (and sometimes paleness) in the face, a strong thirst and an accelerated, weak pulse. After these first signs, the affected person could suddenly collapse and become unconscious. A comrade should help [the affected person] to lie on his side in an airy, shady place, to expose the upper half of the body [of the affected person], to sprinkle it with cold water and then to wipe it dry with a cloth. If the face was red, the head should be placed in an upright position (while paying attention to the airways). Artificial respiration should be administered to unconscious persons, who should quickly be taken to hospital.

Sunstroke was described as caused by the uncovered head being exposed to direct sunshine, which could lead to too much blood entering the head, leading in turn to a life-threatening swelling of the brain. Signs of sunstroke included headache, dizziness, and a fading of the degree of consciousness – ending in unconsciousness. These signs did not have to appear immediately. The help to be afforded by a comrade was the same as that to be afforded in the event of heat stroke.

132. Following the events of the instant case, and further to the recommendations made by the special commission (see paragraph 113 above), the above-mentioned decree was replaced with a new decree issued by the Ministry of Defence on 22 November 2018 (VBl. I Nr. 2/2019). The most important changes, in so far as relevant, are that extreme temperatures are now defined as 28°C or more (in the shade) at 12 noon (as opposed to above 28°C (in the shade) at 12 noon – see point D) 1. a) of the old decree). Furthermore, when planning and conducting training, the performance and training level of the troops must also be assessed (new point added to the new decree). As additional measures, physically demanding activities – especially in open and uncovered areas during the hot hours of the day – are to be avoided (as opposed to the avoidance of foot marches only – see point D) 1. c) cc) of the old decree). Furthermore, when training occurs outside the barracks, the participation of trained medical personnel must be ensured to the extent necessary (as opposed to only “if [such trained medical personnel is] available” – see point D) 1. d) of the old decree). Lastly, the achievement of the training objectives in question is to be striven for despite any restrictions or deviations imposed (as opposed to the obligation to strive for the achievement of the training objectives “by all means available” – see point D) 1. g) of the old decree).

THE LAW

ALLEGED VIOLATION OF ARTICLE 2 OF THE CONVENTION

133. The applicant complained of the violation of her son's right to life, to protection from inhuman or degrading treatment and to respect for his private life. She further alleged that the criminal investigation into the events leading to his death during his compulsory military service had been flawed. In support of her complaints, she relied on Articles 2, 3 and 8 of the Convention.

134. Being the master of the characterisation to be given in law to the facts of a case, the Court is not bound by the characterisation given by an applicant or a Government. By virtue of the *jura novit curia* principle, it has, for example, considered of its own motion complaints under Articles or paragraphs not relied on by the parties. A complaint is characterised by the facts alleged in it and not merely by the legal grounds or arguments relied on (see *Molla Sali v. Greece* [GC], no. 20452/14, § 85, 19 December 2018, with further references). Since the main focus of the present case is the death of the applicant's son and the criminal investigation into the circumstances leading to his death, the Court will consider the case solely under Article 2 of the Convention, the relevant part of which reads as follows.

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

A. Admissibility

135. 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

136. The Court notes that the applicant complained under both the substantive and procedural limb of the right to life (see paragraph 133 above). It considers it appropriate to start its examination on the merits by first addressing the procedural limb of the applicant's complaint under Article 2 of the Convention, namely whether or not the criminal investigation into the circumstances of her son's death was effective, and then turning to the substantive limb, namely the question of whether the State can be held responsible for the death (see, *mutatis mutandis*, *Ohanjanyan v. Armenia*, no. 70665/11, § 139, 25 April 2023).

1. Procedural limb

(a) Submissions by the parties

(i) The applicant

137. The applicant submitted that the criminal investigation into her son's death had been deficient. She criticised notably the following five aspects. Firstly, the applicant insisted that had an ambulance been called immediately at 2 p.m. instead of 3 p.m., this would have increased the likelihood of T.P.'s survival by 8% (a confirmation that she asserted had been provided by the experts) assuming that T.P. had indeed been suffering from sepsis. Such an increase was considerable, given that the survival rate was 80% in the event that adequate treatment for septic shock was administered within the first hour. Even if one were to take 2.19 p.m. as the relevant time (as had the public prosecutor's office), the same would apply. Despite this, the public prosecutor's office had asserted that those survival rates would not have had any bearing on the instant case.

138. Secondly, the commanders involved had not only committed negligent manslaughter (as proscribed by Articles 80 and 81 et seq. of the Criminal Code); they had also – by drilling T.P. for twenty minutes in spite of his exhaustion and his breakdowns – committed further offences (see Article 35 of the Military Code and Articles 92 and 93 of the Criminal Code). However, the public prosecutor's office had not investigated any of those offences.

139. Thirdly, the applicant noted that the public prosecutor's office, under Article 35c of the Public Prosecution Act, had refused to initiate proceedings in respect of A.W.; this meant that it had denied having had even an initial suspicion of wrongdoing – that is, there had been no indication at all of any criminal offence by A.W.

140. Fourthly, the public prosecutor's office had considered decisive the question of whether T.P. had been suffering from an acute septic inflammation. In doing so, however, it had not exhausted all the possible sources of evidence that had been material to the overall evaluation of evidence, in view of the two mutually contradictory expert reports and the deficiency of Dr D.'s expert report (as demonstrated by Dr K.). The public prosecutor's office should have ordered the requested (by the applicant) expert report in the areas of infectious diseases and internal intensive-care medicine in order to clarify the outstanding questions. Instead it had ignored Dr K.'s supplementary expert report refuting Dr D.'s second supplementary expert report and instead had relied exclusively on Dr D.'s findings without addressing Dr K.'s arguments. However Dr D. was neither a specialist in infectious diseases nor in the field of intensive care, while Dr K. was both.

141. Fifthly, while the applicant had been able to challenge the decisions of the public prosecutor's office to terminate the investigative proceedings against K.K., M.G. and M.R. and to refrain from initiating proceedings

against A.W., the Regional Court had rejected her application to continue the investigation *de facto*, without giving reasons. Besides presenting the course of the proceedings, the arguments of both sides and the legal situation, the court had substantiated its decision by merely asserting that there had been no unpardonable decision and that the court was not authorised to dictate how the public prosecutor's office should have evaluated the evidence. The applicant insisted that the court had not even attempted to discuss any of her arguments.

