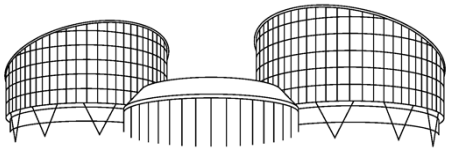

EUROPEAN COURT OF HUMAN RIGHTS
COUR EUROPÉENNE DES DROITS DE L'HOMME

FIFTH SECTION

CASE OF CĂLDĂRARI v. THE REPUBLIC OF MOLDOVA

(Application no. 55294/17)

JUDGMENT

Art 2 (substantial) • Positive obligations • Alleged medical negligence related to the administration of anaesthesia which left the applicant's son with severe neurological damage and complete paralysis, afflictions which were life-threatening and led to his death ten years later • Absence of any of the exceptional circumstances engaging the respondent State's responsibility in respect of the acts and omissions of the health-care providers
Art 2 (procedural) • Positive obligations • Failure to provide an adequate and timely response to arguable medical negligence claims • Ineffective criminal investigation and disciplinary proceedings • Effective civil-law remedy not available

Prepared by the Registry. Does not bind the Court.

STRASBOURG

2 July 2026

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

In the case of Căldărari v. the Republic of Moldova,

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

Kateřina Šimáčková*, President*,
María Elósegui,
Gilberto Felici,
Andreas Zünd,
Diana Sârcu,
Mykola Gnatovskyy,
Vahe Grigoryan*, judges*,
and Victor Soloveytchik, *Section Registrar,*

Having regard to:

the application (no. 55294/17) against the Republic of Moldova lodged with the Court under Article 34 of the Convention for the Protection of Human Rights and Fundamental Freedoms ("the Convention") by two Moldovan nationals, Ms Virgilia Căldărari and Mr Lilian Căldărari ("the applicants"), who are mother and son, on 21 July 2017;

the decision to give notice of the application to the Moldovan Government ("the Government");

the fact that the second applicant died on 3 July 2022 and his mother, the first applicant, expressed her wish to pursue the application before the Court in his stead;

the parties' observations;

Having deliberated in private on 9 June 2026,

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

INTRODUCTION

1. The application concerns a case of alleged medical negligence, which resulted in the severe deterioration of the health of the second applicant (L.) and the alleged lack of a remedy enabling the establishment of possible liability for medical negligence and obtaining adequate civil redress. The applicants complained of a violation of their rights under Articles 3, 8 and 13 of the Convention.

THE FACTS

2. The applicants were born in 1982 and 2005 respectively. They used to live in Chișinău. The applicants were represented by Mr A. Postică, Mr D. Sliusarenco and Ms D. Mazniuc, lawyers practising in Chișinău.

3. The Government were represented by their Agent, Mr D. Obadă.

4. The facts of the case may be summarised as follows.

I. THE MEDICAL PROCEDURE

5. On 23 November 2011 L., aged eight at the time, accompanied by his grandmother, sought medical assistance for problems with his teeth at the Republican Dental Clinic in Chișinău ("the dental clinic"). L. was found to be suffering from ongoing and long-term gum disease (periodontitis) around six teeth and from untreated cavities in two teeth. A dentist, V.C. recommended dental treatment under general anaesthesia. On the same day, L. was seen by an anaesthesiologist (L.O.), who recommended that L. undergo routine tests (blood and urine tests and a heart check-up) and a visit to the family doctor to make sure there were no health risks.

6. The case file contains an informed-consent form signed on that same day, 23 November 2011. The form bore the patient's name in handwritten text in Cyrillic script (*Сынжеряну* – Sângereanu) and a handwritten summary of the procedure in medical shorthand (dental extraction). The rest of the document contained a standardised text according to which "the patient" confirmed that he/she had been informed of "patients' rights, methods of diagnosis and treatment, and available alternative dental treatments", and that he/she agreed to undergo "the proposed treatment by the methods [explained] (local or general anaesthesia)". The form added that the patient had been informed of "the risks and benefits of the treatment [that had been] voluntarily chosen, ... [and of] the possible adverse effects, which may lead to serious complications and even death". The form was signed by a doctor (V.C.) and by the patient (whose signature is indecipherable).

7. On 29 November 2011, both applicants went to the dental clinic, where L. was repeatedly examined by the anaesthesiologist L.O., who found no contraindications for undergoing general anaesthesia. The first applicant informed the doctor that L. had recently developed an allergic skin reaction to wool. The anaesthesiologist assessed the anaesthetic risk level as ASA II – a patient with mild systemic disease.

8. L. was given preparatory medication and taken to the operation theatre. After the administration of an anaesthetic agent (halothane), L.'s pulse rate dropped; despite receiving a heart massage, he went into cardiac arrest for several minutes. He was administered adrenaline and taken by paramedics to the Municipal Children's Hospital ("the hospital"). Although he was resuscitated, he remained in a cerebral coma for several months, which left him with severe neurological damage and complete paralysis.

9. Owing to his critical condition, L. was admitted to the intensive care unit of the hospital, where he remained in a serious condition until 11 January 2012. He was later transferred to the paediatric neuropsychiatry department, where he stayed until 24 April 2012, after which he was discharged to continue his recovery at home.

10. L.'s medical record on discharge read as follows:

"[L.] was admitted to the somatic intensive care unit on 11 January 2012, and was later transferred to the paediatric neuropsychiatry department on 24 April 2012 with the [following] diagnosis: serious brain damage caused by a lack of oxygen and blood flow to the brain; severe mixed-origin sepsis (infection that affected multiple parts of the body); cerebral oedema; signs of deep brain injury (including abnormal body postures that indicate damage to the brain's control centres [and] multiple organ failure; vegetative state.

Medical history: On 29 November 2011, during a dental procedure, the child experienced anaphylactic shock (a severe allergic reaction), complicated by a cerebral coma. Facing an immediate danger to his life, he suffered cardiac and respiratory arrest [and] had to be placed on artificial ventilation, and experienced continuous (epileptic) seizures. He was urgently admitted to the intensive care unit of the Municipal Children's Hospital, where he remained in a critical condition until 11 January 2012 ..., [when], the child was transferred to the general intensive care unit for continued treatment and monitoring. ... The child remained on artificial respiration until 13 March 2012. Following the treatment, the child's blood circulation and heart function gradually stabilised. He occasionally had a slight fever, but his breathing and heart rate returned to normal. Neurologically, the patient shows mild involuntary eye movements, signs of pseudobulbar syndrome (which can affect speech, swallowing, and control of emotions), [and] spastic weakness in all four limbs (especially in the arms); reflexes are reduced,] [and there are also signs of severe brain injury – including abnormal body positions. The patient is in a vegetative state."

11. Until his death, L. received treatment for severe brain damage caused by a lack of oxygen, and for serious infections arising from multiple sources. He lost higher brain function, displayed abnormal posturing, being in a vegetative state and had only minimal awareness of his surroundings. All four limbs were paralysed owing to mixed-nerve damage, and the muscles wasted away from long-term immobility. L. was completely bedridden and could not move independently. He had major swallowing difficulties in respect of both liquids and solids, so feeding was possible only through a tube. He suffered from extreme weight loss and weakness, from repeated episodes of bronchitis (which affected his breathing) and (following episodes of severe sepsis) from a persistent state of inflammation and organ dysfunction.

12. L. died on 3 July 2022, as a consequence of his long-term afflictions.

II. THE INVESTIGATION

13. On 29 November 2011 the Deputy Minister of Health appointed a committee of experts to examine L.'s adverse reaction to medication. The committee examined L. and his medical records, and spoke to the first applicant and to the doctors from the dental clinic who had been involved in his treatment. On 2 December 2011 the committee issued an information note, the relevant parts of which read as follows:

"I. Regarding the evaluation of the [dental clinic], its services, and medical staff

... It was last accredited in ... 2009. It is authorised to provide dental care across all areas of specialisation. Within the institution, outpatient dental procedures are also performed with the application of general anaesthesia.

II. Regarding the clinical case under investigation

... The initial visit to the [dental clinic] was on 23 November 2011, when the child was examined by a dentist who recommended dental treatment under general anaesthesia. On the same day, the child was examined by an anaesthesiologist, L.O., who prescribed standard laboratory tests and an examination by the family doctor to assess contraindications.

The child came for the recommended treatment with his mother on 29 November 2011. A further examination was carried out by L.O., who found no contraindications for general anaesthesia. She assigned [to L.] an ASA II anaesthetic risk grade. The mother reported that the child had experienced a mild allergic skin reaction the previous day. She signed an informed consent form in respect of the dental procedure.

Thirty minutes before surgery, the child received intramuscular pre-medication in the form of Atropine, Suprastin, Analgin, Apaurin, and Dexamethasone in doses appropriate for [L.'s] age and body weight, in order to prevent possible allergic complications.

