

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

FIFTH SECTION

CASE OF LUKASHENKO v. UKRAINE

(Application no. 33944/13)

JUDGMENT

STRASBOURG

11 September 2025

This judgment is final but it may be subject to editorial revision.



In the case of Lukashenko v. Ukraine,

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

Gilberto Felici*, President*,
Mykola Gnatovskyy,
Vahe Grigoryan*, judges*,

and Martina Keller, *Deputy Section Registrar,*

Having regard to:

the application (no. 33944/13) against Ukraine lodged with the Court under Article 34 of the Convention for the Protection of Human Rights and Fundamental Freedoms ("the Convention") on 14 May 2013 by a Ukrainian national, Ms Stepaniya Petrivna Lukashenko ("the applicant"), who was born in 1940, lives in the town of Kitsman, Ukraine, and was represented by Mr E. Markov, a lawyer practising in Strasbourg at the material time;

the decision to give notice of the application to the Ukrainian Government ("the Government"), represented by their Agent, most recently Ms M. Sokorenko from the Ministry of Justice;

the parties' observations;

Having deliberated in private on 3 July 2025,

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

SUBJECT MATTER OF THE CASE

1. The present case concerns allegations that domestic proceedings aimed at establishing the circumstances of the applicant's son's death in a hospital were ineffective. The case falls under the procedural limb of Article 2 of the Convention.

I. MEDICAL TREATMENT AND DEATH OF THE APPLICANT'S SON

2. On 11 March 2003 the applicant's son (born in 1966) went to the local hospital in Kitsman complaining about an abscessed boil on his left shoulder. He underwent surgery and his wound was drained. In the weeks that followed he was under post-operative observation and had outpatient treatment in the same hospital.

3. On 14 April 2003 the applicant's son was diagnosed with a subfascial phlegmon (an infection of the soft tissue) in the right thigh area. The next day he was admitted to the local hospital in Kitsman for inpatient treatment.

4. At the beginning of May 2003, the phlegmon developed and covered a part of his abdominal area, the right buttock and thigh. The applicant's son was diagnosed with sepsis. On 12 May 2003 he was admitted to the Chernivtsi Regional Hospital, where he underwent another operation. The next day he died of sepsis, septic shock and multiple organ failure.

5. The applicant complained to the authorities, arguing that her son had died because of medical negligence.

II. INVESTIGATION INTO THE INCIDENT BY THE HEALTHCARE AUTHORITIES

6. Following the applicant's complaint, the Regional Health Department of the Chernivtsi Regional State Administration ("the Health Department") set up an *ad hoc* commission. In a report of 5 August 2003, it concluded that the cause of the applicant's son's death had been, *inter alia*, sepsis, septic shock and multiple organ failure, and that the outpatient treatment in the local hospital in Kitsman had been inadequate; in particular, (i) neither necessary laboratory tests nor intensive anti-inflammatory therapy had been carried out; (ii) blood test results indicating the presence of an inflammatory disease in the body had not been evaluated by the therapy department; and (iii) the progression of the disease and its complications had not been assessed promptly by the surgical department. The commission proposed that a case review meeting should be held and that an order should be issued for disciplinary action against the doctors who had made errors in the treatment of the applicant's son. It also recommended that a certification commission should be asked to recertify those doctors.

7. On 18 August 2003 the chief doctor of the Chernivtsi Regional Hospital reprimanded five doctors for the shortcomings and negligence in the treatment of the applicant's son: Dr R. was reprimanded for violating a transfer procedure from the local hospital in Kitsman and failing to supervise the applicant's son's treatment and keep proper medical records; Dr S. and Dr Z. were reprimanded for violating instructions on keeping medical records; and Dr D. and Dr Z. were reprimanded for failing to provide surgery promptly.

8. In November 2003 the Health Department informed the local prosecutor's office in Kitsman that the above-mentioned case review meeting had been held and that Dr M., Dr S. and Dr D. from the local hospital in Kitsman had been demoted.

III. CRIMINAL PROCEEDINGS

9. On 18 July 2003 the Kitsman local prosecutor's office refused to institute criminal proceedings in relation to the death of the applicant's son. That decision was subsequently quashed by a higher prosecutor's office.

10. On 19 November 2003 the Kitsman local prosecutor's office instituted criminal proceedings under Article 139 § 2 of the Criminal Code of Ukraine on account of the "failure of healthcare professionals of the local hospital in Kitsman to provide medical assistance" to the applicant's son. The case was sent to the police for investigation.

11. On 24 December 2003 the applicant joined the proceedings as a civil party.

12. Between 2004 and May 2011 the proceedings were terminated on three occasions for lack of evidence of a crime. All those decisions were quashed by higher prosecutors or courts on the basis that the investigation was incomplete because, *inter alia*:

- not all material from the case review meeting held after the applicant's son's death had been seized, so information contained therein had not been taken into account during forensic examinations;
- the applicant's arguments had been disregarded;
- contradictions in the experts' conclusions had not been addressed;
- doctors had not been questioned.

