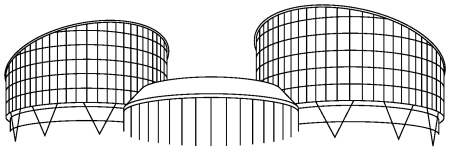

EUROPEAN COURT OF HUMAN RIGHTS
COUR EUROPÉENNE DES DROITS DE L'HOMME

FOURTH SECTION

CASE OF IONIȚĂ v. ROMANIA

(Application no. 81270/12)

JUDGMENT

This version was rectified on 28 April 2017
under Rule 81 of the Rules of Court

STRASBOURG

10 January 2017

FINAL

10/04/2017

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

In the case of Ioniță v. Romania,

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

András Sajó, *President,*
Vincent A. De Gaetano,
Nona Tsotsoria,
Egidijus Kūris,
Iulia Motoc,
Gabriele Kucsko-Stadlmayer,
Marko Bošnjak, *judges,*

and Marialena Tsirli, *Section Registrar,*

Having deliberated in private on 29 November 2016,

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

PROCEDURE

1. The case originated in an application (no. 81270/12) against Romania lodged with the Court under Article 34 of the Convention for the Protection of Human Rights and Fundamental Freedoms ("the Convention") by two Romanian nationals, Ms Dorina Ioniță and Mr Viorel-Aurel[1] Ioniță ("the applicants"), on 13 December 2012. The applicants are the parents of a child who died following surgery.

2. The Romanian Government ("the Government") were represented by their Agent, Ms C. Brumar, from the Ministry of the Foreign Affairs.

3. The applicants complained that there had been no effective investigation into the death of their son.

4. On 20 March 2014 the application was communicated to the Government.

THE FACTS

I. THE CIRCUMSTANCES OF THE CASE

5. The applicants, Dorina and Viorel-Aurel[2] Ioniță, were born in 1976 and 1972 respectively and live in Brăila.

[1] Rectified on 28 April 2017: the text was "Viorel".
[2] Rectified on 28 April 2017: the text was "Viorel".

A. Death of the applicants' son

6. On 7 November 2005 the applicants' son, aged four years and nine months at that time, underwent surgery for the removal of polyps, which was performed by Dr C.B. in the State-run Brăila Emergency Hospital.

7. Dr C.B. decided to perform the operation under general anaesthetic with tracheal intubation. The general anaesthesia was performed by Dr P.A, assisted by P.V.I., a staff nurse.

8. After surgery the child was immediately transferred to the intensive care unit. Ten minutes after his transfer P.V.I. informed Dr P.A that the child was cyanotic and had no pulse.

9. The child suffered a haemorrhage, causing blood to flood his lungs. A team of doctors tried to resuscitate him and clear his respiratory channels, but without any success. The child was declared dead two hours after the operation.

10. A criminal investigation into the cause of death was opened by the Brăila police on the same day.

11. Dr C.B. and Dr P.A. were questioned and gave written statements.

12. An autopsy report issued by the Brăila Forensic Service (*Serviciul de medicină legală Brăila*) on 8 November 2005 said that the applicants' son had died of acute respiratory failure as a result of the blood that had blocked his airways and flooded his lungs. It also noted that the child had suffered from several congenital deficiencies which had probably played a role in the post-operative complications: myocardia and hepatic dystrophy, and interatrial septum aneurisms.

13. The report was sent for the approval of the commission for confirmation and supervision of the Iaşi Forensic Institute (*Comisia de avizare şi control din cadrul IMF Iaşi*). On 5 May 2006 the commission confirmed that the child's death had occurred after surgery and had been caused by the blood that had blocked his airways and lungs. It held that there had been a causal link between the post-operative treatment and the child's death. It noted the deflation of the balloon of the catheter (*balonaşul sondei de întubaţie*), applied after post-operatively to prevent the ingress of blood into the lungs, as a possible cause of the presence of blood there and in his airways.

14. On 12 October 2006 the superior commission of the Mina Minovici Forensic Institute examined all the documents and approved the conclusions of the commission for confirmation and supervision of the Iaşi Forensic Institute.