Anaesthesia induction was performed with the inhalation agent halothane combined with oxygen, at a concentration up to 1.5 vol% [the concentration of the active substance in the inhalation preparation]. Venous access was established via a peripheral catheter.

Immediately after the inhalation of halothane, anaphylactic shock occurred, followed by cardiac arrest.

Resuscitation measures were promptly initiated: mask ventilation with 100% O_2, indirect cardiac massage, the intravenous administration of adrenaline solution, Atropine solution, Prednisolone solution, and sodium bicarbonate solution. Orotracheal intubation was performed using a tube no. 4.5.

Cardiac activity and spontaneous breathing through the orotracheal tube were restored after three minutes of resuscitation, but no neurological recovery (the patient remained in a coma).

An ambulance was called, together with a paediatric resuscitation team, and the child was transported to the intensive care unit of the [hospital] for further intensive treatment of post-resuscitation syndrome.

Upon examining the anaesthesiologist's workplace, [the committee] found modern anaesthesia machines (AEON 7700, manufactured in China) with metrological parameters that were compliant with the requirements.

Vital-signs monitoring equipment: HR, BP, SpO_2.

Instrument sets and medications necessary for specialised anaesthesiology assistance are available, in accordance with the standard equipment requirements.

[Printed copies of] the regulations governing the activity of the institution and the anaesthesiology and dental services are present and comply with the requirements.

Conclusions:

1. The [dental clinic] is accredited, including for outpatient anaesthesiology assistance.

2. The anaesthesiology service's equipment allows for the full range of anaesthesiology assistance for adults and children, in accordance with outpatient anaesthesia protocols.

3. Anaesthesia ... to [L.] was initiated in compliance with the requirements for anaesthesia management necessary for the dental [operation] in question.

4. Anaesthetic and analgesic drugs were used in doses consistent with pharmacotherapeutic guidelines.

5. The intra-anaesthetic accident (anaphylactic shock) occurred against the background of a widespread chronic inflammatory process [that was underway] in the oral cavity (multiple previous attempts at treatment in other dental institutions under local anaesthesia having failed).

6. The anaphylactic shock was caused by the adverse effects of drugs administered in doses appropriate to the anthropometric data, against a background of aggravated somatic and allergic status [*statut alergic agravat*, that is a history of suffering severe allergic reactions].

7. Initial resuscitation measures applied at the [dental clinic] and subsequent intensive therapy measures [applied] at the [hospital] were in accordance with current standards and clinical protocols.

Recommendations:

1. To the director of the [dental clinic]:

- Discuss within the team the information note from the Ministry of Health Committee regarding the adverse-reaction case of [L.], and alert medical staff about [the need for] vigilance [regarding] and the prevention of adverse reactions.

- Refer the dentist V.C. and the anaesthesiologist L.O. for professional development to the Faculty of Continuing Medical Education of the Nicolae Testemițanu University of Medicine and Pharmacy, followed by re-certification [of V.C. and L.O.] by the relevant certification commissions of the Ministry of Health of the Republic of Moldova.

2. Expand the range of anaesthetic and analgesic drugs used in outpatient anaesthesiology assistance [procedures] in order to provide more options from which to select."

14. On 14 August 2012 the first applicant lodged a criminal complaint reporting negligent actions on the part of the doctors who had treated L. She described the events of 29 November 2011 (see paragraphs 8-9 above), noting that some five minutes after L. had been taken to the operation theatre the doctors had run out screaming "Quickly – bring adrenaline!" and that only after two ambulances had arrived had she been told that L. had suffered respiratory and cardiac arrest and was in a coma.

15. On 18 September 2012 a criminal investigation was initiated in respect of charges of medical negligence (Article 213 of the Criminal Code) against the anaesthesiologist, L.O. The decision noted that L. had undergone a dental procedure under general anaesthesia during which he had experienced anaphylactic shock and cardiac arrest. The charges implied that for L.'s resuscitation L.O. had administered adrenaline with halothane – contrary to the medical protocols – which had led to cerebral coma. Owing to his critical condition, he was admitted to the intensive care unit of the hospital, where he remained in a serious condition until 11 January 2012. He

was later transferred to the paediatric neuropsychiatry department, where he stayed until 24 April 2012, after which he was discharged to continue his recovery at home.

16. The prosecutor heard the first applicant, V.C. and the two assistants to the anaesthetist. They submitted that L. had been restless, had refused to sit in the chair and had been afraid of undergoing dental treatment. For those reasons, it was recommended that the dental treatment be carried out under general anaesthesia. Before the actual surgery, which was scheduled to take place six days after the initial consultation, L. conducted blood tests, an ECG and a consultation with the anaesthetist. V.C. submitted that the first applicant had signed the informed consent form in his presence. The medical assistants explained that 30 minutes before the operation they had administered desensitising premedication to L. in the light of the fact that he was prone to suffering allergic reactions. However, one and a half minutes after the administration of the halothane L.'s pulse and rate of breathing had started to slow, and his blood pressure had started to fall. The anaesthetist, L.O., had started to massage L.'s heart and had placed an oxygen mask over L.'s face. Anaphylactic shock and cardiac arrest had followed after two minutes and had lasted for three minutes. L. had been intubated and adrenaline had been applied intravenously. His breathing had resumed, and he had been taken by paramedics (who had arrived in the meantime) to the hospital.

17. On 12 November 2012 the prosecutor ordered a forensic report to be prepared by a committee of experts. On 20 March 2013 the forensic report was issued; the relevant parts read as follows:

> "...7.8. The instructions for the anaesthetic preparation 'halothane' do not specify any contraindications for its use in respect of children; on the contrary, it is noted that 'halothane' is the most frequently used in [anaesthetising] children compared to other potent inhalation anaesthetics. ...
>
> 9. According to the anaesthesia observation chart and anaesthesia protocol [in respect of the operation], the resuscitation measures [undertaken] were as follows: orotracheal intubation, artificial respiration with 100% oxygen, [and] indirect cardiac massage, and among the medications administered were: atropine, adrenaline, prednisolone, furosemide, sodium bicarbonate, and glucose.
>
> 10. All resuscitation measures were correctly undertaken, which confirms the restoration of vital functions – haemodynamic and spontaneous respiration.
>
> 11.27.28. It is not possible to establish with certainty the direct cause of the anaphylactic shock. However, inhalation of any anaesthetic, including halothane, could have triggered an anaphylactic shock in [L.] – especially given the background of an immunodeficient state with an aggravated allergic status, as confirmed by immunological investigations. The occurrence of cardio-respiratory arrest was a complication of the anaphylactic shock, and the cerebral coma was the result of hypoxia induced by the cardio-respiratory arrest.
>
> [The] onset of cerebral coma was more pronounced compared to practically healthy patients, because it occurred against the background of [L.'s] pre-existing pathology – [namely, his] severe allergic status, ... which was a contributing factor in accelerating

the hypoxic action and amplifying its effects, leading to deep coma and subsequent neurotic changes.

12. From the data in the anaesthesia medical record, it appears that the device used was correctly programmed for proper operation.

13. Premedication was carried out correctly, without any violations or deviations, in accordance with the requirements of the pharmacopoeia. ...

18.22. Premedication and anaesthesia were performed correctly. No deviations in the technique applied were identified.

19. No contraindications for the administration of general anaesthesia to [L.] were found. Therefore, the anaesthesiologist had no reason to refuse the administration of anaesthesia.

20. Inhalation of any anaesthetic (including halothane, with or without other substances) could have caused an anaphylactic shock in [L.] – especially against the background of an immunodeficient state – ([namely,] the severe allergic status from which he suffered) and the concomitantly affected vital [organs: namely,] predominantly central nervous (neurocirculatory dystonia) [problems] and respiratory (chronic obstructive allergic bronchitis) [systems], with frequent exacerbation.

21. During preparation for the surgical intervention (inducing anaesthesia), according to the anaesthesia record, the doses of halothane administered were much lower than the approved threshold levels. ...

24. The anaesthesia machine's vaporiser for halothane is calibrated by the manufacturer."

18. On 25 March 2013 the prosecutor ordered an additional expert report to clarify if it was the negligent administration of halothane alone or together with adrenaline that had triggered the cardiac arrest and the anaphylactic shock.

19. On 29 April 2013 the additional forensic report was issued, reading in the relevant parts as follows:

"It is not possible to establish with certainty the direct cause of the anaphylactic shock. However, inhalation of any anaesthetic, including halothane, could have caused anaphylactic shock in [L.] – especially against the background of an immunodeficient state with severe allergic status, manifested also by chronic obstructive bronchitis (allergic). In this case, the anaesthetic substance halothane was not used together (simultaneously) with the preparation adrenaline.

The occurrence of cardio-respiratory arrest was a complication of the anaphylactic shock and the cerebral coma was the result of hypoxia induced by the cardio-respiratory arrest.