(ii) *The Government*

142. The Government considered that the investigation had been Convention compliant. Both the military investigating committee and the criminal investigation authorities had taken expeditious and effective measures to secure evidence regarding the circumstances of T.P.'s death and the potential criminal responsibility of third parties. On the day of T.P.'s death, a forensic autopsy of the corpse and an expert report on the cause of death and on any third-party responsibility had been ordered. All individuals involved in the events had been interviewed; T.P.'s medical records had been secured; meteorological data for 3 August 2017 had been obtained; the route of the march, the rucksack and the chronological sequence of events had been documented; and inconsistencies in the witness testimony had been clarified. Furthermore, all records of the military investigation had been forwarded to the criminal investigation authorities.

143. The Government maintained that it had not been necessary to obtain another expert report, despite the different conclusions regarding the cause of T.P.'s death in the two expert reports. In the event of a contradiction between an expert report by a court or prosecution-appointed expert and an expert report by a privately-commissioned expert, domestic legislation did not provide that another expert be consulted. A privately-commissioned expert report could, however, serve to reveal a deficiency in the formally-commissioned expert report within the meaning of Article 127 § 3 of the Code of Criminal Procedure. Thus, in submitting the privately-commissioned expert report, the applicant had raised alleged contradictions and deficiencies in the expert report by the formally-commissioned expert. In the light thereof, the public prosecutor's office had decided that there was a need to re-examine the cause of death; it had accordingly – by way of attempting to remedy the deficiency, in accordance with Article 127 § 3 of the Code of Criminal Procedure – requested Dr D. to (again) supplement his expert report. In his (second) supplementary expert report, Dr D. had been able to dispel any doubts regarding his findings. There had thus been no deficiencies discernible, and no further expert had needed to be consulted. Consequently, the public prosecutor's office had considered that the facts had been established well enough for the cause of T.P.'s death to be determined with the required level

of certainty. The Regional Court also had had no serious doubts as to the accuracy thereof.

144. Furthermore, the public prosecutor's office had been sufficiently independent of the individuals under investigation. The applicant, as T.P.'s relative, had had adequate access to the investigation and had exercised her right to join the investigative proceedings as a private party, in accordance with Article 67 of the Code of Criminal Procedure. As such, she had had the right to request evidence and inspect files and play an active part in establishing the facts. She had also been entitled to request that the investigative proceedings be continued under Article 195 of the Code of Criminal Procedure. She had been kept informed of the developments and had been free to comment on the findings by Dr D. She had also been given written reasons for the decisions of the public prosecutor's office.

145. The Government emphasised that the Convention did not entail a right to have third parties prosecuted or sentenced for a criminal offence. Following a comprehensive investigation, including additional investigative steps in view of specific arguments by the applicant, the public prosecutor's office had concluded that negligence could not objectively be attributed to K.K., M.G. and M.R. with the level of certainty required for a prosecution. Consequently, the proceedings had had to be discontinued, in accordance with Article 190 (1) of the Code of Criminal Procedure. They had further not given rise to any initial suspicion against A.W. as defined by Article 1 (3) of the Code of Criminal Procedure. No criminally punishable behaviour had been identified, since (as established by Dr D.) it had not been possible to determine (with the necessary certainty, or even any degree of likelihood) whether T.P.'s death might have been avoided. Accordingly, the public prosecutor's office, under section 35c of the Public Prosecution Act, had had to refrain from initiating investigative proceedings.

(b) The Court's assessment

(i) General principles established in the Court's case-law

146. Where lives have been lost in circumstances potentially engaging the responsibility of the State, Article 2 of the Convention entails a duty for the State to ensure, by all means at its disposal, an adequate response – judicial or otherwise – so that the legislative and administrative framework set up to protect the right to life is properly implemented and any breaches of that right are repressed and punished (see *Öneryıldız v. Turkey* [GC], no. 48939/99, § 91, ECHR 2004-XII, with further references). If the infringement of the right to life or to physical integrity was not caused intentionally, the positive obligation imposed by Article 2 to set up an effective judicial system does not necessarily require the provision of a criminal-law remedy in every case and may also be satisfied if civil, administrative or even disciplinary remedies were available to the victims (see, for example, *Vo v. France* [GC],

no. 53924/00, § 90, ECHR 2004-VIII; *Calvelli and Ciglio v. Italy* [GC], no. 32967/96, § 51, ECHR 2002-I; and *Mastromatteo v. Italy* [GC], no. 37703/97, § 90, ECHR 2002-VIII, all with further references).

147. The minimum requirement for such a system is that the persons responsible for and carrying out the investigation must be independent from those implicated in the events. This means not only a lack of hierarchical or institutional connection but also a practical independence (see *Paul and Audrey Edwards v. the United Kingdom*, no. 46477/99, § 70, ECHR 2002-II, and *Mastromatteo*, cited above, § 91; for a more recent and detailed summary of all applicable general principles, see *Nicolae Virgiliu Tănase v. Romania* [GC], no. 41720/13, § 157-171, 25 June 2019). Where a positive obligation to safeguard the life of persons in custody or in the army is at stake, the system required by Article 2 must provide for an independent and impartial official investigation that satisfies certain minimum standards as to effectiveness. Thus, the relevant authorities must act with exemplary diligence and promptness and must of their own motion initiate investigations capable of, firstly, ascertaining the circumstances in which the incident took place and any shortcomings in the operation of the regulatory system and, secondly, identifying the State officials or authorities involved. There must be a sufficient element of public scrutiny of the investigation or its results to secure accountability in practice as well as in theory. The degree of public scrutiny required may well vary from case to case. In all cases, however, the next of kin of the victim must be involved in the procedure to the extent necessary to safeguard his or her legitimate interests (see, for example, *Perevedentsevy v. Russia*, no. 39583/05, § 105, 24 April 2014, with further references; for a recent and more detailed summary of the general principles in the context of an effective investigation, see *Ohanjanyan*, cited above, §§ 135-138, and *Dimakryan v. Armenia*, no. 29906/14, §§ 65-69, 17 October 2023).

148. Furthermore, the Court reiterates that as master of its own procedure and its own rules, the Court has complete freedom in assessing not only the admissibility and relevance but also the probative value of each item of evidence before it. The Court is not bound, under the Convention or under the general principles applicable to international tribunals, by strict rules of evidence and there are no procedural barriers to the admissibility of evidence in the proceedings before it (see *Carter v. Russia*, no. 20914/07, § 97, 21 September 2021, with further references). In assessing evidence, the Court adopts the standard of proof “beyond reasonable doubt”. Such proof may follow from the coexistence of sufficiently strong, clear and concordant inferences or of similar unrebutted presumptions of fact (see *Tanlı v. Turkey*, no. 26129/95, § 109, ECHR 2001-III (extracts)). Where the events in issue lie wholly, or in large part, within the exclusive knowledge of the authorities, as in the case of persons within their control in custody or in the army, strong presumptions of fact will arise in respect of injuries and death occurring

during that detention or service. Indeed, the burden of proof may be regarded as resting on the authorities to provide a satisfactory and convincing explanation (see, among many, *Nana Muradyan v. Armenia*, no. 69517/11, § 123, 5 April 2022).