B. Disciplinary proceedings

15. On 8 November 2005 the child's father lodged a disciplinary complaint against Dr C.B. and Dr P.A.

16. The disciplinary committee of the Brăila College of Doctors opened an investigation into the patient's death, collecting documents from the patient's medical file and taking statements from Dr C.B. and Dr P.A., as well as from the doctors involved in the resuscitation procedure post-operation. It gave its decision on 9 July 2007 by which it concluded that the child's death could be included among cases of sudden death (with a frequency of 2-4 % owing to the child's pre-existing medical conditions: myocardia and hepatic dystrophy, and inter-atrial septum aneurisms). Although the committee concluded that there had been no direct link between the child's death and the doctors' medical conduct, it reprimanded both doctors for their failure to perform the necessary pre-surgical medical tests and to seek the applicants' informed consent before surgery.

17. The applicants objected to the committee's conclusions and their appeal was examined by the superior disciplinary committee of the National College of Doctors.

18. An expert medical opinion was submitted to the committee and was used by it in reaching its final conclusions. The expert noted, among other things, that the child's preparation for surgery had not been appropriate as his examination before anaesthesia had been "very superficial"; in this respect the committee noted the lack of a radioscopy of the lungs, of an EKG and an exploration of the necessary time for blood coagulation. In the expert's view, the doctors had ignored the child's severe congenital deficiencies as they had considered that surgery for the removal of polyps had been a "minor intervention" and therefore no special precautions had been necessary.

19. By a decision of 6 June 2008 the superior disciplinary committee of the National College of Doctors quashed the decision of 9 July 2007 and fined each doctor 1,000 Romanian lei (the equivalent of approximately 220 euros (EUR)). It found that the child's pre-surgical tests had been insufficient for avoiding post-operative complications. Therefore, it held that Dr C.B. and Dr P.A. had infringed Article 53 of the Medical Deontological Code, pursuant to which a doctor should perform diagnoses with maximum diligence in order to determine the adequate treatment and avoid predictable complications that might occur for a patient under his or her care.

20. The committee further stated that the presence of blood in the child's airways could not be explained on the basis of the documents and statements in the file. It noted that all the doctors and the nurses who had given evidence stated that the balloon of the intubation catheter had been leak-proof (*etanche*); however, the fact that the cause of death had been the presence of blood in the child's lungs could only lead to the conclusion that such statements had been inaccurate.

21. Relying on Articles 58 and 60 of the Deontological Code and Article 6 of Law no. 46/2003, the committee also noted that the parents had not given their informed consent.

C. Criminal proceedings against the doctors

1. Criminal investigation

22. On 7 November 2005 the applicants lodged a criminal complaint alleging that the flawed surgical and post-surgical treatment received by their son had resulted in his death. They asked that those responsible be identified and held accountable for their son's death. They joined the criminal proceedings as civil parties.

23. Following a request of the Brăila Police Inspectorate, on 19 July 2006 Brăila Emergency Hospital stated that the medical staff members in charge of monitoring the child were Dr P.A. during the intervention and the child's transfer to the intensive care unit and P.V.I. while in the intensive care unit.

24. On 5 January 2007 the prosecutor's office of the Brăila District Court decided to institute criminal proceedings against Dr P.A.

25. P.V.I. was interviewed as a witness immediately after the child's death, during the preliminary criminal investigation. During the criminal proceedings against Dr P.A., in spite of the fact that she had been repeatedly summoned, the investigating authorities were not able to question her as she had not been found. She had left her job at the Brăila Emergency Hospital in January 2006.

26. The prosecuting authorities interviewed several doctors and nurses from the hospital's medical staff who had been involved in the applicants' son's post-operative care.

27. Dr P.A. lodged a request with the investigating body for a new forensic medical report. He pointed out that there were major contradictions between the autopsy report and the opinion issued by the commission for confirmation and supervision of the Iaşi Forensic Institute.

28. On 4 April 2007 the Brăila Police Inspectorate asked the Iaşi Forensic Institute to carry out a forensic expert report that would identify the cause and circumstances of the child's death. The Iaşi Forensic Institute replied that a new forensic report could not be produced as the evidence examined had been sent by Brăila Forensic Service to the Mina Minovici National Forensic Institute.