The persistent consequences in [L.] are not conditioned by any negligence in the administration of halothane or the medicinal products used during the provision of medical assistance to the patient, including during resuscitation measures.

...

Halothane and adrenaline were not administered simultaneously: the anaesthetic halothane was discontinued before initiating artificial ventilation through mask and tracheal intubation, connecting the child to the artificial ventilation machine, external cardiac massage, and only afterwards was adrenaline administered."

20. On 15 May 2013 L.O. was declared a suspect on charges of medical negligence. On 15 August 2013 charges of medical negligence were pressed against L.O. – in particular, she was charged with administering adrenaline to L. after he had gone into cardiac arrest and that the use of adrenaline had been incompatible with the use of halothane. When interviewed by the prosecutor, L.O. did not admit her guilt and refused to make any statements.

21. In January 2014 the first applicant requested that the prosecutor commission an expert medical report from the Mina Minovici National Institute of Forensic Medicine in Romania. The prosecutor complied with that request and on 20 March 2014 ordered an additional medical expert report from the Mina Minovici Institute to clarify what L.'s medical condition had been before 29 November 2011, if he had been provided with adequate medical assistance, if the use of halothane and adrenaline had been according to the relevant medical protocols, what had been the cause of the anaphylactic shock and of the cardiac arrest, and if the resuscitation measures had been adequate.

22. On 17 February 2015 the Mina Minovici Institute issued its expert report, which in its relevant parts read as follows:

> "...4. Was appropriate medical assistance provided to [L.] at the time of diagnosis?
>
> Answer: Yes. A clinical and paraclinical examination was performed: blood tests, platelet count, coagulation analysis, general urine analysis, ECG. Dental premedication was administered with anaesthesia – combined with spontaneous respiration, preliminary inhalation, and intramuscular desensitising agents. The anaesthesia risk was assessed as Grade II.
>
> 5. Were there any violations by the medical staff regarding compliance with the rules and methods of providing medical assistance during the intervention?
>
> Answer: No.
>
> 7. Is halothane admitted for use on minor patients with cerebral, cardiac and/or other conditions? ...
>
> Answer: Yes. Halothane is indicated for inducing and maintaining anaesthesia. ... Known adverse effects are bradycardia and/or arterial hypertension, chills, fever, ...
>
> From the medical records it appears that after induction with halothane the child presented a bradycardia of 40 beats per minute, followed by cardiac arrest. So the cardiac-respiratory arrest suffered by [L.] was an adverse reaction to halothane and not anaphylactic shock.
>
> 8. Is the use of halothane compatible with the use of adrenaline?..
>
> Answer: ... Adrenaline was used after the cardiac arrest [occurred], as part of the resuscitation protocol. It was administered directly in the heart, so there is no issue of interference between halothane and adrenaline; it is the adrenaline that restored the heartbeat rather that stopped it.
>
> 9. Were there any violations of the rules for administering premedication? If so, what were they, and could they have prevented the anaphylactic shock and cardiac arrest of the minor if they had not occurred?
>
> Answer: No.

12. In what situations is adrenaline administered? In the present case, was its administration mandatory?

Adrenaline was administered correctly, as indicated by the records, strictly according to the resuscitation protocol, after the onset of cardio-respiratory arrest.

13. Were the resuscitation measures and medical assistance provided in full and correctly during the complication (cardio-respiratory arrest and coma)?

Answer: Yes.

14. What is considered the cause of the anaphylactic shock?

Answer: There is no medical evidence to confirm the anaphylactic shock – i.e. there are no clinical and paraclinical data to show that such a shock was sustained. The medical records show that the child had previously undergone anaesthesia without complications – probably according to the same medication protocol, which is usual...

17. Did the anaesthesiologist breach the applicable rules concerning pre-medication and anaesthesia?...

Answer: No. ...

19. Was there an overdose of the anaesthetic?...

Answer: No. ...

22. Was the child provided with the necessary medical assistance by the medical staff correctly, in due time and according to the correct diagnosis?

Answer: Yes.

23. Is there a causal link between the damage [caused] to the body and health [of the child] and the failure on the part of the medical staff to provide qualified medical assistance?

Answer: No."

23. The prosecutor also interviewed two specialists: one from the Centre of Forensic Medicine Centre in Moldova who was part of the committee of experts on the case (see paragraph 13 above) and another from the University of Medicine and Pharmacy. The first specialist reiterated the conclusion that L. had not presented any illnesses to preclude the administration of general anaesthesia and that the premedication and the resuscitation had been carried out correctly. The second specialist clarified that halothane had not been known to cause any allergic reactions (including anaphylactic shock) and that it was impossible to assess a patient's sensitivity to halothane before its administration. He explained that it had been both correct to administer adrenaline and that it had been administered in the correct manner in order to address the cardiac arrest.

24. On 23 April 2015 the prosecutor discontinued the investigation, concluding that L.O.'s guilt had not been proved by the evidence accumulated because the medical reports had not established in her actions any breach of the rules regarding the methods of medical assistance afforded to L. The prosecutor also noted that the commission of the offence was not imputed to

any other alleged perpetrator and that the investigation should be terminated accordingly.

25. The first applicant lodged appeals against that decision with the hierarchically superior prosecutor and then with the investigating judge. She noted in her appeals that L. had previously twice successfully undergone anaesthesia and argued that in this case L.O. must have committed an error in the quantity of the anaesthetic administered.

26. On 1 October 2015, the Chișinău Centru District investigating judge upheld the first applicant's appeal and ordered the reopening of the investigation, finding as follows:

> "...[T]he investigation is incomplete in view of the complexity of the case and the consequences of the actions [in question].
>
> According to [the available information about] the case, the serious harm to a person's life and health has been confirmed, that person being now disabled. The criminal investigation authority has investigated this matter but very narrowly and only with respect to one person; this is, however, insufficient.
>
> It is noted that the prosecutor has carried out various investigative actions, such as [ordering] medical expert reports, [conducting] witness interviews and pressing charges, but these actions were aimed at collecting evidence and clarifying facts only in respect of one [of the people] responsible for the [administration of the] anaesthetic, but have not included all actions related to the harm caused.
>
> ... [T]he witness interviews are identical [that is the same, word-for-word], which shows that the interviews were a mere formality; the simple replication of the same text cannot be considered as [to have constituted] a proper interview or an objective examination. The witness statements should have been tested by confrontations ...
>
> According to the medical reports the pre-medication and the anaesthesia were [administered] correctly and in adequate quantity; however, cardiac-respiratory arrest resulted from an adverse reaction to the substance called halothane. In this regard, according to several sources – including [press] statements by officials from the Ministry of Health and the Drug Agency [*Agentia Medicamentului*] – this anaesthetic was forbidden in medical institutions; later the Drug Agency concluded that the drug was not a danger to patients. [On the other hand], according to the [officially approved] medication leaflet, issued in 2009, halothane was forbidden for persons under 18; [however,] the Drug Agency later submitted that that information was inaccurate, owing to a translation error in the leaflet.
>
> The investigation did not verify the legal conditions regarding the institution's access to and authorisation to use halothane ... and whether the devices for its use corresponded to the standardised requirements... .
>
> ... There has been more than one case in which the medication concerned had such a negative effect. The criminal investigation authority is bound to carry out all measures necessary to prevent the repetition of the negative effects, and for this purpose should have carried out a number of actions aimed at widening the narrow approach [taken by] the investigation so far.
>
> The investigation of the matter does not concern only the actions of the doctor from the standpoint of adequate medical assistance or deficiencies in the administration of the anaesthetic, but also concerns the medication itself, its use by other medical institutions, and its effects.

> In addition, ... the prosecutor's conclusion that 'the act is not imputable to any other person and there is no need to pursue the criminal investigation' is not relevant to the case [merely] because no deficiencies were found in the actions of one doctor. The investigation authority should not only investigate the doctor's actions and the methods of medical assistance [employed, but should look into any] other criminal offences [that may have been committed] ... and other aspects related to the lawfulness of all actions related to the ensuing negative effects."

27. The prosecutor appealed against the decision of the investigating judge, arguing that the investigation had been complete and that the case file contained answers to all of the questions raised by the investigating judge.

28. On 8 February 2016 the Chișinău Court of Appeal dismissed the prosecutor's appeal and upheld the decision of the investigating judge. The appellate court found that the investigation had been incomplete and referred in particular to the absence of any assessment concerning the conditions in which the dental clinic had been authorised to administer halothane, whether the equipment for its administration had been compliant with standardised requirements and, more generally, whether the use of halothane was safe.

29. Reopening the investigation, the prosecutor heard the first applicant a second time and on 29 June 2016 decided again to discontinue the investigation, relying on exactly the same reasons as before (see paragraph 24 above).

