Medical Investigation and Documentation of Torture

A Handbook for Health Professionals

Michael Peel and Noam Lubell
with Jonathan Beynon

Human Rights Centre, University of Essex

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Foreign & Commonwealth Office

HUMAN RIGHTS CENTRE

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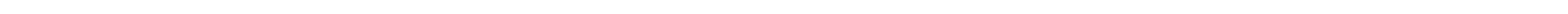

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Foreword

Apart from notorious aberrations, such as the Nazi medical experimentation inflicted on prisoners during the Second World War, it is hardly usual to think of medical personnel as having a role in the area of torture. Those most prominently at risk of being implicated or in a position to prevent or repress it tend to be law enforcement officials and those involved in the administration of justice, such as judges and prosecutors. Yet, occasionally, doctors may find themselves participating in torture, for instance in advising interrogators how much pain an individual may be able to stand during interrogation. More commonly, doctors may be called on to examine victims of torture, for diagnostic or forensic purposes, but then fail to carry out their certification functions professionally. This may be for such reasons as a lack of professional training, fear of reprisals or over-identification with law enforcement.

This Handbook is primarily aimed at raising awareness of relevant medical ethical, legal and professional standards of the many health professionals who would wish to do the most conscientious job, with a view to helping victims of torture and contributing to efforts to eliminate the practice. The key task is to establish the most scientifically valid documentation concerning possible torture of individuals, consistent with the often difficult conditions under which the work sometimes has to be undertaken. It is inspired by The Istanbul Protocol, approved by United Nations bodies, which lays down the best professional standards for physicians working in the field. Yet it recognises that not all health professionals called on to do the work will have extensive experience in this field and it presents the material in a way that aims to be accessible to all these professionals.

Guidance is given in the general skills of interviewing, as well as the medical examination and documentation. In addition to the relevant ethical and legal principles, the Handbook also points to sources of advice for those who wish to further their knowledge or gain support and advice on particular situations

The latest in a series of widely appreciated publications, this Handbook is produced by the University of Essex Human Rights Centre, with the support of the United Kingdom Foreign and Commonwealth Office. Indeed, it is intended to be complementary to its predecessors: ***The Torture Reporting Handbook***, ***Combating Torture: A Manual for Judges and Prosecutors*** and ***Reporting Killings as Human Rights Violations***

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September 2005

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The individuals and organisations involved in the production of this Handbook have long experience of work in this field and have taken part in many anti-torture related projects, including the development of The Istanbul Protocol, and often in collaboration with others. Certain sections of this Handbook therefore owe a debt to existing publications and authors whose material has been relied upon, in particular the following:
The Istanbul Protocol; Peel, M. and Iacopino, V. (eds.) ***The Medical Documentation of Torture***, especially: Chapter 7 (Allden K., Psychological Consequences of Torture), Chapter 9 (Kirschner, R. and Peel, M., Physical Examination for Late Signs of Torture), Chapter 10 (Forrest, D., Examination following Specific Forms of Torture), Chapter 11 (Hinshelwood, G., Sexual Abuse of Females), Chapter 12 (Peel, M., Male Sexual Abuse in Detention), and Chapter 13 (Danielsen, L., The Examination and Investigation of Electric Shock Injuries; Giffard, C., ***The Torture Reporting Handbook***; Foley, C., ***Combating Torture***; Peel, M., Hinshelwood, G. and Forrest, D., The Physical and Psychological Findings Following the Late Examination of Victims of Torture, ***Torture*** 2000. Full details of these publications appear at the end of this Handbook.

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Executive Summary

Torture is the deliberate infliction of severe pain or suffering, physical or mental. When perpetrated by someone who is working as or with the approval of an agent of a state, torture is a violation of international human rights law. Allegations of torture must be investigated by the state and, if they are found to have substance, prosecuted. States that fail to prevent, investigate or prosecute torture may be breaching various universal human rights conventions and, for many countries, also regional international agreements. The United Nations has several mechanisms that investigate widespread allegations of torture, and national and international NGOs are encouraged to gather information and pass it on (see ***The Torture Reporting Handbook*** see section 8.2 for further details).

Torture can be prevented in part by the regular inspection of detention facilities by independent bodies. Different countries do this in different ways, and there are also independent international organisations with considerable experience in visiting places of detention, including the International Committee of the Red Cross (ICRC) and the Committee for the Prevention of Torture (CPT) of the Council of Europe. The Optional Protocol of the UN Convention Against Torture requires signatories both to establish national visiting mechanisms and to allow visits by an international body of experts formed under the Protocol.

The documentation of torture is generally a multi-disciplinary task in which doctors and other health professionals (for example nurses and psychologists) have important roles. These range from the treatment of individuals seeking medical help for health problems that are a consequence of being tortured, through working in NGOs that provide services to victims of torture, to participating in official visiting bodies. Health professionals have an ethical duty to treat victims of torture and, with their consent, to make the relevant authorities aware of the torture, providing this does not put the subjects or those close to them at risk.

Documentation can take a range of formats. Well-written clinical notes are indispensable in medico-legal settings, or an NGO may bring together a number of reports to provide an anonymised summary of human rights abuses in a particular place. A health professional can be asked to provide a medico-legal report, which can be a statement of fact and opinion. It is important, however, not to express an opinion without the necessary expertise. With experience and, if available, training, a health professional should be able to produce a high standard of documentation, and if required, a good quality report. The aim of this Handbook is to introduce health professionals to the framework and key elements for providing accurate medical documentation of allegations of ill-treatment.

The first part of any documentation is an account by the individual of the ill-treatment that he or she suffered. A survivor of torture is in a vulnerable situation, and the circumstances of any interview may contribute to this

vulnerability (e.g. a history and examination that may have to be conducted on someone in custody of the police or military). Witnesses who may not themselves have been similarly ill-treated might also be vulnerable. The health professional may have limited control over the environment of the interview, but where possible the environment should be as neutral as it can be. The interviewer should avoid leading or closed questions. Some cognitive techniques can be valuable. Photography, drawings or body diagrams, and notes about demeanour are helpful. Consent is essential, and intrusive physical examinations must be avoided. An expert clinical opinion can be sought regarding the physical and psychological findings. The absence of any clinical findings does not necessarily mean that ill-treatment has not occurred.

There are many reasons why accounts may differ from one telling to the next, or may conflict with other evidence. This does not mean that the individual is not telling the truth about what happened. For example, both head injuries and post-traumatic stress disorder can interfere with normal memory function. However, discrepancies should be probed, and explained in any subsequent report. Explanations should be in the clinical sphere, as it is not the health professional who is the ultimate arbiter of fact.

The documentation of torture must take into account often complex histories of repeated arrests and detention, and repeated and varying levels of both mental and physical torments and suffering. By approaching the documentation within the framework given in this Handbook, each element of the complex history can be identified and addressed. While medical documentation cannot by itself definitively prove torture, it often provides a central element in corroborating (or refuting) allegations of torture, be they in instances of asylum claims, complaints and investigations against security forces, or investigations by international bodies or organisations. Physical findings are described using standard technical terms such as ‘abrasion’, ‘bruising’, ‘laceration’, ‘dislocation’ and ‘fracture’. Any report can then assess the consistency, within a clinical context, between these findings and the individual’s account.

The psychological evaluation is equally important in the documentation of torture since both physical and psychological methods produce psychological sequelae. ‘Purely psychological’ forms of torture are not uncommon and need to be explored in as much detail as physical torture because the consequences can be equally severe. Frequent diagnoses are depression and post-traumatic stress disorder, and they may co-exist. Many survivors of torture prefer not to show emotion when describing their experiences and may not be aware of the clinical significance of symptoms such as nightmares. So, the absence of psychological findings does not necessarily mean that the account of ill-treatment is false.

Thus health professionals have an important role in the investigation and documentation of torture. Health professionals have a moral, ethical and legal duty to assist within their capabilities. It is within the capability of most experienced health professionals to document torture and to work with multidisciplinary teams investigating allegations. The skills include those of interviewing the patient - taking a history; making a psychological assessment; and documenting both psychological and physical signs of trauma. Report writing involves documenting facts and drawing conclusions within the professional capability of the writer.

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Glossary of Specialised Terms

Medical Terms:

Auditory hallucinations	The experience of external sounds where there are no external stimuli
Axilla	Armpit
Brachial plexus	The nerves running from the spine into the arm
Callus	An area of thickening of bone at the place of healing
Cerebral oedema	Swelling of the brain
Cognitive impairment	Partial impairment of memory, thinking, perception or mood
Depigmentation	Complete loss of pigment from a patch of skin
Haematuria	Blood in the urine
Hyperpigmentation	Increase in pigmentation of a patch of skin
Hypopigmentation	Partial loss of pigment from a patch of skin
Intrusive memories	Involuntary, unpleasant and recurrent memories of an incident
Laceration	A wound in which the skin is torn by blunt force
Medical history	An individual's personal account of a health problem
Medico-legal	Relating to that branch of medicine that assists the courts
Neuropathy	Nerve damage
Oedematous	Swollen
Pathognomonic	A pathological finding that has only one cause
Perianal	Around the anus
Petechiae	Clusters of very small bruises
Psychosomatic symptoms	Apparently physical symptoms that have a psychological cause
Retinal haemorrhage	Bleeding into the back of the eye
Sequelae	The consequences of a medical problem
Striae distensae	Stretch marks of the skin
Subdural bleeding	Bleeding between certain layers of fibrous tissue covering the brain
Tonic-clonic fits	The common form of epileptic convulsions
Urethral meatus	The aperture at the end of the penis through which urine is voided
Vectors of Disease	Agents that can transmit infections

Legal Terms:

Term	Definition
Arrest	The act of apprehending a person for the alleged commission of an offence or by the action of an authority.
Asylum	Asylum is sought by individuals who do not wish to return to a country, usually their own, where they are at risk. If granted, they would be allowed to remain in a country which is not their own. This may be temporary or permanent.
Convention	see Treaty
Corroboration	Evidence which supports or confirms the truth of an allegation.
Crimes against humanity	Serious acts, such as torture, committed as part of a widespread or systematic attack against a civilian population, whether or not they are committed in the course of an armed conflict.
Declaration	A particularly formal resolution, usually of the United Nations General Assembly, which is not as such legally-binding, but sets out standards which states undertake to respect
Deportation	Expulsion from a country.
Derogate	To temporarily suspend or limit.
Detention	Depriving a person of personal liberty except as a result of conviction for an offence.
Domestic law or legal system	National law or legal system; law or legal system which is specific to a particular country.
Enforcement (of obligations)	Making the obligations effective; ensuring that they are respected.
Impunity	Being able to avoid punishment for illegal or undesirable behaviour.
Incommunicado detention	Being held by the authorities without being allowed any contact with the outside world.
Instrument	A general term to refer to international law documents, whether legally binding or not.
Inter-governmental body	A body or organisation composed of the governmental representatives of more than one country.
Judicial	Relating to the administration of justice or the courts of law.
Legally-binding	If something is legally-binding on a state, this means that the state is obliged to act in accordance with it, and there may be legal consequences if it does not do so.
Monitoring	Seeking and receiving information for the purpose of reporting on a subject or situation.
Non-state actors	Private persons or groups acting independently of the authorities.
Perpetrator	The person who has carried out an act.
Ratification	The process through which a state agrees to be bound by a treaty.
Reparation	Measures to repair damage caused, e.g. compensation.
State Party (to a treaty)	State which has agreed to be bound to a treaty.
Treaty	International law document which sets out legally-binding obligations for states.
Violation (of obligations)	Failure by a state to respect its obligations under international law.
War Crimes	Serious violations of the rules of war, for which the perpetrator can be held criminally responsible.

1 Introduction

The purpose of this Handbook is to raise awareness, particularly amongst health professionals, of the existence and nature of torture, and to advise on how to recognise and document it, especially for those health professionals with little or no forensic expertise. Medical documentation may occur shortly after the episode, while the person is still in detention or soon after release (if he or she is detained), or at a later stage (sometimes months or years after) such as during asylum claims.

The principal reference for the medical documentation of torture is the Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (The Istanbul Protocol), published by the United Nations. This Handbook draws substantially on information contained in The Istanbul Protocol and seeks to enhance the accessibility of the subject matter it covers. (For further details about The Istanbul Protocol and other relevant literature, see section 8.)

Torture is prohibited in all legal systems, but it continues to be widespread throughout the world, sometimes disguised by the use of misleading terms such as ‘stress and duress’, or ‘coercive interrogation’. The effective investigation of torture, whether by official bodies or NGOs, requires proper and accurate documentation. A health professional may be faced with documenting allegations alone (for instance when a family practitioner receives such an allegation from a patient in the course of their routine practice); or may potentially have the support of other professional colleagues (for example while working in a hospital setting when confronted by a patient who alleges or shows signs of torture); or may benefit from forming part of a team tasked specifically with investigating and documenting allegations of torture (such a team may include a lawyer, a human rights monitor, a psychologist or others) such as found in centres dealing with asylum seekers.

Torture can occur anywhere but usually occurs during the initial phase of arrest and detention, thus often in the hands of police, gendarmerie, military or other security agencies and may be in official places of detention such as police stations, or in unofficial (or 'secret') locations. The fact that torture may not just be confined to places of detention is recognised in the Statute of the International Criminal Court, which states that it may occur when a person is ‘in the custody or control’ of a party. Torture and other forms of cruel, inhuman and degrading treatment or punishment can also occur in the hands of opposition forces and informal militias. There is a duty on the state to protect people from these groups and to investigate and punish as necessary.

Torture is not just limited to what happens in the interrogation room, but may also relate to specific elements of the conditions of detention which are constructed to deliberately aggravate the mental and physical suffering. Often the generally harsh conditions of detention (including inadequate or insufficient food, hygiene, personal

cleanliness, access to toilets, access to medical care) are aimed at exerting further pressure on individuals and contribute to and form part of ill-treatment that may in some cases constitute torture.

This Handbook does not cover the situation where the victim of torture is dead when first examined. For that situation, please see the UN Manual on the Effective Prevention and Investigation of Extra-Legal, Arbitrary and Summary Executions (Minnesota Protocol), and the University of Essex Handbook, ***Reporting Killings as Human Rights Violations***Also for guidelines on examining the dead see recommendations of the International Committee of the Red Cross in The Missing and their Families: Documents of Reference, ICRC. (For details see section 8.)

1.1 Who is this Handbook for?

The Handbook is designed to assist all health professionals such as doctors, nurses and other clinicians, working with individuals who have suffered from ill-treatment, including torture.

Health professionals may encounter torture survivors in a number of different situations. For each of the health professionals in the different scenarios there are different, although related, ethical and practical issues that apply:

- Health professionals in primary care or emergency departments to whom the individual complains of ill-treatment or who note signs of torture. In such cases the health professional may not necessarily have to write a report, but may just need to know how to make a proper examination and a good set of medical notes which document the case
- Health professionals in hospitals or clinics who may be asked by, for example, police or military, to examine a detainee. Health professionals need to be aware of the possible existence of torture and also of the problems they may face in obtaining a history and examining the person
- Health professionals examining individuals in a specialist centre for survivors of torture
- Forensic doctors and psychiatrists who might be asked by the individual or by the authorities to provide a forensic opinion. The health professional's primary (but not exclusive) duty in such cases is to the court rather than to the patient
- Prison health professionals who may see survivors of torture when these are transferred from police or military detention to prison
- Health professionals working for the authorities who might come across survivors of torture, including health professionals in the prison service, the police and the military. For these groups there are specific issues of dual loyalties (that is, a conflict of interest arising when a health professional owes a duty to a patient on the one hand, and to the state authorities – for instance in the form of prison, police or military hierarchies - on the other hand)
- Those health professionals who are asked to visit a prison or other place of detention as part of an independent investigation or monitoring team.

1.2 How to use the Handbook

Following this introductory chapter, the Handbook opens with a chapter containing an explanation of the prohibition of torture and other ill-treatment, including the legal definitions and relevant international legal and ethical codes of particular relevance to health professionals. The settings in which torture may occur and how they might come to their attention are also described.

Chapter 3 discusses those aspects of medical ethics that are relevant to health professionals and others working with those alleging torture. Some of the practical and ethical dilemmas and difficulties that health professionals may encounter are raised in this chapter, as are the ethical principles governing these situations.

The next chapter sets out the aims and objectives of the investigation and documentation of torture, and discusses the way that different members of the investigation team can work together to gather information and to write reports. Chapter 4 also gives general guidelines on evidence gathering and clarifies the role of medical documentation and evidence within a wider team effort. It includes general principles for effective documentation, and an explanation of how to compile medical documentation and give a medical opinion within the context of the documentation of torture.

Chapter 5 covers the crucial process of interviewing. Guidance is given on the gathering of detailed and accurate information, while taking into account the vulnerability of the individual, cultural and gender issues, and the environment in which the interview is conducted. Information on interview techniques and working with interpreters is also covered in this section.

Chapter 6, the most detailed chapter of the Handbook, describes how to conduct a medical examination of those alleging torture and other ill-treatment. It assumes no previous experience of documenting torture, and covers all major aspects of physical and psychological examination. This section points out some of the common physical and mental effects of torture and other ill-treatment, and how to identify and document them.

Chapter 7 gives specific advice for those visiting places of detention, and explains how to approach a visit, what aspects of the general conditions to look into and how to document allegations of ill-treatment when the individual may still be in the power of the responsible authorities.

Specialised medical and legal terms, if not explained within the body of the text, can in most cases be found in the Glossary at the start of this Handbook.

The Handbook aims to provide a comprehensive understanding and guidance for the reader, and it is recommended that health professionals familiarise themselves with the contents of all sections. However, each chapter is intended to be self-contained and can be read separately.

Following the guidelines provided in the Handbook should lead to a high standard of medical investigation and documentation. However, it is recognised that it may not always be possible to follow every part of the guidelines due to external constraints. In these cases, the documentation and investigation should not be abandoned, but should attempt to follow the guidelines as closely as circumstances allow.

The information in the Handbook relies on a variety of sources, all listed at the end of the Handbook. Those seeking further information on any of the topics covered in the Handbook will be able to use this list of general documents, specific academic articles, and the contact details and websites of relevant organisations, as guidance for further reading and assistance.

2 The Prohibition of Torture

2.1 Introduction

In order to conduct effective documentation and investigation of torture, it is necessary to have an understanding of the meaning of torture, its prohibition, the definitions in international law, and the legal implications of its use. The object of this chapter is to provide an overview of the prohibition, explain the key elements that are found in torture and other ill-treatment, and to give guidance on how to recognise unlawful treatment. Rather than being a technical and detailed description of all legal aspects, this chapter is written for non-lawyers and aims to supply the basic foundations of knowledge needed by all those who come into contact with torture and its victims, with special attention given to health professionals. The chapter also contains information about the types of situations in which allegations of torture might arise, and sets out the aims and objectives which documentation and investigation hope to achieve.

2.2 What is torture?

2.2.1 The prohibition in international law

The prohibition of torture in international law is notable in that it is absolute, applying at all times and in all circumstances. Article 5 of the 1948 Universal Declaration of Human Rights states: 'No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.' The right to be free from torture and other ill-treatment is taken up in major international and regional human rights treaties, including the International Covenant on Civil and Political Rights (1966), the European Convention on Human Rights (1950), the American Convention on Human Rights (1978) and the African Charter on Human and People's Rights (1981). In 1984 the UN adopted the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, highlighting the particular attention given to this absolute prohibition, and providing additional rules to assist in prevention and investigation.

The prohibition of torture is the concern not only of those countries which have ratified particular treaties, but is also a rule of general or customary international law, which binds all states even in the absence of treaty ratification. In fact, the prohibition of torture is generally regarded as having the special status of a 'peremptory norm' of international law, and states cannot choose to disregard or derogate from it.

In addition to international law, many national laws will also include a prohibition of torture. However, the lack of a clear prohibition in domestic law will not release the state from its international legal obligations to refrain from and prevent torture under all circumstances, and to investigate allegations, punish perpetrators, and provide reparation to victims.

The prohibition against torture and other ill-treatment extends even to times of armed conflict, whether the conflict is international (between countries) or internal (within a single country). In times of conflict all parties have to refrain from subjecting anyone in their hands to torture and other ill-treatment, whether they are combatants taking part in the fighting, whether they no longer take part in the fighting (e.g. due to being detained, or being wounded or sick) or whether they are civilians. International humanitarian law, of which the Geneva Conventions form a part, contains laws protecting people in times of armed conflict. The prohibition against torture in humanitarian law is expressly found in a number of provisions of the four 1949 Geneva Conventions and their Additional Protocols of 1977. An act of torture committed in the context of an armed conflict is a war crime.

Torture is also considered to be a crime against humanity when the acts are perpetrated as part of a widespread or systematic attack against a civilian population, whether or not they are committed in the course of an armed conflict.

Under international law, the use of torture can be regarded as both the responsibility of the state itself and engage the individual criminal responsibility of persons involved. Those who carry out the act of torture can be tried in domestic and international courts.

In summary, the strong and unequivocal prohibition of torture means that torture can never be justified, in any situation, including public emergencies and even war. No case of torture, whatever the circumstances, can be ignored.

2.2.2 Definition of torture

2.2.2.1 Definitions of torture and other ill-treatment

The most widely accepted definition of torture is to be found in the United Nations Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT), adopted in 1984:
'any act by which ***severe pain or suffering*** , whether ***physical or mental,*** is ***intentionally*** inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted ***by*** or ***at the instigation of*** or ***with the consent or acquiescence of*** a ***public official*** or ***other person acting in an official capacity***. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions.' (Emphasis added.)

Other treaties and declarations also contain definitions of torture, sometimes with slight variations, though the essence remains the same.

The World Medical Association (WMA), in its Declaration of Tokyo (1975), defined torture more broadly as: 'the deliberate, systematic or wanton infliction of physical or mental suffering by one or more persons acting

alone or on the orders of any authority, to force another person to yield information, to make a confession, or for any other reason'.

2.2.2.2 *Key elements of torture*

The key elements for the determination of torture are:

- The intentional infliction of severe physical or mental pain or suffering
- By or with the consent or acquiescence of the state authorities
- For a specific purpose, such as gaining information, punishment or intimidation.

2.2.2.3 *Other ill-treatment*

In addition to the absolute prohibition of torture, there is also a wider prohibition of cruel, inhuman or degrading treatment or punishment. These are legal terms, describing forms of ill-treatment, also banned by international law. Ill-treatment does not have to be inflicted for a specific purpose, but there does have to be an intent to expose individuals to the conditions which amount to or result in the ill-treatment. Exposing a person to conditions reasonably believed to constitute ill-treatment will entail responsibility for its infliction. Degrading treatment will usually involve humiliation and debasement of the victim. The essential elements which constitute ill-treatment not amounting to torture would therefore be reduced to:

- Intentional exposure to significant physical or mental pain or suffering
- By or with the consent or acquiescence of the state authorities.

2.2.2.4 *Relationship between torture and ill-treatment*

Determining the boundaries between torture and other ill-treatment, and between different types of ill-treatment, can be a difficult task. In most instances it is courts and other authoritative bodies that decide on a case-by-case basis which category may apply, while the role of the doctor is to provide the objective clinical findings of the case without necessarily forming a judgement on whether the treatment was degrading, inhuman or torture. Both torture and other ill-treatment will involve significant suffering and will be caused by or with consent or acquiescence of state or other authorities exercising effective power.

The health professional or other individual investigating and documenting allegations of torture, should document his or her findings, but leave the precise legal interpretation to the legal bodies.

2.2.2.5 *The use of the terms 'torture' and 'ill-treatment' in this Handbook*

Both the terms of torture and of ill-treatment appear throughout this Handbook . While torture in a strictly legal sense does not include all forms of ill-treatment, for the sake of simplicity and clarity in some instances this Handbook will employ the term 'torture' as a shorthand term implying 'torture and all other ill-treatment'. While there are differences of legal definition, within the context of this Handbook the reader should view torture and ill-treatment as interchangeable. As noted above, health professionals need not concern themselves whether the definition of the abusive act was torture or other ill-treatment. Similar legal and ethical rules apply to most cases of torture and other ill-treatment, and any form of these will always be contrary to international law and thus illegal. The individuals who have suffered from torture and all other ill-treatment equally deserve that

investigation, documentation, medical treatment and rehabilitation should take place with utmost efficiency and expedition.

2.2.2.6 Forms of torture and other ill-treatment

It is clear that most forms of torture and other ill-treatment involve both physical and psychological components – physical ill-treatment will generally produce psychological sequelae, and psychological ill-treatment may also produce physical sequelae.

Over the years a wide variety of abusive acts has been declared by authoritative bodies as violating the prohibition of torture and other ill-treatment. A sample could include:

- Beatings on the soles of the feet
- Suspension by the arms while these are tied behind the back and similar forced positions
- Severe forms of beatings
- Infliction of wounds or injuries
- Cigarette burns, or burns with other instruments or substances
- Electric shocks
- Rape or other sexual violence or molestation
- Near asphyxiation
- Pharmacological abuse using toxic doses of sedatives, neuroleptics, paralytics, etc
- Mock executions and mock amputations
- Forced breach of religious or cultural prohibitions or taboos such as dietary codes
- Sensory manipulation methods, such as hooding (sensory deprivation) and constant noise (sensory overload)
- Forced to witness torture or atrocities being inflicted on others
- Prolonged solitary confinement, particularly if combined with incommunicado detention
- Extremely poor conditions of detention
- Threats of any of the above being inflicted on the victim or family.

The above examples do not by any means constitute a definitive list. There are many other forms of abuse that have been witnessed in the past, and there will probably be new forms in the future. All the definitions of torture deliberately avoid providing a list of methods that are seen as torture. One of the reasons for this is that such a list would be read as exhaustive, and those engaged in such practices would simply devise methods that do not appear on the list, in an attempt to circumvent the definition. A complex context-dependent phenomenon such as torture cannot be simply reduced to a list of acts.

It is crucial to document specific methods of interrogation that may variously be used on individuals. Forcing individuals to remain in painful stress positions during or between episodes of interrogation, is an example of a method that has been described as ill-treatment. It is important to understand that the methods used may be

physical or psychological or frequently a combination of the two. Whereas some methods on their own may amount to torture, in other cases significance is attached to the use of a combination of methods, which may collectively amount to torture. Also, the length of time over which the individual is subjected to the methods may be decisive. Again, for this reason, it is important to document as accurately and completely as possible all the events to which an individual was exposed and their consequences.

In describing or determining the existence of torture or other ill-treatment it is important to stress that these terms apply not only to the treatment inflicted during an actual interrogation session, but may also cover the general conditions of detention in which people are held. If the conditions of detention are deliberately harsh with a view to causing more suffering to the individuals, then this may in and of itself amount to torture or other ill-treatment. Thus it is important to document, not only specific physical and psychological methods of interrogation, but also to document the living conditions, including hygiene, food, and access to health care (see Chapter 7 on visiting places of detention).

Particular forms of detention such as prolonged use of solitary confinement might themselves be a form of ill-treatment, particularly if combined with lack of communication with the outside world. It is clear that poor general conditions of detention, particularly poor nutrition, poor medical treatment, exposure to insects and other vectors of disease etc, may all lead to physical as well as psychological ill-health.

2.2.3 The subjective element of suffering

It is important to keep in mind that, when assessing the degree of suffering involved, one should take into account the identity and background of the victim. For example, certain situations that might be relatively bearable for some people could be degrading and humiliating to those of a particular gender, culture or religious faith. Torture and other ill-treatment can also often go hand-in-hand with discrimination, based on race, religion, gender or other factors, which may exacerbate the distress. In addition, physical and mental suffering can differ amongst categories of victims, for example some tortures may exacerbate pre-existing health problems, and children may experience a higher degree of suffering than adults undergoing similar ill-treatment. All these factors should be taken into account in documenting the victim's experience.

2.2.4 Additional rules relevant to the prevention of ill-treatment

Ill-treatment and torture are most common during the initial phase of arrest but may well also occur during ongoing detention or imprisonment, so other internationally accepted standards for the treatment of prisoners can be applicable to the protection of prisoners. While these standards are not legally binding, they provide a useful set of norms and guiding principles which can be used by the international community in interpreting the above prohibitions on torture, cruel, inhuman or degrading treatment or punishment, and the obligation of humane treatment and respect for human dignity. The standards promoted by the United Nations (UN Standard Minimum Rules for the Treatment of Prisoners, the Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment, and the Basic Principles for the Treatment of Prisoners) apply globally, whereas

others, such as the Standards of the Committee for the Prevention of Torture (CPT), and the European Prison Rules apply only regionally, in this case in Europe (for details of all these, see section 8.4).

Health professionals should be aware of the specific provisions of these standards dealing with health care for prisoners and other persons held in detention. These include the availability of medical care, including physical and mental health care; segregation of prisoners with suspected contagious conditions; regular inspections of food, hygiene and sanitation. Non-observance of these standards can contribute to the creation of detention conditions that may well amount to ill-treatment.