29. On 20 February 2008 Dr P.A. submitted an extrajudicial expert report. It stated that the cause of death had not been the presence of blood in the child's lungs owing to a lack of adequate post-operative monitoring, but the post-operative reaction of a child with pre-existing medical conditions (cardiac congenital malformation, hepatic dystrophy, renal stasis,

mesenteric adenopathy and hemorrhagic enterocolitis) mentioned in the medical records kept by the child's paediatrician. The report noted a generalised inflammatory reaction associated with diffused haemorrhages in his digestive tract, lungs, heart and spleen.

30. The applicants gave evidence to the investigating authorities on 23 January 2008. They contended that they had not been properly informed about the risks of surgery and of the general anaesthetic and consequently they had not given their consent for such interventions.

31. On 30 June 2008 the Brăila Police Inspectorate ordered that a new forensic report be produced by the Mina Minovici National Forensic Institute. The applicants, Dr P.A. and the investigating authorities submitted several questions for the forensic experts. They asked, among other things, whether the pre-existent medical condition of the child had influenced his unfavourable post-surgical evolution and whether administration of a general anaesthetic had been the right option, given the age and the diagnosis of the child. The child's father also asked the Forensic Institute whether the post-operative monitoring of the child had been adequate.

32. However, on 28 July 2008 the Forensic Institute replied that it could not deliver such a report because under the relevant domestic legislation a new forensic expert report could not be ordered unless there were new medical and factual elements. Accordingly, the Forensic Institute stated that it maintained its previous opinion.

33. Copies of the documents from the disciplinary file were added to the criminal file.

34. On 30 September 2008 the prosecutor's office of the Brăila County Court decided to discontinue the criminal proceedings against Dr P.A., finding, in the light of evidence gathered in the case, that there had been no element of criminal negligence in his conduct. That decision was upheld on 10 November 2008 by the chief prosecutor of the same prosecutor's office.

2. Court proceedings

35. A complaint by the applicants against the prosecutors' decisions was allowed by the Brăila District Court on 25 February 2009. The prosecutors' decisions were quashed and the District Court kept the file for fresh consideration. It considered that although a new forensic report had not been produced, the decision of the superior committee of the National College of Doctors provided enough information concerning the cause of death, which had been the presence of blood in the child's airways owing to the balloon of the tracheal catheter not being tight enough. It considered that it should be established whether the post-operative monitoring of the child by Dr P.A. had been appropriate and more precisely whether Dr P.A. should have noticed the non-functioning catheter.

36. Dr C.B. and Dr P.A. gave statements before the District Court on 18 January 2010. Moreover, members of the medical staff that had attempted resuscitation gave evidence (on 1 March, 20 April and 8 June 2008). Some of them maintained that the blood in the lungs could be explained by the resuscitation attempts and that the balloon of the catheter had been kept tight all the time after surgery.

37. P.V.I. did not give evidence before the court as, although summoned, she did not attend the hearings. According to several reports issued by bailiffs seeking to bring her before the court, she had left the country for Italy. Based on the material in the case file it does not appear that the court took special measures to identify her address there.

38. The child's father gave evidence before the Brăila District Court on 18 January 2010. He reiterated his claims for pecuniary and non-pecuniary damages. He again contended that the doctors had not informed his family about the risks of surgery and in particular of the general anaesthetic and accordingly they had not given their informed consent.

39. On 1 October 2010, after several hearings, the Brăila District Court acquitted Dr P.A. and dismissed the applicants' civil claim as unfounded.

40. The District Court took into account the extrajudicial forensic report submitted by Dr P.A. It noted that the conclusions of the extrajudicial report were in total contradiction to the conclusions of the medical report of 8 November 2005 and the conclusions of the commission for confirmation and supervision of the Iaşi Forensic Institute.

41. This judgment was upheld by a decision of the Brăila County Court delivered on 21 December 2010.

42. The County Court did not take into account the conclusions of the extrajudicial forensic report as in its opinion it represented only extrajudicial evidence which could not set aside the conclusions of competent forensic institutes.