149. The Court is aware of the subsidiary nature of its role and must be cautious in taking on the role of a first instance tribunal of fact, where this is not rendered unavoidable by the circumstances of a particular case (see *McKerr v. the United Kingdom (decision)*, no. 28883/95, 4 April 2000). It is not the Court's task to substitute its own assessment of the facts for that of the domestic courts and, as a general rule, it is for those courts to assess the evidence before them. Though the Court is not bound by the findings of domestic courts, in normal circumstances it requires cogent elements to lead it to depart from the findings of fact reached by those courts (see *Klaas v. Germany*, 22 September 1993, §§ 29-30, Series A no. 269).

150. Where allegations are made under Articles 2 and 3 of the Convention, however, the Court must apply a particularly thorough scrutiny. When there have been criminal proceedings in the domestic courts concerning those same allegations, it must be borne in mind that criminal-law liability is distinct from international-law responsibility under the Convention. The Court's authority is confined to the latter. Responsibility under the Convention is based on its own provisions, which are to be interpreted and applied on the basis of the objectives of the Convention and in the light of the relevant principles of international law. The responsibility of a State under the Convention, arising for the acts of its organs, agents and servants, is not to be confused with the domestic legal issues of individual criminal responsibility under examination in the national criminal courts. The Court is not concerned with reaching any findings as to guilt or innocence in that sense (see *Tanlı*, cited above, § 111).

(ii) *Application of these principles to the present case*

151. Turning to the circumstances of the present case, the Court notes that the applicant did not question the independence of the criminal investigation into T.P.'s death, and the Court sees no reason to do so. Indeed, the criminal investigation was conducted by the police and the public prosecutor's office – both authorities that were not under any military command or structure or otherwise connected to the Armed Forces (members of which were under investigation). As regards the fact that the involved military commanders and medics and thirteen of the fourteen conscripts who had been in the same marching group as T.P. had first been questioned by the military investigating committee before they were heard by the police (see paragraphs 27 and 101 above), the Court notes that when questioning (in particular) T.P.'s fellow conscripts, the police first verified the content of the statements that they had given to the military authorities and further verified that no one had been pressured by the military authorities in that context (see paragraph 34 above).

The Court is therefore satisfied that the criminal investigation overall was sufficiently independent, as the persons responsible for and carrying out the criminal investigation were hierarchically, institutionally and practically independent from those implicated in the events (see the case-law cited in paragraph 147 above).

152. The Court further notes that the applicant also did not contest that the investigation started promptly, nor did she point to any delays in the investigation. Indeed, the Court agrees that both the military and the criminal authorities reacted with exemplary diligence and promptness to T.P.'s death by immediately and on their own motion initiating the military and criminal investigations and also undertaking several important investigative steps in the days following his death (see paragraphs 22, 27, 49 and 100-101 above). The Court does not lose sight of the fact that although an autopsy was ordered on the day of T.P.'s death, it was only performed four days later (see paragraphs 23-24 above). While this is not to be criticised in itself, it seems to have had important consequences in respect of the subsequent medical findings, as it gave rise to one of the points on which the two medical experts consulted could not agree – namely, the significance in the PCR test of T.P.'s blood of the presence of DNA material from two pathogenic germs. The Court further notes that while Dr D.'s expert report and his (first) supplementary report thereto were obtained within eleven and seventeen weeks of their being requested, it took thirty-one weeks (that is, over seven months) to obtain his second supplementary expert report (see paragraphs 23, 58, 62, 72, 81 and 86 above). Such a delay appears somewhat problematic – particularly given that no further examinations had actually taken place and that the legal assessment of the actions and omissions by the servicemen concerned depended on the medical findings.

153. As regards public scrutiny of the criminal investigation and (more particularly) of next-of-kin involvement, the Court agrees with the Government that the applicant was sufficiently involved in the procedure, as was also demonstrated by the fact that she availed herself of the procedural rights available to her under Article 67 of the Code of Criminal Procedure (see paragraph 125 above). Indeed, she was able to join the criminal proceedings as a private party, she was kept informed of the major developments in the criminal investigation, she was able to request that certain investigative steps be undertaken and to submit evidence and other procedural motions, and she was provided with written grounds for the public prosecutor's decisions (see paragraphs 25, 50, 54, 56-57, 60, 74, 78, 82-83, 87-96 above). She was further able to lodge a complaint with the relevant court and thereby request a judicial review of the decision of the public prosecutor's office to discontinue the investigative proceedings against K.K., M.G. and M.R. (see paragraph 97 above). Consequently, the Court is satisfied that the applicant was involved in the criminal investigation to the extent necessary to safeguard her legitimate interests.

154. The Court will now turn to the question of the general adequacy of the criminal investigation. It reiterates that any deficiency in the investigation that undermines its ability to establish the cause of death will risk falling foul of the Convention standards under Article 2 of the Convention (see *Al-Skeini and Others v. the United Kingdom* [GC], no. 55721/07, § 166, ECHR 2011, with further references). In the present case, it is not disputed by the parties that the conclusions regarding the cause of T.P.’s death (namely, sepsis) reached by the officially-appointed expert in forensic medicine (Dr D.) who had performed the autopsy were contested by the expert in infectiology and tropical medicine, internal intensive-care medicine and internal medicine (Dr K.), who was privately-commissioned by the applicant (and who maintained that sepsis could not be inferred from the available documents and examination results). In view of this difference in views, a question arises as to whether all reasonable investigative steps were carried out during the domestic proceedings with a view to elucidating – to the extent medically possible – the cause of death (see *Tanli*, cited above, § 121).