Miguel Angel Estrella v. Uruguay, Communication No. 74/1980,
U.N. Doc. CCPR/C/OP/2 at 93 (1990).
UN Human Rights Committee

This communication was submitted to the Human Rights Committee by an Argentinean citizen (a concert pianist by profession) who had been detained and tortured in Uruguay. The case highlights the severity of suffering caused by psychological torture.

The communication contained the following description by the victim:

'The tortures consisted of electric shocks, beatings with rubber truncheons, punches and kicks, hanging us up with our hands tied behind our backs, pushing us into water until we were nearly asphyxiated, making us stand with legs apart and arms raised for up to 20 hours, and psychological torture. The latter consisted chiefly in threats of torture or violence to relatives or friends, or of dispatch to Argentina to be executed; in threats of making us witness the torture of friends, and in inducing in us a state of hallucination in which we thought we could see and hear chimes which were not real. In my own case, their point of concentration was my hands. For hours upon end, they put me through a mock amputation with an electric saw, telling me: "we are going to do the same to you as Victor Jara" [a well-known Chilean singer and guitarist who was found dead in the national stadium shortly after the 1973 coup, with his hands smashed]. Amongst the effects from which I suffered as a result were a loss of sensitivity in both arms and hands for eleven months, discomfort that still persists in the right thumb, and severe pain in the knees.'

Following their assessment of the case, the Human Rights Committee found that:

'On 15 December 1977, at a time when the author was about to leave Uruguay, he and his friend, Luis Bracony, were kidnapped at his home in Montevideo by some 15 strongly armed individuals in civilian clothes. They were brought blindfolded to a place where he recognized the voices of Raquel Odasso and Luisana Olivera. There the author was subjected to severe physical and psychological torture, including the threat that the author's hands would be cut off by an electric saw, in an effort to force him to admit subversive activities. This ill-treatment had lasting effects, particularly to his arms and hands.'

And that

'Miguel Angel Estrella was subjected to torture during the first days of his detention (15-23 December 1977).'

2.3 The perpetrators

2.3.1 State actors (t hose who act on behalf of the state)

As is emphasised above (section 2.2.2), the legal definition of torture implies that the behaviour in question be carried out by, or with the approval of, a representative of the authority in power. Considering the common purposes of torture, which may be to obtain information during an interrogation, or sometimes, to intimidate the population as a whole in the face of insurrection or disturbance, it is unsurprising that the principal perpetrators are those officials involved in the criminal investigation process, and those responsible for the security of the state.

This means that those most likely to be involved in torture and other forms of ill-treatment include:

- The police
- The gendarmerie (in countries where this institution exists)
- The military
- State intelligence agents
- Paramilitary forces or other armed groups acting in connection with official forces
- State-controlled counter-insurgency forces
- Prison officers
- Private contractors carrying out any of the above activities
- Co-detainees or other members of the general population acting with the acquiescence of or on the orders of public officials.

Health professionals, even those not directly employed by the state, may also be involved in acts of torture and other ill-treatment. Doctors, psychiatrists or nurses might participate in torture either by direct involvement (be it through medical monitoring of the torture, certifying someone fit for interrogation, or even using medical knowledge to design or refine methods of torture or other ill-treatment), by assisting in a cover-up (for example, by issuing misleading medical reports), or by omission (such as failing to give necessary treatment). As noted earlier, torture is a crime, and any involvement in torture can lead to criminal charges being brought against those involved, including health professionals.

2.3.2 Non-state actors

In addition, torture often occurs in the context of armed conflicts, particularly internal conflicts involving forces in opposition to the recognised authorities, and which exercise effective power. In such circumstances, torture and other forms of ill-treatment may also be inflicted, for example by opposition forces, who are also bound by customary international law and Geneva Convention standards to refrain from torture.

Furthermore, if an organised group, whether or not it is a party to an armed conflict, engages in acts of torture or other ill-treatment against a civilian population, on a systematic or widespread scale, it can be guilty under international law of violating the prohibition of torture or other ill-treatment.

2.3.2.1 Protection from third parties

The main focus of this Handbook is on torture and other ill-treatment by state agents, particularly law enforcement officials. However, there is also a growing acceptance of the importance of safeguarding people from similar treatment carried out by private groups or individuals. States are responsible for safeguarding the rights of everyone within their jurisdiction and may under some circumstances be held accountable for acts carried out by private individuals if it supports or tolerates them, or fails in other ways to provide effective protection in law and in practice against them.

2.3.3 Obligation to investigate and bring to justice

The prohibition of torture is not limited to a negative obligation to refrain from causing suffering, but also contains wider obligations: including the obligation to investigate allegations and bring the perpetrators to justice. The UN Convention Against Torture (UNCAT) states clearly in article 12: 'Each State Party shall ensure that its competent authorities proceed to a prompt and impartial investigation, wherever there is reasonable ground to believe that an act of torture has been committed in any territory under its jurisdiction.' The next article adds an obligation to ensure that individuals have the possibility to lodge a complaint, and that this complaint be investigated.

The European Court of Human Rights has noted that without such a duty to investigate, 'the general legal prohibition of torture and inhuman and degrading treatment and punishment, despite its fundamental importance, would be ineffective in practice and it would be possible in some cases for agents of the state to abuse the rights of those within their control with virtual impunity'. The Inter-American Court of Human Rights has similarly found the failure to mount an effective investigation to be a violation of the right to be protected against torture and inhuman treatment.

Investigations should not be dependent on the lodging of a complaint. States must launch an investigation whenever there is reasonable suspicion that torture has taken place. The European Court of Human Rights has stated in this regard that where an individual is taken into police custody in good health but is found to be injured at the time of release, it is incumbent on the state to provide a plausible explanation as to the cause of the injury. Since it is likely that health professionals would be amongst the first to discover any signs of abuse, the initiation of an investigation relies heavily on their awareness, assessment and subsequent action.

2.4 Situations in which torture allegations may arise

Torture may take place in any location and within numerous contexts. In some countries, torture is commonplace. Certain times and situations could, however, be considered as high-risk circumstances. These include conflict zones, and situations of political unrest or general violence.

Allegations of torture can come from a variety of sources and at different times. The primary source of information is clearly from the individuals themselves, and this could happen while in custody, immediately after release, or at a later date. The families of survivors are another extremely important source of information as the survivors of torture themselves may be unable, or unwilling, to speak out. In any of the descriptions below, the role of families should also be kept in mind. Information can also come from other sources, such as the media and the work of non-governmental organisations.

Health professionals may find themselves being called upon to assist with an investigation in addition to providing medical treatment. Documentation may range from clear, comprehensive notes that may be summarised later, to a full medico-legal report. Sometimes useful evidence can be gained from analysing clinical data on survivors of torture and presenting them in a way that does not permit individuals to be identified.

Detainees are probably the segment of population most likely to suffer torture and other ill-treatment since this kind of abuse is usually inflicted while an individual is in some form of custody. The greatest risk of torture and other forms of ill-treatment to individuals is in the first phase of arrest and detention, before they have access to a lawyer or court. Furthermore, incommunicado detention (i.e. detaining somebody without allowing them access to anyone, such as their lawyer or family) is probably the single highest risk factor for torture because it means that there is no external monitoring of the detention and interrogation process.

It should also be remembered that while torture per se is less common once a person is on remand or sentenced and in prison, deliberately poor conditions of detention themselves, certain treatment or punishments inflicted by staff, or a failure to protect individuals from other prisoners, may also amount to forms of ill-treatment or, in some cases, torture.

2.4.1 Formal inspection of detention facilities

There are a number of bodies that may have the ability to conduct regular inspection of detention facilities. These could be monitoring bodies from within the prison authority; governmental inspection bodies; independent ombudsmen; national human rights commissions; the office of the public defender or other bodies from within the legal system; international organisations; domestic non-governmental organisations (NGOs).

The International Committee of the Red Cross (ICRC) visits people deprived of freedom in times of armed conflict (on the mandate of the ICRC, see section 7.3), to check that they are treated humanely and in accordance with international law (both humanitarian law and human rights law). The ICRC undertakes visits under non-negotiable modalities which include: access to all places of detention and all people detained and to make a register of all those who wish to have their details recorded; the possibility to select individual detainees to talk with in private, and the possibility to repeat the visits as often as is deemed necessary. During visits, the ICRC takes the humane treatment of detainees to encompass not only freedom from torture and other ill-treatment, but also general conditions of detention that maintain both the physical and mental integrity of the individuals. Their findings are communicated and discussed on a confidential basis with the concerned authorities.

Other bodies, particularly human rights NGOs, are sometimes more likely to gain ad hoc permission to conduct an inspection, rather than regular access. On occasion, inspections might be limited by restricted access to the detainees, or detainees may be wary of complaining for fear of retribution. In such cases it is nevertheless often possible for the inspection team to assess the likelihood of prevailing ill-treatment, especially in relation to the physical conditions of detention (see also Chapter 7). Most often, existing national oversight mechanisms will have most access to prisons, but may have less access to police stations. Access to interrogation centres and military camps may be even more restricted.

Recognising the vulnerability and need for enhanced protection of people in custody, the UN adopted an Optional Protocol to the UN Convention Against Torture in December 2002. This instrument creates a mechanism for regular inspection, by independent international and national bodies, of all places where people are deprived of liberty, within countries that agree to be bound by this Protocol.

2.4.2 Official complaints to human rights bodies and other organisations

Allegations of torture and other ill-treatment can be presented to a variety of human rights bodies. Many countries have a human rights ombudsman or a commission which might receive and investigate complaints. This might also be a body with a specific mandate on treatment of prisoners. Additionally, there are numerous regional and international human rights mechanisms which can also, under certain circumstances, receive allegations. These include the UN Committee Against Torture, the UN Human Rights Committee, the UN Special Rapporteur on Torture, the UN Special Rapporteur on the Right to Health, the UN Special Rapporteur on Violence against Women, the European Court of Human Rights, the African Commission on Human and Peoples' Rights, the Inter-American Commission on Human Rights and others (see ***The Torture Reporting Handbook***, section 8.2).

In situations where the ICRC is active, the humanitarian organisation can, under specific circumstances, receive allegations of arrest and detention of individuals and make direct enquiries of their whereabouts with the authorities and during visits to places of detention. If located, the ICRC is often able to put the detainee in contact with their family through a system of Red Cross Messages.

2.4.3 Recently released detainees

Individuals who have recently been released from detention or prison might seek medical and legal advice concerning their treatment while in custody. This could, in some circumstances, be their first opportunity to detail fully their conditions of detention and any ill-treatment they may have undergone. The continuing physical and mental effects of ill-treatment may also lead recently released detainees to seek medical treatment. The initial concern of the individual seeking medical care might be to receive treatment, rather than the actual allegation of torture, but good contemporaneous notes will help if he or she wants these effects to be documented in due course. The person giving advice or treatment should inquire sensitively into the possibility of ill-treatment, and advise on avenues of further action (see ***The Torture Reporting Handbook***, section 8.2).

2.4.4 NGO information gathering

Non-governmental human rights organisations, including medical organisations, or any other body engaged in monitoring and advocacy, may uncover evidence of torture and other ill-treatment during their work. Through a combination of meticulous research including field-work, interviews with survivors and families, meetings with public officials, information from the media, and cooperation between organisations, it may be possible to identify a pattern of human rights abuses that may not have been evident when viewing each source separately. This is often the way in which systematic torture and other ill-treatment come to light.

2.4.5 Late allegations

Given the traumatic effects of torture, evidence may be kept concealed by survivors before being disclosed by them much later. The newly disclosed evidence could be the result of a change in government or government policy which leads to an uncovering of the actions of their predecessors. Mountains of evidence can surface through various types of truth and reconciliation commissions which are working to uncover past abuses as part of a national healing process. Additionally, allegations might come to light at different stages of a legal process, even at quite late stages. There have also been cases when acknowledgement of torture practices appeared in interviews and publications of retired officials who had been responsible for acts of torture or other ill-treatment earlier in their lives.

3 Medical Ethics

3.1 Introduction

Medical ethics broadly describes the moral framework in which health professionals are bound to carry out their work. Many of the rules and principles of medical ethics have been adopted as professional codes of conduct. While ethics must guide every action of health professionals in their work, in the process of investigating and documenting allegations of torture, there are three areas in which the health professional must be particularly cognizant of specific ethical considerations. The first is the duty to the patient, the second is the clinical independence of the health professional and the third is in the production of medical records, reports and testimony (the latter will be covered in section 4.5).

There are certain ethical issues which are more likely to come to the fore depending on the various situations in which health professionals may encounter those alleging or showing signs of torture (see section 1.1). While there is not sufficient space in this Handbook to describe each issue in detail, this chapter points out the particular ethical considerations raised by situations such as the examination of an individual who is brought to a hospital or clinic still in the custody of the police, military or other security forces, and difficulties encountered by health professionals employed by the police, military or prison authorities.

3.2 Duties of the health professional

Health professionals have a duty to treat all patients without any form of discrimination and to provide treatment based only upon medical criteria without outside influence. In cases where torture or other ill-treatment is suspected, the health professional must keep in mind that these are crimes under international law, and probably domestic law. Therefore, irrespective of what the individual may be suspected, charged or convicted, the health professional's duty is to document objectively any psychological or physical findings and, where pertinent, provide treatment or referral to colleagues for treatment. Thus those who become aware of torture have a duty to act, both to relieve the suffering and to document the evidence. To do nothing may be seen as acquiescence and as compounding the abuse. On the other hand, when choosing a course of action, consideration also needs to be given to the torture victim's situation and how the risk of reprisals can be avoided or minimised (see sections 3.2.7, 3.2.8, 3.2.9, 3.2.10 and 3.2.11).

3.2.1 International codes

Many UN documents address the specific ethical obligations of doctors and other health professionals, for example in Principles of Medical Ethics Relevant to the Role of Health Personnel, Particularly Physicians, in the Protection of Prisoners and Detainees Against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment; Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment; Standard Minimum Rules for the Treatment of Prisoners; and the Manual on the Effective

Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (The Istanbul Protocol). These documents stress that it is a gross contravention of health care ethics to participate, actively or passively, in torture or other ill-treatment, or condone it in any way. Medical services must be provided for all patients without discrimination. They reinforce the ethical obligations of health professionals to act in the best interests of patients. For details of all these documents and other sources mentioned in this chapter, see Chapter 8.

3.2.2 Ethical rules directly prohibiting involvement in torture

A number of international ethical standards deal directly with the obligations of health professionals with regard to torture and other ill-treatment. The World Medical Association's 1975 Declaration of Tokyo, Guidelines for Medical Doctors Concerning Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment, contains an unequivocal prohibition on any form of active or passive participation of a doctor in torture or other ill-treatment. According to the declaration:

> 'The doctor shall not countenance, condone or participate in the practice of torture or other forms of cruel, inhuman or degrading procedures, whatever the offence of which the victim of such procedure is suspected, accused or guilty, and whatever the victim's belief or motives, and in all situations, including armed conflict and civil strife.
>
> 'The doctor shall not provide any premises, instruments, substances or knowledge to facilitate the practice of torture or other forms of cruel, inhuman or degrading treatment or to diminish the ability of the victim to resist such treatment.
>
> 'The doctor shall not be present during any procedure during which torture or other forms of cruel, inhuman or degrading treatment are used or threatened.'

Principles of medical ethics apply not only to doctors, but to all health care professionals. Nurses may also find themselves faced with patients who are survivors of torture or other ill-treatment, and the Position Statement on Nurses' Role in the Care of Prisoners and Detainees, of the International Council of Nurses, has stressed the fundamental obligation of the nurse to restore the health and alleviate the suffering of the patient, including prisoners, and to protect them from abuse and ill-treatment. Similarly, the World Psychiatric Association has issued specific guidance which prohibits any participation of psychiatrists in torture (Declaration of Madrid 1996).

'Participation' in torture refers to some action at the time of the abuse or later, or by omission. It includes evaluating an individual's capacity to withstand ill-treatment; being present at, supervising or inflicting ill-treatment; resuscitating individuals for the purposes of further ill-treatment; providing medical treatment on the instructions of those likely to be responsible for torture (rather than on the basis of clinical judgement); or providing professional medical knowledge or individuals' personal health information to torturers. Omission includes the deliberate withholding of medical treatment so as to aggravate suffering intentionally or neglecting

evidence. The failure to report cases of ill-treatment or torture that a health professional has noted is at least acquiescence in torture, and the falsifying of medical notes or reports is a form of complicity in the abuse.

3.2.3 Primary loyalty to the patient

The principles of medical ethics make it clear that the primary loyalty of the health professional is to the patient. While the health professional may feel bound towards the state as an employer or for ideological reasons, their first and foremost obligation is always to the patient. According to the Tokyo Declaration '…the doctor's fundamental role is to alleviate the distress of his or her fellow men, and no motive whether personal, collective or political shall prevail against this higher purpose.'

In fact, according to the World Medical Association's Declaration on the Rights of the Patient**,** 'whenever legislation, government action or any other administration or institution denies patients these rights, physicians should pursue appropriate means to assure or to restore them'.

3.2.4 Dual obligations

Many health professionals have dual obligations (also referred to as 'dual loyalties'), in that they owe a primary duty to the patient to promote his or her best interests and often a separate duty to employers. There is also a general duty to society to ensure that violations of human rights are prevented, and that justice is done when they have already happened. The dilemmas arising from dual obligations are particularly acute, however, for health professionals working with the police, military, and other security services or in the prison system. In these situations, either through the fact of their employment or ideological reasons, the obligations to their employer (the state) as well as the interests of their employer and their non-medical colleagues may all be in conflict with the best interests of their patients. A military doctor, for example, may belong to the very same government forces to which suspected perpetrators belong, thus interposing the loyalty to their comrades, military unit and military objectives, between the obligation to the individual patient. A military or prison doctor may be under pressure to ignore allegations, or not conduct proper examinations and/or to falsify any record of their findings.

However, as a health professional, there is a particular duty to act impartially and to document and report any suspected ill-treatment through the appropriate channels. A health professional must only document that which they have personally verified themselves, and they must document this truthfully, fully and accurately. Health professionals must be able to make clinical decisions independently from employers, governments, and other bodies in order to act in the best medical interests of their patients. They cannot be obliged by contractual or other considerations to compromise their professional independence.

There are various situations in which dual obligations and other ethical and legal issues may arise:

- They could be asked to perform a medical examination prior to interrogation in order to verify that the individual will be able to withstand physical torture or other ill-treatment
- They could be asked to revive or treat an individual during an abusive interrogation to enable further interrogation

- They may be asked to provide medical knowledge or individual medical information concerning physical health or to identify psychological weaknesses or fears, that can be exploited in order to facilitate interrogation, or to develop new methods
- Health professionals could be asked to be complicit in the falsifying of medical reports in order to cover-up any indications of abuse.

Health professionals undertaking the above tasks may be guilty of playing an active or passive role in the abuse of an individual. In all these cases the health professional must abide by the rules of medical ethics and retain their primary loyalty to the patient, refusing to participate in or condone torture or other ill-treatment, and doing all they can to end the abuse, including the full and accurate documentation of any possible psychological or physical sequelae.

It should be kept in mind that in addition to the principles of medical ethics, health professionals working for the state are also bound by the rules of international law (see section 2.2) and which could in certain cases lead to individual criminal responsibility of the health professional for participation in torture. Obeying the orders of a superior would not provide a defence to a charge of participation in torture.

Forensic doctors may have a different relationship with individuals they examine. In their usual function, the main duty of the forensic doctor is to the courts, to which they provide independent medical expert opinion, even though they may be paid by one or other party. Before beginning any examination, forensic doctors must explain their role to the individual and make clear that medical confidentiality is not a usual part of their role, as it would be in a therapeutic context, as their primary duty is to objectively document evidence that can be presented to a court. However, forensic doctors should not examine individuals without making clear the nature of their role and gaining specific consent. If consent is refused, this must be noted and respected. Depending on the jurisdiction, following such refusal by the subject, a court order may be required before any examination or taking of samples can proceed. The forensic doctor should seek to include in their findings and report, only that medical information that is relevant to the case, and should leave out that medical information which can remain confidential to the patient (e.g. if HIV status is not relevant to the case, then it should not be raised in the findings). They must not falsify their reports but provide impartial evidence, including making clear in their reports any evidence of ill-treatment.

3.2.5 The treatment of prisoners and detainees

The rules of medical ethics and medical professional codes do not allow for discrimination in the provision of health care to prisoners and detainees. Individuals under arrest or any form of detention must have access to a standard of health care and services, and compassionate care, which are equivalent to that of the surrounding general population. This applies to health professionals who work directly in prisons or other detention centres, and equally to health professionals working in the national health services to whom prisoners may be referred.

3.2.6 Issues surrounding examinations of individuals in the presence of security forces

Health professionals, whether working in places of detention, called to visit a police station or other place of detention, or working in national health services, may well be presented with detainees to examine in the presence of security forces. The reasons for such examination may include a statutory initial medical examination upon arrival in a place of detention, complaint of illness or ill-treatment by a detainee, or routine referral for medical treatment. When faced with a detainee, the health professional must apply their usual ethical principles in any assessment and treatment. The detainee must give informed consent to any examination, procedure or treatment, and this should include an explanation of who will have access to any findings, and how these findings may be used.

Two further points of particular importance in the examination of detainees must be highlighted: the maintenance of medical confidentiality and the use of restraints (such as handcuffs) on detainees. Medical ethics dictates that consultations and the information gained therein should be confidential between the doctor and the patient. In the case of prisoners, the security forces (police, military or prison guards) will often maintain that they must remain present during any consultation, the most common reason being that it is for the protection of the health professionals. In some circumstances, the security personnel might insist that the detainee remain in restraints (handcuffs, ankle-cuffs) and even with a hood or blindfold during the consultation. Thus there is an immediate conflict between security and medical concerns.

As stated above, health professionals have a duty to observe their usual ethical practice in their treatment of detainees. In brief, there can be no blanket rule that dictates that all detainees are dangerous and merit in all circumstances the presence of security personnel and/or restraints. If escape is an issue, health professionals can conduct consultations with the security personnel outside the door, or as a less acceptable alternative, with the door open and the personnel out of range of hearing. Further, security concerns can be addressed by conducting the consultation in a room that has only one entrance, and either no windows or barred windows.

The routine use of restraints during medical consultation or treatment is also contrary to medical ethics and international standards on treatment of prisoners, and health professionals must not accept such practices. Restraints not only interfere with the proper diagnosis, management and treatment of patients, but they also run contrary to the inherent dignity of all human beings. The only possible acceptable justification for use of restraints is as a last resort when there is substantiated reason to believe that this particular detainee presents an immediate and current violent threat to himself or others. Health professionals can and should question the use of restraints if they have reason to doubt such a risk exists. In the exceptional circumstances that restraints are used, they should be as minimal as possible.

The use of hoods or blindfolds during any contact between a detainee and health professionals is absolutely unacceptable under any circumstances. The use of hoods or blindfolds has in itself been found to be a form of ill-treatment. In the health setting hoods or blindfolds not only impair any meaningful contact with the patient, they

also prevent the identification of any health professionals and may thus add to a perception of impunity in any cases of ill-treatment.

3.2.7 Abusive medical treatment

Health professionals should also be wary of any attempts to ask them to administer treatment or medication that are not aimed at benefiting the physical or mental health of the patient, but only at assisting an interrogation or the management of a patient or detainee.

The individual need not be in prison, or in detention at all, to be tortured. Health professionals must be aware that they might be considered responsible for ill-treatment in settings where patients do not have freedom of movement, for example those detained under mental health legislation or in facilities for the elderly. Inappropriate use of medical treatment, such as overuse of sedatives, may also be ill-treatment.

3.2.8 Consent and confidentiality

It is a principle of ethical practice that patients must understand what is happening to them and consent to it. This is extremely important in working with torture survivors who have been in the situation of having no control over any aspect of their lives. It is essential they do not feel powerless in the subsequent clinical setting. This is particularly true of medico-legal work in which the documentation will be in the public domain. For consent to be valid, the patient must understand how the data gained from the examination will be used, how it will be stored and who will have access to it.

While all statements emphasise the obligation to act in the best interests of the individual being examined or treated, this presupposes that health professionals know what is in the patient's interests. A fundamental idea in modern medical ethics is that patients are the best judges of their own interests. This requires that health professionals should normally give precedence to the competent adult patient's wishes. Where the patient is unconscious or otherwise incapable of giving valid consent, health professionals must make a judgement about how that person's best interests can be protected and promoted. Nurses and doctors are expected to act as the advocate of their patients' well-being and this is made clear in professional statements.

Conflicts arise where health professionals are pressured or required by law to disclose information to third parties about patients without consent. This may include an obligation to report torture or serious crimes (possibly including torture itself). A health professional may receive an allegation of torture on the patients' understanding that they are only seeking treatment and that the information will not be disclosed to others for fear of reprisals or other reasons. The health professional must contemplate the risks to the patient, and indeed to themselves, in disclosing such information, and the potential benefits to society as a whole (e.g. potentially avoiding further harm to others), before acting. Whatever decision is reached the health professional should endeavour to gain consent. In such cases, the fundamental ethical obligations to respect autonomy and to act in the best interests of the patient are more important than other considerations, although the duty to avoid harm includes that to third parties. Health professionals should make clear to any authority requesting information that

they are bound by professional duties of confidentiality. Health professionals responding in this way are entitled to the support of their professional association and colleagues.

The Geneva Conventions give particular protection to doctor-patient confidentiality in periods of international armed conflict, for example, requiring that doctors should not be compelled to disclose information about their patients to the opposing side.

3.2.9 Security

The security of the individual who may complain of or show signs of ill-treatment is closely related to the issues of consent and confidentiality described above. In examining or treating these individuals, the health professional must keep in mind the security of both the patient and themselves. Often, the patient may have the impression that the health professional can provide an element of physical protection, and even prevent further arrest or ill-treatment. This sense of protection may be even more commonplace when health professionals visit the individual while they are still detained (particularly if it is a visit by an international team) since it is assumed that the fact of having access to the place of detention invests them with greater powers.

The security of the individual extends to how any information collected is used or to whom it is divulged. Clearly the release of any information is governed by the issues of consent and of confidentiality since identifiable information may itself lead to recriminations for the individual, or their family, or indeed the health personnel. Health professionals thus have a duty to ensure that individuals are aware of the limits of their ability to protect them, and must ensure that no information is released or passed on that may put interviewees at risk. All documentation must be stored safely.

3.2.10 Involvement of other health professionals in torture

Health professionals may at times have concerns that other health professionals might be participating directly or indirectly in the torture or other ill-treatment of individuals. The appropriate course of action in such cases can depend on the particular circumstances, for instance whether the concerned health professional is working within the same institution as those he or she suspects; whether he or she is a local practitioner or part of an international visiting team; and the assessment of level of risk that may be involved in various courses of action. In some cases, a private discussion with trusted colleagues may be enough to clarify and bring about positive change. In other cases, there may be a need to turn (sometimes discreetly) to outside bodies, national or international (such as medical associations or human rights bodies), in order to seek advice. Section 3.2.11 provides more information on seeking further advice.

3.2.11 Seeking furthe r information and support

Health professionals who encounter any of the above situations, and have concerns on how to act, can seek information and support from a variety of bodies, national and even international, who may be able to provide more specific guidance. If within the police, military or prison medical services there are ethics bodies, then this could be one avenue, although in many contexts these bodies may effectively be unable to work impartially, or

the health professional may feel that turning to these bodies could present a risk of personal security to themselves or the patient. Other bodies the health professional could perhaps turn to include national medical associations, national human rights bodies, or, if these are not available, relevant international bodies, in particular the World Medical Association (WMA). (See also ***The Torture Reporting Handbook***, details in section 8.2.)

4 General Guidelines for Gathering Evidence and Documenting Findings

The primary goal of documenting allegations of human rights violations is to create an accurate, reliable and precise record of events. The uses to which this record may be put are varied, but all rely on the quality of the record that has been established. This chapter sets out the basic guidelines for embarking on an investigation into torture allegations. A description of a typical documentation team is given, detailing the different roles and functions carried out by each member. A general overview of documentation is provided, to illustrate for the health professional how the medical evidence fits into the wider picture of documentation and evidence. It also covers essential information needed in any investigation of allegations, including types of evidence which the health professional should attempt to gather when the lawyer is prevented from doing so. General guidelines are given on the types of evidence needed, what essential information should be collected, how to ensure the quality of information, and various considerations to be taken into account in the gathering of evidence. The compilation of medical documentation, including medico-legal reports detailing the findings of an investigation into torture allegations, is addressed in the second half of this chapter.

4.1 The aims and goals of investigation

Torture and other ill-treatment are prohibited in international law and are likely also to be a crime under national law. International law requires not only that torture not be used, but also that any allegation of torture be investigated, and that those responsible be brought to justice.