43. The County Court concluded that the death of the child had been caused by the presence of blood in his airways and lungs. However, based on the evidence in the file, it was not possible to explain when the blood had entered the child's airways because of the deflation of the catheter's balloon. Moreover, the post-operative complications occurred ten minutes after the child had been transferred to the intensive care unit, while under the supervision of P.V.I. The County Court held therefore that Dr P.A. could not be held responsible for the deflation of the catheter's balloon after surgery.

44. The applicants lodged an appeal on points of law against that decision. They requested that the court extend the criminal investigation to P.V.I., who had had the child under her supervision in the intensive care unit.

45. By a decision of 15 April 2011 the Galaţi Court of Appeal allowed the applicant's appeal and quashed the decisions of the lower courts. Noting

that the lower courts had not examined the allegation made by the child's parents that they had not given their consent for surgery and the general anaesthesia, the appeal court sent the file back to the Brăila District Court.

46. On 22 December 2011 the Brăila District Court acquitted Dr P.A. It held that no causal link existed between the death of the child and the presumed omission of the medical authorities to obtain the applicants' informed consent for the administration of a general anaesthetic.

47. It further held that it could not establish beyond any reasonable doubt that Dr P.A. had been negligent in ensuring the tightness of the catheter's balloon after surgery. Consequently, the court dismissed the applicants' civil claim as unfounded.

48. The court also dismissed the applicants' request to extend the criminal investigation to P.V.I. on the grounds that, under Article 337 § 1 of the CCP, only the prosecutor could ask for the extension of the investigation to other persons while the proceedings were pending before the courts.

49. This judgment was upheld by a final decision delivered by the Galaţi Court of Appeal on 22 May 2012.

D. Separate civil proceedings

50. On 28 October 2008 the applicants instituted separate civil proceedings against the Brăila Emergency Hospital and doctors C.B. and P.A. in the Brăila District Court for the pecuniary and non-pecuniary damages they had sustained as a result of their son's death.

51. On 23 April 2009, referring to Article 19 of the CCP (see paragraph 57 below), the court stayed the civil proceedings pending a final decision in the criminal proceedings. It noted that the outcome of the civil proceedings would depend to a large extent on the verdict in the criminal proceedings.

52. On 29 January 2013 the Brăila District Court lifted the stay of the civil proceedings. However, the applicants gave up their separate civil claim on 6 March 2013.

II. RELEVANT DOMESTIC LAW

53. The relevant legal provisions and the domestic case-law and practice concerning the delivery of forensic reports, as well as the liability of medical staff, are described in *Eugenia Lazăr v. Romania* (no. 32146/05, §§ 41-54, 16 February 2010).

54. Law no. 95/2006 introduced the notion of medical negligence as a basis for the establishment of liability of medical staff and created an obligation on them to obtain insurance for any civil liability resulting from their work (see *Eugenia Lazăr*, cited above, § 54).

The civil responsibility for the damage caused is personal and proportionate to the degree of responsibility (Article 643). The Regulations adopted on 14 March 2007 by the Ministry of Health ("the Regulations") provided that the liability must be established by a court (Article 3 § 2).

Doctors have a legal obligation to insure themselves against claims of malpractice (Article 656). Under Article 662, damages are paid to the patient if the parties reach an agreement or, in the absence of such an agreement, if the doctor's liability is established by a court.

55. A series of laws concerning the public health service and patients' rights establishes an obligation to inform a patient about any surgical procedure proposed, the risks involved in the procedure, alternative treatment, and diagnosis and prognosis: Laws nos. 3/1978 and 306/2004 on public health insurance; Law no. 74/1995 on the establishment and functioning of the College of Doctors; Law no. 46/2003 on patients' rights ("Law no. 46/2003"); and Law no. 95/2006 on reform of the medical sector ("Law no. 95/2006").

56. Under Article 37 of Law no. 46/2003, a breach of a patient's right to be informed and consulted may entail disciplinary or criminal action against the medical practitioner, depending on the applicable law. The Law also regulates the patient's right to seek a second medical opinion (section 11).

57. The relevant provisions of the CCP in force at the time of the pertinent facts read as follows:

Article 15

"A person who has suffered civil damage may join the criminal proceedings ...

He or she may do so either during the criminal investigation ... or before the court ..."

Article 19

"(1) If a victim has not joined criminal proceedings as a civil party, he or she can initiate separate proceedings before the civil courts for damages arising from the offence.