155. The Government argued that in his second supplementary expert report, Dr D. had been able to dispel any doubts regarding his first expert report and that that expert report, taken together with his two supplementary reports, had been conclusive and reasonable so that there were no deficiencies discernible within the meaning of Article 127 § 3 of the Code of Criminal Procedure, and that there was consequently no need to consult a further expert (see paragraph 143 above). Indeed, in the last of those reports, Dr D. had found that even if the emergency doctor had been notified immediately and intervention had taken place on the spot, or if T.P. had been taken directly to hospital by the ambulance service, his death could not have been prevented with certainty or high probability. The Court notes that the said legal provision (Article 127 § 3 of the Code of Criminal Procedure – see paragraph 126 above), was not explicitly mentioned by the public prosecutor’s office or by the reviewing domestic court, but that the latter court clearly relied on the said expert’s findings (see paragraph 99 above). Even if it is acknowledged that the conclusions of the expert – who was appointed for the purpose of the criminal proceedings – only denied the criminal responsibility of the involved persons and left open the possibility that T.P.’s death could have been prevented, the Court accepts that such a “possibility” was not sufficient for anyone to be criminally prosecuted and cannot lead the Court to characterise the criminal investigation as “inadequate”. In cases where State responsibility for a loss of life crucially depends on whether the death in question was caused by State agents (proving which usually requires medical knowledge and research), it cannot be excluded that there may be situations in which even specialised scientific experts are unable to establish the exact cause of death – despite all efforts undertaken in this respect (compare *Kutsarovi v. Bulgaria*, no. 47711/19, § 70, 7 June 2022, where thirteen experts from different scientific fields had been consulted throughout

the criminal investigation and the ensuing proceedings but had been unable to agree on the exact cause of death and instead had supported two different hypotheses, with nine experts supporting one hypothesis and the other four experts supporting another hypothesis). In this connection, the Court reiterates that the obligation to conduct an effective investigation within the meaning of Article 2 of the Convention is not an obligation of result, but of means. The authorities must take the reasonable steps available to them to secure the evidence concerning the incident, including, *inter alia*, eyewitness testimony, forensic evidence and, where appropriate, an autopsy that provides a complete and accurate record of injury and an objective analysis of clinical findings, including the cause of death (see *Al-Skeini and Others*, cited above, § 166).

156. In the present case, the Court notes that the domestic authorities, when faced with Dr K.'s privately-commissioned expert report questioning some of Dr D.'s findings, requested Dr D. to provide additional clarifications and answers, which the latter did by providing two supplementary expert reports. As regards two factual mistakes in Dr D.'s expert reports (which Dr K. pointed out – see paragraph 76 above), the Court notes that these concerned only ancillary circumstances that were not relevant for the medical analysis and clinical findings as regards the cause of death. The Court sees no reason not to believe Dr D. or to question his competence, given that he had been appointed as an independent and a sworn and court-certified expert (see paragraph 23 above). It should also be pointed out that Dr D. was an experienced specialist in forensic medicine and had examined the corpse himself, while Dr K., who was not a specialist in forensic medicine and not court-certified, had not examined the corpse and instead had based his expert report on a review of the case file only. Moreover, while Dr K. contested the finding of sepsis as the cause of T.P.'s death and contended that earlier transportation to hospital would have increased his chances of survival, he did not elaborate on any other possible cause of death, did not contend that T.P. could have survived if he had been taken directly to hospital and mentioned nothing that would have indicated criminal responsibility on the part of any of the persons involved (see paragraphs 75 and 87 above). It was therefore reasonable for the domestic court to follow Dr D.'s conclusions and to believe that the opinion of a third expert would not have shed more light on the cause of death (compare *Kutsarovi*, cited above, § 70). Consequently, the Court can accept the domestic court's position that it was not possible to get closer to the truth in this specific case. It does not lose sight, however, of the fact that the autopsy was only performed four days after T.P.'s death, which created a certain difficulty (see paragraph 152 above). However, not even Dr K. himself alleged that this had constituted a breach of the standards applicable in forensic medicine. The Court therefore considers that this in itself cannot call into question the quality of Dr D.'s expert reports or the general adequacy of the entire criminal investigation.

157. The foregoing considerations are sufficient to enable the Court to conclude that the authorities carried out all reasonable investigative steps available to them with a view to elucidating the cause of T.P.'s death to the extent medically possible (contrast, for example, the defective forensic investigation in *Tanli*, cited above, § 150, in which several fundamental forensic requirements had not been complied with and which had moreover been carried out by apparently unqualified forensic pathologists). Given the very particular circumstances of the present case, the Court cannot discern a deficiency in the criminal investigation that could be considered to have undermined it to such an extent as to have fallen short of the Convention standards.

158. There has accordingly been no violation of Article 2 of the Convention in its procedural limb.

2. *Substantive limb*

(a) **Submissions by the parties**

(i) *The applicant*

159. The applicant insisted that her son's right to life had been violated. While the relevant decree provided measures to prevent the violation of T.P.'s right to life, the authorities had not complied with it. Instead, they had ordered the march while the temperature outside had been 8°C hotter than the limit above which foot marches were to be avoided, without the presence of any trained medic and partially in open terrain. Despite his symptoms of illness, his breakdown and his pleas for a doctor, T.P. had been forced to march on. A.W. had not summoned any medical help at all, while M.R. and M.G. had only done so too late. If one were to assume the view of the public prosecutor's office that the order to proceed with the march had not been in breach of the requirement to exercise due diligence and had been covered by the discretion granted by the decree, the Convention violation would lie in the fact that that decree had granted such discretion, thus not sufficiently protecting the lives of conscripts as a preventive measure. For that reason, the special commission had recommended the reduction of that discretion.

160. The applicant further submitted separate arguments in respect of the military commanders involved. As regards A.W., she argued that, when T.P. had voiced his complaints, A.W. should have called for a doctor and should have immediately taken T.P. to a hospital; instead, A.W. had simply informed his superiors – and even then only more than twenty minutes later. Signs of illness had been perceptible and indeed noticed by others. A.W. had, however, only called his superiors when he had noticed T.P.'s "utter confusion". The public prosecutor's office had also held that A.W. had not acted with due diligence, but only from 2.19 p.m. Moreover, A.W. had been instructed the evening before regarding the obligation to call for medical help in case of need, as it had been done on the previous day when it had been

2.3°C cooler and when the march had been interrupted to call for medical help for another conscript. The finding of the public prosecutor's office that the offence of involuntary manslaughter had not been committed, as A.W.'s negligence had not caused a significant increase in the risk of death, contradicted the results of the investigation that T.P.'s chances of survival would have been greater had an ambulance been called at 2 p.m. instead of 3 p.m. Even if, A.W. had still committed a criminal offence (under Article 35 of the Military Code and Articles 92 and 93 of the Criminal Code) by "drilling" T.P. for twenty minutes after his first complaints.

161. As regards M.G. and M.R., the applicant disagreed with the public prosecutor's office that they had not acted in a negligent manner because they had not recognised T.P.'s state of confusion. The assertion that A.W. had not mentioned this when he had called them, nor any of the other conscripts when M.G. and M.R. had arrived, was not realistic, as T.P.'s state of confusion had constituted precisely the reason for A.W.'s call. However, this was not even decisive because T.P. would in any case have had to be taken to hospital immediately. There could also be no doubt that M.G. and M.R. had been aware of T.P.'s state of exhaustion and physical discomfort, given that they had even had to support T.P. in order to bring him to and help him into the pickup. It would have been sufficient to touch T.P.'s forehead to notice his extremely high body temperature. It was inconceivable that M.R. could not have noticed it when he had checked his vital functions. Even if, M.G. and M.R. had been obliged to proactively question everyone about the circumstances of T.P.'s breakdown and his symptoms. Moreover, M.G. and M.R., as those responsible on the ground, should not have proceeded with the march. The physical exertion in the morning had already led to exhaustion and had thus considerably increased possible health risks. In the light of this, the march should not have taken place at all.