Effective investigation, including the aspect of medical documentation, is a vital component in the struggle to eradicate the practice of torture. Legal bodies, domestic and international alike, rely on factual evidence to reach their conclusions and uphold justice.

By shedding light on cases of torture and other ill-treatment, effective investigation and documentation can assist in the achievement of a number of important goals:

- Raising awareness of the infliction of torture and its absolute prohibition
- Battling impunity: bringing torture into the public eye assists in calling states to account for their actions and having them fulfil their legal obligations. On a different level, torture reporting can also help to cast light on the individuals who carry out such practices, to make sure that they cannot continue to engage in such behaviour without negative consequences
- Redress for the survivor: there are a number of remedies and objectives that may assist the individual survivor of torture, for example

- Preventing and ending ongoing abuse: in certain cases, allegations of torture may be raised by a person who is still in custody of the authorities. Effective and swift investigation can help put an end to the suffering. In other cases, the individual may be seeking protection from abuse in another country, and the determination of whether the individual was a survivor of torture and is personally at risk can prevent the person being deported back into the hands of their torturers
- Compensation and other forms of restitution: survivors of torture may, for example, be able to claim compensation for monetary loss, physical and mental harm, and other damage caused by the torture
- Rehabilitation: many torture survivors are in need of rehabilitation services, including medical treatment, both physical and psychological, legal assistance, and social services. Effective investigation and documentation can assist in diagnosis, treatment (including rehabilitation) and prognosis of the patient
- Official and public acknowledgement of their suffering can also be important in the recovery process of survivors of torture.

- Reform: drawing attention to a situation is not just about seeking condemnation or holding a state to account. Even more importantly, it is about seeking constructive and long-term improvements in a country which will contribute to the ultimate elimination of torture. This will often require changes both in the legislative framework and in official attitudes to torture. The eradication of torture is a fundamental and necessary step for any society aspiring to protect human rights and care for its people.

4.2 Multidisciplinary approach to documentation

Although straightforward allegations of torture can be documented by a health professional on his or her own, the investigation and documentation of torture is ideally a joint effort to be carried out by a number of actors with expertise in different fields. These usually include a lawyer, health professional and human rights monitor. Others who play an important part in the effort are judges, the police, the media, and of course the individuals and their families.

4.2.1 Role of the health professional in the team

Health professionals who encounter survivors of torture may do so in different capacities, and they may thus have slightly different but convergent duties:

- The health professional who is asked to examine an individual expressly for the purpose of providing a medical opinion in a report for a court or other judicial body will be fulfilling a forensic (medico-legal) role
- A health professional who is acting as a care giver to an individual and who in the course of routine work notes signs and symptoms of ill-treatment, or to whom the individual complains of being previously subjected to ill-treatment, may need to make an accurate medical record of the findings in the medical notes

- A health professional who forms part of a team visiting places of detention may record findings of ill-treatment in individuals, but this information may be used more generally in a report on the place of detention without actually forming part of a medico-legal report.

The first and foremost concern for the health professional is the immediate health and well-being of the torture survivor. Health professionals may have a therapeutic role in treating the patient, or a forensic role in establishing the possible causes and origins of injuries and trauma. There are concerns that having a dual role may create the perception of bias in the reporting. The health professional should therefore ensure that the individual is receiving any necessary medical care, taking into account that:

- Care includes immediate treatment and long-term rehabilitation for survivors of torture
- Forms of torture may be used that are psychological or otherwise leave no persisting physical signs. It must always be emphasised that the absence of physical or psychological findings can never be considered to be evidence that ill-treatment did not occur
- A psychological assessment of the individual should take place, noting any psychological effects that may be the result of torture or other ill-treatment
- The strongest evidence supporting the allegation of torture is often of a medical or psychological nature. The health professional should record any external or physical evidence of injury or abuse and any psychological symptoms and signs.

4.2.2 Role of the lawyer in the team

- The lawyer is the primary link between the torture survivor and the justice system
- The lawyer may have the responsibility of representing and advising the individual through the many procedures within the judicial process
- The lawyer's role will often begin at the early stage when the torture survivor is in custody, and will continue until redress has been achieved
- A primary concern for the lawyer will be to establish the facts of the case. This will involve collecting all available details of times and places of the alleged torture, as well as the identification of those responsible
- The evidence collected by the lawyer will include statements of the individual and possible witnesses, and medical evidence obtained with the help of the health professional.

4.2.3 Role of the NGO member in the team

Experience over the past decades has shown that human rights NGOs vary in mandate, focus, and methods, but some can contribute in important ways to the documentation of torture and subsequent legal action:

- They can assist individuals to gain advice, services and treatment, from the legal and medical professions, through lawyers and health professionals who are part of the NGO or by referral to others

- NGOs are often best placed to handle the case of the individual in the international arena, for example by assisting and advising in making complaints to international courts and other mechanisms
- The information held by the NGO on other similar cases and the research conducted on torture and other ill-treatment domestically and internationally, can provide valuable support to the case of the individual. Their knowledge of local circumstances can be very important. In certain cases it may be possible to combine a number of cases into joint complaints and petitions
- NGOs often have the expertise for any necessary work to be done through public advocacy or with the media
- NGOs can assist in the prevention of abuse, for example by circulating information about those who have been recently arrested.

Although the circumstances vary considerably between countries, generally it is better for an NGO to be open about its activities in helping survivors of torture and to develop links with relevant regional and international bodies as this makes it easier to seek protection from intimidation by the national authorities.

4.3 Documenting the allegations

4.3.1 The aim of medical documentation

Medical documentation plays a major role in all the general aims of investigation into torture allegations that have been described at the start of this chapter. Medical documentation fits into those aims through the following means:

- Producing a contemporaneous record (a record as close in time as possible to the event) of signs and symptoms of ill-treatment when an individual presents to any health professional for treatment after the event – the examining health professional may not be called upon to produce a report, but in the future an expert may be asked to use this record to form an opinion of events at the time
- Providing detailed understanding of the case so that the person can be referred for the appropriate treatment and rehabilitation in a specialised centre or by other specialists
- The production of a medico-legal report for submission to a judicial or administrative body:
  - for judicial enquiries or court cases aimed at the prosecution of perpetrators
  - for a judicial process which decides on the responsibility of the state
  - for a judicial process which decides upon compensation/reparations for survivors
  - in individual cases where a medico-legal report may be used as part of a court application to end on-going abuse while the person is still in detention
  - for the case of asylum seekers when medical evidence may be used as part of the evidence (e.g. in hearings) to show a history of ill-treatment in another country and the physical and psychological consequences thereof.
- The documentation of patterns of widespread abuse. Courts, NGOs, and inter-governmental mechanisms, can all have need for knowledge of the existence of widespread abuse. Assessment of the prevalence of torture and other ill-treatment, relies upon well-documented individual allegations

- The production of supporting material during visits to places of detention. Medical documentation may not necessarily lead to the production of a medico-legal report on specific cases, but the medical findings can be used more generally to support allegations of conditions and treatment amounting to torture or other ill-treatment.

4.3.2 Types of evidence

Medical evidence is one of many types of substantiation given to allegations of torture and other ill-treatment, and will often be used in conjunction with other forms of evidence. These will commonly include:

- The individual's statement
- Witness statements
- Other forms of third party evidence, such as the testimony of a forensic scientist or other expert
- Objective evidence of a widespread occurrence of torture in the circumstances referred to
- Anything else which can help to support and prove an allegation.

4.3.3 Medical evidence

Medical evidence is a very important type of evidence as it can add strong support to witness testimony. It is rare for medical evidence to be conclusive (prove with certainty that torture occurred) because:

- Many forms of torture leave very few traces, and even fewer leave long-term physical signs that they ever occurred
- Injuries or marks which are alleged to have resulted from torture cannot always be distinguished with a high degree of certainty from the effects of other causes.

What medical evidence can do is demonstrate that injuries or other clinical findings recorded in the alleged survivor are consistent with (could have been caused by) the torture described (see section 4.6). Where there is a combination of physical and psychological evidence compatible with an allegation, this will strengthen the overall value of the medical evidence.

When obtaining medical evidence, it is important to be aware of the difference between therapeutic (treating a patient's symptoms) and forensic (legal) medicine. The objective of forensic medicine is to assist the courts and other appropriate authorities in medico-legal matters, for example, by establishing the causes and origins of injuries. Sometimes both therapeutic and forensic functions are carried out by the same health professionals but, where possible, they should be separated to avoid a possible conflict between the two roles. Failing that, the possible conflict should be recognised and discussed by the report writer.

Case of Selmouni v France
(Application No. 25803/94)
Judgement
Strasbourg
28 July 1999

The European Court of Human Rights, in reaching its conclusion, cited the medical findings in an earlier judgement of the Versailles Court of Appeal. The reliance on medical findings demonstrates the significance of thorough medical documentation as a tool in establishing allegations of ill-treatment.

'***As to the medical findings***
The accusations made by the civil parties are supported by unequivocal medical findings. In the first place, as regards Selmouni, the expert Professor Garnier noted in his report of 5 May 1998 that all the doctors who had examined him while he was in police custody had found lesions of traumatic origin on the left arm, in the left orbital region, on the scalp and on the back. On 29 November 1991 further lesions were seen on the lower limbs. He added that during his examination on 7 December 1991 he had again found lesions that had been described earlier and that he found others on the buttocks and on the right ankle.

The extent of the injuries on Selmouni's person increased as the uninterrupted police custody continued.

The bruising to the left eyelid, the thin linear scar one centimetre long continuing the line of the left eyebrow, the left and right sub-orbital haematomas found on 29 November 1991 by Dr Edery, and then described on 2 December 1991 by Dr Nicot as being "round the eyes", are consistent with the punching mentioned by Selmouni.

The various haematomas found on the thorax, the left and right sides and the abdomen are consistent with the punching and kicking in his statement of 7 December 1991.

The pain in the scalp and the headaches mentioned by Drs Aoustin and Edery are likewise of a kind to support Selmouni's statements, according to which his hair was pulled and he was repeatedly tapped on the head with an instrument which could have been a baseball bat.

The haematomas found on the buttocks and the thighs could only have come from blows from a blunt instrument. Similarly, the lesions apparent on the legs, ankles and feet are consistent with the blows or crushing that Selmouni complained of.

It follows from the foregoing that the objective injuries, as recorded in successive examinations, match the blows described by Selmouni.'

4.4 Gathering of evidence

The medical evidence will be used in combination with the other types of evidence mentioned above. Detailed guidelines on gathering medical evidence, including the interviewing of victims, physical and psychological examinations, and writing medical reports, are all the focus of the following chapters. See also ***The Torture Reporting Handbook***(section 8.2).

Health professionals engaged in the documentation and investigation of torture ought also, however, to be aware of certain non-medical aspects of evidence gathering. In ideal circumstances, there will be a number of people responsible for collection of evidence, and other members of the team, particularly the lawyers or NGO professionals, will coordinate the collection and ensure that all requisite details have been gathered. However, in some circumstances not all members of the team will have access to the victim, and it is therefore crucial that each member is aware of the necessary details essential for the substantiation of alleged abuse. The level of proof and detail may vary depending on the purpose of documentation: for example, a criminal trial requires higher standards of proof than a civil hearing or administrative procedures determining potential risk in case of deportation. If the health professional is the only person with access to the victim or other source of information, it is vital that he or she attempts to collect, or ensures that others collect, key information, beyond the purely medical evidence.

4.4.1 Essential information

In all cases, in addition to the medical evidence and information, the following non-medical details should be viewed as useful and often crucial information regardless of the purpose of documentation:

Identity of the victim. This should include full name, gender, age, occupation, and address. Date of birth is a useful identifier when the name is a common one; often the year is known although it might not correspond to the age given. Additional useful information would be a description of appearance, a photograph, and any relevant records that may exist on the individual, such as medical files from the time before the alleged abuse.

Identity of the perpetrators . This might include the identification of a particular individual or individuals. However, to establish responsibility of the state for a violation, it might be enough to show the connection with the state. Relevant information would detail whether they were members of a specific security force such as police or military and, if possible, their names and rank. If unsure, then a description of uniforms, vehicles, weapons or any identifying characteristics will assist in the determination. Note, for legal and human rights reasons, great care should be taken in making allegations that particular individuals have been involved in torture. These are, after all, allegations of serious criminality.

Description of how the individual came into the hands of the perpetrators . This should include whether the person was officially arrested, what reason was given for taking the person into custody, the time and date this took place, and whether there was use of violence or restraints.

Description of the location where the abuse took place . This may have been a prison, a police detention facility, a military installation, or any other institution or location, even an outdoor space. Additional useful information would be a description of the conditions in which the individual was held, including size, content of the room, lighting, hygiene, presence of others, and access to lawyers, visitors, and medical care.

Description of the form of abuse . The crucial questions are: Where did it occur? What happened? When? By whom? How often? How long did it last? And what effects did it have on the victim immediately and later? There should be a detailed description of exactly what occurred, and how frequently. Presence of anyone else in the room during the interview, whether detainees, security personnel or others, should be mentioned. Any instruments used should be noted. What were the immediate and long-term effects of the abuse? If the victim received medical attention, or requested it and the request was denied, directly before, during, or after the abuse, this should all be detailed. The following chapters contain further guidelines on interviewing and examining victims.

Possible witnesses . Were there others present at the time of the abuse. Who were they? What was their role (for example, other detainees)? Did others see the individual immediately after the ill-treatment (for example, cellmates or prison medical staff)?

4.4.2 Quality of information

The primary goal of documenting allegations of human rights violations is to create an accurate, reliable and precise record of events. The uses to which this record may be put are varied, but all rely on the quality of the record which has been established. Factors which contribute to the quality of information are:

The source of the information . Was the information obtained directly from the victim? The further away from the victim or incident the information comes, the less reliable it is likely to be.

The level of detail . Is the allegation very detailed? Are there unexplained gaps in the account? The more detail obtained, the better, because it helps others to understand what happened, and it also helps to prevent allegations of fabrication. Psychological and/or organic explanations for gaps should be kept in mind (see section 6.2.3).

The absence or presence of contradictions . Minor inconsistencies are common and should not affect the overall quality of the information, but major inconsistencies or contradictions should prompt seeking further clarification of the information (see section 6.2.3).

The absence or presence of elements which support (corroborate) or disprove the allegation . Are there witness statements, medical certificates or any other supporting information? The more supporting

documentation that is provided, the more likely it is that the allegation will be found credible, but its absence is not evidence that the ill-treatment did not occur.

The extent to which the info rmation demonstrates a pattern . Is the allegation one of a number alleging similar facts? Where there is evidence of a practice there may be a greater presumption that the information is true.

The age of the information . Is the information very recent? Does it relate to facts which occurred several years previously? The fresher the information, the easier it is to investigate or verify the facts alleged.

4.4.3 Comparing records

Different members of the team might have notes or memories that emphasise different aspects of the individual's account. This is particularly true when the team comprises members with different professional backgrounds. Interviews should be reviewed and notes compared before one member is delegated to write up the relevant interview. All notes should be retained.

As the team comes together, it may be able to identify patterns of a general nature, especially if several teams are working together, and not every team member is aware of the information gathered by the others. Evidence that appeared incomprehensible or implausible might be clarified by the understanding of evidence gathered by other team members or teams. They can then discuss how to take the work forward, for example by anonymising data and analysing them in groups.

4.5 Compiling medical documentation

4.5.1 Report writing

Not all medical evaluations will require the writing of a report. Where a health professional comes across a case of torture in their regular practice, a note made in the medical records may suffice. The note in the records may then be interpreted by an independent expert who may form an opinion based solely upon these records. However, the examining health professional may be asked to provide a medical report based upon their own findings, or a summary of a number of similar cases. The type of report they produce is dependent in part on the use to which the report will be put. For example, the report may be used in an application for asylum or in the prosecution of perpetrators. Such reports are of a medico-legal nature since they form part of medical evidence that is put before an administrative or judicial body. In all cases, the duty to the court or other body must be acknowledged.

A health professional who is asked to examine an alleged survivor of torture in order to provide an independent evaluation for a judicial or quasi-judicial body is acting in a forensic capacity rather than in a therapeutic capacity. The health professional's duty is to the court to provide an independent opinion on the allegations

together with any corroborating medical evidence. Thus, in the absence of an acute medical emergency during the examination, the health professional is not acting in a therapeutic capacity. This does not, however, preclude him or her from referring the individual for further clinical assessment and treatment to the appropriate specialist. The section below refers to cases where the health professional has been instructed to produce a medico-legal report.

4.5.2 Destination

Medical documentation can be of value in a number of arenas, including:

- Identifying the need for further care and treatment
- The prosecution in national or international courts of perpetrators alleged to be responsible for torture
- Claims for reparation
- Challenging the credibility of statements extracted by torture
- Identifying national and regional practices of torture in human rights investigations
- Support of allegations of torture in asylum applications.

4.5.3 Content

Further guidance on the approach to the taking of the history, the examination and the compilation of the final report is detailed in The Istanbul Protocol (see section 8.2), which should be viewed as the 'gold standard' for the documentation of torture, and from which this section is adapted.

The report should be based on the health professional's overall opinion made at the end of the interview and on further consideration during follow-up (see section 4.6). Generally the final report has a number of parts:

- The account of the event(s) as described by the individual. As described above, this should detail events during arrest and conditions of any detention (e.g. prolonged solitary confinement) since these conditions in themselves may produce physical and psychological sequelae. The account should further detail specific events and methods of torture, both physical and psychological, during actual interrogation. If there are internal inconsistencies in the narrative, or if it contradicts testimony given elsewhere (for example to a legal adviser), this must be explained
- A description by the individual of his or her physical and psychological symptoms and signs at the time of alleged ill-treatment, and an account of how these symptoms evolved with or without medical treatment
- A description of the individual's physical and mental health at the time of the interview(s) and, if he or she has been seen over a period of time, how they have changed with treatment and as a consequence of concurrent events
- A note of any medical treatment in detention, or any treatment that was requested but denied
- An account of the physical and psychological findings from the interview(s). This should include the demeanour at different times of the process (including any contact before and after the interview(s)), the

results of any psychological assessments, a detailed account of the physical examination, and the results of any investigations performed

- The professional opinion on the likely causes of these findings, discussing other relevant possible causes of those lesions attributed to torture. There should also be a summary, and the conclusions of the overall examination. (Note: it is better to separate the findings and the opinion into separate sections, as this makes it clear to any reader which is which.)

When gathering information to prepare a report, it is important not to over-interpret the findings and so diminish the quality of the evidence. That is to say, however sympathetic the health professional may be to the individual, the report or certificate should not say more than can be supported by the evidence and the level of competence of the report writer to interpret it, or the case might be undermined.

Depending on the intended forum, a summary of the findings of other team members could also be needed, or each might need to provide a separate report. There may also be the sections required by the relevant court, such as the reason for the interview, the background documents read beforehand, a detailed CV of the author and a statement of the duty to the court. Relevant professional qualifications should be listed. The report is an expert document, and the writer should identify the level of expertise, for example as a general health professional, or as someone with forensic expertise but not with survivors of torture.

4.5.4 Inconsistencies

When anyone gives more than one account of his or her experiences, there are inevitably points that are inconsistent with each other. Thus the interviewer should avoid topics that are not directly relevant to the report. Within an interview, it is essential for the interviewer to clarify these points or explain the discrepancies (see section 6.2.3).

Sometimes the account may conflict with one given previously, for example, to a legal adviser or other non-medical interviewer. The medico-legal report should identify these inconsistencies and, if they are relevant, explain them. The report is a legal record of the interviews and should not be amended to minimise these inconsistencies if this reduces the report's accuracy.

4.5.5 Glossary

Many words have a specific meaning in medico-legal reports that differ from their use in everyday speech, such as 'history' or 'laceration'. It may be necessary to append a glossary to the report, so that readers do not misinterpret some of the words by applying their everyday meaning.

4.6 Opinion

Any health professional should be able to document injuries and other physical and psychological findings. When trying to assist the courts or other judicial or administrative bodies, where possible there should also be an opinion on the consistency between these findings and the allegation of ill-treatment. This section is intended to give basic guidance in this process. However, it is important that the health professional does not exceed his or her capabilities. A well-documented account of findings can be very useful to an expert where necessary.

4.6.1 Individual lesions

For each individual lesion, the health professional should determine whether it is congenital, the consequence of a disease process, degenerative or traumatic. For each lesion attributed to trauma and for the overall pattern of lesions the report should indicate the degree of consistency between it and the attribution given by the individual.

It is more important to focus on lesions that are distinctive rather than on their number or size. A few wounds that are highly consistent with an allegation of torture are more significant medico-legally than those that are non-specific. If there are other possible causes for wounds, these should normally be documented. For example, a sportsperson may have many scars on his or her legs, and it is impossible to say which were caused by contact sports and which, if any, were caused by being kicked by soldiers in detention. A stab wound on the trunk, however, is not going to have been caused by sporting activities.

If a survivor of torture has many overt scars on his or her body, this could well be because the security services in the country in which he or she was tortured enjoy impunity. Where judges are encouraged to take seriously allegations that confessions were extracted under torture, interrogators are likely to be careful not to leave identifiable marks, and might not assault a detainee for several days before a court appearance in order to let bruises fade.

Some survivors of torture have no scars or other physical signs. This should be documented and it must be emphasised that the absence of physical findings does not, in itself, invalidate a person's account of torture.

Suitable terms for describing lesions attributed to torture are given in Box 1.

Recommended terms to describe lesions attributed to torture

Not consistent: The lesion could not have been caused by the trauma described. (If this term is used in a medico-legal report, the writer must explain why the individual's account is considered to be credible, despite this inconsistency (see also section 4.6.3 on truth and fabrication).)

Consistent with: The lesion could have been caused by the trauma described, but it is non-specific and there are common alternative possible causes. (Most scars are non-specific and it is important not to over-interpret them. Only if the overall number or distribution of scars is significant can much weight be placed on them in the final report.)

Highly consistent: The lesion could have been caused by the trauma described and there are few other possible causes. (Depending on the level of proof required by the court, such scars may be sufficient to corroborate the individual's testimony.)

Typical of: This phrase is used for lesions that are 'highly consistent' with the attribution and additionally the appearance is one that is usually found with this type of trauma (for example, cigarette burns).

Diagnostic of: This appearance could not have been caused in any way other than that described. (This is strongly supportive of the individual's account, but does not, by itself, confirm that torture has occurred because the status of the perpetrator and the purpose of the assault are also relevant.)

It is the overall evaluation of all lesions that is important in assessing the allegation, rather than the consistency of each lesion with a particular form of torture.

BOX 1 (adapted from The Istanbul Protocol, section 8.2)

Distinctive scars should be described accurately. For example: 'There is a 3 cm laceration, 1 cm wide at the widest, across the back of the left hand.' Very small wounds need not be individually documented unless they are relevant to the allegation.

Sometimes a patient will say that an injury was caused by torture when clearly that is not the case. This may be because of a misunderstanding. For example, the person might not be aware of scars across the upper back from childhood chickenpox. When these are pointed out by a health professional, the patient might say they are the result of torture, believing all scars were a consequence of torture. Another patient may be claiming deliberately that a wound was caused by torture, knowing this is not the case. Perhaps he or she has no scarring from torture but thinks he or she will not be believed without some physical evidence. In both these situations the health professional has a dilemma. A false opinion supporting the patient's attribution must never be given. The alternative is to document the lesion, the patient's attribution and the heath professional's opinion, even though this might undermine the credibility of the patient. However, if the health professional words the report sensitively and emphasises other aspects of the examination that support the allegation of torture, this should minimise the negative impact. However, the health professional should not lose sight of the need for objectivity.

It is sometimes suggested that scars and other lesions might be self-inflicted. True self-inflicted wounds are of two main types. One is where a person is deliberately harming him- or herself to support a false claim of assault. Such wounds are generally superficial and within easy reach of the dominant hand. Very rarely an accomplice might be asked to cause a wound in a place the person cannot reach, such as in the middle of the back. The other form of self-harm is where the person has a mental illness. Such wounds can be complex, but generally the underlying mental health problem can be identified during the interview. Occasionally a person will have wounds from an unsuccessful suicide attempt in detention, perhaps a desperate response to an intolerable situation. Although the person might be unwilling initially to disclose the true cause of the wounds, with sensitive questioning he or she will normally say what happened.

4.6.2 Psychiatric assessment

When writing reports, health professionals should comment on the emotional state of the person during the interview, symptoms, history of detention and torture, and personal and family history prior to torture. Factors such as the onset of specific symptoms in relation to the trauma, the specificity of any particular psychological findings, as well as patterns of psychological functioning should be noted. Additional factors such as forced migration, resettlement, difficulties of acculturation, language problems, loss of home, family, social status, as well as unemployment should be described. If a formal psychiatric diagnosis is given, the reasons should be explained (see also sections 6 and 6.3.1).

4.6.3 Overall picture

At the end, the health professional must give his or her opinion of the totality of his or her findings, both physical and mental. He or she can say how strongly the findings support or do not support the allegations. The report may have corroborative value when it is added to the other evidence in the case.

All the available information should then be brought together in order to prepare the final report, including:

- Copies of any previous court decisions about the individual
- Correspondence from other health professionals to whom the patient has been referred
- Background information about the situation in the country to which the allegations of torture relate (e.g. from the UNHCR (United Nations High Commissioner for Refugees) or Amnesty International)
- The account of the event(s) as described by the individual
- Notes on the individual’s description of his or her physical and mental health
- Records of the psychological and physical findings from the interview(s)
- The results of any clinical investigations
- Recommendations for further treatment.

This will then allow the health professional to give an opinion of the likelihood of the patient having been tortured in the way that he or she described, to the standard of proof required by the appropriate forum. Ultimately, it is for the court to decide whether the individual is credible, but health professionals must not

ignore the issue. Credibility is not an all-or-nothing concept - there is a continuum between the absolute truth and the complete fabrication of events, with at least three points in-between:

a) A mixture of falsehood and truth, e.g. a fabricated history of a recent detention added to a genuine one in the past
b) Conscious or subconscious exaggeration - saying that the ill-treatment was more frequent and more severe than actually happened
c) Genuine errors arising from mistakes and misunderstandings.

The health professional should then make a final statement summarising the opinion.

5 Interviewing

5.1 Introduction

The documentation of torture and other ill-treatment depends on the gathering of detailed and accurate information from the individual on the circumstances of the event, including details of any arrest, detention, conditions of detention and specific treatment while under interrogation. The degree of detail gathered depends on several factors, such as the aim of the interview/examination (producing a note in a medical record of incidental findings during a routine medical visit, versus being asked to provide a medical report for a judicial body), the location and circumstances of the interview (for example in a health clinic, in a police station or prison, or in a rehabilitation centre for survivors of torture) and the degree of access to the individual and amount of time available. This being said, the principles on interviewing set out in this chapter can be adapted and applied to the various circumstances in which a survivor of torture or other ill-treatment may be encountered.

As with most clinical practice the interview or 'history' is the key to this process. Torture usually involves both physical and psychological components, during the ill-treatment and the arrest and detention, so the interview must address both the physical and psychological components of the experiences and events.

There should be a detailed description of the ill-treatment taken as close in time to the event as possible. If there has been an arrest or any period of detention, the description should include details of the conditions of detention, especially the nature of the accommodation (including size, shape, space, natural and artificial light, temperature, ventilation, and hygiene), the daily routine, and access to water, food, sanitation, health care and the open air. All of these elements of arrest and detention can produce physical and psychological manifestations (e.g. malnutrition, vector-borne disease, anxiety etc). The interviewer should then take a detailed description of specific methods of ill-treatment employed during periods of questioning, interrogation or indeed at any time while they are in the control of the authority. It cannot be over-emphasised that it is not sufficient to document only physical ill-treatment and any resulting injuries or scars. Psychological methods must also be accurately noted since these will often produce both psychological reactions and physical symptoms. For documentation of the psychological sequelae the interviewer must take a detailed psychological history and conduct a mental state examination (see section 6.3.1). For physical sequelae the interview should be followed by a thorough physical examination and written description of the findings. The written findings can be supplemented by annotated diagrams of the body and, where possible, photographs (see section 6.6).

An interviewer will make notes of the interview, and may use other recording devices. The reasons for this should be explained to the interviewee who should be reassured as to how the notes and other records will be used and asked for consent (see also section 3.2.8). The way in which any records of such interviews are stored can be important in protecting the security of the interviewer and the interviewee (see also section 3.2.9). In

many countries where torture is prevalent, the police have been known to raid clinics and search or confiscate medical records. In order to protect patients, therefore, in such conditions records should have no obvious identifying information on any document inside (such as initials or date of birth), and the files themselves being numbered with a register kept in a secure place elsewhere. Patients can be given cards with the identifying number so that treatment can be continued even if the register is not available. In some circumstances it may be necessary to hold records at a different location or even in a third country to ensure their security.

