Casenotes

Right to life – European Convention on Human Rights

*Oliver Lewis**

Paul and Audrey Edwards v. The United Kingdom

(2002) 35 EHRR 19

European Court of Human Rights

Chamber composed of Mr Cabral Barreto (President), Sir Nicolas Bratza, Mr Caflisch, Mr Kuris, Mr Türmen, Mrs Greve and Mr Traja.

Judgment 14 March 2002, Application number 46477/99

Facts

In the early nineties, Christopher Edwards, the applicants' son, showed signs of developing a serious mental illness. In 1994 he moved out of his parents' home and stopped taking his medication. On 27 November 1994 he was arrested by police in Colchester for approaching young women in the street and making inappropriate suggestions. Police officers detained him overnight in the police station, suspecting that he might be mentally ill, but that he did not need urgent medical attention. The next day he was brought to the Magistrates' Court where he confronted a female prison officer and shouted obscene suggestions about women. The magistrates considered remanding him to a psychiatric hospital for assessment, but concluded there was no power to do so under section 30 of the Magistrates' Court Act 1980. No consideration was given to civil detention under sections 2, 3 or 4 of the Mental Health Act 1983 or section 35 which allows for a remand to hospital for assessment. Magistrates remanded him into custody for three days and he was taken to Chelmsford Prison that afternoon.

In the meantime Christopher Edwards's father contacted the probation service at the prison, and informed them that his son had a mental illness and had been prescribed stelazine, though he had been refusing to take it or accept that he was mentally ill. The probation officer visited the prison's health care centre and spoke to the senior medical officer (though there was a later dispute about the detail of what was passed on).

The reception staff at Chelmsford Prison noted that Christopher Edwards's behaviour was "strange" and "odd" and when being placed in the holding cell he was aggressive and tried to punch

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a prison officer. After two hours, he was screened by a non-physician member of the prison health care staff who saw no reason to admit him to the Health Care Centre. This person knew nothing about previous discussions in the court or the concerns passed onto the prison probation officer (and then onto the centre's own senior medical officer) about Christopher Edwards's mental health. There was no evidence of active mental disturbance or bizarre behaviour during the short health care interview. By this time there was no doctor on duty at the centre, nor indeed present in the prison. Christopher Edwards was admitted to the main prison and placed in cell D1–6 on his own.

Meanwhile, Richard Linford was arrested on 26 November 1994 for assault. At Maldon police station, a police surgeon certified that Richard Linford was not fit to be detained, but a psychiatric registrar decided that he did *not* need to be admitted to hospital and was fit to be detained. He was transferred to Chelmsford police station, where the police surgeon also found him fit to be detained. The registrar, who had previously treated Richard Linford, knew that he had been diagnosed at various times as suffering from schizophrenia or as having a personality disorder, but also knew him as someone who became ill when abusing alcohol and drugs. On 28 November 1994, Richard Linford was remanded in custody by Chelmsford Magistrates' Court and arrived at Chelmsford Prison shortly after Christopher Edwards, where he was screened by the same member of the prison health care service who had screened Christopher Edwards. Richard Linford was placed in a cell on his own, but later moved into cell D1–6 with Christopher Edwards. This was due to shortage of space, as all the other cells on the landing were doubly occupied.

Each cell had a green emergency light situated on the wall outside the cell next to the door which illuminated when the call button was depressed inside the cell. When the button was pressed, a buzzer sounded on the landing and a red light illuminated on a control panel in the office on the landing. At 9 p.m., either Christopher Edwards or Richard Linford pressed the call button. A prison officer saw the green light outside the cell and was told that they wished one of the cell lights, operated from the exterior, to be switched off, which he did. The two men were reported to be "getting on all right". He noticed that while the green light had gone on the buzzer which should have been sounding continuously had not done so, but did not report the defect.

Shortly before 1 a.m. on 29 November 1994, a prison officer heard a buzzer sound, but saw no red light on the D–landing control panel. Some time later, he heard continuous banging on a cell door on his landing. On going to investigate he saw the green light on outside cell D1–6. Looking through the spy hole, he saw Richard Linford holding a bloodstained plastic fork and blood on the floor and on Linford's feet. There was a delay of five minutes while officers put on protective clothing. They entered the cell to find that Christopher Edwards had been stamped and kicked to death. Richard Linford was making continual reference to being possessed by evil spirits and devils. D–landing had previously been patrolled at 12.43 a.m., which indicated that up to seventeen minutes could have elapsed from the pressing of the cell call button.