162. As regards K.K., the applicant emphasised that on the eve of the march, when the temperatures of the following day had already been known, K.K. had impressed upon the conscripts that as long as they were capable of moaning, grumbling and complaining, they could continue. He had therefore been partly responsible for the fact that T.P.'s complaints had only been believed after twenty minutes had elapsed and that until then T.P. had been shouted at and urged to continue marching, even though he had asked for a doctor. Moreover, K.K. should not have ordered that the march proceed at all, let alone in that form. There had been no room for interpretation under the decree which would allow such marches in extreme heat – especially not when the benchmark temperature had already been exceeded by 1.2°C by 9 a.m. and by 7.9°C by the time the march had started. Moreover, the investigating committee had held that such a march as part of combat training had not been provided for by the training guidelines since 2015. It was incomprehensible how such a "problematic" leadership decision, as the investigative committee had called it, could have been in accordance with the

requirement to exercise due diligence. It did thus not matter whether T.P. had had an acute septic infection or not, as the march should not have been ordered at all.

(ii) *The Government*

163. The Government submitted that – in addition to the general prohibition of orders which would violate human dignity – adequate, appropriate and sufficiently flexible rules had been in place to protect all servicemen (including conscripts) from inhuman treatment and, for example, from risks that could have arisen from extremely high outside temperatures. The relevant decree had, for example, defined extreme temperatures and had set guidelines for training exercises during such temperatures (adequate clothing and gear and sufficient fluids, use of shaded outdoor areas, and so on). If available, the participation of medical personnel in training exercises outside the barracks should be ensured. In the event of an unforeseen incident, such as acute health problems, training should be terminated if there was a risk to health. A conscript's initial report on his or her physical condition should initially be believed without reservation, and he or she should be afforded the services of a doctor. If possible, when high temperatures were expected, training exercises should start at an earlier hour. Following T.P.'s tragic death, these provisions had been further developed.

164. The Government argued that the responsible individuals had taken adequate practical measures to protect the conscripts (including T.P.) on the basis of that decree. In view of the high temperatures, the originally planned march had been modified so that conscripts had been tested on certain skills in the morning at a nearby shaded location; the march had taken place in the afternoon, after an extended lunch break in shaded areas. The route of the march had been changed so that the conscripts would first complete the part of the route exposed to the sun and would then continue in shaded terrain. Changes to clothing and gear had been ordered, additional water and fruit had been distributed, and water supply stations had been set up along the route. Medical personnel had not been able to take part in the march but had been on call. It had not been deemed appropriate to start the march in the cooler early morning hours, because, *inter alia*, the conscripts had only completed their previous day's duties at 10 p.m. When the details of the march had been decided, and even after the march had started, no one had known (or could have known) that T.P. was ill. On the contrary, it had reasonably been assumed that all the conscripts were in good health, not least in the light of their assurances to this effect. Moreover, another platoon had successfully completed the march under similar conditions the day before.

165. Furthermore, the pace of the march had been adapted to suit T.S., who had complained of difficulties in marching right at the start. Breaks had been taken when requested, although A.W. had also tried to encourage the group to keep going so that they would be able to take breaks in shaded areas.

When T.P. had begun to complain of discomfort, there had been initially nothing to suggest to a non-medical that he was in a life-threatening condition. To alleviate his assumed exhaustion, the group had taken his rucksack and had tried, to the extent possible, to provide him with shade and to cool him down with water. It is true that once T.P. had not only shown symptoms of exhaustion but also signs of confusion, even a non-medical should have recognised that he was in a life-threatening condition. Nonetheless, even if the situation had been assessed correctly at that point and A.W. had called the emergency doctor directly, it could not be asserted with the necessary certainty (or any degree of likelihood) that T.P.'s death could have been avoided, according to Dr D.

166. As regards A.W.'s two superiors, M.G. and M.R., when they had arrived on the scene, they had found T.P. responsive. The test that they had carried out, and the fact that T.P. had been able to get into the vehicle on his own, had initially been seen as a further indication that there was no medical emergency. The fact that it had been one had only become apparent when T.P. had lost consciousness in the car. Accordingly, M.G. and M.R. had not only ordered immediately that the (civilian) emergency service be called, but had also arranged for first aid to be immediately administered to T.P. by the army emergency medic until the (civilian) emergency doctor had arrived. The Government concluded that there had been no violation of T.P.'s right to life.

(b) The Court's assessment

(i) General principles established in the Court's case-law

167. The Court reiterates that Article 2 of the Convention, which safeguards the right to life, ranks as one of the most fundamental provisions contained in the Convention. Together with Article 3, it also enshrines one of the basic values of the democratic societies making up the Council of Europe. The object and purpose of the Convention as an instrument for the protection of individual human beings requires that Article 2 be interpreted and applied so as to make its safeguards practical and effective (see *McCann and Others v. the United Kingdom* [GC], 27 September 1995, §§ 146-47, Series A no. 324).

168. The first sentence of Article 2 § 1 enjoins the State not only to refrain from the intentional and unlawful taking of life, but also to take appropriate steps to safeguard the lives of those within its jurisdiction (see *L.C.B. v. the United Kingdom*, 9 June 1998, § 36, *Reports of Judgments and Decisions* 1998-III). The State's obligation in this respect extends beyond its primary duty to secure the right to life by putting in place effective criminal-law provisions to deter the commission of offences against the person backed up by law-enforcement machinery for the prevention, suppression and sanctioning of breaches of such provisions. This also implies in certain well-defined circumstances a positive obligation on the authorities to take

preventive operational measures to protect an individual whose life is at risk from the criminal acts of another individual or, in certain particular circumstances, against him/herself (see *Osman v. the United Kingdom* [GC], 28 October 1998, § 115, *Reports*, 1998-VIII; *Keenan v. the United Kingdom*, no. 27229/95, § 89, ECHR 2001-III; and *Kılınç and Others v. Turkey*, no. 40145/98, § 40, 7 June 2005).