If information about an individual needs to be transmitted to another body (see section 2.4.2), fax transmission is generally safer than e-mail as a copy of the latter may be stored on the sending computer or held on the server of the internet service provider. In some countries the authorities routinely screen all outgoing messages.

5.2 Vulnerability of witnesses

5.2.1 Protecting survivors and witnesses

In many circumstances, survivors and witnesses need to be protected from those they are accusing. Promises must not be made, for example, to provide security for the witness or for relatives who might be at risk, unless the interviewer is certain that they can be fulfilled. Witnesses might believe that international organisations or others investigating allegations of torture have more power to protect them than is the case. It is part of the informed consent process that individuals are aware of all the issues before they agree for a health professional to make a formal report (see section 3.2.8).

5.2.2 Vulnerability

As they are survivors and witnesses of torture, it is inevitable that many interviewees will be vulnerable in the psychological sense. They may also be vulnerable in other senses, for example they or their family members might be at risk of reprisals from the perpetrator.

This means that the survivor or witness who is vulnerable needs to be interviewed especially sensitively but thoroughly. Security, reassurance and tact are very important.

It can be therapeutic for a survivor of torture to give an account of his or her experiences in a supportive, trusting environment. This does not mean that everything must be taken at face value. Questions should be asked to check and clarify points which appear unclear, inconsistent or contradictory; this should be done in a way which does not undermine the trusting relationship necessary for effective interviewing, and with a view to providing as precise a record as possible, so that any documentation is accurate.

It is essential that the interviewee is able to consider him- or herself to be in control of the interview since a central element to torture is the enforced loss of control and autonomy of the person. He or she should feel able to answer only those questions with which he or she feels comfortable at the beginning and postpone others until later. Some witnesses may want to delay discussing more sensitive topics, perhaps to a later interview if that is

possible, by which time they feel comfortable with the interviewer. Others may have been worrying about the interview and may want to start discussing the details of being tortured early in the interview. Attention must be paid to the physical needs of the interviewee - there should be water available to drink, and breaks can be taken at any time.

5.2.3 Interviewing children

Children have the rights to have their consent and confidentiality respected. Except in emergency they should not be given medical treatment without a parent or guardian present. Similarly, a detailed account of the cause of injuries should only be taken from a child in the presence of a parent or guardian or, if they are not available, someone else representing the child's best interests.

Older children may be tortured to suppress political activity. They should be treated in the same way as young adults, and the approach needs to be very sympathetic. Torture of younger children is generally performed to put pressure on parents. Where possible, the family should be treated together and the child's injuries should be documented and managed by paediatric specialists.

A child in particular needs to be in an environment in which he or she feels comfortable before being willing to disclose sensitive information. In discussing traumatic events, a child may prefer to draw a picture and then to explain it. Children's attention spans can be quite short, so it may be necessary to break the interview frequently.

5.3 The environment of the interview

5.3.1 Physical environment

In many situations it is not possible to control the environment of the interview (for example in police stations and prisons), and the interviewer will have to make the best of less than ideal conditions. However, as stated above, the basic principles on interviewing should be adapted and applied as far as possible to the different contexts. Where health professionals and other interviewers are using their own premises, the physical environment can be controlled. Where possible, it is essential to avoid anything that might remind the interviewee of being interrogated in case this triggers psychological symptoms (see section 6.2.2). Such sounds as footsteps, keys and doors should be minimised. Rooms should have a comfortable temperature and be well lit, Most survivors of torture are not distressed by a clinical environment, but some individuals may have been exposed to medical participation in their ill-treatment and so may be wary of the medical setting and personnel.

Where possible, the interviewer should meet the individual wherever the individual is waiting for the interview. Not only is this polite, but it allows the interviewer to notice the individual's demeanour at rest, how he or she gets out of the chair and walks to the interview room. Normally the individual should sit nearer the door of the interview room so that he or she does not feel trapped, although for personal safety reasons it is better if the exit for the health professional is also not obstructed.

5.3.2 Gender considerations

Female interviewees should, if at all possible, be seen by female interviewers, at least in the first instance. If one is needed, the interpreter should be female as well (see section 5.5). In many cultures, women are unwilling to disclose details of ill-treatment in front of a man, so the account will be incomplete. This will be particularly true if she has been raped or sexually assaulted (see section 6.4). One approach that may be considered is to ask the woman if, in addition to the health staff, she would like a friend or relative present for support. Paradoxically the presence of a friend or relative may in fact inhibit the interviewee from revealing more intimate or traumatic events, especially of a sexual nature, and thus the question should preferably be asked when the third person is not present. In clinical interviews, it will also be necessary for the patient to have her body examined by the health professional, and most women prefer that this is not done by a man (see mention of chaperones in section 6.2.1) . This inherent reluctance is considerably increased in survivors of torture as it is likely that the torturers were male.

For male survivors, particularly those who have been sexually assaulted in detention, the situation can be more complex. In general they should be seen by a male interviewer and interpreter, but some men prefer to talk about sexual abuse in front of women. In some cultures and societies this may be due to feelings of shame or embarrassment in describing sexual abuse to another man, or it may be that describing such abuse to men, particularly of the same ethnic background as the torturer, may remind them too much of their experiences.

Following the above, it is clear that the staff team should ideally include health professionals and interpreters from both genders, allowing the individual to choose who they would be most comfortable with. In many settings, such as large organisations and hospitals in big cities, this should be the standard and not deviated from. In some circumstances, however, such as small teams engaged in field missions, it might not always be possible. In these cases, particularly with female interviewees, if the health professional is not of the same gender as the individual, there should be an interpreter present (when one is used) or other team member of the same gender, or another person chosen by the interviewee, thereby easing the discomfort. While vital evidence and information should not be missed due to not having a same gender interviewer, the individual must always consent to being interviewed by the health professional (and to others who may be present), and any gender imbalance or discomfort with the situation should be entered in the notes.

5.3.3 Cultural and religious awareness

Cultural and religious awareness is of utmost importance. The health professional should make sure to conduct him or herself in a manner that does not offend cultural or religious sensibilities, and have an understanding of how culture or religion may be affecting the behaviour or responses of the interviewee. A lack of such awareness risks alienating the individual and/or causing them to feel uneasy, leading to a less effective interview.

5.3.4 Time and space

The pace of the interview must be dictated by the individual. Even if there is limited time for the interview (such as in a police station or prison), the interviewee should not feel rushed. It is better to focus on a few specific

points than to try to cover too much ground in too little time. If there are many interviewees to be seen over several days, each should be seen once or twice for a substantial period of time, rather than several shorter sessions. However, as a rule, interviews should not be scheduled to last more than about one and a half hours (although such a period is a luxury in many schedules), because after this time the interviewer, the interviewee and (if present) the interpreter, all become tired. It may be necessary to allow a session to overrun, for example, if the individual has almost completed the account when the set time is up. In a clinical setting, the interviewer should allow enough time between appointments to allow for this and for sufficient time to write up his or her notes. It is good practice to write up the notes of each interview at the end of that session, as various aspects of the individuals' accounts may become confused if the interviewer attempts to write up all the interviews in a later single session, and details may be forgotten.

5.4 The interview itself

At the beginning of the interview, the interviewer and, if present, interpreter, must introduce themselves and explain the purpose of the interview and about independence and confidentiality. There are three parts to the interview and it is for the interviewer to decide on the order in which these are raised, depending on the way the interviewee responds. It is essential to remember that the well-being of the individual is more important than the information to be gathered. He or she may want to discuss domestic matters before discussing details of ill-treatment, in order to settle and learn to trust the interviewer.

The three parts are:

- The present physical and psychological state, which is what an interviewee would be anticipating discussing with a health professional
- A chronological account of ill-treatment starting with the first episode of conflict with the authorities, which may be what the interviewee has prepared him- or herself psychologically to discuss
- The past, personal, family and social history of the interviewee, which forms the context of the experience(s) of ill-treatment.

Some survivors of torture or other ill-treatment who have been interviewed before about their experiences might have developed a summary that they can recite without undue distress. For example: 'I was arrested, held for five days, beaten and tortured.' It is necessary to acknowledge this account and then ask for substantial details of the experience. Detail about the circumstances of arrest and detention help to demonstrate the authenticity of the history and may provide specific information of use to prosecutors.

Some survivors of torture or other ill-treatment have had little or no education and this can lead to perceived contradictions or require alternative approaches to information gathering. For example, an individual who is not numerate may not be able to give accurate responses to questions about how many soldiers arrested him, or for how many days he was detained. If asked the same numerical question on different occasions, he may give very different answers. It is better to frame questions in more general terms (e.g. 'Were there a few or many of

them?’). The same is true of dates, as many rural societies do not use calendars routinely. It may be better to ask, for example, ‘What was the season?’ rather than ‘What was the month?’

5.4.1 Types of questions

Generally, open-ended questions should be used, for example: ‘Can you tell me what happened?’ or ‘Tell me more about that.’ The individual should be allowed to tell his or her story with as few interruptions as possible. Further details can be elicited with appropriate follow-up questions, such as: ‘How big was the cell?’, ‘Was there any lighting?’ and ‘How could you go to the toilet?’ Asking too many questions too quickly might confuse the individual, or even remind him or her of being interrogated.

Leading questions are avoided wherever possible, because individuals may answer with what they think the health professional wants to hear. This is especially important when interviewing for medico-legal purposes, where the testimony may be challenged in court. Closed questions, which provide the interviewee with a limited number of options and, particularly, list questions, can cause confusion in the individual and might create unnecessary inconsistencies. For example, an individual might be asked, ‘Were you arrested by the police or the army?’ limiting the answer to a choice between the two. If he or she was arrested by a special task force of soldiers and policemen working together, it would be difficult to give an accurate answer without appearing to contradict the health professional. This could in turn create inconsistencies between statements (see section 4.5.4).

5.4.2 Cognitive techniques

Psychological research has shown that the ability to recall important incidents can be enhanced by using some basic cognitive techniques. Having established rapport with the individual, he or she should be allowed to give a free narrative about the events. The interviewer should allow the individual, as much as possible, the time to describe what happened in his or her own words. Clarification of points is permissible but not direct questioning which might break the individual’s recall. Only after the individual has finished his or her narrative should direct questions be asked to clarify points. The survivor of torture should know that it is acceptable to say: ‘I don’t understand the question,’ or ‘I don’t know the answer.’ When closing the interview the next stages in the process should be agreed with the individual.

The quality of the information gained can be improved by some specific techniques. Firstly, in a clinical setting in which time allows it, the individual should be told to describe everything surrounding the time of ill-treatment (for instance describing the events and process of being taken into detention), even if it doesn’t appear directly relevant to him or her. This might relate to events that could be more important than the individual realises. Secondly, as he or she relates them, this can bring other events that are more relevant into his or her mind. It helps if he or she is encouraged to recall the context in which the events happened.

Having encouraged the interviewee to describe the events in a free narrative, in chronological order, the interviewer can seek more detail by asking questions in a different order. For example, by reversing the order: 'You were telling me …, what happened just before that?'

Another tool is changing the perspective, which means trying to describe the events from another point of view, for example if the interviewee is sufficiently well-educated the interviewer could ask: 'How would a tailor describe what the man was wearing?' or 'When you were arrested at the demonstration, what would a spectator have seen?'

It is important to remember that different cultures have different concepts of what is normal behaviour in an interview. In some societies it is considered polite not to look directly into the eyes of someone in a position of relative authority (such as an interviewer), whereas in other cultures such behaviour is considered to be a sign of dishonesty. People from some cultures find constant hand movements a normal part of communication, whereas those from others find them distracting. Personal space varies between and within cultures, and what might be normal between colleagues could feel too close in an interview setting. This could make the individual feel anxious, and behave in a way that the interviewer perceives as uncooperative.

5.4.3 Summarising and clarifying

During the interview, it is often helpful to clarify points, in order to ensure that the information is accurate. For example: 'When you say that you were suspended by your arms, in what position were they?' Alternatively the individual can be asked to recreate the position, but it should be borne in mind that doing so could provoke uncomfortable feelings or other reactions in the individual.

At the end of each session, it generally helps to summarise the key points, to ensure that they are clear. This sometimes has the additional benefit of getting the individual to remember details that add to the narrative.

In the event that a medical report will be produced it is good practice, where circumstances allow, to see the individual again once the report has been completed, to read through to him or her the history/narrative within the report for accuracy and consistency. This also provides an opportunity to follow up any clinical problems that were identified in the interview.

5.5 Working with interpreters

Good interpreters, particularly those from the same background as the individual, are able not only to interpret the words, but also to identify and explain relevant cultural, historical and social factors as well as linguistic idioms to the interviewer. Beware, however, of over-reliance on interpreters, as they are not experts in areas outside their own field.

Interpreters are an important part of the inquiry team. They need to be trained to work with survivors of torture and other ill-treatment even if they have considerable experience of interpreting in other contexts. Most

professional interpreters have their own code of ethics. If not, they must be advised that what they hear and interpret in interviews is ***strictly confidential*** .

Professionals working with interpreters need to remind themselves that, if they do not share a language with the individual, the quality of the interpreter used will impact on all aspects of their interview, examination and report.

5.5.1 Second and third languages

In situations where the health professional is seeing the individual in their routine practice, they will usually speak the same language. In situations where there are several ethnic groups within a country, there may be language barriers within the population. Sometimes the one will speak some of the other's language, or they may share a third language. The danger is that if one person's command of this second or third language is weak, this may lead to inaccuracies and inconsistencies in the report. There may also be difficulties associated with interpreters of a different ethnicity or from a different region from that of the individual. The accent and vocabulary might differ.

5.5.2 Gender and age of interpreters

In many cases, it is necessary to use an interpreter for some, or all, of the interview. The issues of gender discussed above (see section 5.3.2) may be even more important in this situation as the interviewee may relate more to the interpreter than to the interviewer. Some individuals are less concerned about the gender of the interviewer than they are about that of the interpreter. Age may also be relevant. A young male individual may be able to discuss sexual torture with an older woman to whom he may relate as to an aunt, but not to a woman of his own age. Similarly, a young female individual may find an older man easier to talk to than one who is of a similar age to her torturer. Bear in mind, however, for women, having a female interviewer and interpreter is the best practice (see section 5.3.2).

5.5.3 Local and international interpreters

When an international team makes a visit to a country it might include interpreters, or it may choose to employ local interpreters. There are two issues to keep in mind in such cases. Firstly it must be made clear to the local interpreter that he or she may be putting him- or herself into danger by working with visiting interviewers when documenting torture. Secondly, the individual may not trust a local interpreter and so not give a complete account of what happened.

5.5.4 Using an interpreter

Interviewers should remember to talk to the individual and to keep eye contact with him or her even though there is a natural tendency to speak to the interpreter. It helps to pose questions directly to the first person, for example: 'What did you do then?' rather than indirectly through the interpreter, for example: 'Ask him what happened next.' Observing body language, gestures and facial expressions, as well as non-verbal communication, is essential both to enhance the amount of information gained and to give the individual

confidence that the health professional is interested in what is being said. Above all, it encourages the individual to believe that he or she has been heard and is perceived as a reliable witness. When the individual is providing a long, unbroken account, the health professional should pause the interview regularly to note the information. This helps the interpreter not to forget key points and allows the health professional to clarify points when they are still fresh in the individual's mind.

5.5.5 Family members

As a rule, family members and friends must not be used for interpretation for two reasons. First, the quality of interpreting is generally inadequate, and second, there may be topics that the individual will not discuss in front of a family member, and therefore the risk of a failure to disclose torture is greatly increased. Many parents, for example, will not reveal details of their torture in front of their child. Furthermore, revealing such details in their presence may even lead to psychological harm for the child.

5.6 After the interview

5.6.1 Team debriefing

After the interview(s), if a team is working together it must meet to debrief, ideally on every day that members are working. This is necessary both for the mental health of team members and to maximize the use of information (see sections 4.4 and 4.5).

First, those working with survivors of torture need to discuss how they feel about their work. When some team members admit to being distressed, it helps others who are feeling the same but are unwilling to disclose the fact. It also allows team members to identify colleagues who are in danger of burnout and who might need to take a break from the situation.

Those working with survivors of torture and other ill-treatment need to be aware of several psychological pitfalls. They may idealise patients, seeing them only as vulnerable individuals rather than as complex personalities with good and bad aspects. Thus they may become more deeply involved than might be appropriate and may become disillusioned if the client is later revealed not to have been completely honest. Had the professional taken a more balanced approach to the patient, this might not have happened. A team approach with regular peer review of cases, helps to identify this problem.

Second, the interviewer may generalise in the opposite direction, seeing all those alleging torture as liars or cheats. Some of those alleging torture might be fabricating stories for whatever reason. Others may exaggerate their account but this does not necessarily indicate that the person is not a survivor of torture. Again, a team approach with regular peer review of cases helps to identify this problem.

A third danger is that of becoming inured by either hearing similar accounts over time or hearing accounts of such varying gravity that one account is found wanting when compared to another. Often survivors of torture

from a particular country or context tell very similar accounts because torturers employ fairly consistent methods or approaches. Interviewers should be prepared for such eventualities, and approach each case on an objective individual basis rather than comparing it to other cases.

The fourth danger is that of burnout. Having started with high ideals, the process of helping survivors of torture turns out to be slow and frustrating. The professional becomes depressed and cynical about the process, and becomes incapable of action. He or she should be helped to understand that the process is slow and that in the early stages there are few successes. The importance is for team members to share their feelings and experiences, and to celebrate the successes when they come. Where team members seem to be in danger of burnout, they need to be moved away for a time and receive psychological or emotional support.

6 Medical Examination and Documentation

Torture involves the deliberate infliction of severe physical or mental pain. Thus the examination of an individual alleging torture has two distinct but related parts; the physical and the psychological examination. Undue weight should not be given to the physical examination since this may reinforce the perception that in the absence of any marks or scars that torture has not occurred.

While physical pain is a widely understood concept, reflecting the health professional's understanding of the physiology of pain receptors, nerve pathways and brain function, psychological pain is perhaps more difficult to quantify. However, by assessing levels of psychological distress and the psychopathological effects of specific experiences, some level of objective measurement can be obtained. There are, of course, individual subjective influences on both physical and psychological pain, but the health professional should seek to provide the highest degree of objective evidence of the degree of suffering. Ultimately it is for a judge to consider this and other evidence, and decide whether or not the threshold of torture has been crossed, but health professionals can be helpful in informing the courts.

The impact of torture is always psychological, and it is usually physical as well. The concept of the severity of the pain must apply to the totality of the individual's experiences. Thus to look only at the physical pain is insufficient. A pinprick does not generally cause severe pain, but when repeated regularly over a long period, with threats to use it on the genitals, or when it is implied that the needle is infected with HIV, the stress of the experience becomes very much greater. Being detained arbitrarily, without understanding why or for how long, and without recourse to challenge the detention can itself produce psychological distress and psychopathological effects, even without any physical assault.

Medical documentation in cases where there have been allegations of torture can therefore have several uses. It may corroborate or refute allegations of torture. A health professional can conduct a physical and a mental state examination of someone who claims to have been tortured, and give an opinion as to whether the physical or psychological sequelae found are consistent with the allegations made. Also, for example, if a survivor of torture alleges that a lesion was caused by being beaten, but the defence lawyers suggest it was a sporting injury, an experienced health professional might be able to say which of the two attributions was more likely.

A medical examination cannot usually prove torture conclusively, though it may help identify injuries consistent with torture. It is one part of the picture put together by the investigating authority. It cannot identify the perpetrator, nor tell whether the perpetrator was on- or off-duty, acting under orders or not. It may not even be able to determine definitively the cause of a particular injury except in general terms. However, when a detainee

is known to have been in a good state of health at the time of arrest, it is then for the detaining authorities to explain any deterioration in the mental or physical health during or just after the detention.

6.1 Background

A health professional may be asked to examine a person alleging torture in a range of different contexts (see section 2.4). In all these cases it is necessary to take a systematic approach to the documentation of the allegations and findings. Since any documentation may have medico-legal implications it should be considered as a forensic examination. This section is intended to help health professionals in this position, with little or no forensic experience. Other, more detailed source material is listed at the end of this Handbook. Generally, medical examiners experienced at working with survivors of torture or other ill-treatment are willing to help colleagues if they are presented with a detailed situation and given sufficient time to respond.

Where possible, a health professional examining a survivor of torture or other ill-treatment should have access to basic facilities to treat the immediate clinical problems identified, and be aware of other colleagues or health facilities where the person can be referred if necessary.

6.1.1 Medical history taking

If possible, the individual should be asked to give a chronological account of the incident(s) in question (see section 5.4). Sometimes this will not be possible, for example if the individual has had minimal education, or a degree of learning disability. A survivor who has had many episodes of detention and ill-treatment over the years may find it difficult to remember which episodes occurred on which occasion. In such cases it may be better to create a generic account, and then elaborate on those incidents that stand out.

Other reasons why accounts might be incomplete or incoherent include:
(adapted from The Istanbul Protocol, see section 8.2)

- Factors during torture itself, such as blindfolding, drugging, lapses of consciousness
- Fear of placing oneself or others at risk
- A lack of trust in the examining health professional or interpreter
- The psychological impact of torture and trauma, such as high emotional arousal and impaired memory secondary to trauma-related mental illnesses, such as depression and post-traumatic stress disorder (see section 6.2.2)
- Memory impairment from beatings to the head, post-traumatic epilepsy (see section 6.2.6), suffocation, near-drowning or starvation
- Protective coping mechanisms, such as denial and avoidance
- Cultural norms that permit certain traumatic experiences to be revealed only in specific settings, if at all
- Forgetfulness or confusion falling within the spectrum of normal human recall.

These possibilities should be explored in detail. For example, the questioning of an account of loss of consciousness should try to differentiate true loss of consciousness caused by, for example, a blow to the head, from the effects of pain and exhaustion.

The history should include for each relevant incident:

- The circumstances of arrest
- The conditions of detention
- Specific details of any alleged ill-treatment during detention
- A subjective description of the person's mental state, and any changes, during the period of detention
- A description by the individual of the acute appearance of any injuries at the time and how they healed (with or without treatment)
- Means of release or escape.

There should be a description of the individual's past medical history, where relevant, including previous experiences of trauma and any previous psychiatric history. The social background can also be relevant.

If the individual has some educational achievements documented, these can be used as indicators of the premorbid intellectual state (the psychological condition the survivor was in prior to the trauma). They can then be compared with the evaluation of the individual's present level of functioning, and judgements can be made about changes, and any possible causation.

The occupation of the individual is sometimes relevant to the documentation of torture because it might affect the differential diagnosis of any lesions. For example, someone who has worked in a professional kitchen may have scars from burns and scalds sustained occupationally. In such a case, the distribution and shape of the lesions may help to differentiate those following accidental injuries from those caused deliberately (although often a health professional can only say that either cause is possible: see section 4.6).

Occupation can also be a marker of educational attainment, and so can be evidence of a change in cognitive and/or psychosocial functioning. Statements from former colleagues, or documentation of work appraisals, can act as corroboration of this point.

6.2 Common pathologies

6.2.1 Introduction

The examination of the individual alleging torture must be thorough but sensitive and include both a physical and psychological assessment. It is necessary to explain everything that is going to happen. The present mental state should be assessed throughout the course of the interview, with a specific mental state assessment as part of the examination (see section 6.3.1). For the physical examination, generally the entire body should be inspected, because the individual might have injuries of which he or she is not aware, for example on the upper back. There

may be scars relating to an incident that the individual has forgotten, for example running into barbed wire when escaping.

The assessment begins as soon as the health professional meets the individual, starting with the general appearance. Is he or she tidily dressed and well groomed? If not, could this be depression or is there a more practical reason? Do his/her clothes look too big, has he/she lost some weight? How does he or she respond to the health professional's introduction? Is the demeanour appropriate given the circumstances? Does he or she appear agitated or withdrawn? How does he or she move? Is he or she able to get out of the chair? Is there a normal gait? (See section 5.3.1.)

The health professional should have a system to examine the patient, and it is important to ensure that the whole body is examined thoroughly, even where the individual does not think there are any marks. A neurological examination might also be necessary to evaluate motor and sensorial damage to peripheral nerves (see section 6.2.9). If the health professional is not the same sex as the individual undergoing examination, a chaperone needs to be present unless the patient firmly objects. The presence of a chaperone is primarily to ensure the dignity of the patient and address the unease of the individual, but can also protect the health professional from any subsequent suggestion of misconduct. The chaperone should be a staff member of the same sex as the person being examined and this function could be fulfilled by the interpreter if the individual agrees. Also, as mentioned above in section 5.3.2, the patient should be offered the possibility to have a friend or relative present for support during the examination. It should, however, be kept in mind that the presence of a friend or relative could inhibit the individual from revealing certain intimate details. The final decision, of course, rests with the patient. To preserve the person's modesty and to prevent intrusive memories of nakedness in detention, care should be taken not to ask the patient to undress completely, but to uncover only the part of the body being examined. It is helpful to observe the mobility of the joints when the person takes off his or her outer clothes.

6.2.2 Psycholog ical diagnoses

Anxiety and depression are common among survivors of torture and other ill-treatment. Drug and alcohol misuse are also seen more than in the general population, probably as a way of avoiding unpleasant feelings and memories. Questions must be asked about these symptoms.

Anxiety and depression are common in this population and generally recurrent. They have experienced events, particularly unexpected events, that have left them fearful. Anxiety presents with feelings of hopelessness and helplessness. Persons are constantly worrying that other unexpected events may happen again, may feel uneasy and nervous, and may be prone to panic attacks. Therefore they tend to avoid situations that might make them nervous.

Depression presents as sadness, difficulty concentrating, tiredness and lethargy, loss of libido, inability to enjoy things, insomnia and early wakening, changes in eating pattern, mainly loss of appetite but sometimes binge eating, apprehension and fear, feelings of hopelessness and guilt. When severe there may be a preoccupation with death, thoughts of suicide, and sometimes attempts at self-harm.

Acute stress reactions and post-traumatic stress disorder (PTSD) are both seen in victims of torture. They arise as a consequence of an event that threatens death or serious injury of self or others, leading to a response of intense fear, helplessness, or horror. Both are characterised by a specific set of symptoms. While the acute stress reaction occurs immediately after a traumatic event, PTSD occurs after a few weeks. The criteria necessary to make either diagnosis are given in Box 2 below.

Survivors of torture often complain of pain in different parts of their body; sometimes the description of the pain changes. The pain can be described as more or less intense and its location can change over time. Often there is nothing to find on physical examination. These are somatic symptoms and can be direct physical consequences of being tortured, or may be purely psychological.

Hallucinations, especially auditory hallucinations, are not uncommon, and are not necessarily symptoms of psychosis. They cannot always be differentiated from the re-experiencing phenomena of PTSD (see above).

Dissociation, the feeling of being detached from one's self, is seen in victims of torture. It happens when a person lives through experiences that cannot become part of his/her memory (autobiographical memory) because of their intense character, as can happen during torture. There is a breakdown in the integration of consciousness, perception and behaviour. The person may feel as though he or she is observing him- or herself from outside. (See also section 6.2.3.)

True psychosis may be identified, but before making the diagnosis, the symptoms must be evaluated in the individual's cultural context. For example, the person may hold ideas of being possessed or other forms of magical thinking, which may be culturally appropriate. A further complicating factor, regardless of culture, is that individuals may describe intrusive memories in a way that might appear to be hallucinations.

WHO International Classification of Diseases, 10th Edition (ICD10)

Reaction to severe stress, and adjustment disorders

This category differs from others in that it includes disorders identifiable on the basis of not only symptoms and course but also the existence of one or other of two causative influences: an exceptionally stressful life event producing an acute stress reaction, or a significant life change leading to continued unpleasant circumstances that result in an adjustment disorder. Although less severe psychosocial stress ('life events') may precipitate the onset or contribute to the presentation of a very wide range of disorders classified elsewhere in this chapter, its etiological importance is not always clear and in each case will be found to depend on individual, often idiosyncratic, vulnerability, i.e. the life events are neither necessary nor sufficient to explain the occurrence and form of the disorder. In contrast, the disorders brought together here are thought to arise always as a direct consequence of acute severe stress or continued trauma. The stressful events or the continuing unpleasant circumstances are the primary and overriding causal factor and the disorder would not have occurred without their impact. The disorders in this section can thus be regarded as maladaptive responses to severe or continued stress, in that they interfere with successful coping mechanisms and therefore lead to problems of social functioning.

F43.0 Acute stress reaction

A transient disorder that develops in an individual without any other apparent mental disorder in response to exceptional physical and mental stress and that usually subsides within hours or days. Individual vulnerability and coping capacity play a role in the occurrence and severity of acute stress reactions. The symptoms show a typically mixed and changing picture and include an initial state of 'daze' with some constriction of the field of consciousness and narrowing of attention, inability to comprehend stimuli, and disorientation. This state may be followed either by further withdrawal from the surrounding situation (to the extent of a dissociative stupor - F44.2), or by agitation and over-activity (flight reaction or fugue). Autonomic signs of panic anxiety (tachycardia, sweating, flushing) are commonly present. The symptoms usually appear within minutes of the impact of the stressful stimulus or event, and disappear within two to three days (often within hours). Partial or complete amnesia (F44.0) for the episode may be present. If the symptoms persist, a change in diagnosis should be considered.