On 21 April 1995, Richard Linford pleaded guilty at Chelmsford Crown Court to the manslaughter of Christopher Edwards by reason of diminished responsibility. The judge imposed a hospital order under section 37 Mental Health Act 1983, coupled with a restriction order under section 41.

A Coroner's Inquest had been opened but adjourned pending the criminal proceedings against Richard Linford. After his conviction, the Coroner closed the Inquest, as there was no obligation to continue in those circumstances.

In July 1995, a private, non-statutory "inquiry after homicide" was commissioned by three agencies with statutory responsibilities towards Christopher Edwards – the Prison Service, Essex County Council and North Essex Health Authority. Its terms of reference included to investigate the extent to which the various authorities corresponded to statutory obligations, to examine the communication between the agencies involved in providing services to *both* men, and to examine the adequacy of the treatment and care as well as the arrest, detention and custody of them both.

On 16 October 1995, the applicants (Christopher Edwards's parents) were advised by the Assistant Chief Constable that there was insufficient evidence to establish the offence of manslaughter by gross negligence on the part of anyone involved in the case.

In February 1996, the applicants were advised by their solicitors that they had a claim for funeral costs and a potential claim for compensation and any pain and suffering between Christopher Edwards' injury and death. However, the high legal costs made it economically disadvantageous to bring such a claim. In April 1996, the Criminal Injuries Compensation Board awarded the applicants £4,550 for funeral expenses but decided that there should be no dependency or bereavement award.

The Inquiry opened in May 1996. The panel was chaired by Kieran Coonan QC with prominent psychiatric, social services, prison and police experts as members. They were assisted by a firm of solicitors. The Inquiry received evidence on 56 days over a period of 10 months. The Inquiry Panel conducted visits to the police stations, magistrates' court and prison concerned. About 150 witnesses attended the Inquiry to give evidence while a considerable number of others submitted written evidence. It sat in private and – as a non-statutory inquiry – had no powers of compulsion of witnesses or production of documents.

Two prison officers refused to give evidence. The Inquiry Report later noted that one of these had potentially significant evidence and his refusal was said to be "all the more regrettable since he had passed by Christopher Edwards's cell shortly before he met his death".

The Inquiry Report was published on 15 June 1998.[1] It ran to 388 pages and reached numerous findings of defects and made recommendations for future practice. It concluded that ideally Christopher Edwards and Richard Linford should not have been in prison and in practice they should not have been sharing the cell. It found "a systemic collapse of the protective mechanisms that ought to have operated to protect this vulnerable prisoner". It identified a series of shortcomings, including poor record-keeping, inadequate communication and limited inter-agency co-operation, and a number of missed opportunities to prevent the death of Christopher Edwards.

Following the publication of the report, the applicants sought advice as to whether there were any civil remedies available to them in the light of the findings of the Inquiry, but were advised by counsel that there were none.

By letter of 25 November 1998, the Crown Prosecution Service maintained their previous decision that there was insufficient evidence to proceed with criminal charges, an opinion supported by counsel for the applicants. Further, it is not possible under the common law to recover damages in tort for the death of another.

1 *'Report of the Inquiry into the Care and Treatment of Christopher Edwards and Richard Linford: A Report commissioned by North Essex Health Authority, Essex County Council and HM Prison Service in association with Essex Police 2001' (available from the Health Authority).*

By letter dated 15 December 2000, the Police Complaints Authority provided the applicants with a report into their complaints about police conduct in dealing with Christopher Edwards and in the subsequent investigation into the death. The report upheld fifteen of the complaints and made a number of recommendations to Essex Police in relation to practice and procedure.

Judgment

(a) Right to life – substantive aspects

The applicants complained to the European Court of Human Rights that the authorities failed to protect the life of their son and were responsible for his death. They also complained that the investigation into their son's death was not adequate or effective as required by the procedural obligation under Article 2 of the Convention, which provides in its first sentence:

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

The Court reiterated that the first sentence of Article 2(1) obliges States not only to refrain from the intentional and unlawful taking of life, but also to take appropriate steps to safeguard the lives of those within its jurisdiction, primarily by putting in place effective criminal law provisions backed up by law enforcement machinery. It also extends in appropriate circumstances to a positive obligation on the authorities to take preventive operational measures to protect an individual whose life is at risk from the criminal acts of another individual. The Court said that the scope of the positive obligation must be interpreted in a way which does not impose an impossible or disproportionate burden on the authorities. Not every claimed risk to life therefore can entail for the authorities a Convention requirement to take operational measures to prevent that risk from materialising. For a positive obligation to arise, it must be established that the authorities knew or ought to have known at the time of the existence of a real and immediate risk to the life of an identified individual from the criminal acts of a third party and that they failed to take measures within the scope of their powers which, judged reasonably, might have been expected to avoid that risk.