(2) Civil proceedings shall be stayed pending a final judgment of the criminal courts.

(3) A victim who has joined criminal proceedings as a civil party may also initiate separate civil proceedings if the criminal proceedings are stayed. If the criminal proceedings are reopened the civil proceedings opened before the civil courts shall be stayed.

(4) A victim who has initiated civil proceedings before a civil court may abandon these proceedings and lodge a request with the investigating authorities or the trial court if criminal proceedings have subsequently been opened...The civil proceedings may not be abandoned if the civil court has delivered a judgment, even if the judgment is not a final one."

Article 22

"The findings contained in the final judgment of a criminal court concerning the issue of whether the act in question was committed and the identification of the perpetrator and establishment of his or her guilt are binding on a civil court when it examines the civil consequences of the criminal act."

Article 346

"(1) In the event of a conviction or an acquittal, or the termination of a criminal trial, the court shall deliver a judgment in which it also decides on the civil action.

(2) Where acquittal has been pronounced ... because one of the constitutive elements of an unlawful act is missing, the court may award pecuniary and non-pecuniary damages in accordance with civil law."

THE LAW

I. ALLEGED VIOLATION OF ARTICLE 2 OF THE CONVENTION

58. Relying on Article 6 § 1 of the Convention, the applicants complained that the investigation into the circumstances of the death of their son had been ineffective.

59. The Court is the master of the characterisation to be given in law to the facts and can decide to examine complaints submitted to it under another Article than that quoted by the applicant (see *Guerra and Others v. Italy*, 19 February 1998, § 44, *Reports of Judgments and Decisions* 1998-I). It will therefore examine the complaint under Article 2 of the Convention (see *Istrățoiu v. Romania* (dec.), no. 56556/10, § 56, 27 January 2015), which reads as follows:

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

A. Admissibility

60. The Government raised a preliminary objection of non-exhaustion of domestic remedies. They argued that the applicants should have continued the separate general action in tort against the doctors or other persons they considered responsible for the death of their son after their civil claim joined to the criminal proceedings had been dismissed by the Brăila County Court on 22 December 2011. They pointed out that the applicants had given up their separate civil action on 6 March 2013.

61. The Government supported their arguments that proceedings under the general law of tort would have been an effective remedy in the circumstances of the case by referring to the Court's findings in the cases of *Codarcea v. Romania* (no. 31675/04, §§ 38-48, 2 June 2009), *Stihi-Boos*

v. Romania (dec.) (no. 7823/06, §§ 42-43, 11 October 2011) and *Floarea Pop v. Romania* (no. 63101/00, § 47, 6 April 2010).

62. The applicants contested the Government's position. They argued that immediately after their son's death they had lodged disciplinary and criminal complaints, to which they had attached a civil claim. After a few months, as they had considered that the criminal investigation had been too slow and they had become afraid that their civil action would have become time-barred, they had lodged a separate action in tort. However, their compensation in the separate civil action depended on the findings of the criminal courts. Moreover, the criminal courts dismissed their civil complaint lodged together with the criminal complaint. Therefore, as the criminal courts had found no negligence in the pre- and post-operative treatment of their son, they had given up the separate civil action.

63. The Court considers that the Government's objection is closely linked to the substance of the applicants' complaints. It therefore joins the objection to the merits of the case.

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

B. Merits

1. The parties' submissions

65. The applicants complained that the criminal investigation into the death of their son had been ineffective and had exceeded a reasonable time. They claimed in particular that the domestic prosecuting authorities and courts had not exercised their active role nor examined whether P.V.I., the nurse in charge of the post-operative monitoring of the child, and Dr C.B., who performed the operation, had carried out their professional duties.

66. The applicants also contended that they did not agree with the Government's submissions that the findings of the forensic report stating that the cause of death had been the deflation of the catheter's balloon could have been rebutted by statements of witnesses and defendants. Moreover, they pointed out that the investigation performed by the prosecuting authorities had been ineffective as despite the findings of the National College of Doctors and of the forensic experts they had decided to discontinue the criminal proceedings against Dr P.A. and had not examined at all the liability of Dr C.B. and P.V.I.