Acute:
· crisis reaction
· reaction to stress
Combat fatigue
Crisis state
Psychic shock

F43.1 Post-traumatic stress disorder

Arises as a delayed or protracted response to a stressful event or situation (of either brief or long duration) of an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone. Predisposing factors, such as personality traits (e.g. compulsive, aesthetic) or previous history of neurotic illness, may lower the threshold for the development of the syndrome or aggravate its course, but they are neither necessary nor sufficient to explain its occurrence. Typical features include episodes of repeated reliving of the trauma in intrusive memories ('flashbacks'), dreams or nightmares, occurring against the persisting background of a sense of 'numbness' and emotional blunting, detachment from other people, unresponsiveness to surroundings, anhedonia, and avoidance of activities and situations reminiscent of the trauma. There is usually a state of autonomic hyperarousal with hypervigilance, an enhanced startle reaction, and insomnia. Anxiety and depression are commonly associated with the above symptoms and signs, and suicidal ideation is not infrequent. The onset follows the trauma with a latency period that may range from a few weeks to months. The course is fluctuating but recovery can be expected in the majority of cases. In a small proportion of cases the condition may follow a chronic course over many years, with eventual transition to an enduring personality change (F62.0).

BOX 2

6.2.3 Memory

Self-reports of trauma and torture are often not believed or are felt to be distortions or exaggerations for secondary gain. Self-reported physical and psychological symptoms can also be construed as fabrications or exaggerations.

However, there is evidence that cognitive disturbances can follow a range of types of trauma. Many torture survivors have been subjected to physical injury to the brain from blows to the head, suffocation (including near-drowning), and starvation and other forms of prolonged nutritional deficiencies. These may lead to persistent cognitive impairment. Additionally, depression and PTSD affect cognition.

Memory impairment as a result of these factors may affect the accuracy of the details an individual is asked to provide about his/her torture. The inability consistently to reproduce detailed and precise recollections about times, places and incidents can reflect negatively on the individual's credibility. However, most of these factors are sufficiently well researched to allow the reasons for such discrepancies to be understood if they are explained properly to a court. It is the proper function of an expert witness to assist the court by reference to relevant research and other material within his or her field of expertise.

6.2.3.1 Normal inconsistencies in testimony

When a person gives several accounts of the same incident, there are inevitably variations in the description. There are several possible legitimate reasons for this. First, the individual might have misinterpreted what happened. For example, he or she might have been shot at while running away and felt a pain in the calf, which the person thinks is a bullet wound. If the lesion is too small to have been caused by a bullet, it might have been a piece of shrapnel. The individual could not have been aware of this at the time of the incident.

Secondly, memory wanes slowly over time, and people mis-remember events, although it is generally the more peripheral points that are forgotten while the core aspects are preserved. Thirdly, over time, some aspects take on more importance in a person's memory, while others appear less significant. Finally, people relate accounts according to their expectations of what their audience wants. Thus a doctor may be given an account with very different aspects focused on compared to the same incident being described to a lawyer.

6.2.3.2 Pathological processes

Any head injury can lead to loss of episodic memory (memory of events or incidents from a person's past), even if there is no loss of consciousness (see section 6.2.6). There will be a degree of retrograde amnesia (loss of memory for events immediately prior to the trauma) because the information stored in the short-term memory is not transferred into one of the permanent memory stores. There will then be some further prospective memory loss (loss of memory of the period immediately after the trauma) until the memory processes are functioning normally again. The period of memory loss is longer than the period of unconsciousness, and classically there are islands of memory from periods when the individual is more alert.

Some survivors of torture experience episodes on which they appear withdrawn and unresponsive for a short time, and when they return to normal they have no memory of the episode. One possible diagnosis is complex partial seizures (see section 6.2.6), but there are several possible alternative psychological causes (although they could co-exist with epilepsy). One of these causes is panic attacks, although these generally last longer than a couple of minutes, and the sufferer is usually aware that he or she has not lost consciousness. Complex partial seizures (also known as temporal lobe epilepsy, TLE) have been misdiagnosed as panic attacks, and vice-versa. Brain tumours can mimic both syndromes. Also psychiatric problems such as depression and PTSD can interfere with normal memory processes (see above).

Absences associated with memory loss are also seen in dissociation states (see section 6.2.2). These are psychological states which usually start during severe stress (perhaps as a psychological protection mechanism), and recur with memories of the incident. Symptoms can be similar to those felt rarely in the aura of complex partial seizures, such as déjà-vu (the feeling of having experienced something before), mystical experiences, and awareness of the absence of thoughts. The main difference is that episodes of dissociation are much longer than those of complex partial seizures, lasting at least fifteen minutes, and normally for several hours.

6.2.4 Early skin lesions

When the skin is injured it can respond in one or more of five ways:

- Contusions (commonly known as bruises)
- Abrasions (or grazes)
- Incisions (including stab wounds)
- Lacerations (also, commonly but confusingly, known as cuts)
- Burns and scalds.

6.2.4.1 Bruises

A bruise occurs following a blow that does not break the skin. Blood leaks from small blood vessels, making the area tender and sometimes boggy. If the skin and subcutaneous tissues are thin, the bruise becomes apparent relatively quickly and may take the shape of the weapon used, although this might not be obvious in darker skins. For example, a blow from a baton or heavy stick often leaves two parallel lines of bruising (tramline bruising) caused by the blood being pushed sideways by the contact. Ideally bruises should be photographed as soon as possible (see section 6.6), before they spread or fade.

When the bruise is deep the blood tracks slowly to the surface, and it may be several hours or even days before anything is visible. It is often helpful in such cases to re-examine the patient a day or two later. In such cases the extravasated blood (blood that has been lost from the vessels) follows tissue planes and may emerge some distance from the original injury, and is unlikely to be tender. For example, bruising of any part of the face may appear below the eye. Thus the site of the bruise is not the site of the injury, but the size of the bruise could be evidence of the force of the blow. This should be made clear in any report.

In older people and those on certain types of medication, clotting is impaired and bruising is much larger than usual. This is particularly the case in those areas where the skin is loose. In these patients, for example, a minor injury on the neck can result in a large bruise. Dietary deficiencies of, for example, vitamin C (scurvy), can cause spontaneous and widespread bruising. This may be evidence of neglect of detainees. Extensive bruising not explained by the history should, if possible, be investigated in case it is the consequence of a disease. In writing such reports consideration should be taken about those possibilities.

Bruises change colour and fade over a period of hours and days as the blood pigments are metabolised and absorbed, but this takes a different amount of time in different parts of the body following a single incident. However, if there are bruises at different stages of resolution in the same place, this could support allegations of repeated assaults over several days.

6.2.4.2 Abrasions

Abrasions are caused either by a blow with a blunt object or a fall onto a rough surface. Parts of the epidermis are rubbed away, sometimes in lines showing the direction of the impact. They are more likely to occur if the superficial tissues are thin, for example, over a bone.

During the two or three days following the injury, abrasions produce fluid that crusts over. This makes them very susceptible to infection, which delays and distorts the healing process. Unless the abrasions are full-thickness, they will heal with few remaining signs, although they can leave hyperpigmentation (see section 6.2.5.2) or hypopigmentation.

Abrasions may show a pattern that reflects the contours of the instrument or surface that inflicted the injury. For example, ropes can cause abrasions wider than the rope itself. When the blunt force is directed perpendicularly to the skin over the bony prominences, it will generally crush the skin at that point. Sometimes, if there is anything between the object and the skin, its imprint may be observed on the skin. In hanging and other asphyxiation by ligature, patterned abrasions can sometimes be found on the neck.

Sometimes, survivors of torture may be thrown from moving vehicles so that they slide on the road, or they may be dragged along the ground during arrest or capture. In these cases extensive abrasions may be seen, and particles of dirt, sand, etc. will predispose the abrasion to infection. The same particles may become embedded in the skin and leave a sort of ‘tattoo’ effect that can persist for years.

Scratches are caused by sharp objects that produce superficial linear cuts. Identifiable patterns of scratches can be seen, for example, from fingernails.

6.2.4.3 *Incisions*

Incisions are caused by sharp objects like broken bottles and blades that produce a more or less deep, sharp and well-demarcated skin wound. They must be differentiated from lacerations in which the skin is torn (see below). The term 'cut' should never be used in a report, as colloquially the term usually means a laceration.

Incisional wounds have clearly defined edges and, on close inspection, it may be possible to see that hairs have been cut. There are no tissue bridges (see below). Sometimes the wound can be jagged, suggesting that it was not caused by a single stroke. However, because the skin stretches as it is cut, the size of the wound is not necessarily related to the size of the implement used.

Small wounds and those that are supported by surrounding tissues heal at the surface, and they may be difficult to see after only a few days. If the wound is in a part of the skin that is not supported, it will gape. Unless it is sutured or otherwise closed, it will heal from inside.

Stab wounds are incisions that are deeper than they are wide. They should be examined carefully because of the risk of damage to deeper structures.

6.2.4.4 *Lacerations*

Lacerations are caused by a tangential force such as a blow or a fall and produce tears of the skin. The wound edges tend to be irregular, and often any may be bruised or/and abraded. There might be tissue bridges (where the skin has not separated along the entire length of the wound).

6.2.4.5 *Burns and scalds*

Burns are usually caused by dry heat, but the skin can also be scalded with very hot liquids or burnt with chemicals. Burning is the form of torture that most frequently leaves permanent changes in the skin.

The shape of the lesion can sometimes, but not always, reveal the shape of the object that caused the burn. The damage caused by heat is proportional to the temperature and the duration of exposure. Burns are classified into three degrees, according to severity.

- In superficial (first degree) burns there is no permanent damage to the epidermis. They present as a reddening of the skin
- In partial thickness (second degree) burns some of the epidermis is destroyed and there may also be damage to deeper tissues. They present as moist, red, blistered lesions and are normally very painful
- In full thickness (third degree) burns there is complete destruction of the epidermis and significant damage to deeper tissues. They may not be as painful as partial thickness burns. If the burns are widespread, there is usually death from shock and fluid loss.

Cigarettes are commonly used by torturers to inflict pain. Most cigarette burns are superficial and fade over a few hours to a few days. They tend to be circular, have a diameter of up to 1 cm. They cause an erythematous

(reddening of the skin) and an oedematous circle that can blister. Deeper burns are caused when the lit cigarette is pressed against the skin for a long time. When this happens the lesion is deeper and there might be a full thickness burn in the centre surrounded by blisters. If the cigarette is rubbed in it leaves a larger and more irregular lesion.

Burns from hot objects tend to take the shape of the surface that caused the burn. The wound contracts as it heals, so the lesion may be smaller than the object. Liquids flow on contact with the skin, and this can leave a distinctive pattern reflecting the survivor's posture at the time of the incident. Scalds lose heat rapidly so the resulting lesion diminishes away from the point of first contact, whereas chemical burns are often more extensive. A number of lesions from scalding in different parts of the body are suggestive of torture. A single burn might be caused by torture but could also be due to an accident either at work or otherwise. A good occupational history is paramount.

6.2.4.6 Complex lesions

Many lesions comprise areas of different types of wound. For example, as noted above, many lacerations are bruised and abraded at their edges. Wounds caused by broken glass may be a mixture of incision and laceration.

Bites tend to be a mixture of laceration and crush injury:

1. Human bites, especially those that are sexual in nature, can show petechiae from sucking. Petechiae are obvious in the twenty-four hours following the assault. The marks from human bites have a semicircular shape and appear blunt.
2. Animal bites cause deeper and sharper wounds. It is important to look for lacerations caused by the claws.

6.2.4.7 Interpretation

Speculative judgements should be avoided in the evaluation of the nature and age of traumatic lesions since a lesion may vary according to the age, sex, condition, and health of the individual, the tissue characteristics, and the severity of the trauma. Fresh and old injuries can be seen together on people who have a long history of torture.

Infection, irradiation, corticosteroids, scurvy (vitamin C deficiency), diabetes, hepatic cirrhosis, uraemia, blood loss, cold, and shock all inhibit wound healing. Wounds heal faster in young people. Bruises resolve over a variable period, ranging from days to weeks. Estimating the age of bruises is one of the most contentious areas of forensic medicine.

6.2.5 Scarring

It is often the case that a health professional will see a survivor of torture months or years after the incidents. In such cases the wounds are likely to have healed to a greater or lesser extent. Healing is influenced and often impaired by many factors that can be present in places of detention including persistent, untreated infection; repeated trauma to the same area; and malnutrition. When faced with the examination of old injuries it is thus important to obtain a detailed history from the individual of the acute appearance of the injury, any treatment

received (such as sutures, antibiotics) and a description of how the wound healed and in what time frame. Such descriptions from a lay person may in themselves assist in corroborating allegations since they may indicate medical phenomena that a lay person would not usually be aware of. Such a description of wound healing may also reveal elements of the detention which are also deliberately neglected, such as:

- Inadequate healthcare provision
- Poor toilet and washing facilities
- Insufficient or nutritionally incomplete diet.

The commonest physical finding following the late examination of survivors of torture is scarring. Most is non-specific, but some individual scars can be helpful in supporting a history of torture, as can the pattern of scarring. Occasionally the individual will have photographs of the acute lesions, and these can be very helpful in giving an opinion on the cause of the late signs. However, before citing such photographs in an expert report, it is essential to be certain of the date of the photographs, and that they really are of that individual (see section 6.6).

Full thickness wounds (those that go through the epidermis) heal in one of two ways. When the wound is small and the edges are opposed, it heals from the top down (by primary intention). This tends to leave a small, tidy scar. Pockets of infection inside can become abscesses.

If this process cannot occur, especially if the wound gapes, it heals from below (by secondary intention). This is a slow process and prone to infection, and will leave a wide scar. When the original wound was straight, and especially if it was an incision, the scar tends to be symmetrical, with curved edges, and is widest at the middle (a biconvex scar).

The number, position and size of lesions may indicate other aspects of the conditions in which the individual was detained. For example, if the floor of a cell is flooded for any reason, and there is no access to a toilet so that the person has to urinate and defecate in the cell, the detainees will have to sit or stand in dilute sewage. In these circumstances, minor wounds, whether caused by assault or accident, may well become infected and can leave many small scars around the lower legs or buttocks. These must be differentiated from lesions left by childhood skin infections. All scars should be documented, including those that the individual is clear were caused in incidents other than torture. If those detained in certain centres have far more such lesions than other individuals from the same social background, this should be documented.

If a scar has suture marks around it, this should be documented, as this demonstrates that medical care was given. Equally it should also be noted if there are scars from wounds that have clearly not received medical attention, or have been seriously infected. Scars from surgery should also be noted, especially if it is alleged to be associated with torture, for example the removal of a ruptured spleen.

Sometimes scars are self-inflicted in order to support a weak medico-legal case, but these are often apparent (see also section 4.6.1). Generally they are superficial and within easy reach of the dominant hand.

Small regular patterns of scarring, particularly but not exclusively in Africans, could either be tribal marking or caused by traditional healers. The former are generally on the face. The latter tend to be multiple, symmetrical, and around painful parts of the body. However, some torturers may also produce small symmetrical patterns of scarring.

Bullet wounds are rarely caused during torture but may be caused prior to arrest or during escape. Generally, as a bullet enters the body it leaves a small, regular wound, but as it leaves the wound is much larger and more ragged. The appearance depends on the distance from the weapon and its type. If there is an entry wound but no exit wound, it may be appropriate to arrange an X-ray to find out if the bullet is still in the body (see also section 6.5). A photograph or, if a camera is not available, a drawing of the wounds might be helpful if an expert opinion needs to be sought.

6.2.5.1 Keloid scarring

Keloids are scars that exceed the boundaries of the original wound. They are much more common in some skin types than others. The exact pathogenesis is unclear, but the tendency to them is probably inherited. Those who have a tendency to keloid will probably have several thickened scars on their bodies. Thus such scars are more difficult to attribute to specific allegations of torture.

6.2.5.2 Post-inflammatory hyperpigmentation

Hyperpigmentation can follow inflammation in darker skins, irrespective of the cause. It is not seen in pale skins, nor in very dark skins. The hyperpigmentation retains the shape of the original inflammation, which can be important forensically. For example, classic tramline bruising (e.g. parallel lines of bruising following a blow from a baton or similar object – see section 6.2.4) or inflammation from burns can leave distinctive patterns of hyperpigmentation. The increased pigmentation can last for between five and ten years.

Whipping can sometimes leave lines of hyperpigmentation, especially in darker skin. These lesions are rarely confused with ***striae*** (see section 6.3.4). ***Striae*** are caused by sudden gain or loss of weight, so are also seen in some former detainees. They tend to be irregular rather than linear, and have a well-recognised distribution.

Less regular patterns of hyperpigmentation are seen following abrasions, again particularly in darker skins. Tight ropes or handcuffs may leave marks around the wrists, and marks following rope burns can be seen elsewhere on the body where the individual has been tied up or suspended. These are rarely pathognomonic individually, but the locations and distribution of the marks can support the history of torture.

As hyperpigmentation can follow any inflammation, any other cause of inflammation can cause a similar pattern. For example, lines of increased pigmentation that follow an irritant dermatitis from contact with plant stems can be mistaken for similar lines following whipping (although it is not unknown for victims to be whipped with irritant plant stems as a form of ill-treatment).

6.2.6 Head injuries and post-traumatic epilepsy

Head trauma is among the most common forms of torture. Even repeated minor head trauma can cause permanent damage to brain tissues. This can in turn cause permanent physical handicap. Lacerations and abrasions of the head and their late consequences should be documented as above.

Survivors of torture often report that they were unconscious at times, but it is impossible for them to know what happened unless they were with a reliable witness. It is necessary to try to differentiate between loss of consciousness following blows to the head, post-traumatic epilepsy (see below), asphyxiation (see section 6.3.4), pain and exhaustion, or any combination of these.

Many victims of torture have suffered blows to the head, and many complain of persistent or recurrent headaches, whether or not they have sustained any head injury. Generally the headaches are psychosomatic or due to tension headache (see section 6.2.2). In some cases with a history of repeated blows to the head it is possible to feel areas of hyperaesthesia (extreme sensitivity of neurological sensation) and some thickening of the scalp from scar tissue.

Violent shaking of the upper body has been reported as a form of torture (as it has as a form of child abuse). Survivors complain of severe headaches and persistent changes in cognitive function. In these cases no injuries are visible. Shaking can lead to death due to cerebral oedema and subdural bleeding. Retinal haemorrhages have been noted on post-mortem examination and when seen in children are very suggestive of shaking injuries.

Immediately after severe head injury there may be concussive convulsions, but these do not necessarily lead to epilepsy. Convulsions in the first week or so after a severe head injury tend to be tonic-clonic. They may recur for a year or more, but are not generally lifelong. Severe head injuries leading to brain lesions, specifically in the temporal lobe, can cause convulsions that start months or years after the incident. These latter are complex partial seizures.

Typically (>90% of cases), complex partial seizures start with an aura (a strange feeling that precedes the convulsion). This is followed by an absence that can last up to two minutes. Concurrent automatic movements, particularly lip smacking have been reported. After these episodes there is usually a period of a few minutes of disorientation. Often the aura is described as a strange feeling in the stomach, but it could be bizarre smells or tastes. These must be differentiated from the re-experiencing phenomena of PTSD (see section 6.2.2) where the person is always capable of being roused and never completely loses consciousness.

In most countries the prevalence of epilepsy in the population is 2%. About 65% of epilepsy is due to complex partial seizures. The cause of complex partial seizures is unknown in 45% of cases. Traumatic events including birth events account for 3% of it. The likelihood of acquiring epilepsy after a head injury depends on the severity of the injury (see table).

Degree of head injury	Loss of consciousness	Relative risk of epilepsy	Duration of increased risk
Minor	< 30 minutes	1.5 (50% increase)	5 years
Moderate	< 24 hours	2.9 (three times)	
Severe	> 24 hours	17.2 (17 times)	20 years

Survivors of torture rarely have an accurate account of their head injuries, and unless they have an external reference, they cannot know for how long they were unconscious. One problem with attributing epilepsy to head trauma is that there is rarely any information about the individual's neurological state prior to the incident.

6.2.7 Fractures

Beatings and falls can lead to fractures of bones. In the acute setting it is generally possible to diagnose a fracture clinically if no X-ray facilities are available.

Fractures can be caused by a direct blow, in which case the fracture is at the site of the impact, or by twisting or crushing, in which case the fracture tends to be at the weakest part of the bone. The commonest fractures in survivors of torture are of the nasal bones; the radius and ulna (bones of the forearm); the carpal, metacarpal and the phalangeal bones of the hand; the ribs; the transverse processes of the vertebrae, and the coccyx (the bone at the end of the spine, below the pelvis). (For further information see The Istanbul Protocol, section 8.2.)

If fractures heal well, there will be no way of knowing whether the injury was caused by torture or by accidental causes. However, the fact that an injury can be demonstrated may be corroboration of the individual's account. It can also be significant if there are multiple fractures at different stages of healing. If the fracture has healed at an angle, or has become chronically infected, this may support an allegation of inadequate treatment at the time of the original injury. If old X-rays are available, new X-rays (if the equipment is available) can help to determine how long ago the injury occurred.

If a person alleges that a bone was fractured during torture and a callus is palpable, that should normally be sufficient to document. X-rays are unlikely to add anything. Generally, even with an X-ray, it is only possible to say that a bone was fractured within a wide time-frame, but very rarely that the fracture was caused by torture. Mal-united fractures are highly supportive of a history of torture with no immediate medical treatment.

6.2.8 Joint damage

Many forms of torture involve damaging joints. Indeed the word 'torture' comes from the Latin ***torquere*** (to twist) because many tortures involved distending and twisting joints.

Suspension is a common form of torture, in which the individual is suspended by the arms or wrists. The body weight distends the shoulder joints, causing pain. In one variant, 'Palestinian suspension' (also referred to as

‘Palestinian hanging’), the arms are behind the back, increasing the strain on the shoulder joints and often stretching the nerves running into the arms (see below).

Other forms of joint damage are specific to particular parts of the world. For example, the knees may be forcibly bent backwards around a heavy pestle, causing permanent damage to ligaments; or the thighs may be forced apart, damaging the adductor tendons (tendons running from the muscles that separate the thighs) which may remain tender for a long time afterwards.

6.2.9 Nerve damage

Many forms of torture can cause nerve damage, including stretching injuries associated with joint damage and physical damage from fractures and incisions. The speed of resolution of nerve damage is relatively predictable, so it may be possible for an expert to determine the approximate time of the original injury from a series of examinations over several months.

‘Palestinian suspension’ can lead to neuropathy of the brachial plexus, especially if it has been prolonged. Sometimes there will be residual signs of this, and if they are still present after two years, they will probably be permanent. ‘Winging’ of the scapula must be looked for (by asking the person to push against a wall and observing the shoulders from behind). Survivors will sometimes describe having suffered weakness of the muscles around the shoulder associated with the loss of certain movements which have recovered progressively over a period of months. If he or she did not have access to information about the clinical processes involved, this description can be very supportive of allegations of torture. Often there is residual pain around the chest and shoulder joint which may be partially or completely physical or may be psychosomatic.

Peripheral nerve lesions of the hands and feet may also be detected following the prolonged application of restraints (wires, ropes, handcuffs, etc.) to the wrists or ankles. Motor and sensory changes may be transient or, in cases of excessive and prolonged tightening, may be permanent. These lesions are sometimes known as handcuff ‘neuropathies’.

6.2.10 Electrical injuries

Electric shocks have been used commonly by torturers for many years because they cause exquisite pain but rarely leave identifiable physical signs. The equipment can be as basic as the magneto of an old military field telephone or a couple of bare wires in an electrical socket to complex stun guns.

Magnetos are generally hand-cranked devices that provide a direct current (DC) related to the speed at which a rotor is turned – giving an opportunity to threaten the victim further. Mains electrical current can be delivered through bare wires touched against the skin, which might have been previously covered in water. Clips are sometimes used, and these can cause small lacerations when they pull off as the victim jolts with the force of the current. Some torturers have used fixed systems using switches or levers which again can be used to increase the threat of the torture.

Battery operated devices are portable but can still deliver a high voltage which may be alternating current (AC) or DC. Electric shock batons are being superseded by a range of devices including stun shields, remote control stun belts, and tasers, many of which were originally designed for law-enforcement purposes.

Electrical torture uses the property of the electrical current to cause pain: in the body the current travels along nerves and blood vessels as they are the paths of lower resistance. As the current travels it causes contractions to the muscles involved and severe pain. These contractions can cause dislocation of joints and, if the chest muscles are involved, difficulties in breathing. If the current passes through the heart, arrhythmias (irregular heartbeat) can develop, leading to sudden death. Torturers apply electricity to the most vulnerable and intimate parts of the body. Genitals and breasts are often targeted and the victim is threatened on his or her reproductive capacity. When the current involves the muscles controlling urination and defecation those can occur without the victim being able to exercise control. The mouth also is very sensitive and often targeted.

Areas of reddening may persist for weeks. Occasionally the electrodes can leave small burns, probably from sparking. Both tend to be circular and less than 0.5 cm in diameter. These lesions may create hyperpigmentation (see section 6.2.5.2). However, as these lesions are small they may be difficult to find. Although non-specific, they can corroborate allegations of electric shock torture, especially if they are in certain parts of the body. Studies have shown distinctive changes to cells beneath the site of the shock on microscopy, but such investigations should only be performed if they are essential to the legal case.

6.3 Order of examination

Where circumstances make it possible, it is advisable to conduct a full medical examination of the patient, including vital signs and anthropometry and physical examination, documenting the lesions caused by ill-treatment as part of the procedure.

6.3.1 Psychological assessment

Torture always has a psychological component, as well as usually being physical, and in many cases the psychological state will be the most significant part of the examination. Although many perpetrators deliberately set out to destroy the mental stability of the survivor, sometimes the psychological damage is an unintended consequence of creating fear through physical abuse. Some of the psychological distress is caused by such issues as loss of control, losing the ability to trust, and a belief in the world as a just place, as well as feelings of guilt when others have been tortured as well.

During the history taking, the individual's past and present mental state should be evaluated. Ask, for example, about a typical day, visits to doctors, going to classes or work, and socialising. Distress may be visible, some individuals displaying it openly, while others attempt to keep it in check, often to the point of presenting in a rather detached manner.

Torture has variable effects on people because the social, cultural and political contexts vary widely (see above). Outcomes can be influenced by many interrelated factors that include but are not limited to the following (adapted from ***The Medical Documentation of Torture*** – see section 8.2):

- Circumstances, severity and duration of the torture
- Cultural meaning of torture/trauma and cultural meaning of symptoms
- Age and developmental phase of the individual
- Genetic and biological vulnerabilities of the individual
- Perception and interpretation of torture by the individual
- The social context before, during and after the torture
- Community values and attitudes
- Political factors
- Prior history of trauma
- Pre-existing personality
- Alcohol and/or drug misuse.

The psychological assessment of a survivor of torture, like all clinical assessments, is of two parts. Firstly, there needs to be a systematic discussion of symptoms, including sleep disturbances, behaviour changes, and mood. Some of these elements may be corroborated by family members or those sharing accommodation. Secondly, the health professional must be aware continually of the individual's demeanour, and how it changes when particular topics are discussed. Thus it is possible to get a degree of objectivity in the psychological assessment.

Most survivors of torture describe a range of psychological symptoms, although they may not perceive them as medical problems. Psychosomatic symptoms are particularly common, but many survivors come from cultures where the Western concept of the mind/body split does not exist. The symptoms include sleep disturbances, particularly lying awake worrying, then waking with nightmares when they do get to sleep. Sometimes it is difficult to differentiate between nightmares and intrusive memories. Feelings of depression and anxiety are common, although they can be a consequence of post-torture or non-torture experiences such as becoming a refugee. There may be changes in behaviour to avoid stimuli that remind them of the trauma. It is rarely possible from the symptoms described by the individual to establish the original trigger.

Torture does not always produce persistent psychological problems. Thus, in the same way that survivors of torture can have no identifiable physical problems, if an individual does not have mental problems, it does not mean that torture has not occurred. When there are no physical or psychological findings, this can neither support nor disprove someone's allegations of torture.

The psychological impact of ill-treatment depends very much on the prior awareness of the individual. Someone who is politically active might be able to undergo substantial torture without necessarily developing persistent psychological symptoms because he or she could have anticipated the experience, and put the episode into a personal and political context. However, someone who was arrested simply as a result of being in the wrong

place at the wrong time might not suffer much ill-treatment, but could still be devastated by the experience, because the incident was not anticipated and the person was not sustained by a political ideology or religious faith.