169. Not every claimed risk to life can entail for the authorities a Convention requirement to take operational measures to prevent that risk from materialising. A positive obligation will arise where it has been established that the authorities knew, or ought to have known at the time, of the existence of a real and immediate risk to the life of an identified individual and, if so, that they failed to take measures within the scope of their powers which, judged reasonably, might have been expected to avoid that risk (see *Shumkova v. Russia*, no. 9296/06, § 90, 14 February 2012, and *Branko Tomašić and Others v. Croatia*, no. 46598/06, §§ 50-51, 15 January 2009). These preventive obligations are equally applicable to any activity in which the right to life may be at stake, such as the deactivation of an arms cache or training in the armed forces (see, more recently, *Ribcheva and Others v. Bulgaria*, no. 37801/16, § 159, 30 March 2021, with further references). While the specific preventive measures required in each situation of risk hinge on the origin of the threat and the extent to which it is susceptible to mitigation, the duty incumbent on the authorities is, at its most general level, to do what can reasonably be expected of them to avert the risk, and that depends on the entirety of the circumstances of each case (*ibid.*, § 161).

170. Within the context of persons undergoing compulsory military service, the Court has previously had occasion to emphasise that, as with persons in custody, conscripts are in a vulnerable position, and the authorities are under a duty to protect them (see *Ohanjanyan*, cited above, § 133). Furthermore, they are within the exclusive control of the authorities of the State since any events in the army lie wholly, or in large part, within the exclusive knowledge of the authorities. The State is also under an obligation to account for any injuries or deaths occurring in the army (see *Perevedentsevy*, cited above, § 93; *Mosendz v. Ukraine*, no. 52013/08, § 92, 17 January 2013; and *Beker v. Turkey*, no. 27866/03, §§ 41-42, 24 March 2009). However, the test under Article 2 of the Convention does not require it to be shown that “but for” the failing or omission of the authorities the death in question would not have occurred. Rather, what is important, and what is sufficient to engage the responsibility of the State under that Article, is that the reasonable measures that the domestic authorities failed to take could have had a real prospect of altering the outcome or mitigating the harm (see *Lyubov Vasilyeva v. Russia*, no. 62080/09, § 62, 18 January 2022, with further references).

171. The primary duty of a State is to put in place rules geared to the level of risk to life or limb that may result not only from the nature of military

activities and operations, but also from the human element that comes into play when a State decides to call up ordinary citizens to perform military service. Such rules must require the adoption of practical measures aimed at the effective protection of conscripts against the dangers inherent in military life and appropriate procedures for identifying shortcomings and errors liable to be committed in that regard by those in charge at different levels (see the above-cited cases of *Perevedentsevy*, § 94; *Mosendz*, § 91; and *Kılınç and Others*, § 41). Furthermore, there must also be regulatory measures in place to ensure the protection of conscripts, it being understood that the acts and omissions of the military medical corps in the context of health policies concerning them may, in certain circumstances, engage their responsibility from the point of view of the material aspect of Article 2 of the Convention (*ibid.*, § 42, with further references). This also includes the authorities' duty to safeguard life by providing proper medical treatment in a timely manner (see *Plokhovy v. Russia*, no. 45024/07, §§ 85-87, 22 December 2020; for a recent summary of the general principles pertaining to emergency medical treatment in general, see *Dimakhsyan*, cited above, §§ 62-64).

172. In two cases concerning accidents during military training exercises, the Court considered that whenever a State undertakes or organises dangerous activities, or authorises them, it must ensure through a system of rules and through sufficient control that the risk is reduced to a reasonable minimum (see *Stoyanovi v. Bulgaria*, no. 42980/04, § 61, 9 November 2010, and *Trofin v. Romania* (dec.), no. 4348/02, § 49 (d), 21 February 2012). While it may indeed be considered that the armed forces' activities pose a risk to life, this is a situation that differs from those "dangerous" situations of specific threat to life that arise exceptionally from risks posed by violent, unlawful acts of others or man-made or natural hazards. The armed forces, just as doctors in the medical world, routinely engage in activities that potentially could cause harm; it is, in a manner of speaking, part of their essential functioning (for example, parachute jumping or flying military planes is an inherently dangerous but an ordinary part of military duties). Consequently, if damage nevertheless arises, it will only amount to a breach of the State's positive obligations if it was due to insufficient regulations or insufficient control, but not if the damage was caused through the negligent conduct of an individual or the concatenation of unfortunate events (see *Stoyanovi*, cited above, § 61).

173. Furthermore, the Court reiterates that its task is not normally to review the relevant law and practice *in abstracto*, but to determine whether the manner in which they were applied to, or affected, the applicant or the deceased gave rise to a violation of the Convention. Therefore, the mere fact that the regulatory framework may be deficient in some respects is not sufficient in itself to raise an issue under Article 2 of the Convention. It must be shown to have operated to the person's detriment (see *Gvozdeva v. Russia*, no. 69997/11, § 33, 22 March 2022, with further references).

(ii) *Application of these principles to the present case*

174. The Court notes that the applicant mainly argued that the respondent State had failed to comply with its positive obligation to protect her son's life and to prevent his death during his compulsory military service. The Government disagreed, maintaining that adequate and appropriate rules had been in place and that adequate practical measures had been taken in respect of the conscripts (including T.P.).

175. As the Court has already held, the armed forces' activities can indeed be considered to pose a risk to life; this is, however, also part of their essential functioning (see the case-law cited in paragraph 172 above – notably *Stoyanovi*, cited above, § 61). This applies not only to professional servicemen but also to conscripts performing mandatory military service, like T.P.; those conscripts are, moreover, in a vulnerable position and must be protected by the authorities (see *Ohanjanyan*, cited above, § 133). In the Court's view, the "heat march" ordered for 3 August 2017 could be considered to have fallen into the category of dangerous activities, which routinely are to be performed during military service. The question therefore arises whether the positive duty to protect was complied with in the present case (including whether the risk created was reduced to a minimum).

176. The Court observes that special regulations were in place in respect of conditions of extreme heat or cold in the form of the decree on the performance of military-service duties during extreme outside temperatures (see paragraph 130 above). It further observes that certain changes were made to its provisions in the form of the new decree issued in the wake of the events of the instant case – notably the new requirement that trained medical personnel be present during training that takes place outside the barracks (for all details, see paragraph 132 above), and that the authorities proceeded to review the applicable training regulations (see paragraph 113 above). The Court reiterates, however, that its task is not an *in abstracto* review of the relevant system of rules and control that were in place at the time of the events in question, but rather to determine whether the manner in which they were applied to, or affected, the deceased gave rise to a violation of the Convention (see the case-law cited in paragraph 173 above). Furthermore, even if the Court were to conduct such a review and find that the regulatory framework at the time in question might have been deficient, this would not be sufficient in itself to raise an issue under Article 2 of the Convention, as it must also be shown to have operated to the victim's detriment (*ibid.*). It follows that, assuming that an insufficient regulatory framework was in place at the material time, the central question relates to how that regulatory framework had been applied in practice in the present case.