67. The applicants also reiterated that they had not been informed about the nature and the risks of the procedure and accordingly they had not given their informed consent in writing as requested by law, neither for surgery nor for the general anaesthesia.

68. The Government contended that the criminal investigation had been comprehensive and thorough, in compliance with the requirements of Article 2 of the Convention. The measures taken by the authorities had been appropriate and sufficient to comply with the requirements of Article 2 of the Convention.

69. The Government considered that the present case differed significantly from *Eugenia Lazăr* (cited above). They pointed out that while in the latter case the superior commission of the Mina Minovici Institute had not been able to produce a new reasoned report to clarify contradictions between different forensic reports, in the present case the only contradictions that could be seen were between medical forensic documents on the one hand, and the documents drafted in the disciplinary proceedings and the witnesses' statements on the other.

70. According to the Government, the domestic courts examined all the evidence in the file and could not find beyond any reasonable doubt that Dr P.A. had been negligent in performing his duties. Moreover, Dr P.A.'s departures from established procedures were identified and sanctioned by the disciplinary bodies.

71. For the reasons above, they concluded that the State's responsibility could not be engaged under Article 2 of the Convention.

2. The Court's assessment

(a) General principles

72. The Court reiterates that the positive obligations imposed on the State by Article 2 of the Convention imply an obligation to put in place an efficient and independent judicial system by which the cause of death of an individual under the responsibility of health-care professionals can be established, whether they are working in the public sector or employed in private organisations, and, if necessary, to ensure accountability for their actions (see, in particular, *Calvelli and Ciglio v. Italy* [GC], no. 32967/96, § 49, ECHR 2002-I).

73. Although it cannot be inferred from the foregoing that Article 2 may entail the right to have third parties prosecuted or sentenced for a criminal offence (see *Armani Da Silva v. the United Kingdom* [GC], no. 5878/08, § 238, ECHR 2016), the Court has stated on a number of occasions that an effective judicial system, as required by Article 2, may, and under certain circumstances must, include recourse to the criminal law. However, if the infringement of the right to life or to personal integrity is not caused intentionally, the positive obligation imposed by Article 2 to set up an effective judicial system does not necessarily require the provision of a criminal-law remedy in every case. In the specific sphere of medical negligence the obligation may for instance also be satisfied if the legal system affords victims a remedy in the civil courts, either alone or in

conjunction with a remedy in the criminal courts, enabling any liability of the doctors concerned to be established and any appropriate civil redress, such as an order for damages and for the publication of the decision, to be obtained. Disciplinary measures may also be envisaged.

However, the obligations of the State under Article 2 of the Convention will not be satisfied if the protection afforded by domestic law exists only in theory: above all, it must also operate effectively in practice within a time-span such that the courts can complete their examination of the merits of each individual case (see *Calvelli and Ciglio*, cited above §§ 51-53; *Vo v. France* [GC], no. 53924/00, §§ 89-90, ECHR 2004-VIII, and *Byrzykowski v. Poland*, no. 11562/05, § 105, 27 June 2006).

74. The requirements of an effective investigation also include, among other things, the need for "thoroughness", which means that the authorities must always make a serious attempt to find out what happened and should not rely on hasty or ill-founded conclusions to close their investigation or as the basis of their decisions. They must take all reasonable steps available to them to secure the evidence concerning the incident (see *Elena Cojocaru v. Romania*, no. 74114/12, § 113, 22 March 2016).

(b) Application of the general principles to the present case

75. Turning to the facts of the present case the Court notes that following the operation performed by Dr C.B. under general anaesthetic administered by Dr P.A., the applicants' son lost his life in hospital.

76. A criminal investigation was opened. The investigating authorities ordered an autopsy and took statements from the two doctors and the applicants. This preliminary investigation ended in decisions by the prosecuting authorities on 30 September and 10 November 2008 not to commence criminal proceedings against Dr P.A. as no medical error by him had been found (see paragraph 34 above). The prosecutors did not assess the liability of Dr C.B. concerning his medical conduct.

77. On 25 February 2009 these prosecuting authorities' decisions were quashed by the Brăila District Court and the opening of criminal proceedings against Dr P.A. was ordered. The District Court observed that the investigating authorities had ignored the conclusions of the committee of the National College of Doctors, which had noted irregularities in the post-operative monitoring of the child (see paragraph 35 above).