One aspect of torture that makes it harder to cope with is the complete unpredictability of events. Some perpetrators deliberately change routines so that survivors never know what to expect. The opposite approach is also used, of torturers assaulting the victims at exactly the same times each day.

The same symptoms probably occur in survivors of torture from every socio-cultural background, but torture has unique social and political meanings for each individual. This will affect both the individual's ability to describe the experiences, and the impact that the torture has inflicted on them psychologically. Thus the symptoms that the health professional is seeking might not be the symptoms that concern the individual the most, and he or she might not interpret them in a biomedical manner. For example, intrusive memories may be interpreted as a supernatural experience. Therefore the health professional's inquiry has to include the individual's beliefs about their experiences and meanings of their symptoms.

The mental state exam begins the moment the health professional meets the subject. The interviewer should make note of the person's appearance (such as signs of malnutrition, lack of cleanliness), changes in motor activity during the interview, use of language, presence of eye contact, and the ability to relate to the interviewer (see Box 3 below).

Brief mental state exam

- Appearance - self, clothing, marks
- Behaviour on observation (e.g. does s/he look perplexed)
- Look and smell for signs of alcohol, drugs, disease
- Assess speech - form, content, flow
- Mood, subjective as the patient defines, objective (affect) as the clinician observes
- Thought processes (delusions, obsessions, ideas of helplessness, morbid ruminations, etc)
- Perception, illusions and hallucinations (auditory, visual, olfactory and somatic)
- Cognitive function (i.e., orientation, time, place, person, short-term and long-term memory)
- Insight (how aware the patient is of his or her psychological problems)

BOX 3

Interpretation of the clinical findings is a complex task. The following questions will help reach conclusions (adapted from: The Istanbul Protocol, see section 8.2):

1. Are the psychological findings consistent with the alleged report of torture?
2. Are the psychological findings expected or typical reactions to extreme stress within the cultural and social context of the individual?
3. Given the fluctuating course of trauma-related mental disorders over time, what is the timeframe in relation to the torture events? Where in the course of recovery is the individual?
4. What are the co-existing stresses impinging on the individual (e.g. ongoing persecution, forced migration, exile, loss of family and social role)? What impact do these issues have on the individual?
5. What physical conditions contribute to the clinical picture? Pay special attention to head injury sustained during torture and/or detention.
6. Does the clinical picture suggest a false allegation of torture?

6.3.2 Upper limbs

Small wounds to the backs of the hands can be caused by punching or being hit. Wounds on the backs of the forearm could be defence injuries. The inside of the non-dominant forearm is the usual location of self-inflicted wounds. (See also section 4.6.1.) Superficial abrasions or reddening around the wrists could have been caused by tight handcuffs or cords. At a later stage there is often hair loss and there may be hyperpigmentation (see section 6.2.5.2).

Finger and toe nails can be extracted or crushed during torture, but the late appearance is normally indistinguishable from infection or innocent trauma. Vaccination scars should be noted to ensure they are not attributed to ill-treatment.

6.3.3 Head and neck

Lesions on the face are particularly distressing for survivors of torture because they are a frequent reminder of the episode. Most traumatic scars on the face tend to be relatively small, and scars from acne and chickenpox, and tribal markings, must not be mistaken for them.

Lesions are common over bony points, especially the eyebrows and the cheekbones. These may be associated with a fracture of the malar bone (cheekbone). Subconjunctival haemorrhages (bleeding seen in the white of the eye) should be noted. Sometimes victims of torture complain of soreness in the eyes after a history of long detention in dark cells; on examination mostly only redness of the eye is apparent.

Bruises and scars in the scalp can be difficult to find, especially if the hair is thick. Bruises will normally be tender to touch. Broken or missing teeth are often shown by individuals as evidence of assault, but where the general oral hygiene is poor this usually makes this sign unhelpful. Petechiae of the palate may be evidence of forced oral intercourse (see section 6.4). Slaps to the ear can sometimes damage the eardrum. However, the finding of scars of the tympanic membrane (eardrum) does not exclude childhood infections.

6.3.4 Chest, back and abdomen

Lesions on the trunk, as in all parts of the body, can be accidental or self-inflicted, or a consequence of torture. The late effects of whipping and beating with sticks can include lines of hyperpigmentation as well as scarring. Sometimes torturers embed small pieces of metal in whips, or hammer nails through sticks, and these can leave a distinctive appearance.

Striae distensae (stretch marks) are most common on the abdomen (especially after pregnancy), the lower back, the upper thighs, and around the axillae. They are hypopigmented lines in which the skin might be folded. They must not be confused with scars from whipping. In *striae*, the skin is intact. They can be evidence of significant weight loss, for example in detention. (See also section 6.2.5.2.)

Survivors of torture frequently complain of non-specific pains, and the chest is a regular site for them. On examination there is rarely anything significant to find, except perhaps some tenderness of the chosto-chondral joints (joint between the rib and the sternum (breastbone)). The pain is often helped by sympathetic physiotherapy. Patients with acute rib fractures should be examined thoroughly to ensure that there is no damage to underlying tissues.

Back pain is also common in survivors of torture, and there may be some local tenderness in the lumbar spine. However, these findings are non-specific and common in the general population. Fractures of the vertebral pedicles (the parts of the vertebra going away from the main body) may result from direct blunt force and in some instances radiography of the vertebrae may indicate recent or healed fractures.

Partial asphyxiation is very frightening for the victim and torturers have used many methods of causing it. These include putting plastic bags or other sealed objects over the head, holding the head under water, and forcing objects into the mouth, such as a wet cloth. Sometimes chilli pepper, petrol or sewage are added. Victims can be exposed in a confined space to smoke or tear gas. Many survivors will give an account of a persistent dry cough for a few days or weeks afterwards, probably as a result of inhalation pneumonitis (inflammation of the lungs). Some survivors say that they have been asthmatic since such an incident, but it would be very difficult to demonstrate causation. Examination of the lungs, and respiratory function tests are usually normal.

Incision wounds to the abdomen can be mistaken for surgical wounds, including those from surgical drains, and vice versa. If the wound was not sutured properly, this increases the likelihood of it not having been made surgically. The location of the wound is always helpful. Renal failure due to crush syndrome may be seen acutely following severe beatings, severe burns and electrical torture.

6.3.5 Lower limbs

Scars on the knees and shins are common in many people, especially those who have played contact sports. Thus lesions in this part of the body can rarely be significant, though they might be consistent with allegations of torture (see section 4.6). Additionally, tropical ulcers in childhood can leave large, irregular scars primarily

around the lower legs. Lesions on the upper thighs and particularly those inside the thighs are much more important, as they are less likely to be the result of disease or accidental causes.

Falaka (beating of the feet) is a common method of torture, particularly around the Mediterranean and in the Middle East. Survivors will usually describe painful, swollen feet for days or weeks after the torture. Some will describe pain on walking several years later, or burning pain in the foot radiating up to the calf or even the thigh in bed at night. There may be some tenderness of the sole of the foot on palpation. However, the recognised syndromes of permanent damage to the foot probably only occur in those whose feet were beaten most severely.

6.4 Sexual assault

Sexual assault is probably common worldwide as a form of torture, but less widely discussed. Perpetrators generally claim that torture is necessary to gain information, but sexual abuse suggests a motivation more to debase, humiliate and intimidate, not only the victim, but often the family and even the wider community. Survivors of sexual assault are often unwilling to disclose the abuse openly. In many cultures victims are blamed, even though they were powerless at the time of the incident. This makes it even less likely that they will testify against their torturers.

All forms of torture include an element of humiliation. Although far fewer women than men are detained, those women who have been tortured in detention are disproportionately likely to have been sexually abused and raped. If there has been no other torture, this can be very difficult to document, as the opinion may have to be based on the demeanour of the woman and her description of what happened to her and of her psychological symptoms. As many as 25% of all male survivors of torture have been sexually assaulted. If there are conclusive physical signs from other forms of torture, a survivor may not disclose sexual abuse. It is necessary to be sensitive to this during the history taking, as it is important for a health professional treating the individual to be aware of it (see also section 5.3.2 about gender considerations).

Children may also be victims of rape and sexual assault. Even older children may be unaware of what happened to them, and may not be able to give a coherent account of their experience. Using drawings and, if available, dolls may help them explain where they do not have the necessary language or understanding. It is even more important that the examination is by someone who is experienced in this field.

Sexual abuse often occurs in the context of detention and ill-treatment. Several patterns can be identified. In one, the genitals are treated like any other parts of the body and they are assaulted with the rest of it with the aim of hurting. Giving an electric shock to the genitals is just another way of causing severe pain.

In another pattern, particularly in societies where extramarital sexual activity is taboo, the victim will be criticised for the sexual act, even if it was perpetrated when he or she was unconscious. This in itself is an obstruction to disclosure, and a threat by the perpetrator to publicise the rape can itself be very harmful. Sexual assault and rape are intended to add to this by maximising the humiliation as well as the pain of the torture.

A third pattern is where detainees are treated like prizes. The guards, often drunk, abuse and rape the detainees. Although such activity is said to be the guards acting for their own gratification, it is often systematic and widespread and part of the humiliation of the detainees.

The sexual assault is clearly not simply a physical assault on the individual, but in many instances it is the psychological insult that is most injurious. Often, sexual assaults will be accompanied by direct or implied threats. In the case of women, the threat may be one of becoming pregnant. For men, those inflicting the torture may also threaten (incorrectly but usually deliberately) that the victim will become impotent or sterile. For men or women there may be the threat of contracting HIV or other sexually transmitted infections (STIs) and often the threat or fear that sexual humiliation, assault or rape will lead to ostracism from the community and being prevented from ever marrying or starting a family.

Sexual assaults can be categorised as:

- Assaults to the genitals
- Electric shocks to the genitals and anus
- Forced sexual acts on themselves or on/with others
- Object inserted into the vagina (in women)
- Object inserted in the urethral meatus (in men)
- Object inserted through the anus
- Penis forced into the mouth
- Penis forced through the anus
- Penis forced into the vagina (in women).

The term 'rape' always means the last of these, but in many jurisdictions it can mean one or more of the others. Thus if the term is used, the act should also be specified.

Following the above, when examining an individual who may have been sexually assaulted, the health professional should be aware of and sensitive to the particular unease that the individual is likely to be experiencing, and should take note of gender and culture considerations and the use of chaperones (see sections 5.2.2, 5.3.2, 5.3.3, 5.5.2, and 6.2.1).

6.4.1 Examination of women

Lesions on the breasts, particularly from bites, should be enquired about in women who have been sexually assaulted. When the legs are examined, the inner thighs should be inspected thoroughly. Where women have had their legs forced apart, there may be finger bruising, scratches, cigarette burns, incisions and other wounds, or their late consequences.

The vaginal examination is generally the last part of the physical examination. The doctor must seek specific consent prior to a genital examination, even if consent for the physical examination has already been given. Prior

notice of an intention to conduct a detailed physical examination that may include a genital examination could be reassuring to the person and help her to give informed consent. A clear, unambiguous explanation of the reason for the genital examination should be given while the victim is fully clothed. Rape victims in particular may feel disempowered, and may feel that they cannot refuse a request from the doctor, who should make every effort to ensure that any consent given is real and informed.

If the victim refuses consent, the doctor should record any relevant observations on the victim's demeanour, such as embarrassment or fear. It is unwise to draw conclusions about a refusal to consent to genital examination. Lying prone on an examination table, exposed and with legs apart in front of a relative stranger, can trigger powerful recall of the rape. The victim may be anxious, and shame can be profound, making genital examination unacceptable to her.

If informed consent is obtained, the woman should be made at ease, reassured and explained the procedures that are going to be performed. The genitals should be inspected for the presence of a hymen, the likelihood of having been pregnant, and evidence of genital mutilation. Is there vaginal discharge or tenderness, or spasm of the vaginal muscles?

If the woman is being examined shortly after the rape, it is important to discuss issues of pregnancy and emergency contraception, and however long has passed since the assault, sexually transmitted diseases (especially gonorrhoea, chlamydia, syphilis and trichomoniasis) and other infectious diseases such as Hepatitis B (HBV) and HIV must be considered (see below), and treated where present if the necessary facilities are available. If rape occurred within the previous seventy-two hours, consideration must be given to the administration of post-exposure prophylaxis (PEP) of anti-retrovirals (ARVs) for preventing infection by HIV and this depends on a detailed assessment of the nature of the sexual assault. The risk of infection with HBV should be assessed and the need for immunisation determined.

Some women are raped persistently over a long period which increases the likelihood that they will become pregnant; in some cases they are then detained until it is too late to consider termination of pregnancy (if that would otherwise be an option). In such cases routine ante-natal examinations should be performed including, if possible, ultrasounds. This will enable the time of conception to be estimated.

6.4.2 Examination of men

As for women, the men's genitals are best examined last. The skin of the male genitals is tough and wounds are an indication that considerable force has been used. Wounds then heal with relatively small scars. It is therefore necessary to examine the area thoroughly if there is a history of injury, or if electricity has been applied through clips. As for women, the insides of the thighs may also have been injured.

Men who are sexually assaulted in detention may develop an erection and sometimes ejaculate. This is often quite distressing. It can be a physiological response to stimulation of the prostate following anal penetration,

and/or a consequence of emotional arousal from anger, fear and pain. Survivors should be reassured that this can happen to any man irrespective of his sexual orientation.

As with sexual assault of women described above, male victims of sexual violence also need to be assessed for prophylaxis of sexually transmitted diseases, Hepatitis B and HIV.

6.4.3 Perianal examination

The examination of the patient alleging sexual torture is not technically different from a general anogenital examination. The essential aspect, even more than for other medical purposes, is to gain the confidence of the individual. By this stage the health professional will have already completed an interview and general physical examination.

Following a more general history, questions should be asked about urinary function after the episode(s). Some survivors of torture described haematuria for a median of two days, mostly after beating or electric shocks to the genitals, although some could have had haemaglobinuria (haemoglobin in the urine) from beatings elsewhere in the body. Where an object has been inserted into the anus, including anal rape, there is normally bleeding and pain for a few days afterwards, but these symptoms do not normally last for more than about two weeks.

Generally, visual inspection of the anogenital region is sufficient to find scarring and other lesions of the skin. The focus of the examination will depend on the history.

Anal rape or objects pushed through the anus in either sex can sometimes lead to scarring. Scarring from haemorrhoids or anal fissures is seen in a proportion of the general population, but may also relate to constipation due to a poor prison diet. If a health professional sees scarring in an unusual part of the anus, or scarring that is bigger than commonly seen following anal fissures, this should be emphasised.

It is best to examine the anus with the patient lying on her or his left side. The buttocks can be separated gently to see if there is any perianal scarring. It is only necessary to check the tone of the anal sphincter if the survivor has been anally raped repeatedly. If the survivor had persistent bleeding after an object was pushed through the anus, there may be scarring of the rectal mucosa and this can be looked for by proctoscopy.

Following rape, the possibility of sexually transmitted diseases should be considered and local protocols followed. If there is any possibility of the perpetrator being prosecuted, air dried internal and external anal swabs can be taken up to five days after the rape, even if the survivor has defecated, and stored for DNA testing.

6.5 Investigations

The use of clinical investigations of allegations of torture may take two forms. First, health professionals who examine a survivor of torture during their routine practice may need to conduct investigations as part of their therapeutic role. While these investigations are primarily part of the diagnostic and treatment process, they may

well serve as forms of documentation that can be referred to later. The second form of investigation may be that which is carried out during the course of an examination dedicated to the medical documentation of torture. The latter investigations aim specifically at the production of medical evidence that may corroborate or rebut allegations of torture.

The investigation of allegations of torture will depend on several factors. First, the resources available might be limited in some resource-poor countries, and it would be unethical to divert valuable clinical resources for medico-legal purposes. However, the results of investigations such as X-rays taken for clinical purposes can be important pieces of evidence.

Second, the nature of the investigations will depend on the level of proof necessary for the situation. Unnecessary X-rays, for example, increase the radiation exposure of the individual and of the community and should be avoided. Only if such investigations are likely to make a significant difference to the case can they be justified.

Additionally, some survivors will have been tortured using, for example, electric shock devices, and being examined using medical equipment might trigger intrusive memories.

Where investigations are indicated, and the individual consents, possible investigations include X-rays, ultrasound, CT scans, MRI, and scintigraphy. Studies have also shown pathognomonic changes in skin biopsy for several months following electric shocks (see section 6.2.10). In many of these cases, the findings wane after about a year, and it must always be emphasised that negative findings after an investigation cannot be construed as evidence that the alleged torture did not occur (for further information about the investigation of allegations of torture, see *The Medical Documentation of Torture* section 8.2).

6.6 Medical photography

One helpful tool in the documentation of physical assault is photography. It may be possible to ask experts elsewhere to comment on photographs if there is no local expertise available to interpret them. Those interviewing in custodial settings may not be permitted to use such equipment, but it can sometimes be negotiated with the detaining authorities. Failing this, drawings and diagrams can be useful (see Annex).

When working with a person who is alleging recent torture, it is very helpful to be able to document the injuries as quickly as possible, before any change occurs. Any photographic equipment can be used to capture a wound in the first instance and more photographs can be taken later, with a better camera if possible.

The subject of clinical photography must consent to having the pictures taken and agree about how the photographs will be stored and used.

The first photograph should show the individual clearly with, if possible, the lesions visible to allow identification in court if necessary. The front page of a recent newspaper (or other object of verifiable age) can demonstrate that the photograph was not taken prior to that date. If there are date and time settings on the camera, these should be used correctly. There should always be an indicator of scale for close-up images. A tape measure is best but, if necessary, any well-known object of standard size can be used, such as a 35mm film canister or a coin. In photographs taken using the camera's built-in flash, wounds tend to be obscured. It is better to work in daylight or to use background lighting.

Digital cameras allow many photographs to be taken using different angles and lighting conditions and the best produced as evidence, although every image taken should be stored securely (for example, on a secure computer, with password protection). Films can also be useful as courts have not generally agreed how digital images should be treated as evidence. Digital images and scanned prints can be useful as they can be e-mailed to experts for an opinion. If necessary they can be cropped and enlarged, but the original version must always be retained. Further interference must be avoided as allegations of manipulation are difficult to refute.

Once the photographs have been taken, the chain of custody of the images must be ensured. A 'chain of custody' is a detailed record showing the exact date, time and location in which a piece of evidence entered the possession of different individuals. A chain of custody aims to prevent outside interference with evidence. It may be valuable to add to a witness statement a phrase such as: 'I took photographs of [name] on [date] using my [type] digital camera. I kept it in my possession until I transferred the images to [X] directory on [X] computer. To the best of my knowledge it has not been tampered with, and the photographs in this report were made from that file.'

7 Visiting places of detention

7.1 Why visit places of detention?

Visits to places of detention are seen as one of the cornerstones of the prevention of torture, firstly since they can have a direct deterrent effect, and secondly because the members of a visiting team can directly observe, document and report on the conditions of detention and treatment of detainees. Visits serve to break down the idea that prisons and other detention places are 'closed institutions', and thus to increase the transparency of their functioning.

A third but no less important role of visits is the psychological support that they may bring to the detainees. This support is not through therapeutic procedures, but often the mere presence of someone from outside who acknowledges the existence of the individual and thus provides a link with the outside world is of value. Visiting a place of detention may also facilitate the re-establishment of contact between the detainee and the family, or between the detainee and a legal advisor or other external source of support or assistance.

7.1.1 Places and stages of detention prone to torture

As described in earlier sections, the most common period for torture to occur is during the phase after initial arrest. Thus torture more commonly occurs in the hands of security forces (police, gendarmerie, military etc.), in short-term places of detention, which may be official, recognised places, but which are sometimes also unofficial or secret places of detention. Visiting teams may have little or no access to these places, or if access is granted, detainees may be moved or hidden before the team arrives.

Access is often more likely to be granted to regular prisons, where detainees who are under-trial (on remand) and prisoners who have been convicted, are held. In these prisons, the visiting team and those detained may be more concerned with the conditions of detention and other issues such as fundamental judicial guarantees. However, it is important to keep in mind that especially in remand prisons, detainees who have undergone torture and other ill-treatment in a previous place of detention to which the visiting team may have no access, may well be present and the circumstances and events of the ill-treatment can still be obtained through detailed interviews with the individual. A picture of the layout of the place where torture took place, the general conditions, food, hygiene, medical care and specific methods of ill-treatment can be built up through cross-checking with as many individuals as possible who have passed through the same place.

7.1.2 Constraints on documentation during visits to places of detention

Visits to a place of detention do not usually provide the ideal conditions for documenting allegations of torture or other ill-treatment which have been described in the previous sections. This is most commonly related to constraints on time that can be spent inside a prison and the number of prisoners who are present. The fears and

concerns of the prisoners (for example, of reprisals, of interviewers maintaining confidentiality etc.), the near-by presence of guards or indeed of other prisoners, may also inhibit them from talking. Although, at first glance, it would appear that conducting interviews under such controlled conditions as prisons would seriously impede the process, it is often the case that detailed and useful information can be obtained after carefully identifying the team, their organisation, the aims and purpose of the interviews, and how the information will be used.

7.2 What to assess in a place of detention?

As described in Chapter 2 of this Handbook, in describing or determining what is torture and other ill-treatment it is important to stress that these terms apply not only to the treatment inflicted during an actual interrogation session, but may also cover the general conditions of detention in which people are held. If the conditions of detention are deliberately harsh with a view to causing more suffering to the individuals, or there is simply wanton neglect of the basic necessities for daily life, then this may in and of itself amount to cruel, inhuman, degrading treatment and/or even torture. Particular forms of detention, such as prolonged use of solitary confinement, may in themselves be a form of ill-treatment.

7.2.1 General conditions of detention

Establishing an accurate picture of a place of detention is a question of compiling information from three main sources: the prisoners, the authorities and one's own observations. It is important to document not only specific physical and psychological methods of interrogation, but also the living conditions, including hygiene of the premises, access to and quality of food and water, access to personal hygiene, including toilets and the state of the facilities, and access to health care. It is clear that poor general conditions of detention, particularly poor nutrition, poor medical treatment, exposure to insects and other vectors of disease etc, may all lead to physical as well as psychological symptoms and signs. It is well documented that the prolonged use of isolation can lead to specific psychological as well as some physical sequelae.

7.2.2 How much time to allow for visits

The depth of the information that the visiting team is able to gather depends partly on the type of place being visited, the size and skills of the visiting team, and the amount of available time. Commonly, police stations hold smaller numbers of detainees in small facilities, and thus a visit may be conducted in a day or less. On the other hand, prisons in different contexts may hold as few as fifty prisoners or up to several thousand and a visit may need several days.

For a large prison, careful planning of the objectives of the visit, division of the tasks and selection of individuals to talk to will have to be made. In visiting places of detention where individuals may actually be subjected to ill-treatment (interrogation centres, police stations, military and paramilitary camps), the visiting team should not press the detainees too much for information, since they will usually be extremely fearful of reprisals in the event that they are seen to have complained in any way about their treatment. More detailed information can be gathered from detainees at a later stage when they reach a mainstream prison or other more long-term place of detention.

7.2.3 Documenting specific methods of torture or other ill-treatment

As well as documenting the conditions of detention it is crucial to document specific methods of interrogation that may variously be used on individuals. It is important to understand that the methods used may be physical or psychological or more usually a combination of both. In many cases, it is a combination of methods (whether physical, psychological or both) which are collectively seen as torture or other ill-treatment. The length of time over which an individual is subjected to certain treatment may also affect the determination of whether this is torture. Again, for these reasons, it is important to document as accurately and completely as possible all the events to which an individual was exposed, and their consequences, and not be overly concerned at this stage about legal thresholds or definitions.

If the allegations of torture relate to a place of detention previous to the one where the interview is being conducted, the same detail of information on conditions and specific methods of interrogation should still be collected.

The same methodology as detailed in the previous sections of this Handbook should be applied, but the constraints of the location (within a prison or even a police station) and time will mean that the team will have to abbreviate much of the process. Nevertheless, the team should obtain a description of the conditions of detention, in particular the cell, block or barrack where the person was held, noting any degree of over-crowding present, and other elements such as the bathroom and toilet facilities, amount of time allowed outside of the cell; the frequency, quantity and quality of food and water; the level of health care available. When describing elements such as bathing facilities and health care, it is not enough simply to describe the structures, it must also be ascertained how the person accessed these facilities and what barriers there were to such access. For example, there might be discrimination of access to health care, food or even exercise for some minorities, foreigners or political groups.

Then, in relation to interrogation, there should be a description of the methods (physical or psychological), the immediate or acute effects on the person, any medical (including psychological) treatment received at the time and the immediate healing or recovery phase following the events. Then the health professional should ask about any lasting or chronic physical or psychological disturbances which may be related to the previous detention and any further medical, psychological or psychiatric care and how this has affected the evolution of any symptoms. This should be completed with a brief physical examination focusing not only on the systems that relate to the person’s symptoms, but also those systems in which the health professional would expect to find signs that would relate to the detention or interrogation described. There should also be an abbreviated mental state examination, but many elements of this can be noted during the course of the interview itself.

7.3 Composition of the visiting team

The monitoring of places of detention can take place at both a national and an international level. The composition of the visiting team may vary, and depends partly on the mandate of the team. From the above description of what to assess, it can be seen that 'health', in the broad sense of the term, is a crucial aspect for

assessment. Thus a doctor should ideally form part of the team, but certainly where the documentation of individual survivors of torture is likely.

When the team is composed of international members it will usually be necessary to use interpreters. In order to ensure confidentiality, and to build trust with the prisoners it is preferable to use expatriate interpreters who may also be able to assist with providing background cultural and contextual information to the team (see also section 5.5 on working with interpreters). If, during a visit where no interpreter is present, it becomes apparent that a prisoner needs to be interviewed via an interpreter, the prisoner him- or herself should be asked to choose a fellow prisoner to assist him. The team should always keep in mind that in using fellow prisoners as interpreters they may relay confidential information to third parties and so should always exercise caution when doing so.

National visiting bodies may include a system of 'lay visitors' (often only with access to prisons); the Office of the Ombudsmen or National Human Rights Commission; parliamentary commissions; independent NGOs etc.

International visiting bodies may cover specific geographical regions, or may be able to conduct visits around the world. The European Committee for the Prevention of Torture (CPT) has a mandate to visit places of detention (which include not only prisons and police stations, but also institutions such as psychiatric hospitals, homes for the elderly, orphanages etc.) throughout Europe, even in the absence of any complaints or allegations. The International Committee of the Red Cross (ICRC) has a mandate to work in areas of armed conflict across the globe and to visit places of detention (military camps, police stations, interrogation centres, prisons etc.) in these contexts. In the case of international armed conflict the ICRC has a right to visit both prisoners of war (POWs) and civilians who are interned; that is, states are obliged to allow access. In the case of non-international armed conflict or even situations of internal unrest in a country, the ICRC can offer its services to visit people deprived of freedom; that is they may only visit places of detention with the permission of the state authorities, which many states do indeed grant. The aim of visits in all these contexts is to prevent or end torture and ill-treatment, disappearances and extrajudicial killings, as well as to address the overall conditions of detention, including health care.

The Optional Protocol to the United Nations Convention Against Torture (OPCAT) incorporates a dual system for the prevention of torture through the establishment of both international and national bodies to visit places of detention. Both categories of monitoring mechanism should include a doctor as part of the team.

7.4 Safeguards for visits

Effective visits to prisoners for the purpose of documenting torture depend upon certain conditions and guarantees, without which they should not be attempted. It is essential in any visit to prisoners to be able to interview all persons concerned, and who freely accept to be interviewed, in conditions of safety and privacy. Non-adherence to these conditions could further compromise the safety of those interviewed. Wherever feasible the visiting team should choose the location in which they wish to interview individuals, and choose for themselves which prisoners they wish to meet. Additionally, the team or others on their behalf, should be able to

repeat the visit at a date in the future in order to check that no reprisals have taken place, and that all the prisoners are accounted for.

7.4.1 Choosing which prisoners to talk to

It is clear that in most prisons it will be impossible to interview each and every prisoner, and thus the team should select a sample of prisoners. There is no single formula for sampling of prisoners, but during the tour of the prison the team should look out for certain individuals such as the obviously sick, the quiet withdrawn individuals, prisoners who appear particularly young or old. There may also be prisoners from particular sections of the prison that the team wishes to interview, such as those in punishment cells/solitary confinement, the women's section, the juveniles' section, those in the prison hospital etc. If the team has a good knowledge of the patterns of torture in the country and knows that particular police stations or interrogation centres are responsible, the team might select those prisoners who have passed through these places, or who come from those particular regions or towns (although care must be exercised since this may clearly indicate to the authorities the purpose of the interviews). Equally the team may decide to interview a number of prisoners who have arrived in the prison within the last month. In so doing they can be asked about their time in the prison as well as events in any prior places of detention.