The Court stressed that persons in custody are in a vulnerable position and that the authorities are under a duty to protect them, a duty recognized in English and Welsh law where inquests are automatically held concerning the deaths of persons in prison and where the courts have imposed a duty of care on prison authorities in respect of those detained in their custody.

The Inquiry panel had concluded that any prisoner sharing a cell with Richard Linford that night would have been at risk to his life. For the Court, the essential question therefore was whether the prison authorities knew or ought to have known of his extreme dangerousness at the time the decision was taken to place him in the same cell as Christopher Edwards. The Court was satisfied that the answer to this question was yes.

Notwithstanding the defective buzzer system, the Court concluded that on the information available to the authorities Christopher Edwards's life was placed at risk by placing a dangerously unstable prisoner into his cell. The failure of the agencies involved to pass on information about Richard Linford to the prison authorities and the inadequate nature of the screening process on Richard Linford's arrival in prison disclosed a breach of the UK's obligation to protect the life of Christopher Edwards, in violation of Article 2 of the Convention.

(b) Right to life – procedural aspects

The obligation to protect the right to life under Article 2 of the Convention, read in conjunction with the State's general duty under Article 1 of the Convention to "secure to everyone within [its] jurisdiction the rights and freedoms defined in [the] Convention", also requires by implication that there should be some form of effective official investigation when individuals have been killed as a result of the use of force (see, *McCann and Others v. the United Kingdom*).[2] Such investigations must seek to secure the effective implementation of laws which protect the right to life and, in those cases involving State agents or bodies, to ensure their accountability for deaths occurring under their responsibility. What form of investigation will achieve those purposes may vary in different circumstances, but whichever form is employed, the authorities must act of their own motion, once the matter has come to their attention. It is not the duty of the next of kin either to lodge a formal complaint or to take responsibility for the conduct of any investigative procedures.

The Court reiterated that for an investigation into alleged unlawful killing by State agents to be effective the following points must be observed:

The persons responsible for and carrying out the investigation must be institutionally and practically **independent** from those implicated in the events.

The investigation must also be **capable of leading to the identification and punishment of those responsible**, and to a determination of whether any force used was or was not justified in the circumstances. The authorities must take reasonable steps to secure evidence, including eye witness testimony, forensic evidence and, where appropriate, an autopsy which provides a complete and accurate record of injury and an objective analysis of clinical findings, including the cause of death. Any deficiency in the investigation which undermines its ability to establish the cause of death or the person or persons responsible will risk falling short of this standard.

Inquiries must be **prompt**, to maintain public confidence in the adherence to the rule of law and in preventing any appearance of collusion in or tolerance of unlawful acts. For the same reasons, there must be a **sufficient element of public scrutiny** of the investigation or its results to secure accountability in practice as well as in theory. The degree of public scrutiny required may well vary from case to case. In all cases, however, the **victim's next-of-kin must be involved** in the procedure to the extent necessary to safeguard his or her legitimate interests.

In this case, the Court found that because Christopher Edwards was a prisoner under the care and responsibility of the State when he died from acts of violence of another prisoner, a procedural obligation arose to investigate the circumstances of his death. It was irrelevant whether State agents were involved by acts or omissions in the events leading to his death. Even if civil proceedings were available, such actions initiated by the applicants would not satisfy the State's obligation to hold an investigation of its own motion.

As no inquest was held in this case and criminal proceedings where Richard Linford was convicted did not involve a trial at which witnesses were examined, the investigation at the heart of the Court's examination was whether the Inquiry provided an effective investigative procedure, fulfilling the requirements already identified.