177. In this context, the Court notes first that the events within the military unit which led to T.P.'s death happened on 3 August 2017 within a very short period of time, between 1.05 p.m. (the start of the march) and 3.07 p.m. (the arrival of the civilian emergency doctor). As pointed out by the forensic

expert, Dr D, the period between 2.19 p.m. (telephone call by A.W. to his superior) and the emergency doctor's arrival at 3.07 p.m. was only around fifty minutes. During this period, T.P.'s health deteriorated very quickly (see paragraphs 14-16 above). While the "heat march" constituted a "problematic" leadership decision (see paragraph 111 above), it was nevertheless – in view of the weather forecast – accompanied by certain preventive measures, such as lightening of uniforms and equipment, extra water, and fruit and water supply stations along the way (see paragraph 11 above). Furthermore, only the first part of the march route was in open terrain, with the second part being set in a wooded valley (*ibid.*). After the morning exercises, the conscripts had been asked how they felt and whether they were fit – T.P. did not, however, report any problems at that stage (see paragraphs 9 and 13 above). When T.P. could not go on anymore, he was provided with shade and water (*ibid.*); still, at 2.48 p.m., he gave correct answers to M.R.'s questions and got into the vehicle on his own (see paragraph 15 above). Only later, on his way back to the barracks, he became listless and collapsed (see paragraph 16 above). In reaction to this, the emergency doctor was immediately called who arrived at the barracks at 3.09 p.m. (see paragraph 19 above). Thus, in the respective situations, the military staff attempted, at least to a certain extent, to take the steps they considered necessary to overcome T.P.'s quickly worsening state of health.

178. The Court cannot ignore the fact that certain questionable acts or omissions on the part of State agents preceded T.P.'s death – in particular: K.K. ordering and holding the "heat march", which was assessed as a "problematic" leadership decision by the military investigating committee and which took a form that had not existed under the training regulations since 2015 (see paragraph 110 above); the absence of any medically trained personnel during the march itself; A.W. (belatedly) contacting the supervisor of T.P.'s unit instead of directly summoning medical help (possibly in breach of the decree on the performance of military-service duties during extreme outside temperatures – see paragraph 130 above), after T.P. had not only clearly voiced his concerns about his own health during the march and had asked for a doctor to be called, but had also shown signs of deteriorating health (such as confusion, collapsing and shivering); and M.R. and M.G. taking T.P. back to the barracks instead of taking him directly to hospital (see paragraphs 14-16, 110-111 and 130 above). In this regard, it is remarkable that the public prosecutor's office considered A.W.'s failure to call a doctor earlier a breach of the duty to exercise due diligence by relying on Dr D.'s expert reports (see paragraph 91 above). However, none of the experts, not even Dr K. who was commissioned by the applicant and on whose expert reports she relied, could indicate with the necessary degree of likelihood that T.P. would have survived if the military personnel involved had acted diligently and T.P. had reached the hospital earlier. In his supplementary expert report of 21 October 2019, Dr K. denied in only general terms that it

was possible to determine bacterial sepsis (see paragraph 87 above). Thus, the Court cannot speculate that any reasonable measure that the authorities failed to take could have had a real prospect of avoiding T.P.’s tragic death (see the case-law cited in paragraph 170 above). The Court must be cautious in taking on the role of a first-instance tribunal of fact, where this is not rendered unavoidable by the circumstances of a particular case. Moreover, errors of judgment or mistaken assessments, unfortunate in retrospect, will not *per se* entail responsibility under Article 2 of the Convention (see *Machalikashvili and Others v. Georgia*, no. 32245/19, § 105, 19 January 2023, with further references). It follows that there is insufficient evidence before the Court for it to conclude beyond reasonable doubt that there existed a causal link between the acts and omissions of the military staff in respect of the “heat march” on 3 August 2017 and T.P.’s death, and that the authorities’ acts or omissions were therefore responsible for T.P.’s death (see, *mutatis mutandis*, *Jabłońska v. Poland*, no. 24913/15, § 79, 14 May 2020, and *Ayvazyan v. Armenia*, no. 56717/08, §§ 90-91, 1 June 2017). The Court reiterates that not every alleged risk to life can activate for the authorities the Convention requirement to take operational measures to prevent that risk from materialising. A positive obligation will only arise where it has been established that the authorities knew or ought to have known of a real and immediate risk to life and if so, that they failed to take measures which judged reasonably, might have been expected to avoid that risk (see the case-law cited in paragraph 169 above). In a case such as the present one, where it has not been shown that the reasonable measures that the domestic authorities failed to take would have had a real prospect of altering the outcome or mitigating the harm, a State’s preventive positive obligation under Article 2 is not violated.

179. The Court is aware that in its past case-law, it has held that in respect of persons in the army (where the events in issue lie wholly, or in large part, within the exclusive knowledge of State authorities), strong presumptions of fact will arise in respect of injuries and death occurring. In such a context, the burden of proof lies on the authorities as regards the provision of a satisfactory and convincing explanation for such injuries or death (see the case-law cited in paragraph 148 above). However, in the instant case – given that the failure of A.W. to exercise due diligence was established (see paragraph 91 above) – the crucial question was of a medical nature: namely, whether A.W., had he acted with due diligence, could have prevented T.P.’s death in view of the medical condition from which T.P. was suffering at the time of the events in question. Given the fact that during their investigation, the domestic authorities relied on three expert reports by a court-appointed forensic doctor, who held that it could not be said (with the probability required for criminal proceedings) that death could have been prevented, it cannot be asserted that those authorities did not exert sufficient efforts to uncover the facts of the case. No presumptions of facts (notably the

presumption that T.P.'s death could have been prevented) can therefore apply here.

180. In view of the above considerations, the Court is unable to find that there has been a violation of Article 2 of the Convention in its substantive limb.

FOR THESE REASONS, THE COURT

1. *Declares*, unanimously, the application admissible;
2. *Holds*, by six votes to one, that there has been no violation of the procedural limb of Article 2 of the Convention;
3. *Holds*, by six votes to one, that there has been no violation of the substantive limb of Article 2 of the Convention.

Done in English, and notified in writing on 26 November 2024, pursuant to Rule 77 §§ 2 and 3 of the Rules of Court.

Andrea Tamietti
Registrar

Tim Eicke
President

In accordance with Article 45 § 2 of the Convention and Rule 74 § 2 of the Rules of Court, the dissenting opinion of Judge Vehabović is annexed to this judgment.

T.E.
A.T.

DISSENTING OPINION OF JUDGE VEHABOVIĆ

I regret that I am unable to endorse the view of the majority that there has been no violation of Article 2.