7.4.2 Privacy of interviews

Some security measures on the part of the authorities are to be expected, but the privacy of interviews is paramount both for gaining trust and for obtaining reliable information. If the authorities insist on the presence of guards, they should be out of hearing range of the interview. Moreover, the privacy of the interview must also preclude the presence of other prisoners, since it is feasible that other prisoners may inform the authorities on the content of any discussion! Generally, if the interviews are being conducted in a secure location within a prison, then the use of restraints (handcuffs etc) should not be accepted by the visitors. Certainly where any medical examination is concerned this should not be conducted with the person in any form of restraints (see section 3.2.6).

7.4.3 Informing and obtaining consent from prisoners

Information about conditions in custody may be sensitive, and information regarding torture may be even more sensitive, at least where the prisoner is still being held in the place where the torture occurred; so prisoners may be reluctant to reveal such details. Visitors should not assume that prisoners will necessarily trust them. Conversely, some prisoners may have an exaggerated perception of the powers of the visiting team (since they have obtained permission from the government to enter the place of detention which is barred to most outside organisations). Often this translates to a feeling that the visiting team can protect the individual against any future harm, including any harm that may result from raising complaints about their current situation. In some cases the prisoner may think that the team can get them released.

Thus, from the outset, it is vital to explain the purpose, mandate and limitations of the visit and obtain the consent and co-operation of the prisoners, which can be facilitated by the production of booklets or leaflets and

so on. The visiting team has a high degree of responsibility not to cause additional harm to the prisoners through the process of the visit. Thus, explanations of the purpose of the visit should not only highlight the possible benefits, but must also make clear the potential harms, and the consent of the individuals must be obtained before proceeding. The team must use sound judgement in deciding what information, if any, to use and how to use it.

It is important to explain the role of the health professional on the team to the prisoners, which should be to assess the overall conditions and impact on the health of the prisoner population as a whole, and, where relevant to document as many cases of allegations of torture or other ill-treatment as possible. Equally, the health professional should explain their limitations, principal among which is that they are not replacing the existing medical service and not necessarily taking on a therapeutic role (although this should not rule out notifying the prison authorities and seeking treatment for especially grave cases who have not received any attention). Before proceeding, consent should be obtained to the process. If individuals decline to meet or talk with the team, this decision must be respected, but the team should also be aware that prisoners may have faced intimidation either not to talk, or to portray everything as acceptable or good.

7.4.4 Touring the premises

Wherever possible, before commencing interviews, the team should seek to tour the premises to observe directly the conditions and also to ensure that prisoners are not hidden in far flung parts of the premises. Such a tour should include the cells or barracks, the exercise/recreational areas, the kitchens and dining areas, the toilets and bathrooms, the health service, any workplaces and the areas where family visits take place. If time allows, the health professional on the team should also visit any outside health referral centres since this provides an understanding of the level of health care available to the community, and thus enables the team to determine what is an ‘equivalent’ level of health care for the prisoners.

7.4.5 Health services in place of detention

From the point of view of the health services the health professional should make time to talk privately with the prison health staff, in particular the physician, to obtain their perspectives on the running of the health service. Keep in mind that in caring for the prisoner-patient, prison physicians are often faced with professional and ethical dilemmas stemming from clashes between prison security and medical care (see section 3.2.4, Dual obligations). Part of the discussion may thus involve raising their awareness on the ethical issues, on international standards and on ways to resolve such clashes.

Where torture is the issue, the prison physician may face additional pressures from the authorities in charge either to ignore prisoner complaints, or even to falsify medical reports. There may be no existing mechanisms in the prison system, or even nationally, for the prison physician to obtain support or to raise complaints, or the prison physician may be unaware of their existence. Thus the visiting team may be able to provide information on national and international support and complaint mechanisms or organisations (e.g. National Medical Association; World Medical Association – see section 3.2.11 and 8.1).

7.5 What to do with the information?

Information obtained during a detention visit can be used in varying ways and at different levels of authority from those running the concerned prison, up to the level of the concerned government ministries.

7.5.1 The use of named or anonymous allegations

In compiling reports or interventions to the authorities responsible for a place of detention the visiting team may include allegations from named or unnamed sources. While allegations from named sources are often seen as more credible, the decision to identify individuals is one that the individual prisoners themselves must make, based on clear explanations by the visitors of the possible benefits and potential risks. It should be made clear that there can be no absolute guarantee against reprisals.

7.5.2 Compiling and using a report of the visit

At the end of a visit, the team may decide to give immediate verbal feedback and relay specific issues to the authorities running the prison. Subsequently a report summarising the findings and discussions could be sent to the prison. Similarly, a report can be sent to either the regional or central prison authority, and/or to the responsible ministry and subsequent meetings held to discuss the issues. Whether any of the information obtained is made public will depend on the agreement reached before entering the prison. Certain visiting bodies, such as the ICRC, have a strict policy of confidentiality concerning detention visits. The international monitoring mechanism of the OPCAT will in principle also operate on a confidential basis, whereas the national mechanism might not.

7.5.3 Repeating the visits

One way to ensure that prisoners are not subjected to harassment or outright reprisals for having talked to outsiders is to visit and interview them again. The interval between visits obviously will depend on the actual risk of harm from the side of the detaining authorities. In order to be able to locate each person effectively and to interview him or her personally about any such reprisals, it is necessary to have a system for collecting and recording personal information so as to ensure reliable identification of the same individuals on subsequent visits. These data may also serve to follow the prisoner throughout their detention and may help to prevent ‘disappearances’ by checking whether they are present or have been transferred or released. Information on how to contact the individuals if they are released may also be useful should this be needed in the future.

Report to the Russian Government on the visit to the Russian Federation carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 2 to 17 December 2001

The Committee visited a large number of places of detention, noting varying degrees of compliance with expected standards. Physical conditions of detention were amongst the focus points of the inspection. As mentioned in this handbook, extremely poor conditions can be detrimental to the physical and mental health of those in custody.

From the CPT report:

'Cells measuring 7.5 m² usually held 3 to 4 prisoners, dormitories measuring 20 m² accommodated as a rule between 17 and 20 inmates, and dormitories measuring 33 m² held up to 30 inmates. In a number of cells, not every prisoner had his own bed (the most extreme case seen being a cell measuring 20 m² which contained 8 beds and was accommodating 25 persons) and inmates took turns to sleep on the available beds or slept on the floor.

'The negative effects of the overcrowding were exacerbated by the fact that cell windows (including those in the section accommodating prisoners with TB) were covered with slatted metal shutters, which severely restricted access to natural light and fresh air. As for artificial lighting - which was left on 24 hours a day - it was poor in many of the cells. The level of hygiene was also dubious: in some cells the delegation saw cockroaches, and prisoners also referred to the presence of mice and rats.'

8 Further information

8.1 Organisations

Inter-Governmental Organisations (IGOs)

African Commission on Human and Peoples' Rights

Kairaba Avenue
P.O. Box 673
Banjul
The Gambia
Tel.: +220 4392 962
Fax.: +220 4390 764
E-mail: achpr@achpr.org
http://www.achpr.org

European Court of Human Rights

67075 Strasbourg-Cedex
France
Tel.: +33-3-88 41 20 18
Fax: +33-3-88 41 27 30
http://www.echr.coe.int/

European Committee for the Prevention of Torture

Human Rights Building
Council of Europe
F-67075 Strasbourg Cedex
France
Tel.: +33 3 88 41 39 39
Fax: +33 3 88 41 27 72
E-mail: cptdoc@coe.int
www.cpt.coe.int

Inter-American Commission on Human Rights

1889 F St., NW,
Washington, D.C.
USA 20006.
Tel.: +1-202-458 6002
Fax: +1-202-458 3992.
E-mail: cidhoea@oas.org
http://www.cidh.oas.org/

Office of the UN High Commissioner for Human Rights

OHCHR-UNOG
CH 1211 Geneva 10, Switzerland
Tel.: +41-22-917 9000
Fax: +41-22-917 9022
E-mail: tb-petitions@ohchr.org
http://www.unhchr.ch/

UN Committee Against Torture

c/o Office of the High Commissioner for Human Rights (above)
www.ohchr.org/english/bodies/cat/

UN Special Rapporteur on the Right to the Highest Attainable Standard of Health

c/o Office of the High Commissioner for Human Rights (above)
Fax: +41 22 917 9003
E-mail for urgent appeals: urgent-action@ohchr.org
http://www.ohchr.org/english/issues/health/right/index.htm

UN Special Rapporteur on Torture

c/o Office of the High Commissioner for Human Rights (above)
E-mail for urgent appeals: urgent-action@ohchr.org
http://www.ohchr.org/english/issues/torture/rapporteur/index.htm

UN Voluntary Fund for Victims of Torture

Secretariat of UN Voluntary Fund for Victims of Torture
c/o Office of the High Commissioner for Human Rights
Trust Funds Unit/Support Services Branch
CH-1211 Geneva 10
Switzerland
Tel.: +41 22 917 93 15
Fax: +41 22 917 90 17
E-mail: unvfvt@ohchr.org
www.unhchr.ch/html/menu2/9/vftortur.htm

Non-Governmental Organisations (NGOs) and Professional Associations

Amnesty International (AI)

International Secretariat
1 Easton St
London WC1X 0DW
UK
Tel.: +44 20 7413 5500
Fax: +44 20 7956 1157
E-mail: amnestyis@amnesty.org
http://www.amnesty.org/

Association for the Prevention of Torture (APT)

Route de Ferney 10
Case postale 2267
CH-1211 Geneva 2
Switzerland
Tel.: +41-22-919 21 70
Fax: +41-22-919 21 80
E-mail: apt@apt.ch
http://www.apt.ch/

British Medical Association

BMA House
Tavistock Square
London WC1H 9JP
UK
Tel.: 020 7387 4499
Fax: 020 7383 6400
E-mail: http://www.bma.org.uk/ap.nsf/Content/Hubcontactus (through web form)
http://www.bma.org.uk/ap.nsf/Content/Hubethics

The Center for Victims of Torture (Minnesota)

Minneapolis Healing Center
717 East River Road
Minneapolis, MN 55455
USA
Tel.: +1 612.436.4800
Fax: +1 612.436.2600
E-mail: cvt@cvt.org
www.cvt.org/main.php

Human Rights Foundation of Turkey

Menekşe 2 Sokak No: 16/5,
06440 Kızılay, Ankara
Turkey
Tel.: +90 312 417 71 80
Fax: +90 312 425 45 52
E-mail: tihv@tr.net
www.tihv.org.tr/eindex.html

Human Rights Watch (HRW)

350 Fifth Avenue, 34th Floor
New York, NY
10118-3299 USA
Tel.: +1-212-290 4700
Fax: +1-212-736 1300
E-mail: hrwnyc@hrw.org
http://www.hrw.org/

International Committee of the Red Cross

19 Avenue de la Paix
CH 1202 Geneva
Switzerland
Tel.: +41-22-734 60 01
Fax: +41-22-733 20 57
E-mail: webmaster.gva@icrc.org
http://www.icrc.org/

International Rehabilitation Centre for Torture Victims (IRCT)

Borgergade 13
P.O. Box 9049
DK-1022 Copenhagen K
Denmark
Tel.: +45-33-76 06 00
Fax: +45-33-76 05 00
E-mail: irct@irct.org
http://www.irct.org
(includes the contact details of centres for victims of torture in many countries)

Medical Foundation for the Care of Victims of Torture

111 Isledon Road
London N7 7JW
UK
Tel.: +44 20 7697 7777
Fax: +44 20 7697 7799
E-mail: through form on website
www.torturecare.org.uk

Physicians for Human Rights (PHR)

Two Arrow Street
Suite 301
Cambridge, MA 02138
USA
Tel.: +1-617- 695-0041
Fax: +1-617-301-4250
E-mail: phrusa@phrusa.org
http://www.phrusa.org/

REDRESS

87 Vauxhall Walk
London SE11 5HJ
UK
Tel.: +44 207 7793 1777
Fax: +44 207 7793 1719
E-mail: info@redress.org
http://www.redress.org/

World Health Organisation

Avenue Appia 20
1211 Geneva 27
Switzerland
Tel.: + 41 22 791 21 11
Fax: + 41 22 791 3111
E-mail: info@who.int
http://www.who.int/ethics/en/

World Medical Association (WMA)

13 ch. du Levant
CIB - Bâtiment A
01210 Ferney-Voltaire
France
Tel.: +33 4 50 40 75 75
Fax: +33 4 50 40 59 37
E-mail: wma@wma.net
http://www.wma.net/

World Organisation Against Torture (OMCT)

PO Box 21
8 rue du Vieux-Billard
CH-1211 Geneva 8
Switzerland
Tel.: + 41 22 809 4939
Fax: + 41 22 809 4929
E-mail: omct@omct.org
http://www.omct.org/

8.2 Comprehensive Works

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8.3.3 Psychological assessment

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8.4 Documents of international standard setting

Human Rights Instruments:

United Nations (all available on http://www.ohchr.org/english/law/):

- Universal Declaration of Human Rights
- International Covenant on Civil and Political Rights
- Declaration on the Protection of All Persons from Being Subjected to Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment
- Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment
- Standard Minimum Rules for the Treatment of Prisoners
- Basic Principles for the Treatment of Prisoners
- Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment
- United Nations Rules for the Protection of Juveniles Deprived of their Liberty
- United Nations Standard Minimum Rules for the Administration of Juvenile Justice ('The Beijing Rules').

Regional (available through websites of regional organisations listed above):

- African Charter on Human and Peoples' Rights
- American Declaration on the Rights and Duties of Man
- American Convention on Human Rights
- Inter-American Convention to Prevent and Punish Torture
- European Convention on Human Rights
- European Convention on the Prevention of Torture
- European Prison Rules.

Professional Standards:

United Nations:

- United Nations Manual on the Effective Prevention and Investigation of Extra-Legal, Arbitrary and Summary Executions
- Model Autopsy Rules
- Code of Conduct for Law Enforcement Officials
- Basic Principles on the Use of Force and Firearms by Law Enforcement Officials
- Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

World Medical Association (available on http://www.wma.net):

- Declaration of Geneva (1948, 1968, 1983, 1994)
- International Code of Medical Ethics (1949, 1968, 1983)
- Declaration of Tokyo: Guidelines for Medical Doctors Concerning Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment (1975)
- Declaration of Hamburg Concerning Support for Medical Doctors Refusing to Participate in, or to Condone, the Use of Torture or Other Forms of Cruel, Inhuman or Degrading Treatment (1997)
- Resolution on the Responsibility of Physicians in the Denunciation of Acts of Torture or Cruel or Inhuman or Degrading Treatment of which they are Aware (2003)

International Council of Nurses (available on http://www.icn.ch/psdetainees.htm):

- Nurses' Role in the Care of Prisoners and Detainees (1998)

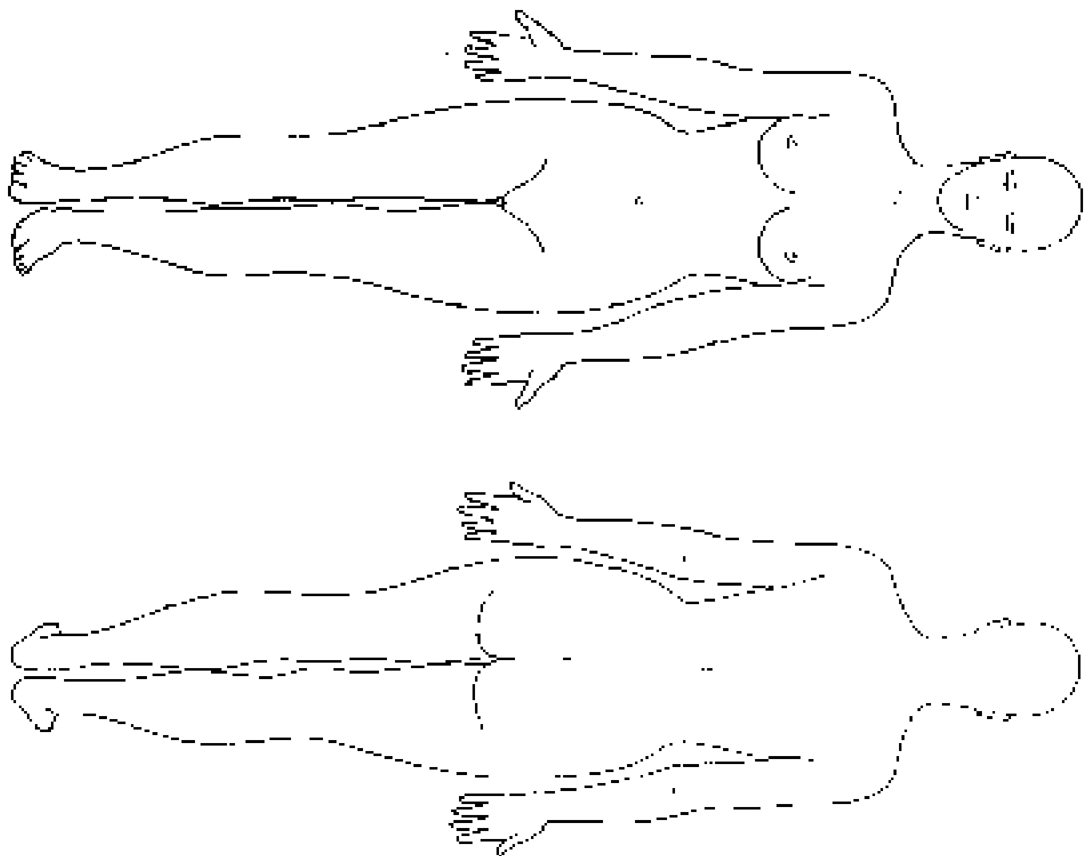
World Psychiatric Association (available on http://www.wpanet.org/generalinfo/ethic1.html)

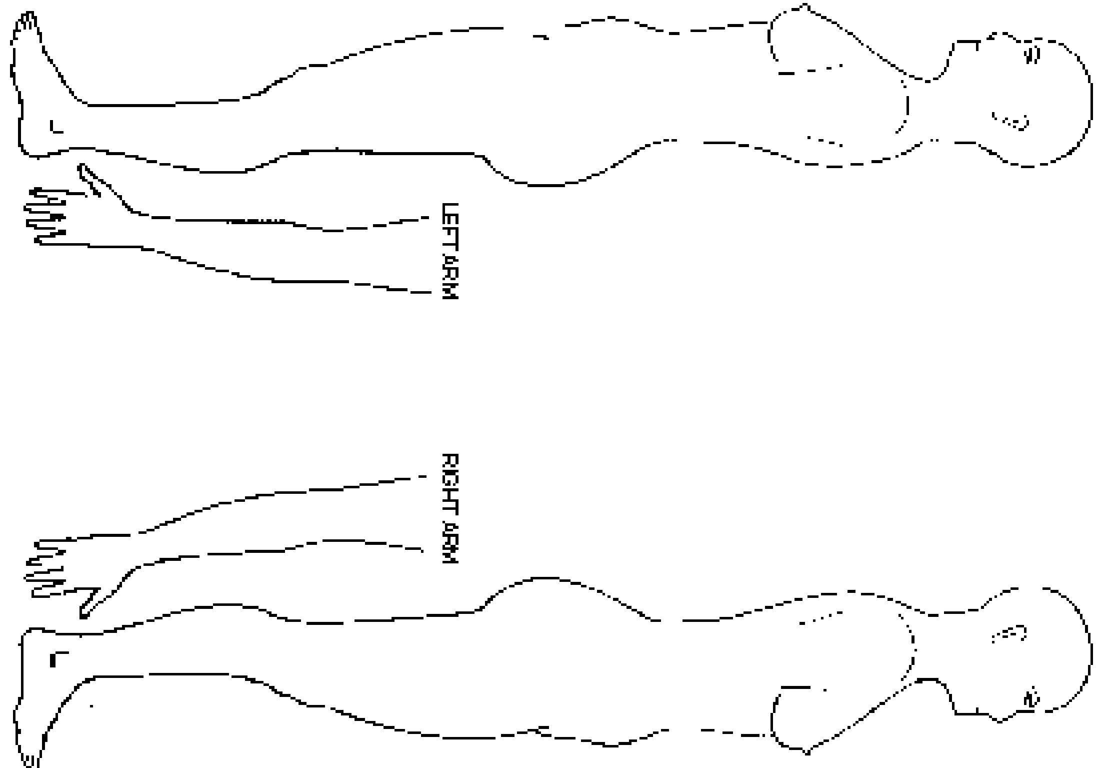
- Madrid Declaration on Ethical Standards for Psychiatric Practice (1996,2002)

Annex: Anatomical drawings

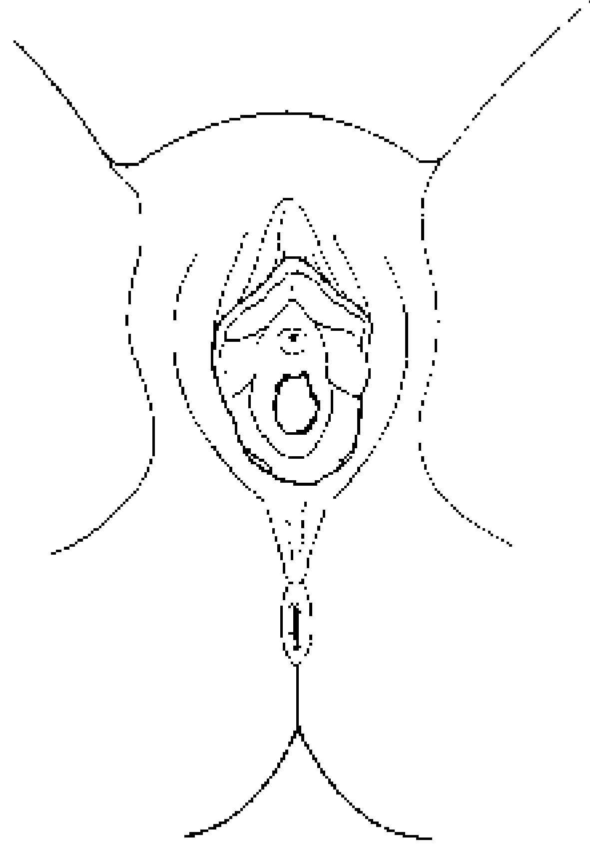
Reproduced from The Istanbul Protocol (see section 8.2)

Anatomical drawings for documentation of torture and ill-treatment





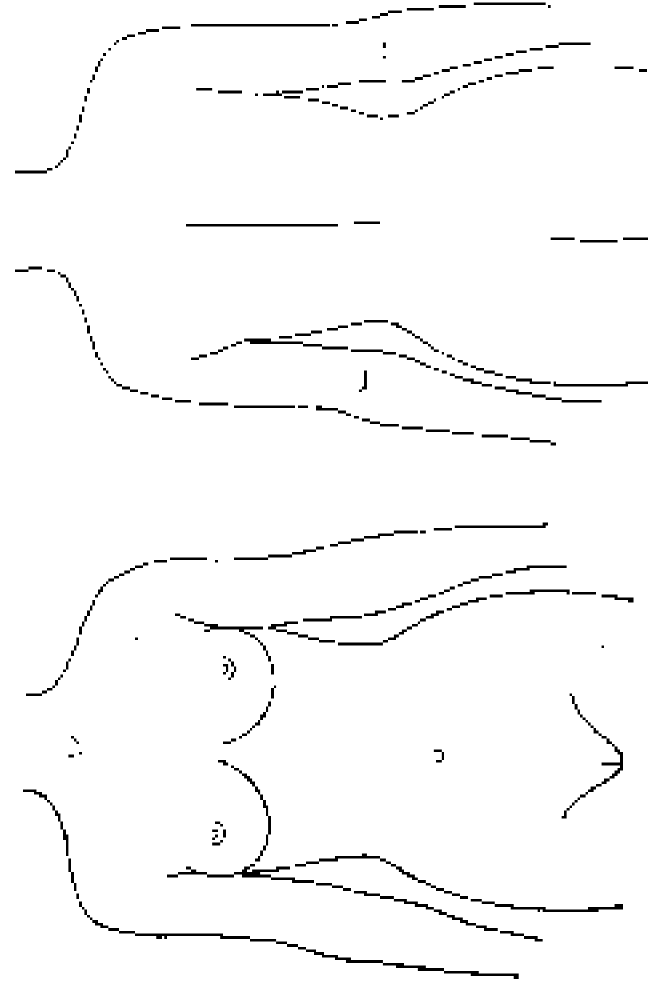
PERINEUM—FEMALE



Name ______________________ Case No ____________

Date ____________

THORACIC ABDOMINAL FEMALE—ANTERIOR AND POSTERIOR VIEWS



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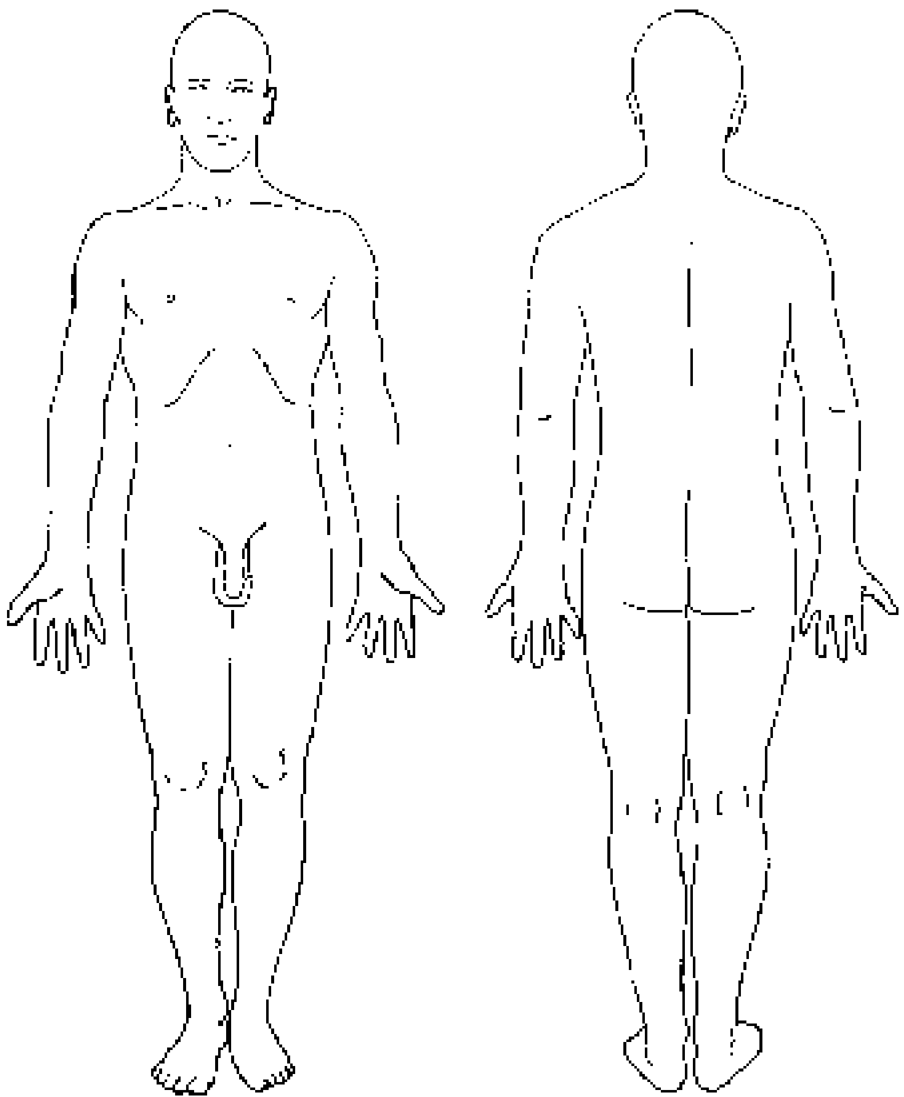
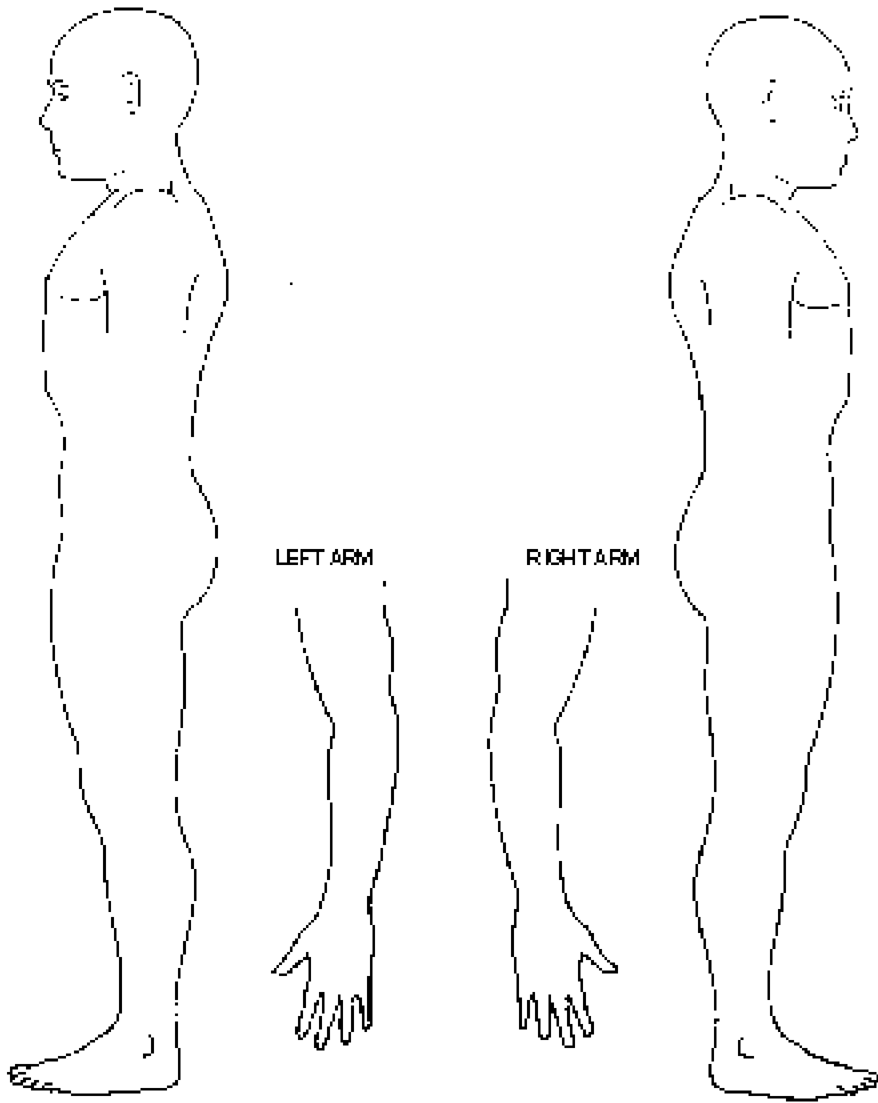
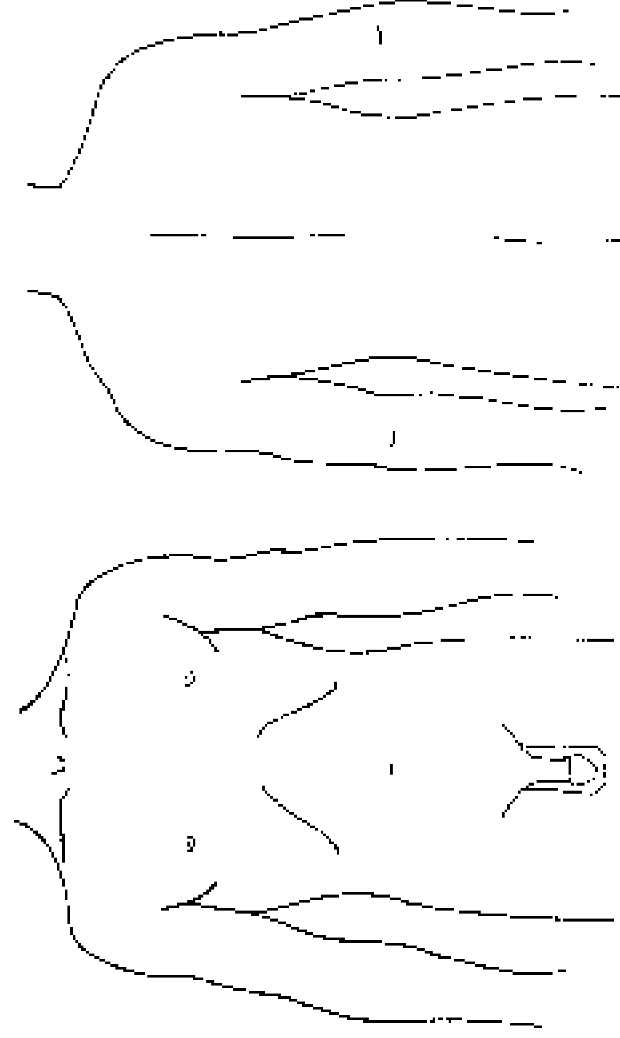