The Court noted that this Inquiry heard a large number of witnesses and reviewed in detail the

2 *Judgment of 22 September 1995, Series A no. 324, p. 49, § 161*

way in which the two men were treated by the various medical, police, judicial and prison authorities. The Report of the Inquiry was a meticulous document, Nonetheless, the applicants complained that the Inquiry proceedings failed to reach the required standards under Article 2 on a number of grounds:

(i) Alleged shortcomings in the investigation

The applicants complained that the police omitted certain significant steps in their investigation, a claim which the government denied. The Court found that this did not prevent the Inquiry from establishing the principal facts of the case.

(ii) Lack of power to compel witnesses

As a non-statutory inquiry, the Inquiry had no power to compel witnesses and as a result two prison officers declined to attend. One of the prison officers had walked past the cell shortly before the death was discovered and the Inquiry considered that his evidence would have had potential significance. The Government asserted that this witness had submitted two statements and that there is no indication that he had anything different or additional to add.

The Court noted that he was not available for questions to be put to him which might have required further detail or clarification or for any inconsistency or omissions in that account to be tested. The lack of compulsion of witnesses who are either eye-witnesses or have material evidence related to the circumstances of a death must be regarded as diminishing the effectiveness of the Inquiry as an investigative mechanism. In this case it detracted from its capacity to establish the facts relevant to the death, and thereby to achieve one of the purposes required by Article 2 of the Convention.

(iii) Alleged lack of independence

The applicants alleged that the Inquiry lacked independence as it was set up by the agencies with statutory responsibilities towards both Christopher Edwards and Richard Linford. The Court noted that the chairman was a senior member of the bar with judicial experience, while the other members were eminent or experienced in their fields. None had any hierarchical link to the agencies in question. It is not asserted that they failed to act with independence or that they were constrained in any way. They acted in an independent capacity, therefore the Court found no lack of independence in the Inquiry.

(iv) Alleged lack of public scrutiny

Notwithstanding the public nature of the Inquiry's report, the Inquiry sat in private during its hearing of evidence and witnesses. The applicants, parents of the deceased, were only able to attend three days of the Inquiry when they themselves were giving evidence. They were not represented and were unable to put any questions to witnesses, whether through their own counsel or otherwise. They had to wait until the publication of the final version of the Inquiry Report to discover the substance of the evidence about what had happened to their son. The applicants argued that this did not meet the standards of public scrutiny required by Article 2. The Government argued that the publication of the report secured the requisite degree of public scrutiny, but gave no reason for holding the inquiry in private.

The Court stated that where the deceased was a vulnerable individual who lost his life in a horrendous manner due to a series of failures by public bodies and servants who bore a responsibility to safeguard his welfare, the public interest attaching to the issues thrown up by the

case was such as to call for the widest exposure possible. Given their close and personal concern with the subject-matter of the Inquiry, the Court found that the parents cannot be regarded as having been involved in the procedure to the extent necessary to safeguard their interests, in violation of the procedural requirements of Article 2.

(v) Alleged lack of promptness and reasonable expedition

The applicants alleged that the Inquiry lacked sufficient promptness. Christopher Edwards died on 29 November 1994. The decision to hold an inquiry was taken in July 1995 and the proceedings opened in May 1996, with witnesses heard over the following ten-month period. The report was issued on 15 June 1998, some two years after the Inquiry opened and three and a half years after the death.

The Court noted the considerable amount of preparation required for an inquiry of this complexity, the number of witnesses involved in the proceedings (about 150 people gave oral evidence) and the wide scope of the investigation which covered the involvement of numerous public services. It held that authorities acted with sufficient promptness and proceeded with reasonable expedition.

(c) Article 13

Article 13 of the Convention provides:

> "Everyone whose rights and freedoms as set forth in [the] Convention are violated shall have an effective remedy before a national authority notwithstanding that the violation has been committed by persons acting in an official capacity."

Article 13 guarantees the availability at national level of a remedy to enforce the substance of the Convention rights. Article 13 thus requires the provision of a domestic remedy to deal with the substance of an "arguable complaint" under the Convention and to grant appropriate relief.

The remedy required by Article 13 must be "effective" in practice as well as in law. There must be a mechanism for a victim or family to establish any liability of State officials or bodies for acts or omissions involving the breach of their rights under the Convention. The Court added that in the case of Articles 2 (right to life) and 3 (right to be free from torture, inhuman and degrading treatment or punishment) of the Convention, compensation for the non-pecuniary damage flowing from the breach should in principle be available as part of the range of redress.