30. The first applicant appealed against the prosecutor's decision before the superior prosecutor and subsequently to the investigating judge. She argued that the investigation had not been efficient because it had not clarified the contradictions between the expert reports concerning the facts – whether anaphylactic shock had occurred and then cardiac arrest, or cardiac arrest only. The investigation had also failed to establish whether it had been appropriate to administer halothane to L. in the light of his history (as found by the experts) of suffering serious allergic reactions. The investigation had only been initiated ten months after the events in question, and the first expert report had only been issued 16 months after the event – without any reasonable explanation for those delays. Lastly, she argued that the investigation had looked into one lead only and had never sought to look at the wider facts. Since its reopening, no serious attempt to investigate the facts of the case had been made.

31. On 17 February 2017 the Chișinău Centru District investigating judge upheld the first applicant's appeal and ordered the reopening of the investigation. The court reiterated its previous findings (see paragraph 26 above), adding as follows:

> "... Following the last reopening [of the investigation], the only further investigative action taken was to interview the [first applicant] again. ... [T]he court concludes that the investigation [was] incomplete and insufficient."

The decision became final by virtue of the fact that no further appeal was lodged.

32. The investigation was reopened and the above-mentioned medical assistant was heard again (see paragraph 16 above); she merely stated that she maintained her previous statements concerning the second applicant's adverse reaction to halothane.

33. On 31 July 2017 the prosecutor discontinued the investigation, once again citing similar reasons to those that he had given before (see paragraphs 24 and 29 above). The decision became final by virtue of the fact that no appeal was lodged.

III. INFORMATION CONCERNING THE SAFETY OF HALOTHANE

34. Citing recorded adverse reactions to halothane, on 13 February 2012 the Ministry of Health issued an order to stop the use of halothane for the purpose of general anaesthesia for an undetermined period of time until a comprehensive assessment of its quality and the safety of patients was carried out. On an unknown date the use of halothane was again authorised.

35. Drug registration certificate no. 20605, issued on 29 April 2014, specified in the medication leaflet a contraindication for using halothane on children under 18 for dental procedures outside hospitals. The certificate also noted that heart rhythm disturbances (arrhythmia) were very common in children undergoing anaesthesia with halothane, and that resuscitation equipment must be readily available, along with trained personnel capable of performing paediatric resuscitation. It further stated that additional risk factors that could trigger arrhythmia should also be taken into consideration. To help prevent hypoxia, inhalation anaesthetics were to be administered with oxygen concentrations higher than 21%. The incidence of cardiac arrhythmia could increase when adrenaline was administered simultaneously.

36. The Government submitted an undated note regarding the inhalation anaesthetic agent halothane addressed to the Ministry of Health by the chairperson and three members of the specialised commission of the Ministry of Health that was concerned with the field of anaesthesia and intensive care. The note confirmed that in the Republic of Moldova, halothane 100% (250 ml) was officially listed as a necessary anaesthetic drug and was not banned from use. However, it could only be administered by qualified anaesthesia and intensive-care specialists, in properly equipped hospital settings with dedicated vaporisers and resuscitation equipment, in order to ensure child patient safety.

37. A supplementary undated note signed by the chairperson of the same specialised commission stated that halothane had been widely used in the past, but that its use had become rare over the previous decade owing to the availability of newer anaesthetic agents like sevoflurane and isoflurane, which had fewer side effects. Halothane affected all major heart functions and could lead to bradycardia and reduced heart muscle excitability

(depending on the size of the dose). It also increased the risk of serious arrhythmia, especially when combined with other stimulants.

38. A letter dated 1 November 2022 addressed to the Ministry of Health from the dental clinic stated that between 2007 and 2011, dental procedures under general anaesthesia with halothane had been performed on 2,551 patients. Of these, 2,337 were children. During this entire period, only one instance of complications had been recorded.

RELEVANT LEGAL FRAMEWORK AND PRACTICE

I. DOMESTIC LEGAL FRAMEWORK

39. At the time in question, Article 1398 of the Moldovan Civil Code provided for liability in tort (*răspundere delictuală*), namely that a person could be held liable if they unlawfully caused damage through their own fault (*cu vinovăție*). The law provided the injured party to claim compensation for financial damage and, in certain cases set out by law, for non-pecuniary damage as well. The same Article further provided that damage caused by lawful acts in the absence of fault could be compensated for only in cases directly provided by law. Article 1422 of the Civil Code regulated compensation for non-pecuniary damage in general (paragraphs (1) and (2)) and provided that compensation for non-pecuniary damage was due in the absence of any fault when the damage in question had been caused by illegal conviction, illegal prosecution, or unlawful detention on remand, and in other cases provided by law (paragraph (3)).

40. Section 19(3) of Law no. 411 of 28 March 1995 on health protection provides a patient's right to compensation for damage caused by medical and sanitary institutions through failure to comply with medical-treatment standards, through the prescription of contraindicated medicines, or through the application of inappropriate treatments that worsen the patient's state of health, cause permanent disability, endanger the patient's life, or result in the patient's death.

41. The regulation on the operation of the anaesthesia-resuscitation section/team and of the intensive care section/room of a medical institution, approved by Order of the Ministry of Health no. 331 of 22 January 2007, provided that children scheduled for minor and medium-scale surgical procedures were to be admitted to hospital on the day before such a procedure, and that laboratory tests were to be carried out on an outpatient basis; children scheduled for major surgical procedures involving possible blood transfusions and intravenous or inhalational general anaesthesia with artificial ventilation were to be admitted to hospital three days before the operation (sections 13.9 and 13.10).

II. DOMESTIC JUDICIAL PRACTICE

A. Case no. 2ra-79/14

42. On 21 January 2015 the Supreme Court of Justice ruled on a case initiated in 2013 by a widow against a public hospital seeking compensation for a breach of medical deontological rules in respect of the allegedly deficient medical treatment provided to her late husband – in particular, the refusal in 2013 to diagnose in a timely fashion and later to provide palliative care for her husband during his final months before his death from terminal liver cancer. The court referred to the findings of a committee established by the Ministry of Health, according to which the doctors concerned had breached the deontological rules of their profession but that different conduct on the doctors' part still could not have saved the patient's life. The court – citing the provisions of the Civil Code concerning tort liability (Article 1398) – ordered the hospital to pay the plaintiff 20,000 Moldovan lei (MDL) as compensation for the non-pecuniary damage inflicted.

B. Case no. 2ra-2183/17

43. On 20 December 2017 the Supreme Court of Justice ruled on a case initiated in 2008 by two parents against a public hospital and four doctors seeking compensation for pecuniary and non-pecuniary damage for their incorrectly diagnosing and treating their daughter in August 2007, which had resulted in her death a month later. The doctors and the hospital had denied the accusations concerning misdiagnosis and improper treatment and, therefore, any responsibility for the patient's death. The court proceeded to examine whether the treatment provided had been adequate. The court cited the conclusions of an information note issued by the Ministry of Health on 18 October 2007, according to which the diagnosis had been incorrect; the treatment, although initially correct, had not been re-assessed and changed/interrupted when it had found to be no longer efficient; the medical assistance had been poorly organised. The court also referred to a medical report investigating the cause of death and imposing disciplinary sanctions in respect of all four doctors. The court cited the conclusions of a medical expert and rejected the findings of the forensic medical report (which excluded any medical negligence), as contradicted by other evidence in the file. Referring to the provisions of the Civil Code concerning tort liability (Article 1398), the court ordered the hospital to compensate the plaintiffs for the damage inflicted – namely MDL 200,000 for non-pecuniary damage and MDL 16,527.38 as pecuniary damage.

C. Case no. 2-163/14

44. On 28 January 2016, the Chișinău Centru District Court ruled on a case initiated against a public hospital in 2012 by the Ombudsperson on behalf of parents seeking compensation for pecuniary and non-pecuniary damage in respect of the medical errors that had resulted in their son's death. In particular, the patient had undergone surgery for the removal of his amygdalae (having been administered halothane-induced anaesthesia) but had suffered cardiac arrest, and it had not been possible to resuscitate him. The court cited a medical report, prepared by the Centre of Forensic Medicine in Moldova, according to which the child's death had been caused by serious lung damage resulted from the sudden change of pressure in the lungs, which had led to the bursting of lung alveoli – an injury that had been further complicated by cardiac arrest. However, referring to a medical report prepared by the Mina Minovici National Institute of Forensic Medicine in Bucharest, the court questioned the reliability of the Moldovan report and made refence to the Court's criticism of "the [Moldovan] forensic experts' [work]" in the case *Ghimp and Others v. the Republic of Moldova* (no. 32520/09, 30 October 2012), where a violation had been found owing to the Moldovan authorities' failure to properly investigate the circumstances of the applicant's death. The court further cited the findings of the Bucharest-based institute's report, which had concluded that "the rapid onset of cardiac arrest suggested a malfunction in the halothane vaporizer and [that] the most probable cause of death [was] halothane overdose". The court also referred to the above-mentioned criminal investigation into medical negligence, which had been initiated in 2012 and discontinued in 2015 owing to the absence of any elements of a crime in the actions of the medical staff. The court concluded that the outcome of the criminal investigation precluded any conclusion that the public hospital had been responsible for the death of the child. However, the court went on to find that the anaesthesia machine used during the procedure had had technical deficiencies (as documented in the investigation report on the equipment used) and that the responsibility for this failure lay with the Ministry of Health. With reference to the provisions of the Civil Code concerning tort liability (Articles 1398 and 1422), the court ordered the ministry to pay the plaintiffs compensation for non-pecuniary damage of MDL 80,000.