Following one of those decisions, the investigating officer was disciplined and replaced. The new investigating officer then reclassified the offence as a more severe one under Article 140 of the Criminal Code of Ukraine, namely "improper performance of professional duties by a healthcare professional owing to negligence or carelessness in the performance of those duties resulting in serious consequences for a patient".

13. In the course of the proceedings, five forensic medical examinations were conducted. All of them noted various deficiencies in the applicant's son's treatment, but concluded that his recovery had not been certain. In the last forensic medical conclusion of 9 March 2011, the experts pointed out the following shortcomings in the medical treatment which he had received in the local hospital in Kitsman:

- the operation on his left shoulder and the draining of the abscess had been performed under local anaesthesia, which made it impossible to ensure adequate draining;
- no laboratory tests had been conducted at the relevant time;
- subsequently, the patient's condition had been underestimated and no adequate treatment had been prescribed.

The experts found that there was a direct causal link between the above-mentioned deficiencies in the treatment and the death of the patient. However, they concluded that the applicant's son had already been in a critical condition with little chance of recovery when he had been admitted to the Chernivtsi Regional Hospital, and that there had been no deficiencies in his treatment there.

14. On 24 May 2011 one of the doctors from the local hospital in Kitsman, Dr M., was notified that there was a suspicion that he had committed a crime under Article 140 of the Criminal Code of Ukraine. However, on 9 June 2011 a prosecutor asked a court to terminate the criminal proceedings on the grounds that they were time-barred. The court initially granted the request, but later, after that decision had been quashed on appeal, the prosecutor continued the investigation, drew up a bill of indictment and sent it to the court.

15. On 10 October 2013 the Kitsman Local Court terminated the criminal proceedings against Dr M. on the grounds that they were time-barred. On 21 January 2014 the Chernivtsi Regional Court of Appeal upheld that decision. The applicant did not appeal against the appellate court decision in cassation.

16. As regards the other doctors who had been involved in the applicant's son's treatment, on 8 June 2011 the investigator decided that there were no grounds to institute criminal proceedings against them, since their actions had had no causal link to his death.

IV. CIVIL PROCEEDINGS

17. On 10 October 2012 the applicant filed a civil claim against the local hospital in Kitsman, seeking compensation in respect of pecuniary and non-pecuniary damage caused by the inadequate medical treatment which her son had received which had led to his death.

18. On 25 October 2012 the Kitsman Local Court suspended the civil proceedings, pending the outcome of the criminal case.

19. On 10 April 2014, after the civil proceedings had resumed, the Kitsman Local Court allowed the applicant's claim in part, relying exclusively on the facts established in the criminal proceedings. It ruled that the hospital should pay her 11,827.90 Ukrainian hryvnas (UAH) in respect of pecuniary damage, UAH 60,000 (around 3,628 euros (EUR)) in respect of non-pecuniary damage, and UAH 3,000 in respect of legal costs. The court stated that the hospital was liable for the misconduct of its employee, Dr M.

20. On 4 June 2014 the Chernivtsi Regional Court of Appeal upheld the above decision, but reduced the amount awarded in respect of pecuniary damage to UAH 11,367.90.

21. On 24 August 2014 enforcement of the above court decisions was terminated, since all the awards had been paid to the applicant.

THE COURT'S ASSESSMENT

22. The Government submitted that the applicant had had at her disposal effective domestic procedures in relation to her allegations of medical negligence.

23. The applicant insisted that the official investigations into the death of her son had not been effective, and the authorities had belatedly established medical negligence on the part of Dr M. The compensation for the medical negligence was insufficient, and the proceedings had lasted approximately eleven years.

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

25. The general principles concerning the State's procedural obligations under Article 2 of the Convention in the context of healthcare are summarised in *Lopes de Sousa Fernandes v. Portugal* ([GC], no. 56080/13, §§ 214-21, 19 December 2017).

26. The Court notes at the outset that following the applicant's complaint of medical negligence, the healthcare authorities conducted their own investigation. The applicant also had recourse to criminal and civil-law remedies.

27. The Court reiterates that in cases where the infringement of the right to life or to personal integrity is not caused intentionally, the procedural obligation imposed by the Convention to set up an effective and independent judicial system does not necessarily require the provision of a criminal-law remedy. The choice of means for ensuring the positive obligations under the Convention is in principle a matter that falls within the Contracting State's margin of appreciation. There are different avenues for ensuring Convention rights, 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, for this obligation to be satisfied, such proceedings must not only exist in theory, but also operate effectively in practice (ibid., §§ 215-16).

28. In the present case, the Court notes that the investigation by the healthcare authorities was carried out quite promptly. As a result, various shortcomings in the applicant's son's treatment in both hospitals were identified, and several doctors from both hospitals were disciplined (see paragraphs 6-8 above). However, the Court is not convinced that the actions taken within the disciplinary proceedings may be considered to have provided the applicant with proper redress.