78. The Court, like the domestic investigation authorities, notes significant discrepancies among the different forensic medical reports drafted during the criminal prosecution. The result was that the investigating authorities considered that a new forensic report was necessary for the determination of the cause of death (see paragraphs 28 and 31 above).

79. The applicants and Dr P.A. forwarded questions to be answered by forensic experts. These questions were relevant and in answering them the

forensic authorities could have helped shed light on the unfortunate events that led to the applicants' loss.

80. However, their requests to the Mina Minovici National Forensic Institute for a forensic report were rejected as the applicable law did not allow for a new forensic report to be commissioned, as the Forensic Institute had already given its opinion on the case.

81. The Court has already identified shortcomings in the Romanian legal system in this respect. In the *Eugenia Lazăr* case it considered in particular that the very existence in domestic law of provisions authorising the forensic medical institutes to ignore requests by the judicial authorities was not compatible with the State's primary duty to secure the right to life by putting in place an appropriate legal and administrative framework to establish the cause of death of an individual under the responsibility of health-care professionals (see *Eugenia Lazăr*, cited above, § 80).

82. For the Court, only a detailed and scientifically substantiated report containing reasons for the contradictions between the lower institutes' opinions and answers to the questions put by the prosecuting authorities and the applicants would have been capable of inspiring public confidence in the administration of justice and assisting the judicial authorities in discharging their duties.

83. Moreover, the Court notes that the investigating authorities never elucidated whether P.V.I. (the attending nurse) had diligently carried out her duties during the post-operative monitoring of the child. In this respect the Court points out that according to the forensic reports one of the main hypotheses for the presence of blood in the child's lungs was the deflation of the balloon of the catheter (whose role had been to prevent the ingress of blood into the child's airways) while under the surveillance of either Dr P.A. or P.V.I. After P.V.I. had been heard as a witness immediately following the child's death, she resigned from the hospital and left the country for Italy (see paragraph 37 above). The prosecuting authorities also dismissed the applicants' requests to extend the criminal proceedings and to investigate whether she could be held accountable for their son's death (see paragraph 48 above). The Court notes that although her testimony was quite important in determining the cause of the child's death no special measures had been taken by the authorities to identify her domicile in Italy to have her return to testify.

84. The applicants also complained about the alleged failure to obtain their informed written consent for the procedure. The Court has emphasised that it is important for individuals facing risks to their health to have access to information enabling them to assess those risks. It has held in particular that the Contracting States are bound to adopt the necessary regulatory measures to ensure that doctors consider the foreseeable impact of a planned medical procedure on their patients' physical integrity and to inform patients of these consequences beforehand in such a way that the latter are

able to give informed consent. As a corollary to this, if a foreseeable risk of this nature materialises without the patient having been duly informed in advance by doctors, and if, as in the instant case, those doctors work in a public hospital, the State Party concerned may be held directly liable under Article 8 for this failure to provide information (see *Trocellier v. France* (dec.), no 75725/01, § 4, ECHR 2006-XIV; *Codarcea*, cited above, § 105; and *E.M. v. Romania* (dec.), no. 20192/07, § 54, 3 June 2014).

85. The Court notes that domestic legislation expressly provided for the patient's right to receive information sufficient to allow that patient to give, with a corollary obligation on the doctor to obtain, informed consent prior to a procedure involving any risk (see paragraphs 55-56 above).

86. In the Court's opinion the informed consent of the parents in the present case was even more relevant given that the doctors involved in the applicants' son's surgery could and should have been aware that the child suffered from serious congenital medical conditions which suggested that post-operative complications should have been envisaged. Therefore, these conditions should have imposed a careful examination of all available options.

87. However, although the disciplinary committees concurred that both the surgeon and the anaesthetist had failed, prior to the procedure, to obtain the applicants' informed written consent for the procedure (see paragraphs 16 and 21 above), the domestic courts found no medical negligence in the way the doctors had performed their professional duties.