45. In the same case, the appellate court concluded that the hospital was equally responsible for the failure to check the medical equipment and ordered the hospital and the Ministry to jointly and severally pay MDL 400,000 in compensation for non-pecuniary damage.

THE LAW

I. LOCUS STANDI

46. The Court notes at the outset that L., the second applicant, died after the lodging of the present application and that his mother, the first applicant, has expressed a wish to continue the proceedings before the Court. The Court sees no reason why the second applicant's mother cannot pursue the application on his behalf (compare also *David v. Moldova*, no. 41578/05, § 28, 27 November 2007).

II. ALLEGED VIOLATION OF ARTICLE 2 OF THE CONVENTION

A. Legal classification

47. The applicants complained that L. had been a victim of medical negligence relating to the improper use of halothane as an anaesthetic agent owing to its side effects, which had resulted in a serious deterioration of his health. They also complained of the alleged failure of the investigation to properly establish the circumstances of the case, hold those responsible accountable, and compensate for the damage that L. had suffered as a result of the medical procedure. She relied on Articles 3 and/or 8 of the Convention and Article 13 of the Convention, read together with the other complaints.

48. The Court notes at the outset that the present case concerns an alleged act of negligence within the context of medical procedures, as a result of which L. sustained severe brain damage and life-long tetraplegia along with other complications (see paragraph 11 above). It is not disputed that L.'s life was placed in real and imminent danger, that he required emergency resuscitation and life-long treatment, and that the effects of the medical procedure included coma, severe damage to L.'s central nervous system, long-term severe disability, complete loss of personal autonomy, and eventually his death. For this reason, the Court considers that Article 2 of the Convention is applicable in the instant case (see *Nicolae Virgiliu Tănase v. Romania* [GC], no. 41720/13, § 143, 25 June 2019).

49. The Court, therefore, considers that the applicants' complaints concerning medical negligence should be examined from the standpoint of the substantive and procedural aspects of Article 2 of the Convention, bearing in mind that the medical procedure placed L.'s life in real and imminent danger and that L. eventually died on 3 July 2022. Since it is master of the characterisation to be given in law to the facts of the case, the Court is not bound by the characterisation given by an applicant or a government (see *Lopes de Sousa Fernandes v. Portugal* [GC], no. 56080/13, § 145, 19 December 2017). Article 2, in so far as relevant to the present case, reads as follows:

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

B. Admissibility

50. The Government submitted that the applicants had failed to exhaust the civil remedies that were available under the Civil Code. In particular, the applicants could have claimed compensation for pecuniary and non-pecuniary damage from the dental clinic for the purportedly illegal actions committed by its medical staff. The Government emphasised that the establishment of guilt in criminal proceedings was not a precondition for bringing a civil action in the ordinary courts for civil liability in tort because civil courts were able to assess all the evidence independently and were not formally bound by any findings of the related criminal investigation. The Government provided three examples of domestic practice to support its argument (see paragraphs 43-45 above).

51. The Government also argued that the applicants had also failed to appeal against the decision of the prosecutor to discontinue the investigation on 31 July 2017, although this remedy was available to them.

52. The applicants submitted that the recovery of any damages was conditional upon establishing the guilt or fault of the person who had caused the damage in question. Since in the present case the prosecutor had terminated the investigation with the conclusion that no one had been responsible for the consequences suffered by L., the civil avenue had been ineffective and could not have secured any redress. For the applicants, a civil action in the present case had been ancillary to and interdependent of the criminal investigation and its findings concerning liability. In particular, only a criminal investigation could have determined the cause of the medical error, identified the circle of persons concerned and prevented similar errors from happening again in the future.

53. The first applicant also submitted that once she had used the criminal remedy, there had been no obligation on her to exhaust also the civil remedy.

54. Lastly, the first applicant submitted that she had never challenged the repeated termination of the criminal investigation because she had concluded that it had become ineffective owing to the absence of any genuine attempt to determine the causes of the medical error, despite the repeated orders by the investigating judge to reopen the case.

55. The Court notes that the Government's objection regarding the applicants' failure to exhaust the available domestic remedies is closely linked to the substance of their complaint under Article 2 of the Convention. In particular, it relates to the domestic avenues available to the applicants to clarify the circumstances of the case, hold those responsible accountable, and obtain compensation for the damage suffered by L. (see *Scripnic v. the Republic of Moldova*, no. 63789/13, § 24, 13 April 2021).

56. Consequently, the Court decides to join the Government's objection of non-exhaustion of domestic remedies to the merits of the applicants' complaint under Article 2 of the Convention.

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

C. Merits

1. The parties' submissions

(a) The applicants

58. The applicants submitted that the preparations for the medical intervention had been superficial and formalistic, having failed to assess L.'s medical history or experience of undergoing local or general anaesthesia, and carry out a risk assessment for adverse reactions – especially any fatal reactions that halothane might cause, such as arrythmia or anaphylactic shock. The applicants submitted that the procedure for obtaining informed consent had also been formalistic, as it had been a pre-condition for providing any and all kinds of dental treatment and had lacked specific information about the medication to be used and its possible effects.

59. The investigation into the facts of the case had been superficial. The medical commission that had investigated the case had approached its mandate from a technical angle, reviewing compliance with the accreditation requirements only on paper and not in detail, as attested by the very general recommendations that it had made.

60. The criminal investigation – which had been initiated at the first applicant's request and not of the prosecutor's own's motion some nine months after the events in question – had been unable to collect fresh evidence unaffected by the passage of time. The first applicant alleged in general that the medical data had been altered in the meantime by the medical staff concerned (without specifying exactly which information had been altered).

61. While the domestic experts had insisted that L.'s allergic status had caused the anaphylactic reaction to halothane, the Romanian experts had found that no anaphylactic shock had occurred and that the cardiac and respiratory arrest had been a reaction to halothane; this indicated, according to the applicants, that the treatment applied had included the administration of a dangerous preparation that had had an adverse effect on L.'s health.

62. The applicants also submitted that the criminal investigation had been ineffective because the prosecutors had consistently discontinued the investigation, arguing that no criminal offence had been committed, only for the investigating judge to order twice the reopening of the investigation and a more detailed assessment of the facts. Moreover, the investigation had lasted for five years and had relied on evidence derived from forensic experts

who had not been independent, but rather subordinate to the authority of the Ministry of Health; moreover, no confrontations had been organised between the opposing parties, and no in-depth investigations had been aimed at assessing the risks of the halothane substance.

63. In the absence of any elucidation of the circumstances of the medical intervention, the applicants had been deprived of an effective remedy capable of identifying those responsible and punishing them, and of affording compensation. The defective criminal investigation had failed to gather the evidence necessary for a civil action for damages, having reached the unfounded conclusion that there was no basis for anyone to be held liable.

(b) The Government

64. The Government argued that the domestic authorities had fulfilled all their obligations arising under Articles 3 and 8 of the Convention and that during his treatment in the dental clinic, L. had benefitted from qualified medical assistance, in accordance with national protocols. They further submitted that his health had deteriorated severely as a result of an adverse reaction suffered by L.'s circulatory system and not from any medical error.

65. The Government noted that L. had been assessed by the medical team as not presenting any contraindication for general anaesthesia and that the procedure had been carried out with his legal representative's informed consent. The Government submitted that the medical personnel had explained the medical treatment in a clear and accessible manner to the first applicant and that she had never complained of any alleged failure to inform her properly about the medical treatment under general anaesthesia to be provided to her son.

66. The authorities had carried out effective investigations into the circumstances of the case. In particular, the commission established by the Ministry of Health had undertaken onsite research at the dental clinic and had concluded that the decision to use general anaesthesia and to administer a halothane preparation had been correct – despite L.'s allergic status. The commission had also established that the instruments and drugs which were required for specialised anaesthesiologic care and which were maintained by the dental clinic complied with the required standards; the dental clinic had procured the halothane preparation in a manner that had complied with all the relevant standards, and the relevant invoices contained information regarding the serial number of the halothane preparation and the date on which the batch analysis had been carried out by the Medicines Quality Control Laboratory of the Drug Agency. According to a quality certificate dated 6 December 2011 and issued by the Drug Agency, the sample "halothane liquid/inhalation vapour 250 ml N1 series A B33H08A complies with the [manufacturer's specification]".