On the basis of the evidence adduced in the present case, the Court found that the Government was responsible under Article 2 for failing adequately to protect the life of Christopher Edwards while he was in the care of the prison authorities. The Court recalled that in general actions in the domestic courts for damages may provide an effective remedy in cases of alleged unlawfulness or negligence by public authorities. However the Court did not find that civil action in negligence or under the Fatal Accidents Act 1976 was in the circumstances of the case of practical use. Nor would a case which could be brought under the Human Rights Act 1998, as it would relate only to any continuing breach of the Convention after the entry into force of the Act (2 October 2000) and would not provide damages related to the death of Christopher Edwards which preceded that date.

No other procedure whereby the liability of the authorities can be established in an independent, public and effective manner was referred to. The Court therefore found the applicants did not have

available to them an appropriate means of obtaining a determination of their allegations that the authorities failed to protect their son's right to life and the possibility of obtaining an enforceable award of compensation for damages. For a bereaved parent this was an essential element of a remedy under Article 13, which in this case had been violated.[3]

Costs

Under Article 44 of the Convention, the Court ordered the government to pay the applicants £20,000 in respect of non-pecuniary damage and £20,000 in respect of costs and expenses plus taxes.

Commentary

The tragic death of Christopher Edwards and the determination of his parents to seek justice[4] demonstrates the way that a system may fail adequately to protect the life of an individual and then fail to allow that person's grieving family to have a full investigation into the death. Although it was not the purpose of the Inquiry to offer comfort to the family of Christopher Edwards, Inquiries must have in mind not just the feelings of secondary victims of homicides, but also their human rights.

Perhaps the more interesting aspect of this case from a legal perspective is how the procedural aspects of Article 2 – not set out in the Convention itself – have evolved since the mid 1990s in a series of cases brought to the Strasbourg court against primarily the UK and Turkey. It is now clear that where a death occurs – whether or not at the hands of state agents,[5] and whether or not violence was used[6] – there must be an investigation which is independent, public, prompt, thorough, effective, capable of imputing responsibility for the death, and enables effective involvement of the next of kin. This obligation now extends to cases of possible medical negligence in respect of an individual under the care and responsibility of health professionals,[7] and to situations where victims have been paid compensation but there has been no (or an inadequate) investigation.[8]

The death of Christopher Edwards was the central issue of at least six different domestic investigations: *First*, the criminal trial of Richard Linford at which he pleaded guilty to the manslaughter of Christopher Edwards by reason of diminished responsibility. *Second*, the Crown Prosecution Service which decided there was insufficient evidence to proceed with criminal charges. *Third*, the Coroner's Inquest which had closed without hearing evidence after the conviction of Richard Linford. *Fourth*, the Police Complaints Authority reported on police conduct in dealing with Christopher Edwards and in the subsequent investigation into the death,

3 *See also Keenan v. the United Kingdom, (2001) 33 E.H.R.R. 38, paragraph 132*

4 *See Edwards, A, "No Truth, No Justice: A David and Goliath Story of a Mother's Struggle Against Public Authorities to Secure Justice for Her Son, Murdered While in Their Care" Waterside Press, 2002*

5 *See Yasa v. Turkey (1999) 28 E.H.R.R. 408; Kaya v. Turkey (1998) 28 E.H.R.R. 1; Cakici v. Turkey, Judgment 8 July 1999 (paragraph 87)*

6 *See McShane v. the United Kingdom (2002) 34 E.H.R.R. 23*

7 *See Erikson v. Italy, Application no. 37900/97, judgment 26 October 1999, Siemiska v. Poland, Application no. 37602/97, judgment 29 March 2001 and Powell v. the United Kingdom, Application no. 45305/99; admissibility decision 4 May 2000.*

8 *See Jordan v. the United Kingdom , (2001) 11 B.H.R.C. 1*

upholding fifteen of the applicants' complaints and making a number of recommendations to Essex Police in relation to practice and procedure. *Fifth*, the Health and Safety Executive carried out an investigation focusing on the management of the two people in prison. *Sixth*, the private, non-statutory Inquiry chaired by Kieran Coonan QC which was the subject of the case at Strasbourg.

Notwithstanding the elaborate (not to mention expensive) system of investigating deaths in England and Wales, the Court found that the UK had failed in its obligation under the procedural aspects of the right to life. Principally there were two aspects of the Inquiry which were found to violate Article 2:

First, that the Inquiry sat in private. Thus Christopher Edwards's parents were not allowed to be present or take part in the proceedings. They had to wait two years after the Inquiry opened and three and a half years after the death to find out the circumstances surrounding their son's death. Had there been a full coroner's inquest, the family would have been entitled to be present and be represented (albeit without public funding) by counsel.