29. As regards the criminal proceedings, the investigating authorities initially refused to institute such proceedings when the applicant made a complaint. Ultimately, they did institute the proceedings, having admitted that there was prima facie evidence of a criminal offence. Nevertheless, despite the healthcare authorities drawing the above-mentioned conclusions, the investigator subsequently attempted to terminate the criminal proceedings on three occasions. However, the relevant decisions were set aside on the basis that they were premature because the criminal investigation was incomplete (see paragraph 12 above).

30. The Court emphasises that there is no apparent reason why the criminal investigation, which lasted for more than ten years, focused mainly on the circumstances of the applicant's son's treatment in the local hospital in Kitsman (see paragraph 10 and further above). It appears that no consistent investigative steps to clarify the circumstances of his treatment in the Chernivtsi Regional Hospital were taken. Ultimately, only one accused was identified, Dr M. The investigator disregarded the fact that the Health Department had found two other doctors who worked at the local hospital in Kitsman liable for deficiencies in the applicant's son's treatment

(see paragraph 7 above). The Court further observes that the last forensic medical examination (see paragraph 13 above), which concluded that no deficiencies were present in the treatment provided at the Chernivtsi Regional Hospital, was conducted almost eight years after the death of the applicant's son.

31. Furthermore, there was an unusually high number of repeated forensic examinations during the criminal proceedings (ibid.). It could be accepted that in certain circumstances, a repeated expert examination might be required to clarify the circumstances of the case. At the same time, the fact that the same type of forensic examination was ordered several times within the same criminal proceedings suggests the lack of a comprehensive approach to the collection of evidence during the pre-trial investigation phase (see *Sergiyenko v. Ukraine*, no. 47690/07, § 52, 19 April 2012, and *Basyuk v. Ukraine*, no. 51151/10, § 68, 5 November 2015).

32. On the basis of the foregoing, the Court considers that the termination of the criminal proceedings on the grounds that they were time-barred and the eventual release of the only accused from criminal liability was the result of the flawed and protracted investigation which lasted more than ten years. The Government have not proved otherwise.

33. The Court notes that as a result of the separate civil proceedings, the applicant received compensation in respect of damage from the local hospital in Kitsman (see paragraphs 19-21 above). However, the mere fact that the outcome of those proceedings was favourable to her could not remedy the substantial shortcomings of the preceding criminal proceedings, which concern the core of the applicant's complaints under the Convention. Although it is true that the civil courts considered her claim within a relatively short period of time, such promptness was possible largely because they relied on the findings of the criminal courts.

34. The Court has previously emphasised the need for a prompt examination of cases concerning medical negligence in a hospital setting (see *Lopes de Sousa Fernandes*, cited above, § 218). Assessing the circumstances of the present case cumulatively, the Court considers that the domestic authorities failed to carry out a prompt examination of the applicant's complaint. Taken overall, the domestic legal proceedings concerning the circumstances of the death of the applicant's son lasted an excessively long period of time, were marked by various flaws and were therefore incompatible with the State's obligation under Article 2 of the Convention to carry out an effective investigation (see *Arskaya v. Ukraine*, no. 45076/05, 5 December 2013; and, *mutatis mutandis*, *Akopyan v. Ukraine*, no. 12317/06, § 97, 5 June 2014).

35. In the light of the foregoing, the Court finds a violation of the procedural aspect of Article 2 of the Convention in the present case.

APPLICATION OF ARTICLE 41 OF THE CONVENTION

36. The applicant claimed 15,000 euros (EUR) in respect of non-pecuniary damage and EUR 2,810 in respect of costs and expenses incurred before the domestic courts and before the Court.

37. The Government contended that both claims were unsubstantiated and excessive.

38. The Court awards the applicant EUR 6,000 in respect of non-pecuniary damage, plus any tax that may be chargeable.

39. Having regard to the documents in its possession and to its case-law, the Court considers it reasonable to award the applicant EUR 1,000 for costs and expenses, plus any tax that may be chargeable to her.

FOR THESE REASONS, THE COURT, UNANIMOUSLY,

1. *Declares* the application admissible;

2. *Holds* that there has been a violation of the procedural aspect of Article 2 of the Convention;

3. *Holds*
   (a) that the respondent State is to pay the applicant, within three months, the following amounts, to be converted into the currency of the respondent State at the rate applicable at the date of settlement:
      (i) EUR 6,000 (six thousand euros), plus any tax that may be chargeable, in respect of non-pecuniary damage;
      (ii) EUR 1,000 (one thousand euros), plus any tax that may be chargeable to her, 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;

4. *Dismisses* the remainder of the applicant's claim for just satisfaction.

Done in English, and notified in writing on 11 September 2025, pursuant to Rule 77 §§ 2 and 3 of the Rules of Court.

Martina Keller Deputy Registrar	Gilberto Felici President