67. The forensic examination reports confirmed the elements described above: that there had been no violations of the standards, rules and methods

regarding the provision of medical assistance and that there had been no causal link between the consequences to L.'s health and the failure to provide qualified medical assistance. The forensic expert report of 23 February 2015 found that L.'s cardio-respiratory arrest had been the result of an adverse reaction to halothane. That conclusion had been confirmed by a university professor, who had acted as an independent expert (see paragraph 23 above).

68. With regard to the administration of halothane in the Republic of Moldova, the Government referred to the notes provided by the Ministry of Health (see paragraphs 36-37 above), to the updated leaflet of April 2014 for the medication (see paragraph 35 above), and to the letter from the dental clinic to the Ministry of Health concerning the use of halothane (see paragraph 38 above). They emphasised that only two cases of suspected adverse reactions had been reported in respect of the product halothane: one had been L.'s case in 2011; the other had concerned a 13-year-old who had died in 2012 from an overdose of halothane due to the incorrect calibration of the equipment (see paragraphs 44 and 45 above) and not from an adverse reaction to halothane as such. In connection with those cases, on 13 February 2012 the Ministry of Health had ordered the discontinuation of halothane for the purpose of general anaesthesia for an indefinite period, pending the evaluation of all components related to product quality and patient safety. Subsequently, after an inspection by the Pharmaceutical Inspectorate, that order had been annulled.

69. For those reasons, and in the absence of other possible investigation leads, the case prosecutor had correctly decided to discontinue the investigation on 31 July 2017 on the grounds that no evidence of a criminal nature had been obtained to establish the existence of the elements of the crime in question under Article 213 of the Criminal Code. The Government noted that the applicants had never availed themselves of any civil remedy that would have allowed them to obtain compensation for the purportedly illegal actions committed by the medical staff of the dental clinic.

70. The applicants had not argued that the alleged negligent actions of the doctors had gone beyond mere error or negligence. Although an effective civil remedy had been available to them, on 14 August 2012 – nine months after the events in question – the first applicant had lodged a criminal complaint with the General Prosecutor's Office concerning the alleged negligent actions of the doctors who had treated L. An investigation had been initiated 15 days later. The domestic case file revealed that numerous investigative measures had been undertaken – including interviewing the doctors involved and the medical staff of the dental clinic, university professors and expert witnesses – which had ensured a diligent, meaningful, and complete investigation into the allegations (see paragraphs 13-23 above). The investigation showed that the cardio-respiratory arrest suffered by L. on 29 November 2011 had constituted an adverse reaction to the halothane preparation – a hypothesis later confirmed by the international forensic report

ordered from Romania. The experts had also concluded that there had been no violations of the standards, rules and methods of providing medical assistance; there had been no violations of the rules governing the administration of pre-medication; adrenaline had been correctly administered – in accordance with the resuscitation protocol – after the onset of cardio-respiratory arrest; and all necessary resuscitation measures had been performed at the onset of complications.

71. Contrary to the applicants' allegation concerning the failure of the national authorities to perform a biological forensic examination of the halothane administered and of the medical equipment, the Government noted that that aspect had been covered by the onsite investigation carried out by the commission established by the Ministry of Health, which had concluded that the requirements concerning specialised anaesthetic medication and the use of equipment had been complied with.

72. The Government conceded that a full investigation into the equipment in question had not been possible because the first applicant had complained to the authorities about the alleged acts of negligence only nine months after the events in question, during which time the equipment had not remained intact (being in daily use). It followed that no traces of the alleged offence could have remained on it, and nor could material evidence establishing the circumstances of the offence have been preserved in such conditions. Therefore, no procedural measure would have been capable of replicating certain objective events that had taken place on 29 November 2011.

73. In conclusion, the Government argued that the domestic authorities had taken all reasonable measures in order to comply with the principle of an effective investigation. In any event, the applicants' representative did not specify – either before the Court or before the domestic authorities – what other procedural measures could have, but had not, been, conducted by the prosecution.

2. The Court's assessment

(a) General principles

74. The applicable general principles concerning the State's substantive and procedural obligations under Article 2 of the Convention within the context of healthcare have been summarised in *Lopes de Sousa Fernandes* (cited above, §§ 186-196 and §§ 214-21).

75. Within the context of alleged medical negligence, the States' substantive positive obligations relating to medical treatment are limited to a duty to have in place an effective regulatory framework compelling hospitals, whether private or public, to adopt appropriate measures for the protection of patients' health (see, *mutatis mutandis*, *Lopes de Sousa Fernandes*, cited above, § 186). In the very exceptional circumstances described below the responsibility of the State under the substantive limb of Article 2 of the

Convention may also be engaged in respect of the acts and omissions of health-care providers.

76. The first type of exceptional circumstances concerns a specific situation where an individual patient's life is knowingly put in danger by denial of access to life-saving emergency treatment. It does not extend to circumstances where a patient is considered to have received deficient, incorrect or delayed treatment (ibid., § 191). The second type of exceptional circumstances arises where a systemic or structural dysfunction in hospital services results in a patient being deprived of access to life-saving emergency treatment and the authorities knew or ought to have known about that risk and failed to undertake the necessary measures to prevent that risk from materialising – thus putting the patients' lives, including the life of the particular patient concerned, in danger (ibid., § 192).

77. In order for a case to fall into these exceptional categories, four cumulative criteria must be met. Firstly, the acts and omissions of the health-care providers must go beyond a mere error or medical negligence, in so far as those health-care providers (in breach of their professional obligations) deny a patient emergency medical treatment despite being fully aware that the person's life is at risk if that treatment is not given. Secondly, the dysfunction at issue must be objectively and genuinely identifiable as systemic or structural in order to be attributable to the State authorities, and must not merely comprise individual instances where something may have been dysfunctional in the sense of going wrong or functioning badly. Thirdly, there must be a link between the dysfunction complained of and the harm that the patient sustained. Lastly, the dysfunction at issue must have resulted from the failure of the State to meet its obligation to provide a regulatory framework in the broader sense indicated above (ibid., §§ 194-196).

78. In determining whether the State has fulfilled its positive procedural obligation to set up an effective independent judicial system, the Court will examine whether the available legal remedies, taken together, as provided for in law and applied in practice, secured the effective legal means capable of establishing the relevant facts, holding accountable those at fault and providing appropriate redress to the victim (see *Sarishvili-Bolkvadze v. Georgia*, no. 58240/08, § 79, 19 July 2018). The choice of means for ensuring that the positive obligations under the Convention are fulfilled is in principle a matter that falls within the Contracting State's margin of appreciation. There are different avenues for ensuring that Convention rights are respected, and even if the State has failed to apply one particular measure provided by domestic law, it may still fulfil its positive duty by other means. However, in order for this obligation to be satisfied, such proceedings must not only exist in theory but also operate effectively in practice (see *Lopes de Sousa Fernandes*, cited above, § 216, with further references).

79. The compliance with the procedural requirement of Article 2 is to be assessed on the basis of several essential parameters. These elements are

inter-related and each of them, taken separately, does not amount to an end in itself, as is the case in respect of the requirements for a fair trial under Article 6. They are criteria which, taken jointly, enable the degree of effectiveness of the investigation to be assessed (see *Nicolae Virgiliu Tănase*, cited above, § 171). Within the context of investigations into allegations of medical negligence, those essential parameters have been stated to include the following – as recently summarised in *Harutyun Karapetyan v. Armenia* (no. 53081/14, § 72, 29 October 2024):

(a) the investigation must be thorough, which means that the authorities must take all reasonable steps available to them to secure the evidence concerning the incident, always make a serious attempt to find out what happened and not rely on hasty or ill-founded conclusions to close their investigation or to use as the basis of their decisions;

(b) even where there may be obstacles or difficulties preventing progress in an investigation, a prompt response by the authorities is vital for public safety and in maintaining public confidence in their adherence to the rule of law and in preventing any appearance of collusion in, or tolerance of, unlawful acts. The proceedings must also be completed within a reasonable time;

(c) it is generally necessary that the domestic system set up to determine the cause of death or serious physical injury be independent. This means not only a lack of hierarchical or institutional connection but also a practical independence implying that all persons tasked with conducting an assessment in the proceedings for determining the cause of death or physical injury enjoy formal and *de facto* independence from those implicated in the events.

80. This procedural obligation is not an obligation of result but of means only. Thus, the mere fact that proceedings concerning medical negligence have ended unfavourably for the person concerned does not in itself mean that the respondent State has failed in its positive obligation under Article 2 of the Convention (see *Lopes de Sousa Fernandes*, cited above, § 221, with further references).