In order not to fall foul of ECHR standards in future Inquiries, the Inquiry Chairperson could meet the family of the deceased to enquire into whether they would like to be present during the hearing, and if so, whether they would like to be legally represented. Such representation would have to be funded by the commissioning health or social services authority. In *Edwards* the UK government provided no reasons for the Inquiry being held in private. The Court stated that it "considers that the public interest attaching to the issues thrown up by the case was such as to call for the widest exposure possible".[9] How one would challenge an Inquiry which (with the next-of-kin's consent) sits in private is a matter for speculation. It would be difficult if not impossible for a non next-of-kin to challenge this given the current rules of victim status in Article 34 of the Convention and jurisprudence under that Article.[10]

Second, the Court found that the Inquiry's inability in law to compel witnesses to attend to give live evidence diminished the effectiveness of the Inquiry as an investigative mechanism and detracted from its capacity to establish the facts relevant to the death.[11] Although it has been said that witnesses who do not attend voluntarily are "usually unwilling and unforthcoming witnesses, if not actually unreliable",[12] this was an exceptional case where there were witnesses who could usefully have been cross-examined about information not contained in their written statements.

The UK government has issued no guidance following the *Edwards* case. Given that there are numerous Inquiries taking place across the country, Inquiry panels may find themselves – as many have done in the past – in a position where they want to compel a witness to attend but lack the legal basis on which to do so. In such circumstances (and if the specific statutory criteria are met) the panel or the appointing authority could ask the Secretary of State to establish a statutory inquiry either under section 125 Mental Health Act 1983 or under section 84 National Health Service Act 1977. If this is refused, the Inquiry or appointing authority might contemplate issuing proceedings in the Administrative Court to challenge the Secretary of State's refusal to comply

9 *Paragraph 83 of the judgment.*

10 *Article 34 ECHR states that the Court may receive an application from any individual or group "claiming to be the victim of a violation" of the Convention.*

11 *The Inquiry lacked the power to compel witnesses as it was non-statutory and thus fell outside the scope of the Tribunals and Inquiries Act 1992.*

12 *Clothier, C., "Ruminations on Inquiries", in Peay, J. (ed), Inquiries After Homicide, 1996*

with Convention requirements.

A final point of interest is that of victim status. The Strasbourg Court has said that, "[t]he mere knowledge of the killing on the part of the authorities gives rise *ipso facto* to an obligation under Article 2 of the Convention to carry out an effective investigation into the circumstances surrounding the death."[13] Relatives do not need to instigate such investigations, but the Convention allows relatives of those who have died to be regarded as "victims".[14] What happens in cases where there are no family members? There are alarming cases of grossly elevated mortality rates within some State-run mental health institutions within the Strasbourg Court's jurisdiction.[15] When residents die (for example of malnutrition or hypothermia) there are no investigations of any sort. For thousands of vulnerable people facing early and un-investigated death there is often no-one – like Paul and Audrey Edwards – to bring such gross failures to the Court's attention. The Council of Europe should re-visit the Convention's rule on victim status and allow non-governmental organizations to lodge Article 2 complaints in which they are not the primary victim. This may save the lives of numerous people for whom the right to life protection under the European Convention of Human Rights is currently meaningless.

13 *Ergi v. Turkey, Judgment 28 July 1998. R.J.D. 1998–IV 1778 (paragraph 82)*

14 *See Article 34 of the Convention and Yasa v Turkey (1999) 28 E.H.R.R. 408 (nephew of deceased as victim); H v. the United Kingdom, Application no. 9833/82; 42 D.R. 53 (mother of murdered person as victim); Wolfgram v. Germany, Application no. 11257/84; 49 D.R. 213 (parents of deceased as victims).*

15 *See for example, Amnesty International, "Bulgaria: Where are the men of Dragash Voyvoda?", AI Index: EUR 15/005/2003, which states that, "[t]he most telling indicator of the gross neglect that men of Dragash Voyvoda had been subjected to was the unacceptably high mortality rate in the institution. During 2001, approximately every fifth man in this social care home, which held around 140 men, died apparently as a result of inadequate medical treatment and care."*