88. The Court is not in a position to contradict the domestic courts' findings concerning the absence of criminal responsibility in respect of the doctors in the case. Still, it considers that for the assessment of the case it was relevant to examine whether the operation was carried out according to the rules of the medical profession and the safeguards created by the domestic system itself (see *Csoma v. Romania*, no. 8759/05, § 57, 15 January 2013).

89. Moreover, the Court observes that the death of the applicants' son occurred in November 2005 and that the final decision in the case was taken in May 2012, six years and a half later. However, the file does not suggest that such lengthy proceedings were justified by the circumstances of the case.

90. The Court reiterates in this respect that a requirement of promptness and reasonable expedition is implicit in the investigation of cases concerning death in a hospital setting. It had already held that the knowledge of facts and possible errors committed in the course of medical care should be established promptly in order to be disseminated to the medical staff of the institution concerned so as to prevent the repetition of similar errors and thereby contribute to the safety of users of all health services (see *Byrzykowski*, cited above, § 117).

91. Against this background, the Court recalls that after the death of their son, the applicants did not remain passive and asked that the real cause of death be properly established. They lodged a disciplinary complaint with the College of Doctors and attached a civil claim to a criminal complaint asking that those responsible be identified and held accountable for their son's death (see paragraphs 15 and 22 above).

92. At the end of those proceedings, the applicants could have obtained, at least in theory, an assessment of, and compensation for, the damage suffered. However, neither of these solutions offered them redress.

93. Bearing in mind that the prosecuting authorities and the domestic criminal courts excluded medical negligence as a cause of death and dismissed their civil claim to be compensated for the damage suffered without providing additional reasons (see paragraph 47 above), although based on the same medical documents and reports with which the National College of Doctors had imposed disciplinary sanctions on both doctors involved in the intervention (Dr C.B. and Dr P.A.), the Court finds it even more difficult to see how the separate civil claim, lodged on 28 October 2008 (see paragraphs 50-52 above), could have been effective in practice in the applicants' particular situation.

94. The Court finally considers that, having pursued criminal investigations - which they had joined as civil parties (see paragraph 22 above) - for more than six years, it would be onerous to expect the applicants to continue the suspended civil proceedings.

95. In the light of the above considerations, the Court considers that the Government's objection of non-exhaustion of available domestic remedies should be dismissed and that the applicants were not provided with effective legal procedures compatible with the procedural requirements of Article 2 of the Convention.

96. Therefore, there has been a violation of Article 2 of the Convention under its procedural limb.

II. APPLICATION OF ARTICLE 41 OF THE CONVENTION

97. Article 41 of the Convention provides:

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

A. Damage

98. The applicants claimed EUR 195,000 in respect of non-pecuniary damage.

99. The Government considered the claims excessive.

100. Having regard to all the circumstances of the present case, the Court accepts that the applicants must have suffered non-pecuniary damage which cannot be compensated solely by the finding of a violation. Making its assessment on an equitable basis, the Court awards the applicants jointly EUR 12,000 in respect of non-pecuniary damage.

B. Costs and expenses

101. The applicants also claimed EUR 5,000 in total for the costs and expenses incurred before the domestic courts and the Court. However, they did not submit any documents to support their claim.

102. The Government objected to this claim and submitted that the applicants had not proved their claims.

103. 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 have been actually and necessarily incurred and are reasonable as to quantum. In the present case, regard being had to the documents in its possession and the above criteria, the Court rejects the claim for costs and expenses.

C. Default interest

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

FOR THESE REASONS, THE COURT, UNANIMOUSLY,

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

2. *Declares* the application admissible;

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

4. *Holds*

   (a) that the respondent State is to pay the applicants jointly, within three months from the date on which the judgment becomes final in accordance with Article 44 § 2 of the Convention, EUR 12,000 (twelve thousand euros), plus any tax that may be chargeable, in respect of

non-pecuniary damage, to be converted into the currency of the respondent State at the rate applicable at the date of settlement;
(b) that from the expiry of the above-mentioned three months until settlement, simple interest shall be payable on the above amount at a rate equal to the marginal lending rate of the European Central Bank during the default period plus three percentage points;

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

Done in English, and notified in writing on 10 January 2017, pursuant to Rule 77 §§ 2 and 3 of the Rules of Court.

Marialena Tsirli	András Sajó
Registrar	President