FULL BODY MALE—ANTERIOR AND POSTERIOR VIEWS (VENTRAL AND DORSAL)
Name
Case No
Date


FULL BODY, MALE—LATERAL VIEW
LEFT ARM
RIGHT ARM
Name
Case No
Date

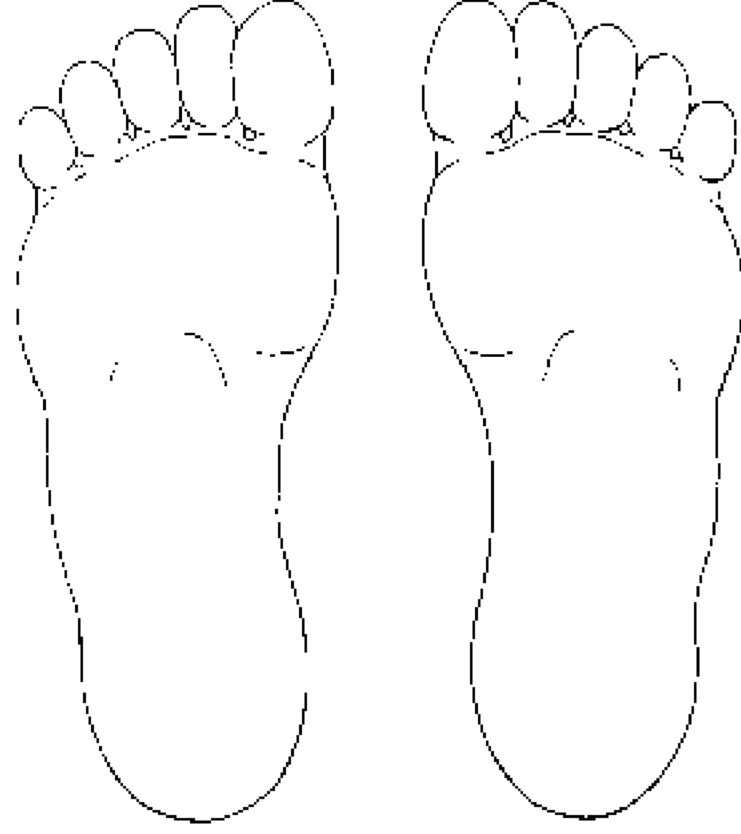
THORACIC ABDOMINAL MALE—ANTERIOR AND POSTERIOR VIEWS



Name ______________________ Case No ______________

Date ______________

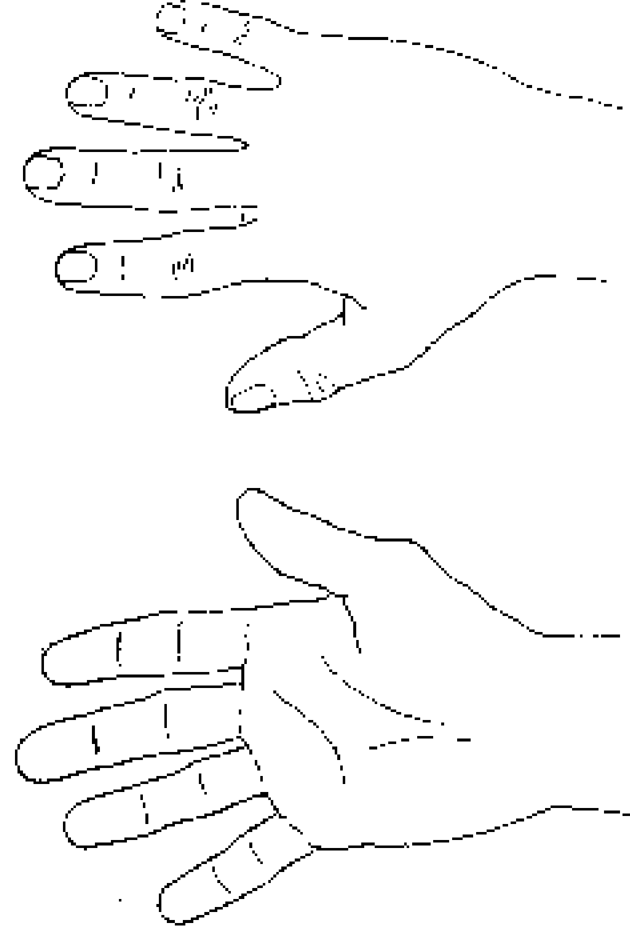
FEET—LEFT AND RIGHT PLANTAR SURFACES



Name ______________________ Case No ______________

Date ______________

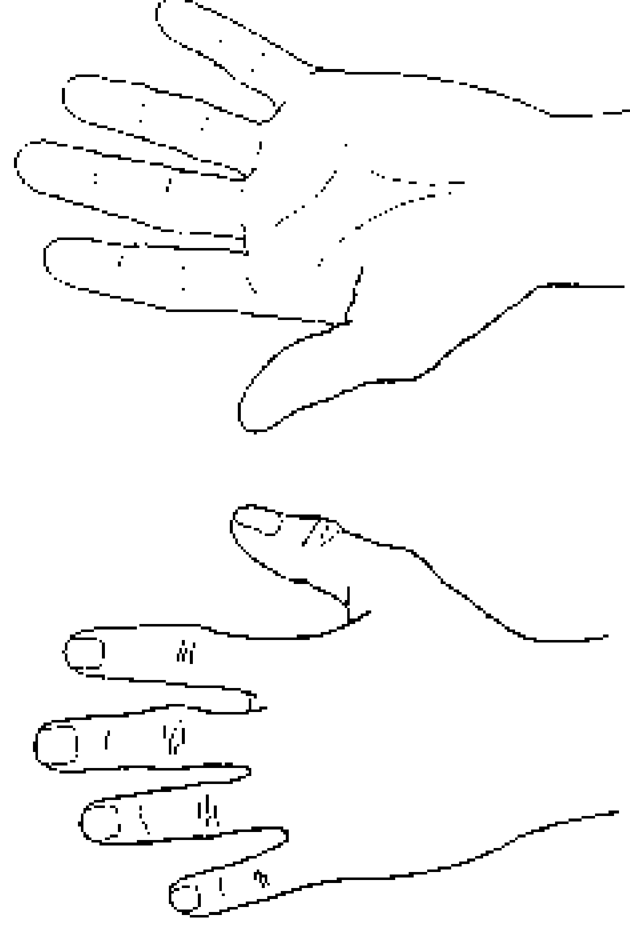
RIGHT HAND—PALMAR AND DORSAL



Name ____________________ Case No __________

Date __________

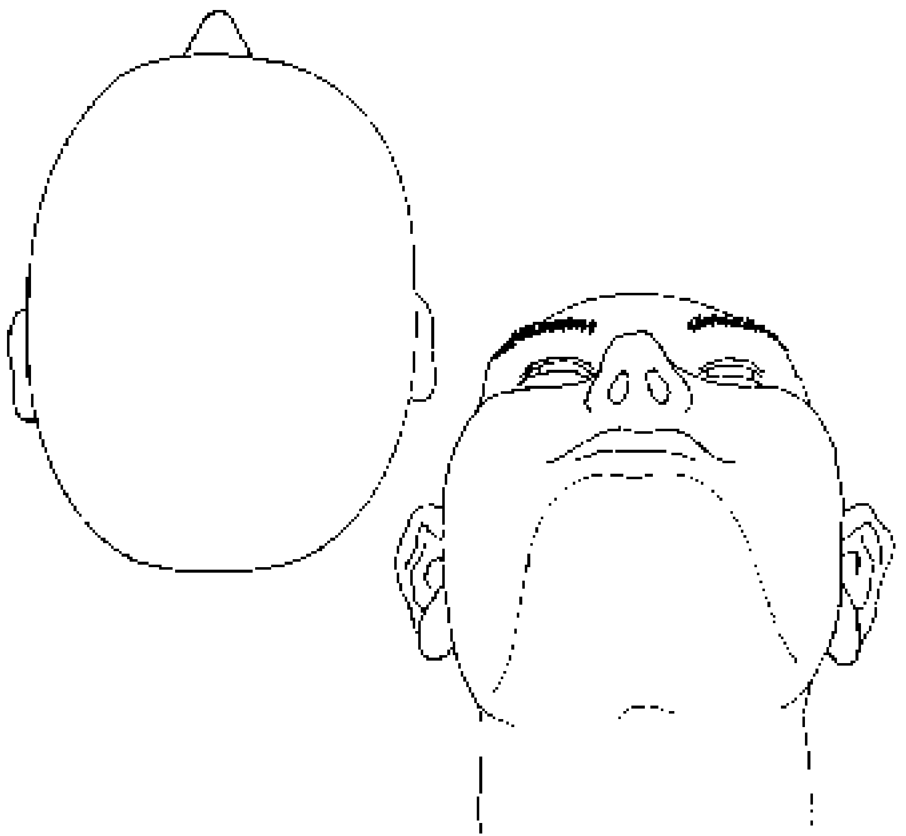
LEFT HAND—PALMAR AND DORSAL



Name ____________________ Case No __________

Date __________

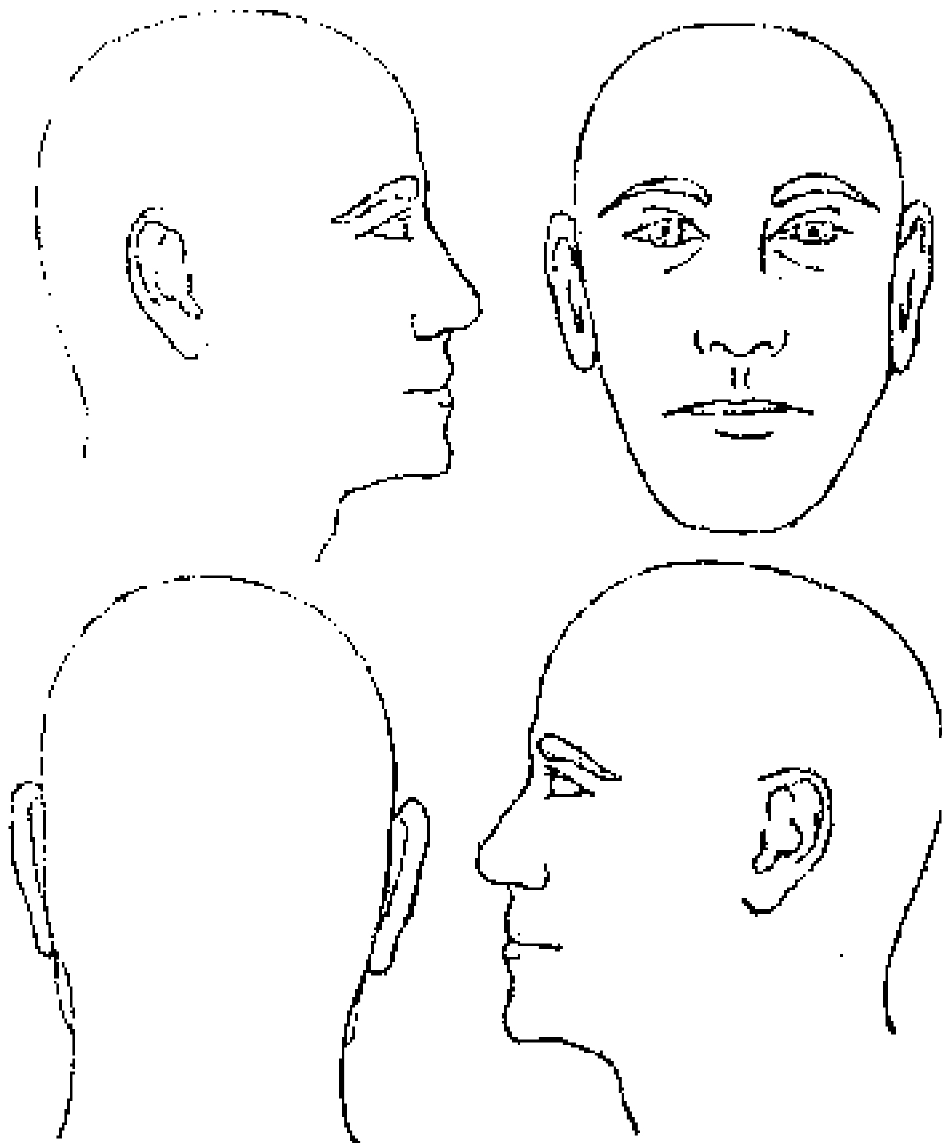
HEAD—SURFACE AND SKELETAL ANATOMY SUPERIOR VIEW—INFERIOR VIEW OF NECK



Name ______________ Case No ______________

Date ______________

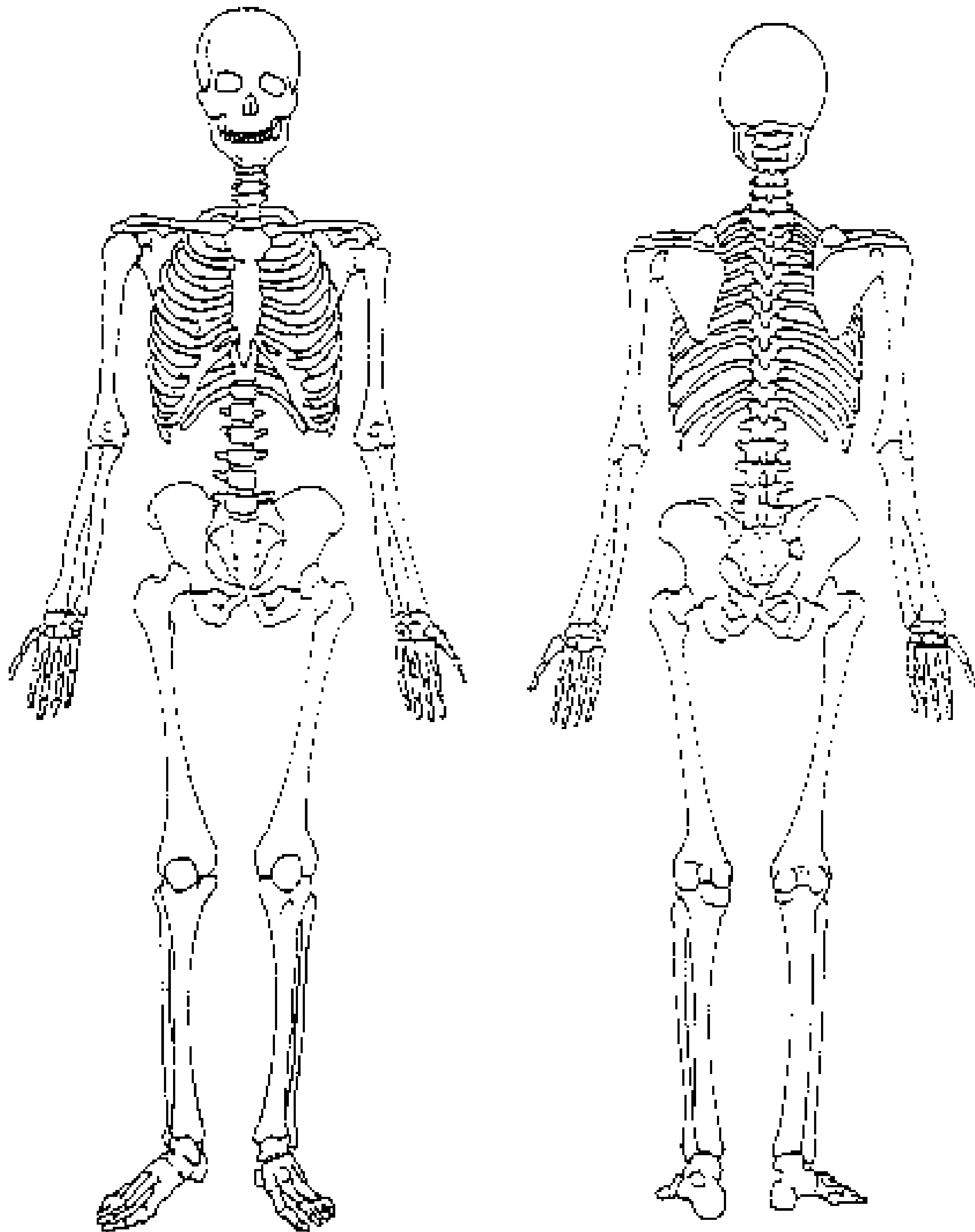
HEAD—SURFACE AND SKELETAL ANATOMY, LATERAL VIEW



Name ______________ Case No ______________

Date ______________

SKELETON—ANTERIOR AND POSTERIOR VIEWS



Name ______________________

Case No. ______________________

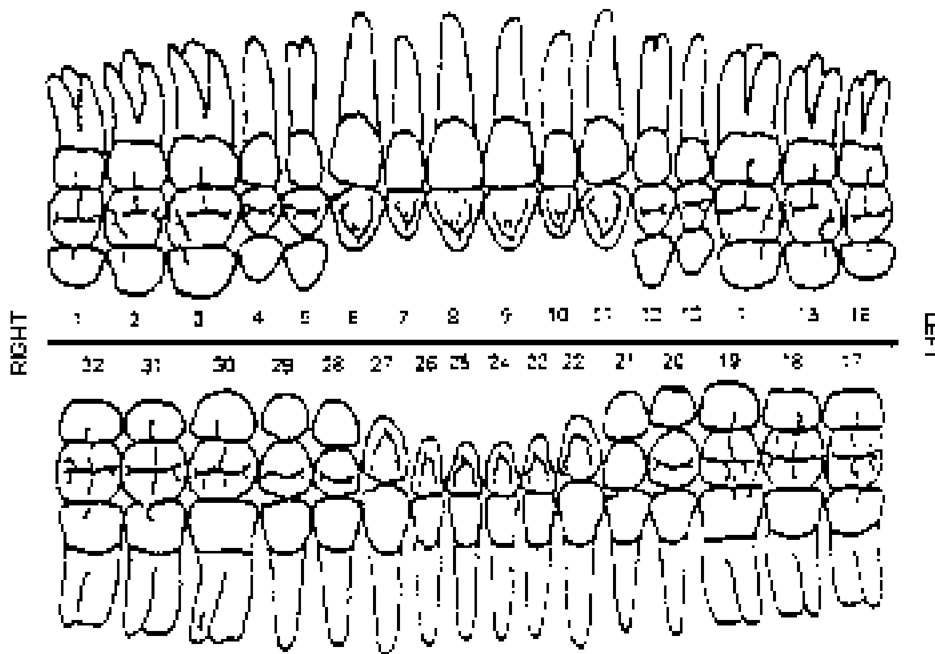
Date ______________________

MARK ALL EXISTING RESTORATIONS AND MISSING TEETH ON THIS CHART

Estimated Age ______

Sex ______

Race ______



Circle descriptive term

Prosthetic Appliances Present

Maxilla

- Full Denture
- Partial Denture
- Fixed Bridge

Mandible

- Full Denture
- Partial Denture
- Fixed Bridge

Describe completely all Prosthetic Appliances or Fixed Bridges ______________________

____

____

____

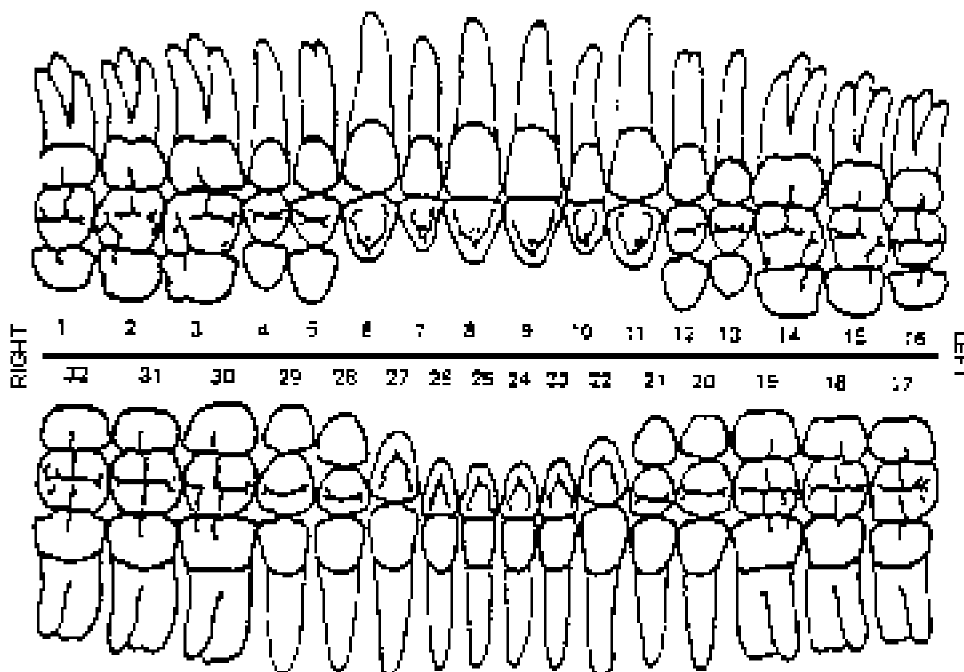
____

Stains on teeth

- Slight
- Moderate
- Severe

MARK ALL CARIES ON THIS CHART

Outline all caries and "X" out all missing teeth



Circle descriptive term

Relationship

- Normal
- Undershot
- Overbite

Periodontal Condition

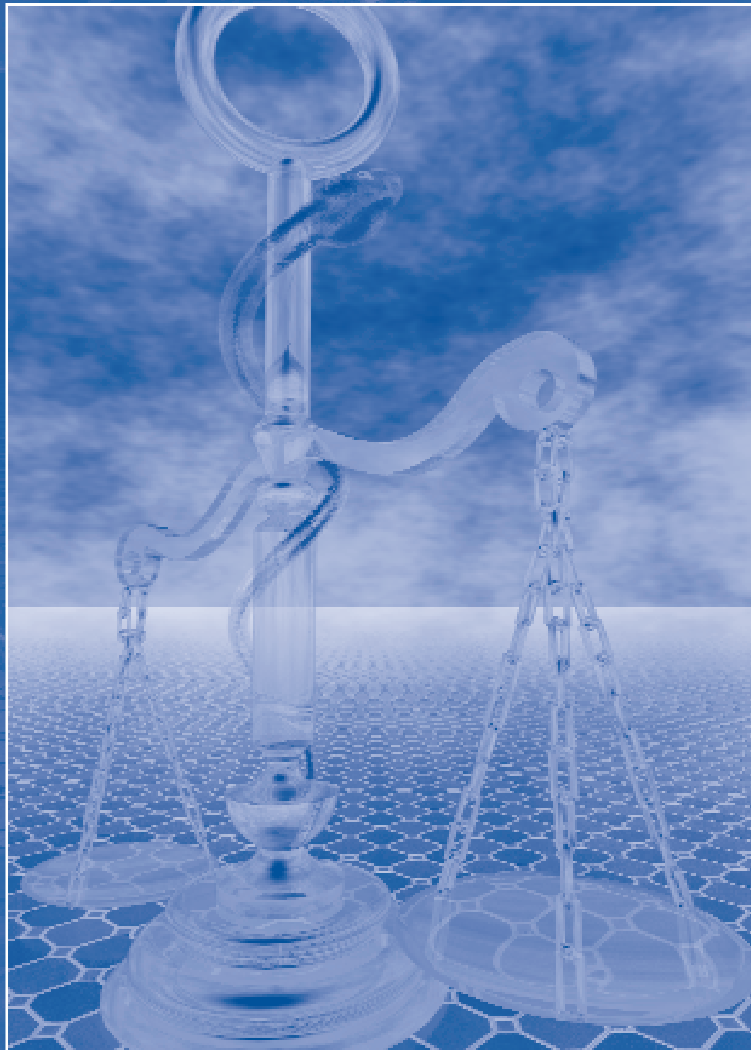
- Excellent
- Average
- Poor

Calculus

- Slight
- Moderate
- Severe

This Handbook provides detailed guidance for medical documentation and investigation of torture. The Handbook is designed to assist all health professionals such as doctors, nurses and other clinicians, working with individuals who have suffered from torture and other ill-treatment. It raises awareness of the existence and nature of torture and its prohibition under international law, and gives advice on how to recognise and document torture, particularly for those health professionals with little or no forensic expertise. Following an explanation of the legal and ethical principles involved, it gives practical advice on gathering evidence and compiling reports. Guidance is supplied on how to conduct interviews with individuals who have been subjected to torture, and there is a detailed and extensive explanation of the physical and psychological effects of torture and other ill-treatment, and how to document them.

The Handbook is part of a series of publications produced by the Human Rights Centre at the University of Essex, and should be seen as complementary to its predecessors. These include *The Torture Reporting Handbook*; *Combating Torture: A Manual for Judges and Prosecutors*; and *Reporting Killings as Human Rights Violations*.



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