81. Lastly, the Court would add that the nature and degree of scrutiny which satisfies the minimum threshold of effectiveness depends on the circumstances of each particular case. Each case must be assessed on the basis of all relevant facts and with regard to the practical realities of investigation work. It is not possible to reduce the variety of situations which might occur to a bare check-list of acts of investigation or other simplified criteria (see *Velikova v. Bulgaria*, no. 41488/98, § 80, ECHR 2000-VI, with further references). Where there is a *prima facie* arguable claim of a chain of events possibly triggered by an allegedly negligent act that may have contributed to the death of a patient, the authorities may be expected to conduct a thorough examination into the matter (see *Lopes de Sousa Fernandes*, cited above, § 237; *Garrido Herrero v. Spain*, no. 61019/19, § 86, 11 October 2022).

(b) Application of the above principles in the present case

82. The Court observes that the applicants did not allege that L.'s life had been put in danger intentionally. Nor did they allege that L. had been denied access to medical treatment in general or to emergency medical treatment in particular. Nor had there been any question of a systemic or structural dysfunction in hospital services.

83. In the domestic proceedings the applicants argued that the medical treatment and supervision that had been provided to L. by the staff of the dental clinic had been inadequate and had led to his life being put in danger, mainly owing to the use of unsafe medication such as halothane and the improper assessment of possible risks from its use – particularly given L.'s history of suffering allergic reactions, and that the investigation into the events had been purely superficial (see paragraphs 14, 25 and 30 above). Before the Court the applicants also complained of the alleged failure to secure informed consent in respect of the procedures, the alleged failure of the domestic authorities to address their allegations of inadequate medical treatment and the failure to establish a causal link between the alleged medical negligence and the adverse reactions that had put L.'s life at risk (see paragraphs 58-63 above).

84. Accordingly, the Court will examine the State's substantive and the procedural obligations under Article 2 of the Convention in the case at hand.

(i) The substantive aspect

85. The Court notes that it is undisputed in the present case that the impugned medical procedure took place in a public clinic and was performed by medical staff employed by this public clinic. However, the Court observes that the applicants' claims were limited to the allegations that the medical treatment and supervision that had been provided to L. had been inadequate and had led to his life being put in danger, mainly owing to the use of unsafe medication and the improper assessment of possible risks from its use (see paragraph 83 above). There is no allegation of denial of access to medical treatment nor any question of a systemic or structural dysfunction in hospital services. It cannot be considered either that the applicants' complaints relate to a State failure to put in place an effective regulatory framework. It does not appear, therefore, that there has been any of the exceptional circumstances in which the Court may consider that the responsibility of the State under the substantive limb of Article 2 of the Convention is engaged in respect of the acts and omissions of health-care providers (see general principles cited in paragraphs 75-77 above).

86. For these reasons, The Court finds therefore that there has been no violation of Article 2 of the Convention in its substantive aspect.

(ii) The procedural aspect

87. The Court firstly notes that in the present case there were two investigative procedures: an internal investigation carried out by the Ministry of Health (see paragraph 13 above) and a criminal investigation (see paragraphs 14-33 above). The applicants have not initiated any civil proceedings. In the absence of any allegation that L.'s life was put in danger intentionally, a criminal remedy was not necessarily required. However, if deemed effective, criminal proceedings would by themselves have been capable of satisfying the procedural obligation under Article 2 (see *Lopes de Sousa Fernandes*, cited above, § 232).

(α) Criminal proceedings

88. In terms of promptness, the Court notes that the criminal investigation was initiated one month after the first applicant lodged a complaint in August 2012 (see paragraph 15 above). Unlike in cases concerning the lethal use of force by State agents (where the competent authorities must of their own motion initiate investigations), in cases concerning medical negligence where the risk to life was caused unintentionally, the States' procedural obligations may come into play upon the institution of proceedings by the patient or her or his relatives (ibid., § 220). Accordingly, the delay of over nine months between the day of the medical procedure which put L.'s life in danger and the initiation of the criminal investigation is not imputable to the domestic authorities.

89. An expert report was commissioned two months after the investigation was opened and a second report several days after the first expert report had been concluded (see paragraphs 17-19 above). The prosecutor heard the first applicant, V.C., the two assistants to the anaesthetist (see paragraph 16 above) and later two specialists to explain the findings of the expert reports (see paragraph 23 above). Dr L.O. refused to make any statements (see paragraph 20 above).

90. While the initial response of the authorities was prompt, the overall length of the proceedings was four years, 10 months, and 13 days. This cannot be considered *per se* as unreasonable. However, the Court cannot lose sight of the fact that investigative measures were undertaken mainly in the first two and a half years, of which one and a half years were devoted to the preparation of expert reports (see paragraphs 17-19 and 21-22 above). After the investigation had been discontinued for the first time on 23 April 2015 the only procedural steps concerned the first applicant's successful appeals against the prosecutor's repeated discontinuation decisions (see paragraphs 26-28 and 31 above). During that time, which lasted two years, no significant investigative measures – other than the formal repeated interviews of a medical assistant and of the first applicant (see paragraphs 29 and 32 above) – were undertaken by the prosecutor, in spite of the explicit court orders to

carry out additional in-depth scrutiny of the events (see paragraphs 26-28 and 31 above). Seen from this angle and in the absence of any explanation from the Government, the duration of these proceedings was unreasonable (ibid., § 230).

91. As regards thoroughness, the Court notes the following. The investigation into the applicants' claims of malpractice relied on expert findings. Those findings did not show a direct causal link between the damage to L.'s health and the treatment provided by the dental clinic staff. They also found no fault on the part of the staff (see paragraphs 17, 19 and 22 above). While the applicants questioned the objectivity of the Moldovan forensic experts, the Court notes that the same conclusion had also been reached by the Romanian forensic experts, whose objectivity was at no point questioned by them. Although it was established that L. had suffered a serious adverse reaction to the anaesthetic used by Dr L.O., the investigative bodies found no fault on the part of the medical staff of the dental clinic and that neither Dr L.O. nor anyone else could be held criminally liable (see paragraphs 24, 29 and 33 above). The Court notes here that, except in cases of manifest arbitrariness or error, it is not its function to call into question findings of fact made by the domestic authorities – particularly when it comes to scientific expert assessments, which by definition call for specific and detailed knowledge of the subject (see *Počkajevs v. Latvia* (dec.), no. 76774/01, 21 October 2004).

92. That said, the Court observes that the investigation was concerned primarily with the administration by Dr L.O. of halothane together with adrenaline (see paragraphs 15 and 20 above), although general questions about the breach of medical protocols were addressed to the forensic experts. Upholding the first applicant's appeals against the discontinuation of the criminal investigation, the domestic courts repeatedly noted that the investigation had been focussed on a narrow aspect of the case and stated that the prosecutor should reopen the investigation in order that other aspects could be looked into – such as the conditions in which the dental clinic had been authorised to use halothane, whether the used equipment had been compliant, and whether the use of halothane had been sufficiently safe (see paragraphs 26, 28 and 31 above; concerning the deficient investigation into the quality of the used medication see paragraph 101 below). In spite of these precise indications, at no point during the investigation – including the reopened investigation – were these elements examined thoroughly.

93. Notably, the criminal investigation file does not contain any document confirming that the anaesthesia machine used by the dental clinic was inspected. A forensic report refers to the equipment operating properly, but this conclusion was drawn on the basis of written medical records and not on the actual inspection of the machine (see paragraph 17 above). A direct inspection of the machine was an important investigative measure. This is especially clear from the example cited by the Government where in a case

involving a life-threatening risk caused by the improper use of an anaesthetic machine, an inspection report showing that the machine had been faulty (and which the criminal investigation failed to take into account) was a piece of evidence on which the domestic courts relied to determine the authorities' fault and award compensation (see paragraph 44 above). In the present case, the prosecutor's decision does not contain any reference to or analysis of the operation of the equipment, nor any discussion as to whether an inspection had been rendered impossible owing to the passage of time. Moreover, even when the authorities had the opportunity to timely inspect the equipment during the internal investigation, they had failed to do so (see paragraph 101 below).

94. The Court further observes that, contrary to the precise instructions of the judicial review (see paragraph 26 above), the investigation failed to clarify whether the dental clinic could lawfully use halothane for the purpose of general anaesthesia. The prosecutor's decision does not contain any reference to or consideration of this matter. It is noteworthy in this regard that at the time of the prosecutor's decision the instructions for the use of halothane of April 2014 explicitly prohibited its use on children outside hospitals and required that resuscitation equipment be readily available, along with trained personnel capable of performing paediatric resuscitation (see paragraph 35 above). This should have prompted the prosecutor to inquire into whether the same or similar instructions, in one form or another, had been in place at the time of the events.