It is obvious from the facts of the case that the military personnel reacted poorly to a clearly life-threatening series of events. They were indecisive and unprepared for such a situation, something one would not ordinarily expect from professional military personnel.

During a break at around 2 p.m., after marching for approximately 3.4 km in direct sunshine, T.P. suddenly sat or lay down on the ground and complained that his feet and skin were burning. Instead of calling for medical help, the officer in charge let the other conscripts shout at T.P. to convince him to continue marching, which he did. Military service is a serious “business”, not a school nature outing. The march was interrupted several times on account of T.P.’s difficulties but resumed in each case and all his requests for an ambulance to be called were denied until he collapsed. Even after T.P. was taken back to the barracks he was laid on hot asphalt without any shade until the Red Cross arrived. According to the Red Cross, their medics found T.P. “lying in a stable lateral position on the hot asphalt in the bright sunshine, without any shade, with a body temperature measured at over 42°C and over 43.5°C (the maximum levels) on their respective thermometers (that is, too high to measure)” (see paragraph 19 of the judgment).

On the day of T.P.’s death the public prosecutor’s office ordered a forensic autopsy, appointing as expert Dr D., a specialist in forensic medicine (*Facharzt für gerichtliche Medizin*) and a sworn and court-certified expert (*allgemein beeideter und gerichtlich zertifizierter Sachverständiger*). Dr D. was further requested to submit an expert report on the cause of death and on any third-party responsibility (*Fremdverschulden*). It was only on 7 August 2017 – four days after T.P.’s death – that Dr D. actually performed the autopsy, and only between 8 August and 10 September 2017 that four additional tests – a PCR test and blood alcohol, toxicological and virological tests – were performed by other specialised doctors and laboratories.

Subsequently, another perspective on T.P.’s medical condition and cause of death was developed based on the findings of a different medical expert, Dr K. (a specialist in infectiology and tropical medicine), who essentially explained that the mere fact that the autopsy had been performed four days after T.P.’s death rendered infection inconclusive as the cause of death.

Without wading into the debate as to which doctor’s findings were more credible, one can reasonably conclude, based on other details of the case, that the reaction to T.P.’s condition was inadequate, at least to the point of rendering the cause of death inconclusive by failing to perform a timely autopsy. Any subsequent investigation into the case was destined to fail owing to the irreparable damage already done. Such situations are rarely seen in military service.

Lastly, it is important to keep in mind the respondent State's own recommendations and procedures, as detailed at length in paragraphs 130-32 of the judgment:

“V. MILITARY SERVICE REGULATIONS

130. The decree (Erlass) of the Federal Ministry of Defence and Sport of 15 September 2014 on the time regulations for subordinate departments/guidelines (Zeitordnung für den nachgeordneten Bereich/Richtlinien; VBl. I Nr. 45/2014) regulated general working hours for servicemen and granted the power to set special regulations – for example, in the interests of the well-being of individual service personnel. It contained a specific chapter on the performance of military-service duties during extreme outside temperatures, the relevant parts of which at the time of the events read as follows.

‘D) Service in extreme outside temperatures and/or increased environmental pollution

1. Service in exceptional heat or extreme cold [performed by] troops, academies and schools

In the event of extreme temperatures, field service in the barracks or a training area is to be carried out in a manner that deviates from the valid regulations with the aim of reducing heat- or cold-related stress on the soldiers as follows.

a) Extreme temperatures exist when the following values are reached:

- at 12 noon, above 28°C (in the shade).
- at 07 a.m., minus 15°C.

[...]

The assessment of the other above-mentioned components is usually the responsibility of the unit commander or the local heads of training.

b) In addition, the troop commanders shall ensure the timely communication of the detection of extreme outside temperatures for their area.

c) Unit commanders shall be responsible for organising training ... under extreme temperature conditions that are in accordance with the following guidelines:

[...]

cc) **Additional measures:**

- The use of cool rooms and shady places outdoors when it is very hot.
- The avoidance of foot marches, especially in open and uncovered areas during the hot hours of the day.

[...]

131. Appendix 5 to the above-mentioned decree contained detailed information on the symptoms and treatment of heat stroke and sunstroke, as follows.

Heat stroke was described as heat accumulation (*Wärmestauung*) in the body, which could occur during excessively muggy heat and periods of physical exertion. It was a life-threatening condition. The first signs of the onset of heat stroke were faintness, dizziness (staggering when walking), a feeling of anxiety, redness (and sometimes paleness) in the face, a strong thirst and an accelerated, weak pulse. After these first signs, the affected person could suddenly collapse and become unconscious. A comrade

should help [the affected person] to lie on his side in an airy, shady place, to expose the upper half of the body [of the affected person], to sprinkle it with cold water and then to wipe it dry with a cloth. If the face was red, the head should be placed in an upright position (while paying attention to the airways). Artificial respiration should be administered to unconscious persons, who should quickly be taken to hospital.

Sunstroke was described as caused by the uncovered head being exposed to direct sunshine, which could lead to too much blood entering the head, leading in turn to a life-threatening swelling of the brain. Signs of sunstroke included headache, dizziness, and a fading of the degree of consciousness – ending in unconsciousness. These signs did not have to appear immediately. The help to be afforded by a comrade was the same as that to be afforded in the event of heat stroke.

132. Following the events of the instant case, and further to the recommendations made by the special commission (see paragraph 113 [of the judgment]), the above-mentioned decree was replaced with a new decree issued by the Ministry of Defence on 22 November 2018 (VBl. I Nr. 2/2019). The most important changes, in so far as relevant, are that extreme temperatures are now defined as 28°C or more (in the shade) at 12 noon (as opposed to above 28°C (in the shade) at 12 noon – see point D) 1. a) of the old decree). Furthermore, when planning and conducting training, the performance and training level of the troops must also be assessed (new point added to the new decree). As additional measures, physically demanding activities – especially in open and uncovered areas during the hot hours of the day – are to be avoided (as opposed to the avoidance of foot marches only – see point D) 1. c) cc) of the old decree). Furthermore, when training occurs outside the barracks, the participation of trained medical personnel must be ensured to the extent necessary (as opposed to only ‘if [such trained medical personnel is] available’ – see point D) 1. d) of the old decree). Lastly, the achievement of the training objectives in question is to be striven for despite any restrictions or deviations imposed (as opposed to the obligation to strive for the achievement of the training objectives ‘by all means available’ – see point D) 1. g) of the old decree).’’

It appears that almost none of the measures prescribed were complied with in the context surrounding T.P.’s death.

As a result of all the elements mentioned above, I have no doubt that there was a violation of both the substantive and procedural limbs of Article 2 in this case.