95. While the investigation ruled out the liability of medical personnel at the clinic, it failed to explore what form the adverse reaction caused by halothane had taken, despite the dispute between the Moldovan and Romanian experts and the obvious importance of this question in the assessment of compliance with the relevant medical standards. If L. had indeed suffered anaphylaxis owing to his aggravated allergic status (as explained by the Moldovan specialists but denied by the Romanian experts), than it remains unclear why the investigation never attempted to clarify whether the information concerning L.'s immunological condition signalled by the applicants prior to the operation required a more detailed preliminary assessment. Namely, against this context, the investigation did not seek to clarify whether recording L.'s immunological status as low risk ASA II and choosing the anaesthetic without additional analysis revealed lack of due diligence and deficiencies in obtaining a genuine informed consent concerning the associated risks (see paragraph 7 above). There was also no assessment made as to whether the need to prepare properly for the procedure had required L.'s admission to the ward some time before that procedure, as explicitly provided by medical protocols (see paragraph 41 above).

96. The Court notes that the first applicant did not contest giving her consent for the medical intervention but complained about being improperly informed about the risks of the medical procedure. The prosecutor's decisions

repeatedly note that the first applicant had signed the informed consent form and that V.C. had stated that she had signed it in his presence (see paragraph 16 above). There was no attempt to investigate if and when the first applicant had been warned about the risks of the procedure involving halothane and what information exactly she had been provided, considering that the form does not contain the applicants' name and bears the date of 23 November 2011 (see paragraph 6 above), when L. had not been accompanied by her to the dental clinic.

97. On a separate point, in her initial complaint the first applicant noted witnessing medical staff calling out in the clinic's hallway for adrenaline (see paragraph 14 above), which may have indicated low readiness on the part of the operation theatre for resuscitation procedures. However, the investigation never looked into such details, but instead relied on medical records, without, moreover, questioning their content, despite her submissions.

98. In the Court's view, the matters raised by the applicants and by the domestic courts themselves concerned important factual issues pertaining to the medical care provided to L. and to the possible liability of the health professionals involved, which called for a proper examination (see, *mutatis mutandis*, *Csoma v. Romania*, no. 8759/05, § 52, 15 January 2013, and *Lopes de Sousa Fernandes*, cited above, § 172). However, as noted above, those matters were not addressed in the course of the criminal proceedings, which leads the Court to conclude that those proceedings did not meet the requirement of thoroughness (ibid., § 226).

99. In view of the above-noted shortcomings, the Court considers that the criminal investigation in the present case was not effective for the purposes of Article 2. It is further necessary to examine whether the applicants had a disciplinary or civil-law remedy available to them.

(β) Disciplinary proceedings

100. The Court notes that an internal investigation was carried out by a commission that was set up promptly by the Ministry of Health after the events of November 2011. The investigation resulted in the issuing of an information note, which concluded that L. had suffered anaphylaxis as an adverse reaction to halothane – mainly due to his highly allergic status. No breaches of medical protocols were discerned. The commission recommended that the staff of the clinic be alerted to the risk of an adverse reaction in certain patients, that the dentist and the anaesthetist undergo training and then apply for repeat certification, and that alternative anaesthetic agents be considered by dentists for outpatient procedures requiring anaesthesia (see paragraph 13 above).

101. The Government did not argue, and from the mandate of this commission the Court cannot discern, that it had any disciplinary jurisdiction. But even assuming that it did, the Court cannot consider the commission's deliberations as sufficient for the purpose of Article 2, as its investigation

amounted merely to an examination of L.'s medical records, the opinions of the doctors concerned and of the first applicant, and documents relating to the certification of the clinic and its equipment. However, no evidence was heard, no expert reports were sought, and the first applicant had no involvement in those proceedings. While a quality certificate for halothane was attached to the commission's report (see paragraph 66 above), the report itself does not clarify if the quality check was carried out in December 2011 in respect of a sample of the halothane used for L.'s procedure in November 2011 or simply a random sample of the dental clinic's stock of halothane. Describing the inspection of the equipment, the report only stated that it was modern and compliant "with metrological parameters", but did not contain any in-depth assessment of whether or not it functioned correctly. A proper inspection of the equipment was not caried out, despite the importance in medical practice of analysing in detail and learning from each and every incident. Moreover, this inquiry failed to clarify the same elements in respect of which the criminal investigation was found deficient (see paragraphs 93-96 above).

102. In view of the above, the Court considers that the disciplinary proceedings in the present case can hardly be regarded as effective for the purposes of Article 2. It is further necessary to examine the effectiveness of the civil proceedings.

(γ) Civil-law remedy

103. In respect of the civil-law remedy, the Court notes that a civil action in tort was and is possible under the Moldovan Civil Code (see paragraph 39 above) and seems to be available and effective in practice – as exemplified by the practice cited by the Government (see paragraphs 43-44 above). In this regard, it is undisputed that at the time of the events in question, liability for medical negligence under Moldovan law was based on the fault of the person concerned (see paragraphs 39-40 above). At the same time, the Government provided only one example of a civil tort claim having succeeded despite a criminal investigation finding no fault, but where the courts relied on an inspection report indicating fault in the maintenance of medical equipment. There were no such reports in the applicants' case. Moreover, it is noteworthy that in the case cited by the Government the first instance court did not disregard completely the conclusions of the criminal investigation but relied on them to exonerate one of the respondents from civil liability (see paragraph 44 above).

104. In the present case, as the Court established above, all investigations were incomplete and insufficiently thorough and, therefore, cannot be seen as having allowed the authorities to reach a reliable and an informed conclusion on whether or not a medical mistake had been committed (see, in particular, paragraphs 92-99 and 101-102 above). In these circumstances, and seeing that the investigations did not mention any criticism, let alone fault, a civil action had no, or at least highly uncertain, prospects of success. The Government

have not claimed that domestic law or practice allowed no-fault doctor's liability based on, for example, the notion of risk inherent in the exercise of the profession. It does not appear that, at the time of the events in question, a healthcare professional or a health institution could have been ordered to pay damages in the absence of any medical fault. For this reason, the Court concludes that no effective civil-law remedy was available (see *Eugenia Lazăr v. Romania*, no. 32146/05, § 90, 16 February 2010).

105. In the light of its findings above concerning the ineffectiveness of the available criminal, disciplinary and civil-law remedies, the Court finds that the applicants were not required, under the circumstances prevailing at the time in question, to lodge further appeals in the criminal proceedings or to lodge a civil claim; it therefore dismisses the Government's preliminary objection (see paragraphs 50-56 above).

(iii) Conclusions

106. In sum, while the responsibility of the State under the substantive limb of Article 2 of the Convention was not engaged in respect of the acts and omissions of health-care providers (see paragraphs 85-86 above), the Court considers that the domestic system as a whole, when faced with an arguable case of medical negligence resulting in L.'s life being put at real and immediate risk, failed to provide an adequate and timely response consistent with the State's procedural obligation under Article 2. Accordingly, there has been a violation of the procedural aspect of that provision.

III. APPLICATION OF ARTICLE 41 OF THE CONVENTION

107. Article 41 of the Convention provides:

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

108. The applicants claimed 60,000 euros (EUR) in respect of non-pecuniary damage for the unremedied medical negligence, which had left L. living an isolated and traumatic life in a state of unconsciousness – completely dependent on constant care and assistance to survive and to manage medical crises. The applicants also claimed EUR 2,520 for the costs and expenses they had incurred before the Court. An itemised timesheet and description were submitted; these listed the assistance provided at the national level in systematising the pieces of evidence and submitting observations to the Court.

109. The Government submitted that, since the domestic authorities had fully discharged their positive obligations under the Convention, the applicants should not be entitled to an award. In addition, the Government

invited the Court, in the absence of any violation, to dismiss the claims for costs and expenses as unsubstantiated.

110. In the light of the circumstances of the case, the Court awards the applicants the sum of EUR 20,000 in respect of non-pecuniary damage, plus any tax that may be chargeable.

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

FOR THESE REASONS, THE COURT, UNANIMOUSLY,

1. *Joins to the merits* the Government's preliminary objection concerning the exhaustion of domestic remedies and *dismisses* it;

2. *Declares* the application admissible;

3. *Holds* that there has been no violation of Article 2 of the Convention in its substantive limb;

4. *Holds* that there has been a violation of Article 2 of the Convention in its procedural limb;

5. *Holds*
   (a) that the respondent State is to pay the applicants, within three months from the date on which the judgment becomes final in accordance with Article 44 § 2 of the Convention, the following amounts, to be converted into the currency of the respondent State at the rate applicable at the date of settlement:
      (i) EUR 20,000 (twenty thousand euros), plus any tax that may be chargeable, in respect of non-pecuniary damage;
      (ii) EUR 2,520 (two thousand five hundred and twenty euros), plus any tax that may be chargeable to the applicants, in respect of costs and expenses;
   (b) that from the expiry of the above-mentioned three months until settlement simple interest shall be payable on the above amounts at a rate equal to the marginal lending rate of the European Central Bank during the default period, plus three percentage points;

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

Done in English, and notified in writing on 2 July 2026, pursuant to Rule 77 §§ 2 and 3 of the Rules of Court.

Victor Soloveytchik Registrar	Kateřina Šimáčková President